Health at a Glance

HEALTH

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OECD

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ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

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FOREWORD

Good health is essential for people to flourish as citizens, family members, workers and consumers. Aided by technological advances, health systems are of crucial importance in promoting good health and in curing, or mitigating, the consequences of disease. The benefits that modern health systems provide cannot be achieved without cost. Health expenditure has been absorbing an increasing proportion of national income and health systems now represent the largest service industry in many OECD countries.

There is much interest among policy makers in scrutinizing variations in the growth, efficiency and equity of health systems. In particular, there is a growing demand for evidence that can be derived for health policy from international comparisons across health systems. The OECD has developed a large international database on health and health system data for the OECD area. For many years that data has been published on a CD-ROM (*OECD Health Data*). The main aim of this publication – *Health at a Glance* – is to display some of the key indicators from *OECD Health Data* in an easily accessible, printed form. Hence, this document makes extensive use of charts, graphs and tables. A subsidiary aim is to draw attention to some of the messages for policy which can be derived from *OECD Health Data*.

Health at a Glance was prepared by the Health Policy Unit at the OECD. The main authors were Jeremy Hurst and Gaetan Lafortune. The statistical analysis and preparation of the charts and tables were carried out chiefly by Andrew Devlin, who also managed the project. Jan Bennett, Stéphane Jacobzone, Zeynep Or and Andy Thompson all made contributions to particular sections. Secretarial support was given by Marianne Scarborough. Editorial comments and advice were provided by Manfred Huber and Peter Scherer. All of these people owe a debt to Jean Pierre Poullier, since it was he who created *OECD Health Data*.

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ACKNOWLEDGEMENTS

The OECD acknowledges gratefully the effort made by the national correspondents in Member countries over many years to report their health statistics to *OECD Health Data* and to other international agencies with whom OECD co-operates. It also acknowledges gratefully the helpful comments which many of our correspondents offered on an earlier version of this document.

Particular thanks go to the United States Health Care Financing Administration, which has given financial support to the collection of *OECD Health Data* over many years.

Thanks are due also to the Australian Institute of Health and Welfare for their publication *International Health: How Australia Compares*. *Health at a Glance* was inspired by their report.

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INTRODUCTION

Aims of this report

Health systems are of growing size and importance in OECD countries. They have contributed to the steady improvements in health status that have been enjoyed in past decades in OECD countries. At the same time they have consumed a growing share of national resources.

Health at a Glance presents in printed form some of the key indicators found in *OECD Health Data 2001*. Its main aim is to display in an easily accessible form some of the variations and trends found in major health variables across OECD countries.

Subsidiary objectives of this publication are:

- to present health expenditure data in real terms over time and adjusted for different currencies (see Annex 2) across countries;
- to draw attention to associations between the indicators which may be interesting for policy purposes;
- to place the OECD definitions of variables alongside the data and to report on significant departures of the data from these definitions where such departures have been reported to the Secretariat;
- to encourage improvement in the availability and comparability of data.

Relationship of this report to *OECD Health Data*

Since this publication is the companion to *OECD Health Data*, which is released on a CD-ROM, the indicators presented here are arranged in a similar order as they appear in *OECD Health Data*. However, the indicators on "Expenditure on health", "Financing and remuneration", "Social protection" and the "Pharmaceutical market" in the CD-ROM have been combined into one section on "Expenditure on health" in this publication. We have also collected indicators on "Demographic references" and "Economic references" into one section on "Demographic and economic context". As a result, the six sections in this report correspond to the ten parts in *OECD Health Data* as follows:

Health at a Glance	*OECD Health Data*
Section 1: Health status	Part 1: Health status
Section 2: Health care resources	Part 2: Health care resources
Section 3: Health care utilisation	Part 3: Health care utilisation
Section 4: Expenditure on health	Part 4: Expenditure on health Part 5: Financing and remuneration Part 6: Social protection Part 7: Pharmaceutical market
Section 5: Non medical determinants of health	Part 8: Non-medical determinants of health
Section 6: Demographic and economic context	Part 9: Demographic references Part 10: Economic references

More details on the content of *OECD Health Data 2001* can be found in Annex 3. A full list of the indicators included in the database is available at *www.oecd.org/els/health/*.

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Sources

All data come from the CD-ROM, *OECD Health Data 2001,* unless otherwise stated. Data contained within that database originate from a variety of sources, with the bulk of it coming directly from Member countries' statistical agencies. Some of the data have been provided by other international agencies. This includes data on life expectancy and infant mortality which, for European countries, have been extracted from the Eurostat *New Cronos* database. Crude data on premature mortality and causes of mortality for all countries have come from WHO-Geneva (*World Health Statistics Annual*), with the age-standardised death rates being calculated by the OECD Secretariat based on the OECD population structure. Some data on childhood immunisations have come from the WHO-Europe *Health for All* database. For further details on sources and methods, please consult *OECD Health Data 2001*.

Indicators chosen

The indicators presented in *Health at a Glance* are derived largely from the "core indicators" in *OECD Health Data*. That is a subset of indicators which the Secretariat considers to be of particular interest from a health policy point of view. Also, the "core indicators" are often those most requested by users of the database. An additional criterion for an indicator to be included in *Health at a Glance* is whether there are sufficient data to justify making an "OECD" comparison. As a general rule, only those indicators for which there were data available for at least half of the 30 OECD countries have been included.

Text and charts

Each indicator is usually presented over two pages, which display:

- a few paragraphs of commentary relating to the indicator, including the preferred international definition of the indicator and a note on significant national variations from that definition which might affect data comparability;
- one or two bar charts bringing out differences between countries in the indicator in the most recent year available;
- one or two charts showing trends over time in the indicator or relationships with other variables. In the case of trends over time, the general rule has been to show the countries with the highest and lowest rates of change (to demonstrate the range) together with the unweighted average, for countries with complete and unbroken data series.

Tables

All tables are found in Annex 1 at the end of this report. In most tables, individual country data, averages for groups of countries and annual growth rates, are presented.

Averages have been calculated for all those countries for which data are available over the complete time period, with interpolation of up to two years and extrapolation of up to one year of data for any country with missing data. Such interpolation and extrapolation is not shown in the tables but it does enter into the calculation of the averages. This procedure allows additional countries to be included in the averages.

Where all 30 countries are included in the average, it is called the "OECD average". However, in most cases, data are only available for a subset of OECD countries. In such cases, the averages are labelled the "x-country average", reflecting the size of the subset.

All averages are unweighted except where otherwise stated. The rationale for using unweighted averages is that for many indicators it is appropriate from a health policy perspective, to treat each Member country's experience as one observation, carrying equal weight to any other observation. However, in the chapters on health status and on the demographic and economic context, population-weighted averages have also been presented. That is because there is interest in capturing vital statistics for the OECD population as a whole, with appropriate weighting for the very different sizes of OECD populations.

Growth rates are usually annual average growth rates, unless otherwise stated.

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Data limitations

It is important to note that variations in the indicators across countries and through time may reflect variations in the definitions of variables as well as variations in the phenomena being observed. In other words, despite growing agreement about international definitions of health variables, and growing adherence to these definitions among countries when reporting their data, there remain many definitional divergences and changes in what is reported. Major divergences and changes which have been brought to the attention of the Secretariat are reported in the text, below. However, it is not possible to guarantee that the Secretariat has picked up all those which are of significance. For this reason, care should be exercised before drawing conclusions about variations and trends in the underlying phenomena, especially for comparisons across countries. Work is continuing on harmonising international reporting of health data. Meanwhile, for fuller explanations of the definitions of individual variables for each country, readers are encouraged to consult the "Sources and Methods" section of *OECD Health Data*, either on the CD-ROM or on the Internet. To do so, go to the OECD health web site at *www.oecd.org/els/health/*, and click on "Definitions, sources and methods" from the main menu of the *OECD Health Data 2001* web page.

Particular caution should be exercised when considering time trends for Germany. Data for Germany up to 1990 generally refers to west Germany and data from 1991 refers to unified Germany.

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1. HEALTH STATUS

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Life expectancy at birth

Life expectancy at birth is one of the oldest and most widely available measures of the health status of a population at the national level. It is an indicator based only on mortality data.

There have been remarkable gains in life expectancy in almost all OECD countries over the last four decades. These gains have been made possible by rising standards of living, public health interventions and progress in medical care. Improvements in life expectancy at birth reflect a decline in mortality rates at all ages, including a sharp reduction in infant mortality (see the infant mortality section) and higher survival rates at older ages (see next section on life expectancy at age 65).

From 1960 to 1998, the average (unweighted) life expectancy at birth across all OECD countries has increased by 7½ years for men (from 66.2 to 73.7 years) and by almost 9 years for women (from 70.9 to 79.8 years) (Charts 1.3 and 1.4, and Tables 1.1 and 1.2). The greater gains in longevity for women over the last four decades have widened the gender gap from an average of 4.7 years in 1960 to 6.1 years by the end of the 1990s. This long-term trend, however, covers two different periods in many countries: the 1960s and the 1970s, when the gender gap in longevity widened markedly in several countries, and the period since 1980 which has seen a reduction in the gender gap in many countries, due to the rapid gains in men's life expectancy over the last two decades. In 1998, differences in male/female life expectancy among OECD countries ranged from a high of 9.1 years in Hungary to a low of 4.5 years in Iceland.

At the end of the 1990s, life expectancy at birth was the highest in Japan, with 77.2 years for men and 84 years for women (Charts 1.1 and 1.2). Other countries where men enjoyed relatively long life expectancy include Iceland, Sweden, Switzerland, Australia and Canada, while for women life expectancy is relatively high in Switzerland, France, Spain, Sweden and Italy.

Although the gains in life span were not uniform across countries, there has generally been a strong convergence towards the OECD average. This is particularly the case for countries such as Turkey, Mexico and Korea, which started with relatively low levels of life expectancy 40 years ago. In Turkey, while life expectancy remains low for both men and women in comparison with other OECD countries, there have been gains of more than 20 years since 1960.

On the other hand, some Central and Eastern European countries (*e.g.* Hungary and Slovakia) have experienced much lower gains in life expectancy in recent decades. In Hungary, the life expectancy of men has remained more or less unchanged between 1960 and 1998. As a result, it is now the lowest amongst OECD countries. While female life expectancy in Hungary is also relatively low, it has been rising over time. Unhealthy lifestyles, such as poor diet and excessive alcohol and tobacco consumption have been suggested as the main factors explaining this lack of progress in men's life expectancy in Hungary (OECD, 1999).

Definition and deviations

Life expectancy at birth is the average number of years a person can be expected to live from the time he or she is born, assuming that age-specific mortality levels remain constant.

Each country calculates its own life expectancy, using life table methodologies that can vary somewhat. These differences in methodology can affect the comparability of the life expectancy measures presented here, as different life table methods can change a nation's life expectancy by a fraction of a year.

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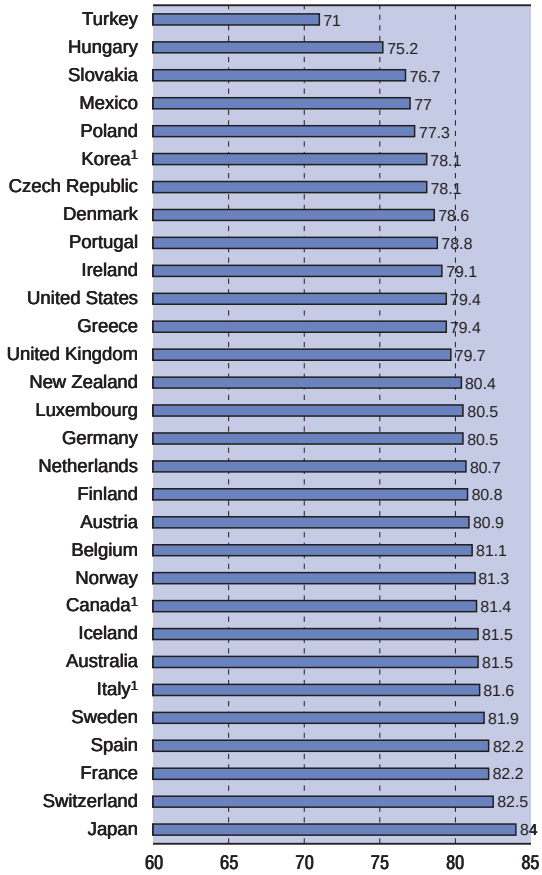
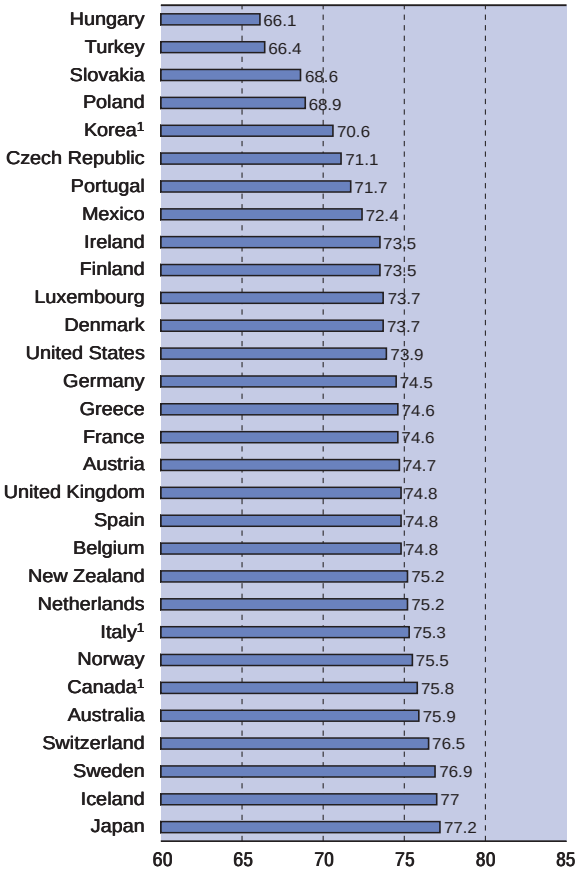
Chart 1.1. **Female life expectancy at birth, 1998**



1. 1997 data.

Chart 1.2. **Male life expectancy at birth, 1998**



1. 1997 data.

Chart 1.3. **Female life expectancy at birth, 1960-1998**

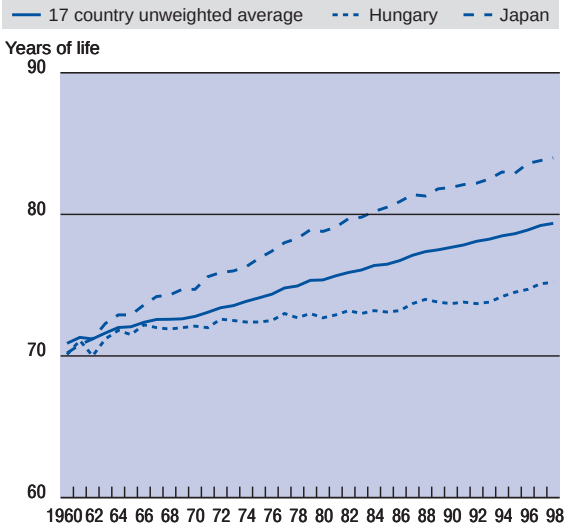
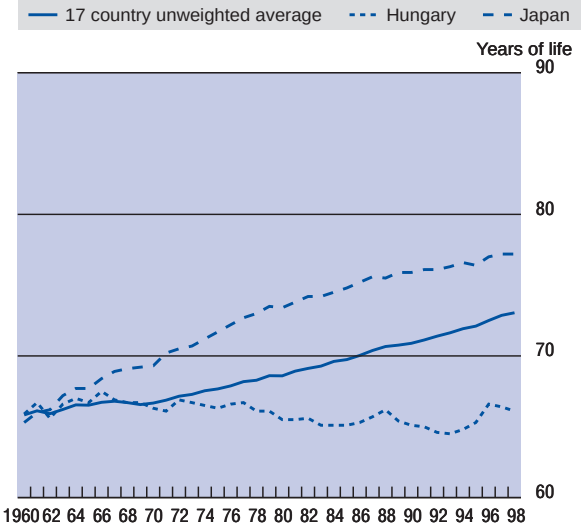


Chart 1.4. **Male life expectancy at birth, 1960-1998**



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Life expectancy at age 65

Life expectancy at age 65 is a broad, mortality-based indicator of the health of elderly people. It has been steadily improving over the last few decades in most OECD countries. Far from showing signs of reaching a limit, the life expectancy for people at age 65 has been increasing, on average, at least as fast for women or even faster for men since 1980 compared with the period from 1960 to 1980 (Charts 1.7 and 1.8, and Tables 1.3 and 1.4). These gains in longevity at old age, combined with the reduction in fertility rates, have led to a steadily rising proportion of older persons in OECD countries (see Section 6, indicator "Share of the population aged 65 and over").

From 1960 to 1998, the average (unweighted) life expectancy at age 65 for the 21 OECD countries with complete time series has increased by 4.1 years for women and 2.7 years for men, thereby increasing the gender gap from 2.2 to 3.6 years. By the end of the 1990s, people at age 65 in these 21 OECD countries could expect to live, on average, an additional 19 years for women and 15.4 years for men.

Increases in life expectancy at age 65 were particularly strong in Japan, with gains of almost 8 years for women and 5½ years for men between 1960 and 1998. As a result, Japanese women now enjoy the longest life expectancy at age 65, with an expectation of 22 additional years of life, while Japanese men come second after Mexican males, with 17.1 additional years (Charts 1.5 and 1.6). It is important to keep in mind that differences in methodologies used to calculate life expectancy may affect national estimates by a fraction of a year.

In general, the factors that have been behind improvements in life expectancy at birth also explain the steady gains in life expectancy at age 65. These include rising standards of living, improved working conditions, and advances in medical care and public health interventions. In many countries, improved life expectancy at age 65 has been driven mainly by a reduction in mortality from cardiovascular diseases (Australian Institute of Health and Welfare, 1998*a*; World Health Organisation and Ministero della Sanità Repubblica Italiana, 1999).

As the life expectancy of people at older ages increases, the quality of life of the elderly population becomes an important policy concern in many countries. There is some evidence indicating that life expectancy without severe disability at age 65 has increased in most OECD countries for which data are available (with the exception of Australia), thereby suggesting that elderly people live in better functional health than in the past (Jacobzone *et al*., 2000*a*).

Definition and deviations

Life expectancy at age 65 is the average number of years which a person at that age can be expected to live, assuming that age-specific mortality levels remain constant.

The same caution about national sources applies as for total life expectancy.

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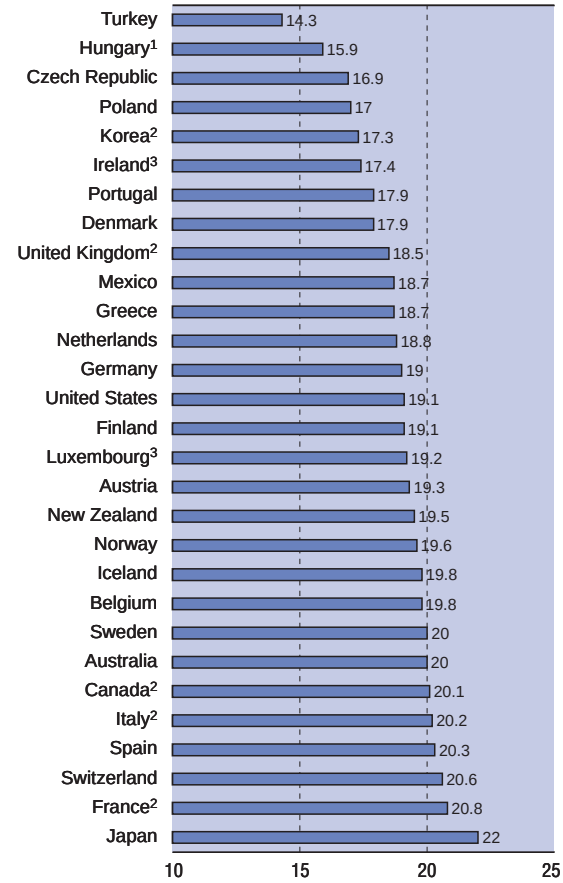
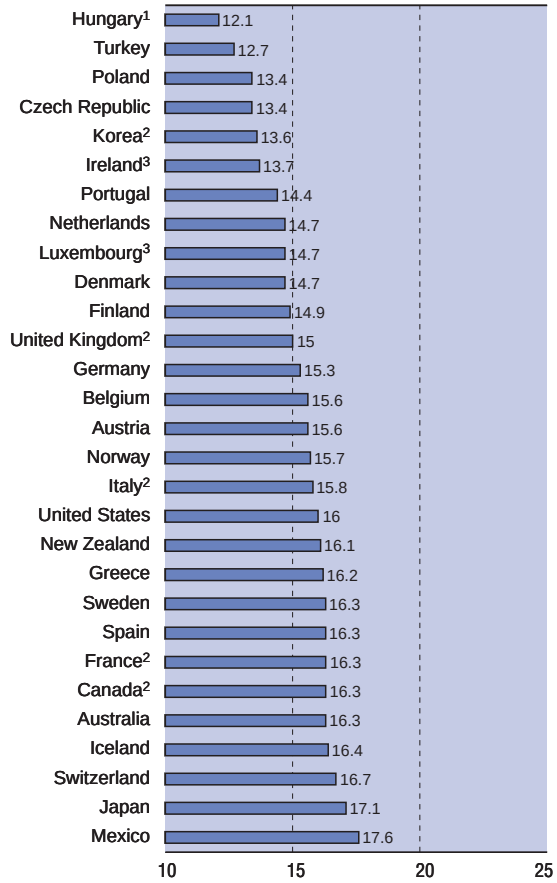
Chart 1.5. **Female life expectancy at age 65, 1998**



1. 1996 data. 2. 1997 data. 3. 1995 data.

Chart 1.6. **Male life expectancy at age 65, 1998**



1. 1996 data. 2. 1997 data. 3. 1995 data.

Chart 1.7. **Female life expectancy at age 65, 1960-1998**

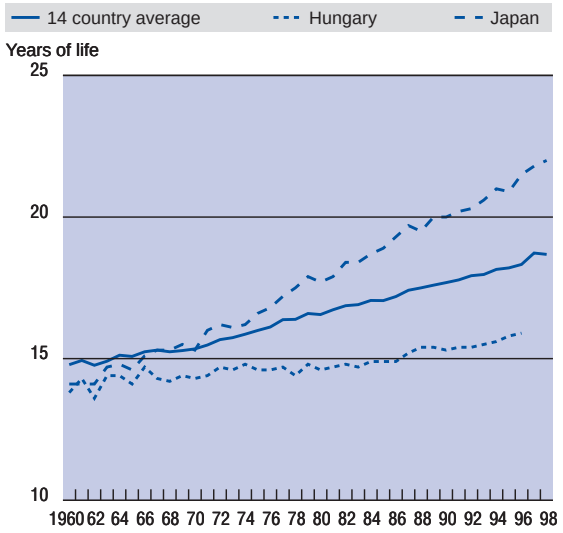
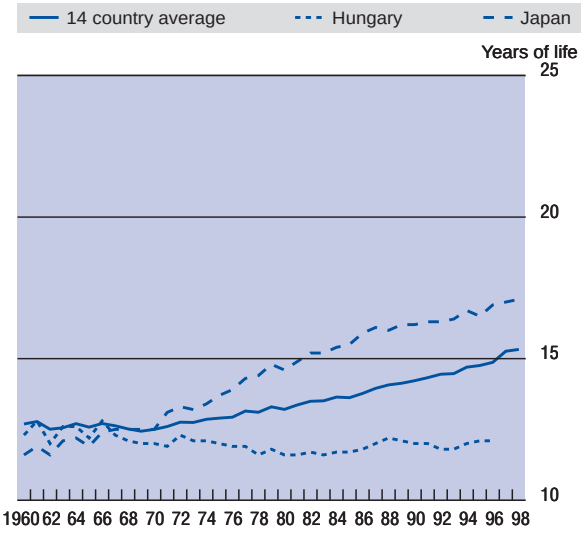


Chart 1.8. **Male life expectancy at age 65, 1960-1998**



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Infant mortality

Infant mortality rates are one of the most widely used indicators in international comparisons to judge the effect of economic and social conditions on human health. They are an important indicator of the health of both pregnant women and newborns.

Over the last four decades, infant mortality has declined steadily in all OECD countries (Charts 1.10 and 1.11, and Table 1.5). Infant mortality rates were on average (unweighted) more than 5 times higher in 1960 than they were by the end of the 1990s. The decline in infant mortality has been particularly impressive in Portugal, as it came down from 77.5 deaths per 1 000 children in 1960 – twice as high as the OECD average at that time – to 5.5 per 1 000 by 1999 – lower than the OECD average now (Chart 1.11). Reductions in infant mortality rates have also been remarkable in Japan in the 1960s, in Korea and Mexico in the 1970s, and in Turkey in the 1980s.

Although progress has been achieved in all countries, and disparities across countries are narrowing, there continue to be significant variations in levels of infant mortality among OECD countries (Chart 1.9). In 1999, the countries with the lowest rates of infant mortality were Iceland, Sweden, Japan, Finland and Norway, with less than 4 deaths per 1 000 live births.

Infant mortality rates are related to a number of social and economic factors, including the average income level in a country, the income distribution and the availability and access to health services. Higher average income per capita is generally related to lower infant mortality rates, although this relationship tends to be less pronounced in developed countries (Chart 1.12). It is likely that the higher health expenditure per capita which tends to be associated with higher GDP per capita plays a role in explaining the relationship. Infant mortality rates have also been shown to be influenced by the distribution of income within societies. Countries with a more equal distribution of a certain level of income tend to have lower infant mortality rates than more unequal societies (Hales *et al.*, 1999). Cross-country variations in infant mortality rates have also been associated more specifically with variations in the availability of certain health care resources, such as the number of doctors and the number of hospital beds (Grubaugh and Santerre, 1994).

Between 40% and two-thirds of infant mortality in OECD countries are deaths occurring during the first week of life (early neonatal mortality). After the first week of life, the main causes of infant mortality in most countries are congenital anomalies and sudden infant death syndrome (Australian Institute of Health and Welfare, 1998*b*).

Definition

Infant mortality is the number of deaths of children under one year of age expressed per 1 000 live births.

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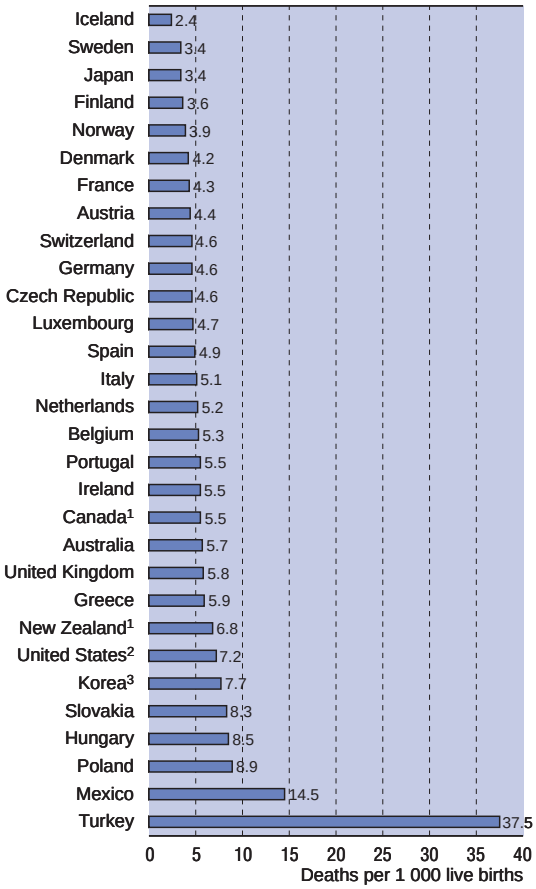
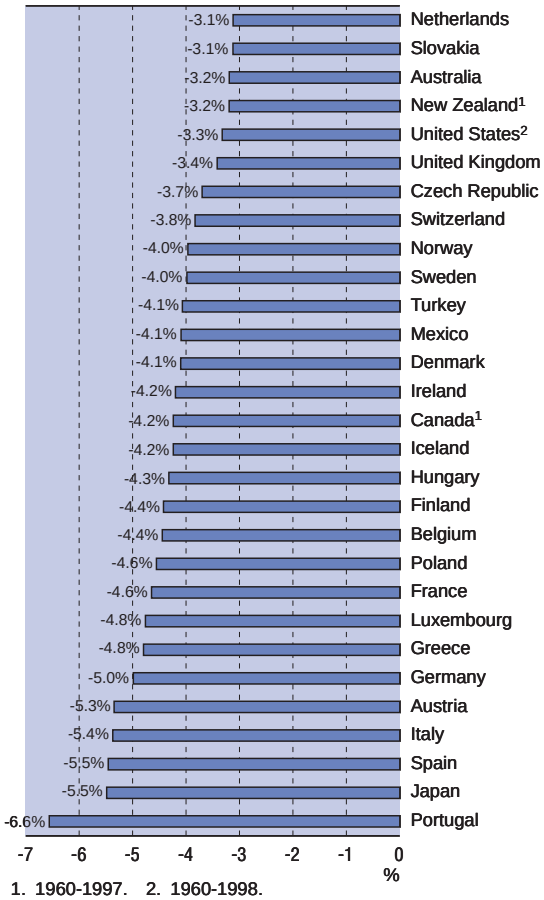
Chart 1.9. **Infant mortality in OECD countries, 1999**



1. 1997 data. 2. 1998 data. 3. 1996 data.

Chart 1.10. **Average annual decline in infant mortality rates, 1960-1999**



1. 1960-1997. 2. 1960-1998.

Chart 1.11. **Infant mortality, 1960-1999**

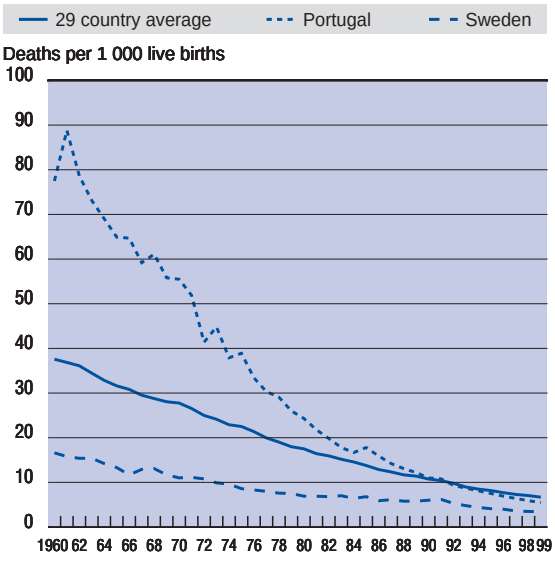
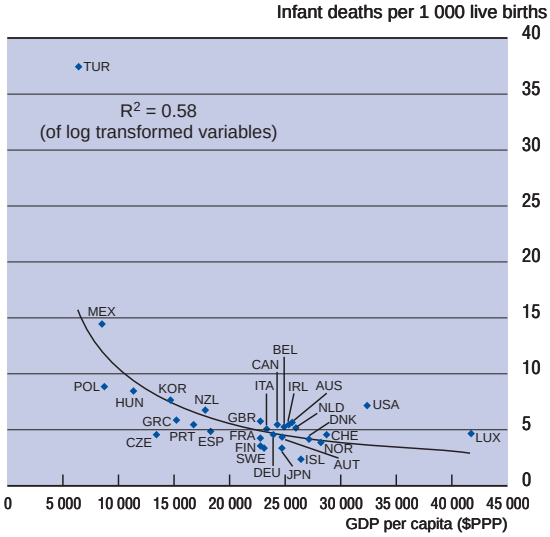


Chart 1.12. **Infant mortality and GDP per capita ($PPP), 1999**



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Premature mortality

Premature mortality is measured by the total potential years of life lost (PYLL) due to deaths prior to age 70 given current age-specific death rates. As a measure, it is weighted towards deaths amongst the young: a death at 5 years of age represents 65 PYLL; one at 60 years of age only 10.

In the last four decades, premature mortality, so measured, has on average more than halved across OECD countries (Tables 1.6 and 1.7). While the decline has been more rapid for females than for males between 1960 and 1990, since 1990 PYLL has on average been declining at the same rate for men and women.

In 1997 (or latest year available), death rates of men and women under 70 years of age were still relatively high in Mexico, Hungary, Poland and Slovakia (Charts 1.13 and 1.14). In the United States as well, premature mortality was still 20% higher for men and 32% higher for women than the (unweighted) average for the 22 countries with complete time series. Japan, Sweden and Iceland registered the lowest level of premature mortality for both males and females.

Charts 1.15 and 1.16 show the causes of death that contributed the most to premature mortality in OECD countries in 1995. Cancers (malignant neoplasms) and external causes of death (including car accidents) accounted for almost half of premature deaths for both men and women. While the main causes of premature deaths are generally similar between genders, there are significant differences in rankings and the numbers of premature deaths associated with each cause. For women, the main causes of premature mortality are cancers (29%), followed by external causes (18%), and circulatory diseases (14%). For men, it is external factors such as car accidents and violence which represent the most important source of premature death (30%), followed by cancers (19%) and circulatory diseases (18%).

An investigation of the determinants of premature mortality using the extensive list of explanatory variables and the long time series that are now available in *OECD Health Data* suggests that a large number of medical and non-medical factors are involved (Or, 2000*a*). Everything else being equal, higher health expenditure per capita is associated with lower premature mortality for women. There is no significant effect for men, perhaps because a high proportion of premature mortality among males is due to accidents and violence. Certain non-medical determinants of health are however the most important factors affecting PYLL. Occupational status is the most important factor, followed by GDP per capita, with an increase in both the proportion of non-manual workers and GDP per capita associated with a reduction in PYLL. By contrast, and as expected, pollution and the consumption of alcohol, tobacco and fat are unfavourable for PYLL. That suggests further scope for the promotion of healthy lifestyles in OECD countries (see Section 5). A more recent study indicates that higher numbers of doctors are also associated with reduced premature mortality, both for women and for men (Or, 2000*b*).

Definition

Premature mortality is measured by the indicator “potential years of life lost” (PYLL) under age 70. This indicator adds up potential years of life lost prior to age 70, given current age-specific death rates (for example, a death at 5 years of age is counted as 65 years of PYLL). The indicator is expressed per 100 000 females and males.

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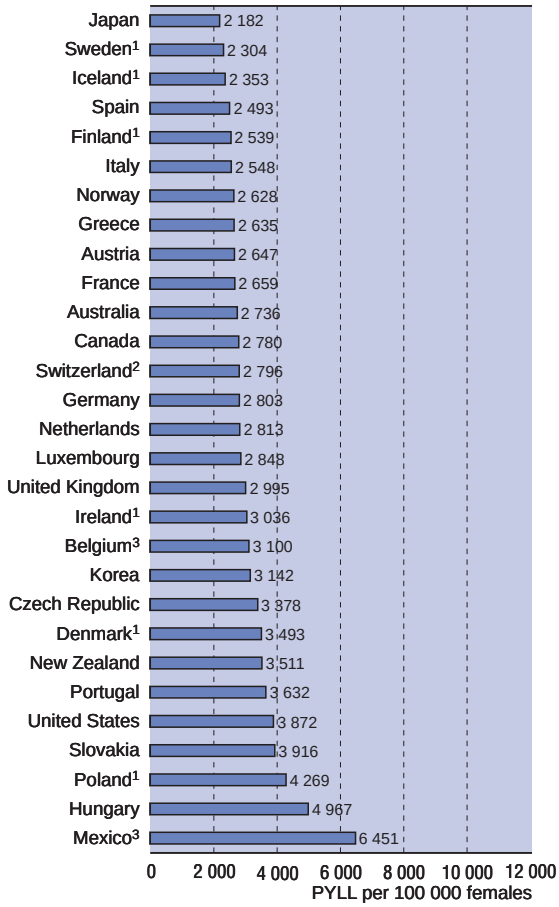
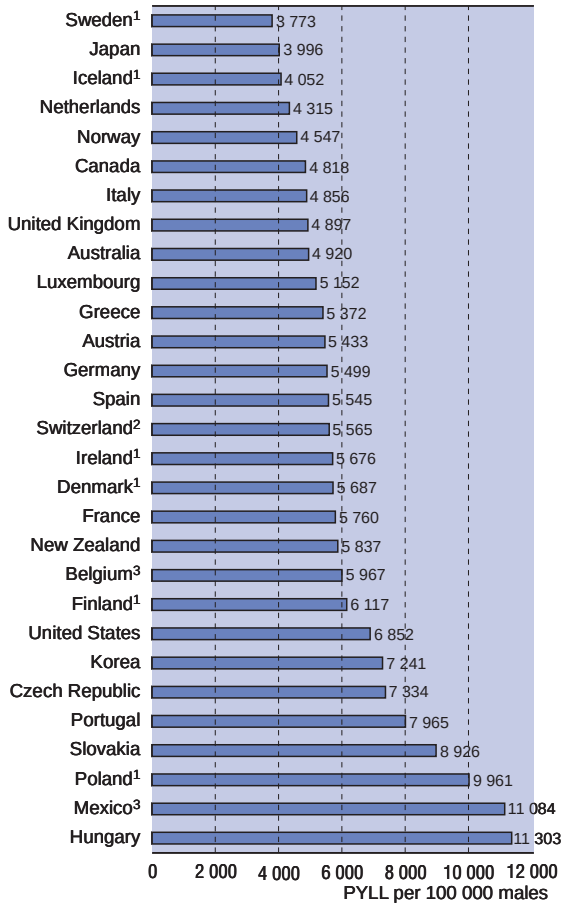
Chart 1.13. **Female PYLL before age 70, all causes, 1997**



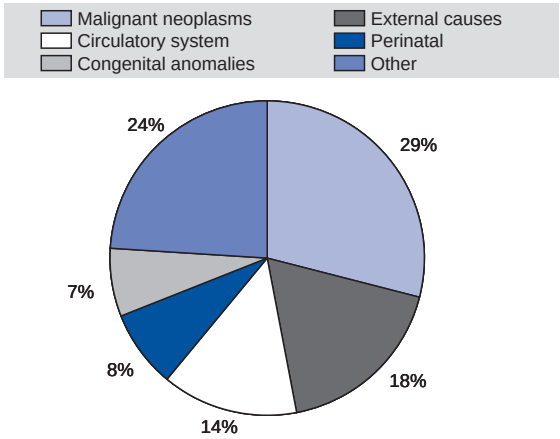
1. 1996 data. 2. 1994 data. 3. 1995 data.

Chart 1.14. **Male PYLL before age 70, all causes, 1997**



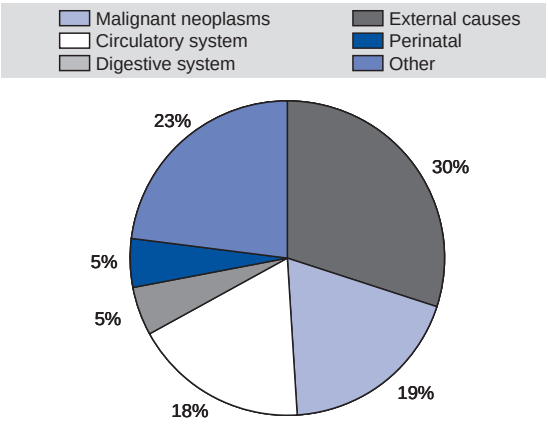
1. 1996 data. 2. 1994 data. 3. 1995 data.

Chart 1.15. **Leading causes of female premature mortality, 27 country average,[1] 1995**



1. Includes all OECD countries except Iceland, Switzerland and Turkey.

Chart 1.16. **Leading causes of male premature mortality, 27 country average,[1] 1995**



1. Includes all OECD countries except Iceland, Switzerland and Turkey.

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Self-reported general health

A major challenge is to complement the traditional emphasis on mortality-based measures of health status with a set of reliable morbidity measures, to provide a fuller description of the health status of populations across space and time. Reliable morbidity data are still scarce across the OECD area. However, an increasing number of countries are conducting health interview surveys which allow respondents to report on their health status. A frequently asked question is "How is your health in general? Very good, good, fair, bad or very bad"? Despite the general and subjective nature of this question, indicators of self-rated general health have been found in several countries to be a good predictor of future health care use and mortality (for instance, see Miilunpalo *et al*., 1997).

In over half of OECD countries, 75% or more of the adult population report their health to be "good" or better (Charts 1.17 and 1.18, and Table 1.8). The United States and Canada have the highest percentage of people assessing their health to be "good" or better, with over 90% of the population (males and females combined) in these two countries reporting being in "good/very good/excellent" health. On the other hand, reported "good or better health" status is lowest in Portugal, in Asian countries (Japan and Korea) and in Central and Eastern European countries (Hungary, Poland and Slovakia). Here, less than half of the population report being in "good" or "very good" health. Caution is required however in making cross-country comparisons of self-reported general health, for three reasons. First, there remain some variations in the question and answer categories used to measure self-rated general health across surveys/countries. Second, translation of survey questions and answers into different languages affects the responses. Third, and probably most importantly, people's overall assessment of their own health is subjective and can be affected by a number of factors, such as cultural background, education and access to health care services.

Within each country, for people aged 15 years and over, men are more likely than women to report their health to be good or better, with the exception of Finland, Iceland, Ireland and New Zealand. As expected, positive self-reported health generally declines with age. In many countries, there is a particularly marked decline in self-rated general health after age 45 and a further decline after age 65.

Looking at trends over time (Charts 1.19 and 1.20), from the late 1970s to the late 1990s, self-reported "good or better health" status has remained generally stable for both men and women in the four countries for which long time series are available (Finland, the Netherlands, Sweden and the United States). Variations in self-reported health over time may reflect both changes in *true* health status and changes in health *expectations*. If improvements in *true* health status in the population are accompanied by an equal rise in health *expectations*, it is not surprising that self-reported health status has remained more or less stable over time.

Definition and deviations

Self-reported general health reflects people's overall perception of their health, possibly including all physical and psychological dimensions. Typically, survey respondents are asked a question along the following lines: "How is your health in general? Very good, good, fair, bad, very bad". *OECD Health Data* provides figures related to the proportion of people reporting their health to be "good/very good" combined.

There remain some variations in the formulation of the question and answers in different surveys/countries, which limit data comparability.

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Chart 1.17. **Females, percentage reporting their health as "good" or better, latest year available**

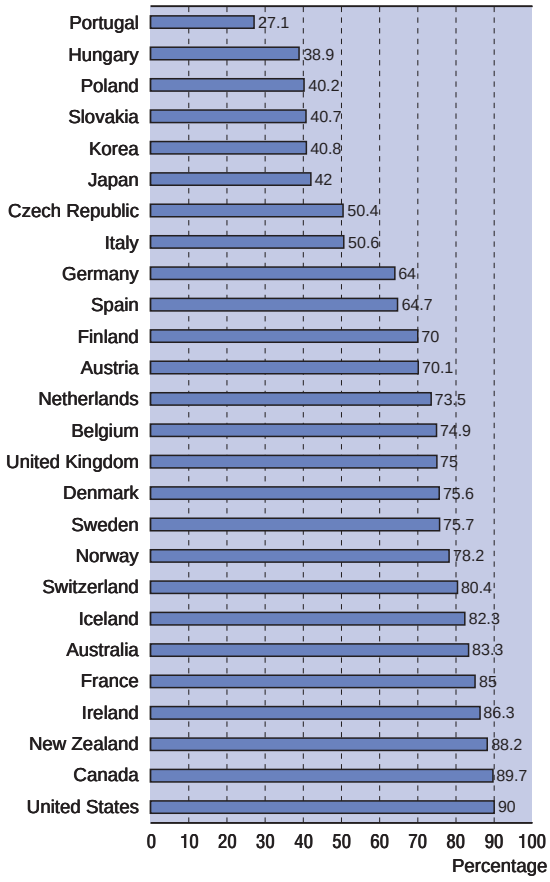


Chart 1.18. **Males, percentage reporting their health as "good" or better, latest year available**

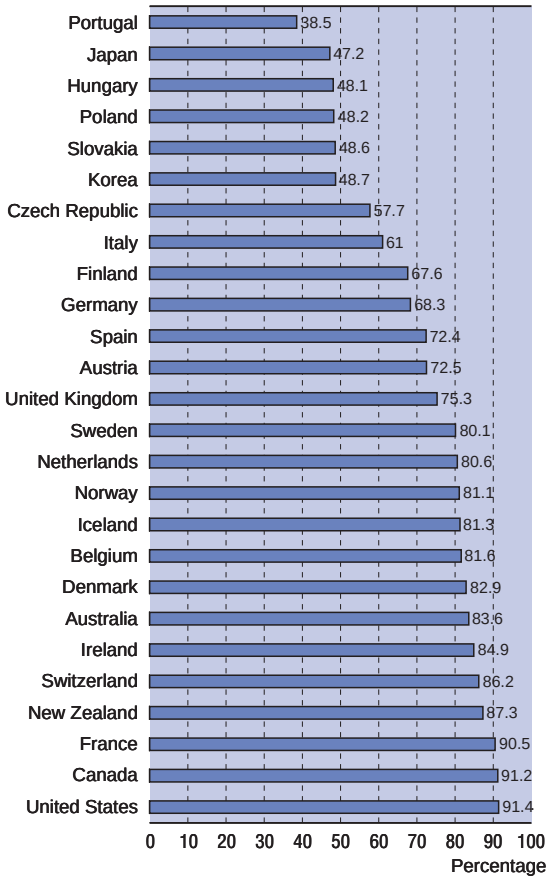


Chart 1.19. **Trends in the female population aged 15 and over reporting their health to be good or better**

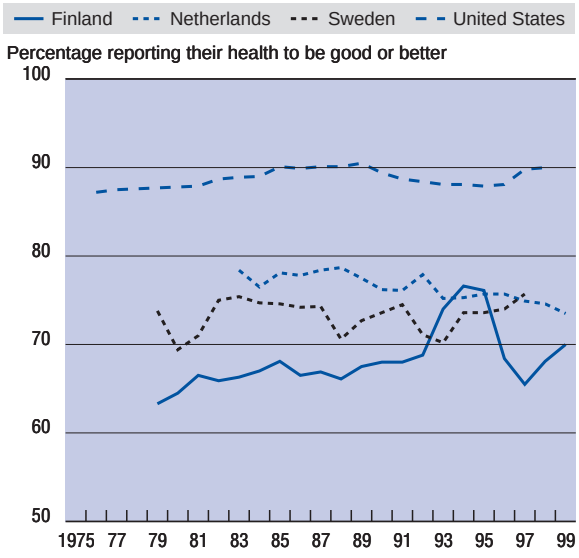
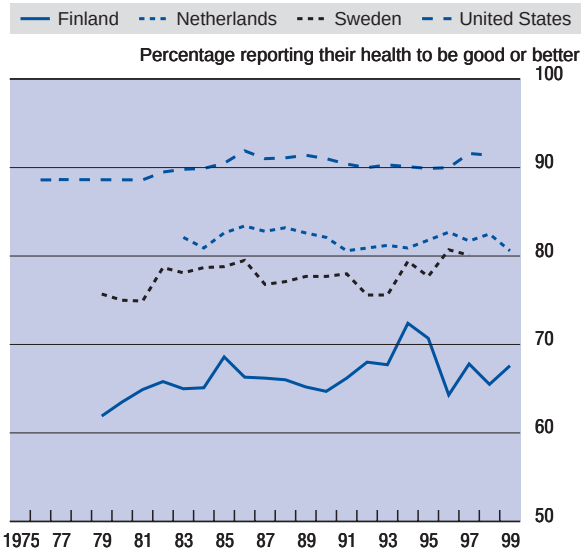


Chart 1.20. **Trends in the male population aged 15 and over reporting their health to be good or better**



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2. HEALTH CARE RESOURCES

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Inpatient and acute-care beds..... 26

Practising physicians and nurses

Doctors and nurses are the primary resource for producing health care in any health system. The numbers of doctors and nurses per capita can have significant impact on the cost, utilisation and outcome of health services.

Numbers of physicians per 1 000 population have been increasing steadily over time in all OECD countries: the average number of physicians per 1 000 population increased from 1.1 in 1960 to 3.0 in 1999 (Table 2.1). In most countries the bulk of the growth has taken place in the 1970s and 1980s, but many physician/population ratios have continued to rise in the last 10 years.

The average hides, however, significant variation in physician numbers across countries (Chart 2.1). Chart 2.3 suggests that physician numbers increased fastest in Turkey with an average annual growth rate of 4.3% and slowest in Canada with an average annual growth rate of 1.5%.

Empirical evidence from OECD countries suggests that higher doctor numbers are significantly associated with lower mortality, after controlling for other determinants of health (Grubaugh and Santerre, 1994; Or, 2000*b*).

There is no simple relationship between the number of doctors in a country and the total expenditure on health. Surprisingly, the physician stock appears to be relatively low in some countries where health expenditure is known to be high such as the United States and Canada. The regulations controlling patient access to physician services (direct access to specialists or not) and methods of remuneration play an important role in determining their cost. For example, there is some evidence to suggest that in countries where physicians are paid by salary or capitation (a fixed payment per period for each patient registered with the doctor), a higher number of doctors is associated with lower health expenditure whereas in countries where physicians are paid by fee-for-service, a higher number of doctors is associated with higher health expenditure, after controlling for other factors (OECD, 1994*b*).

Nurse numbers, as reported to OECD, also vary significantly across countries (Table 2.2 and Chart 2.2). Numbers have been increasing in nearly all countries for which we have data except in Australia and Canada in the 1990s (Chart 2.4).

The relative productivity of different types of health personnel, in particular doctors relative to nurses, has been explored by health economists. In the United States, some studies suggested that between 25% to 60% of physician services could be carried out by nurses (Reinhardt, 1972; Stein *et al.*, 1990).

The possibility of increasing doctors' productivity with more paramedical help is recognised by other studies (Hershey and Kroop, 1979; Richardson and Maynard, 1995).

Definition and deviations

Practising physicians are defined as the number of full-time equivalent physicians who are actively practising medicine in public and private institutions.

Most countries provide headcounts rather than full-time equivalents. Finland, Italy and Spain provide the numbers of physicians entitled to practise rather than practising physicians, which makes per capita ratios relatively high compared to other countries.

Practising nurses are defined as the number of actively practising certified/registered nurses employed in public and private hospitals, clinics and other health facilities.

Nursing assistants (also called licensed practical nurses or enrolled nurses) are not included in nurse numbers in some countries such as Australia, Austria, Canada and the United States. Most countries report head-count numbers, while the Czech Republic, France, Germany, Hungary and the United Kingdom report full-time equivalents. The United Kingdom and Spain provide only publicly employed nurses (nurses employed in the National Health Service). Finland reports all nurses entitled to practice.

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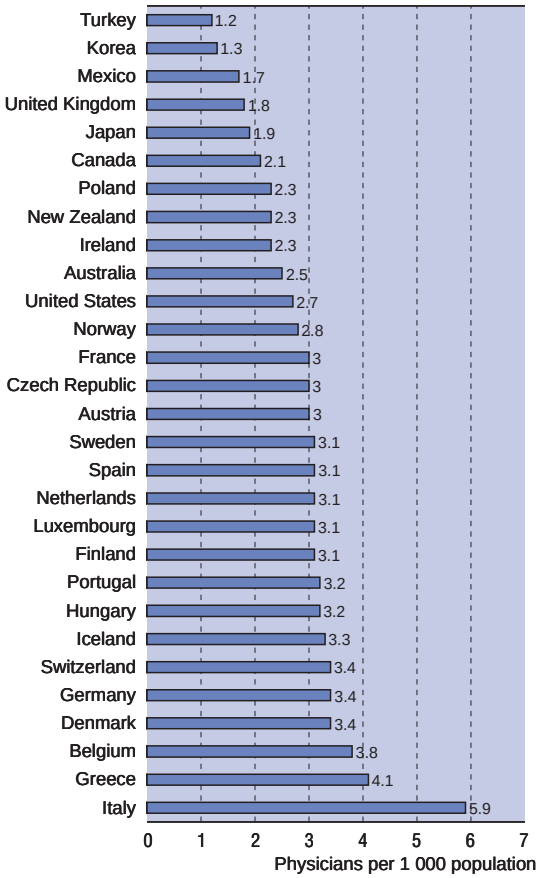
Chart 2.1. **Practising physicians[1] per 1 000 population, late 1990s**



1. Data for Finland, Italy and Spain are physicians entitled to practise.

Chart 2.2. **Practising and certified nurses per 1 000 population, late 1990s**

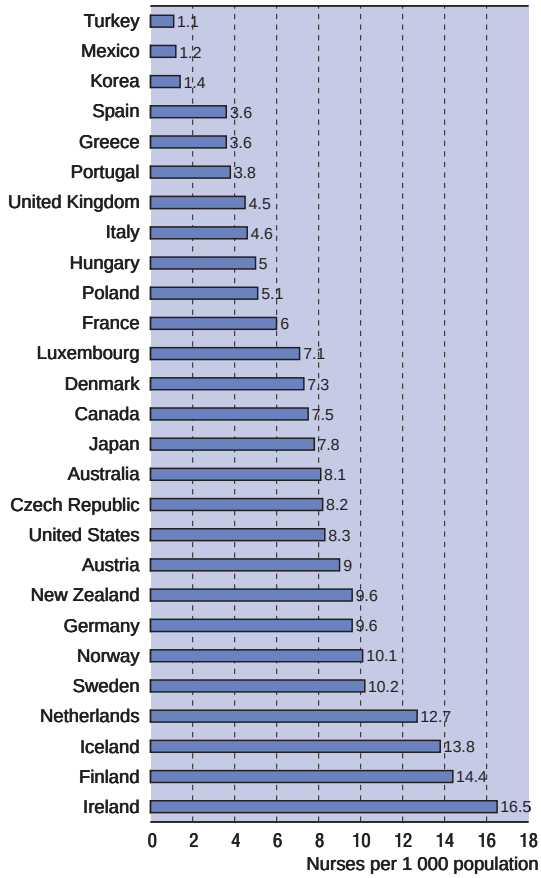


Chart 2.3. **Practising physicians per 1 000 population, 1960-1998**

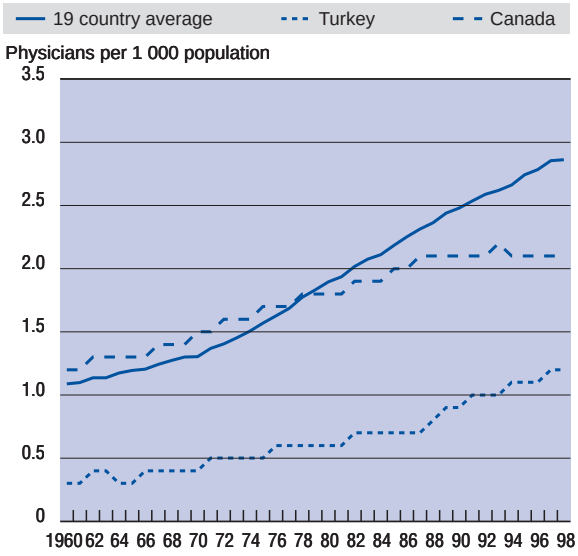
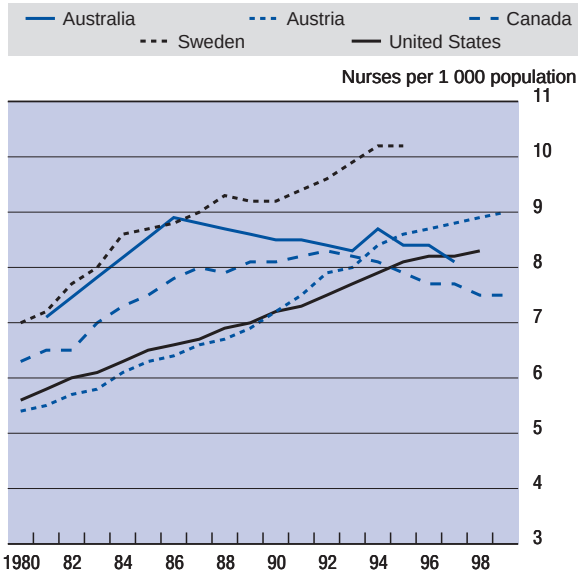


Chart 2.4. **Trends in number of certified nurses per 1 000 population**



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Inpatient and acute-care beds

Hospitals and nursing homes are both important components of health care provision. However, in the case of hospitals, with the rapid development of new medical technologies and growing pressure for cost containment in the past 30 years, they have had to modify radically the way they operate. In most OECD countries, hospitals have found opportunities to improve efficiency with shorter hospital stays and an increasing proportion of day-surgery patients.

Accordingly, the number of hospital and nursing home beds has declined steadily in the past three decades in the OECD area. Table 2.3 shows that the average number of inpatient care beds has dropped from 8.9 per 1 000 population in 1980 to less than 7 in 1998. There remain however notable variations in the reported data across countries (Chart 2.5). In some cases, this relates to exclusion of nursing home beds from the reported figures. There are smaller variations across countries in acute beds, which will mainly be in hospitals (Chart 2.6).

Charts 2.7 and 2.8, respectively, show annual changes in average numbers of inpatient and acute hospital beds per 1 000 population in the OECD countries for which there are complete time series. Since 1980, the average annual decline has been 1.4 per cent for inpatient beds and 1.7 per cent for acute-care beds. Table 2.3 shows for countries with complete time series data with no suggestions of breaks that Finland and the United Kingdom had the largest declines in bed numbers per 1 000 over this period. Bed numbers per 1 000 in Japan increased by 1.0% per annum over the period.

Definition and deviations

Inpatient beds are defined as including all available beds in public and private inpatient institutions, including nursing homes.

The United Kingdom and Ireland include only public beds. Beds in nursing homes are not included for Canada, Ireland, Portugal, Korea and the United Kingdom.

Acute-care beds are beds accommodating patients where the principal clinical intent is to do one or more of the following: manage labour (obstetrics), cure illness or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce severity of illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, perform diagnostic or therapeutic procedures.

Some countries still define acute-care beds by a length of stay criterion following earlier OECD guidance.

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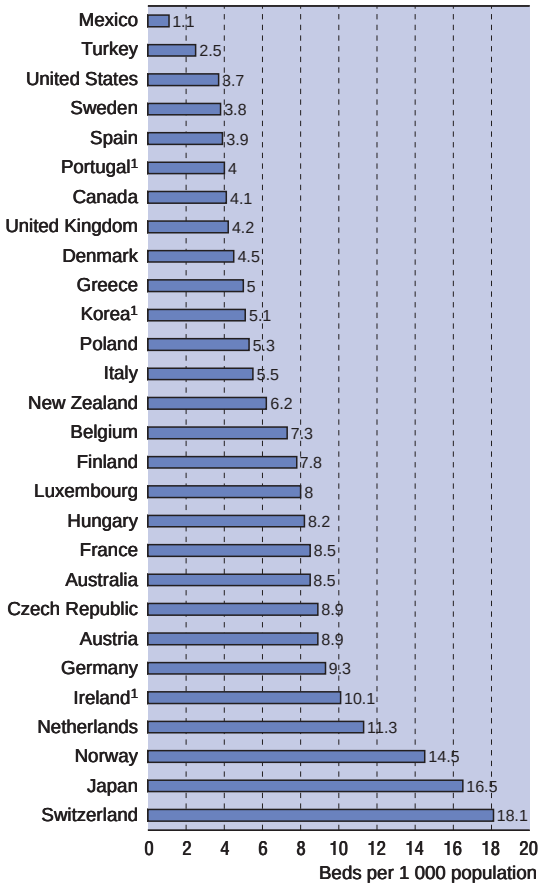
Chart 2.5. **Total inpatient beds per 1 000 population, late 1990s**



1. Beds in nursing homes are not included.

Chart 2.6. **Acute-care beds per 1 000 population, late 1990s**

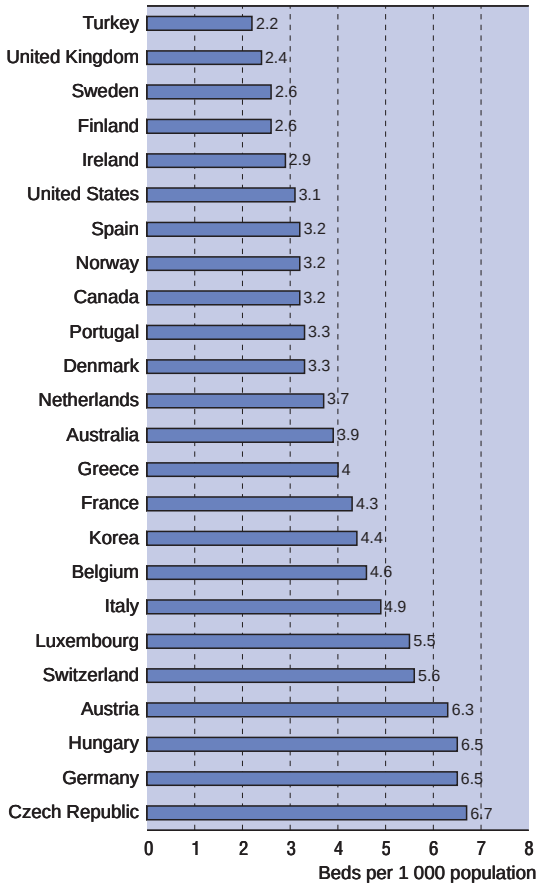


Chart 2.7. **Total inpatient beds per 1 000 population, 1960-1998**

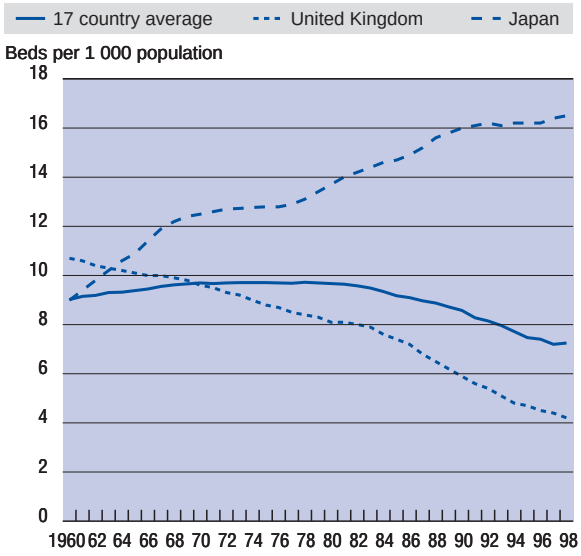
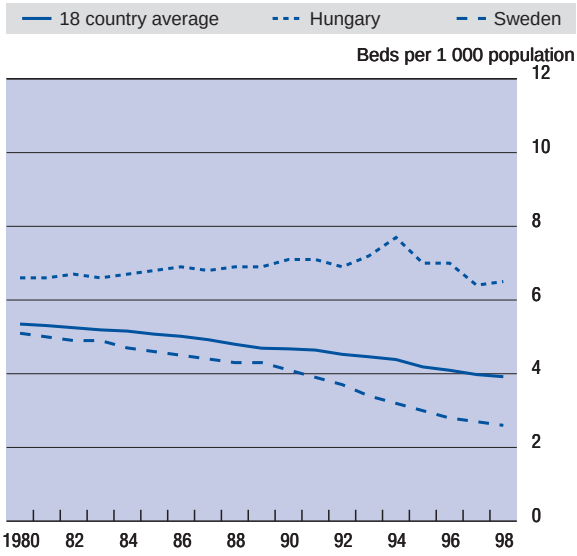


Chart 2.8. **Acute-care beds per 1 000 population, 1980-1998**



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3. HEALTH CARE UTILISATION

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Consultations with doctors

In some countries, patients can approach a specialist directly and in others they are either required or encouraged to approach a general practitioner "gatekeeper" who will decide whether they need referral to a specialist or not. The great bulk of patient contacts with health care systems involve a consultation with a doctor on an ambulatory care basis either in a primary care clinic or in a hospital outpatient department. In either case, doctors are patients' main agents of information regarding appropriate treatment. An important preoccupation for health policy is to provide the right incentives to doctors both to ensure quality of care and to control costs.

By the late 1990s, there were considerable differences across countries in per capita consultations with doctors (Chart 3.1). In 1997 the average for the 18 countries for which data are available was around seven visits per capita (Table 3.1).

The number of consultations with doctors per capita has increased in all countries since 1980, except in Poland and Portugal (Charts 3.2 and 3.3). The biggest increases over this period have been in Hungary, Mexico and Turkey which were building up their physician numbers and services. France and Australia have also had a rapid increase in consultations.

It might be assumed that more doctors would lead to more consultations. However, Chart 3.4 suggests that there was only a weak positive association between the growth in the number of physicians per capita and the growth in the number of consultations per capita between 1980 and 1996/97 in countries for which data have been reported. On average, the percentage growth in consultations has been smaller than the percentage growth in the number of physicians. It is not clear whether the length and quality of consultations has been rising: if it has not, it would imply that productivity per doctor has been declining. However, it should be noted that the figures for consultations do not include other activities of doctors, such as non-ambulatory hospital work. Also, the figures for physicians are mainly headcounts which are not adjusted for increasing part-time working, partly as a result of increasing female participation.

Definition and deviations

Consultations with doctors refer to the number of ambulatory contacts with physicians. Consultations in physicians' offices, in primary-care clinics and in the outpatient wards of hospitals as well as home visits should be included. Both public and private consultations should be included.

Several countries exclude consultations with specialists, others do not include contacts for maternal and child care. Turkey excludes visits to private practitioners.

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Chart 3.1. **Doctor consultations per capita, late 1990s**

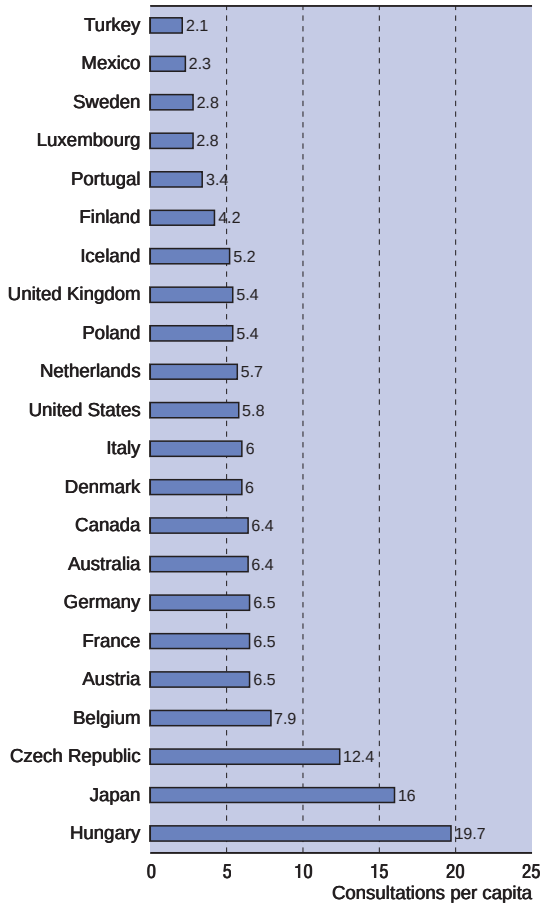


Chart 3.2. **Change in doctor consultations per capita, 1980-late 1990s**

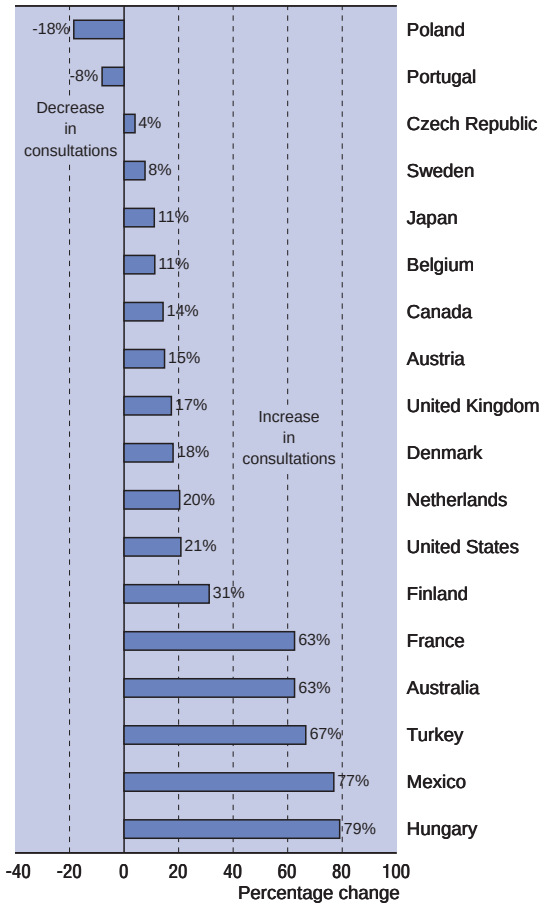


Chart 3.3. **Trends in doctor consultations per capita, 1980-1997**

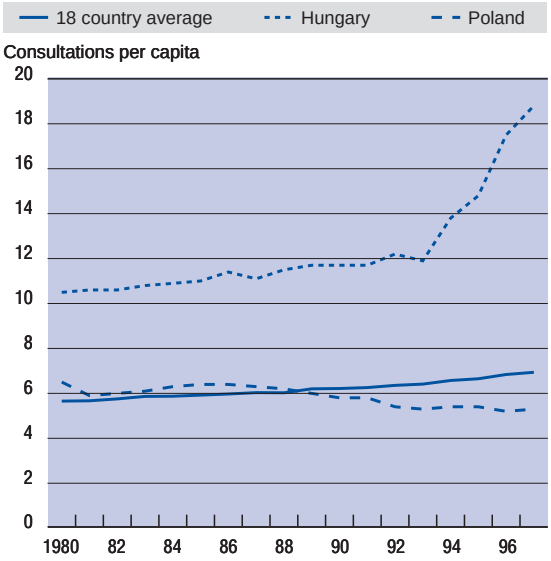
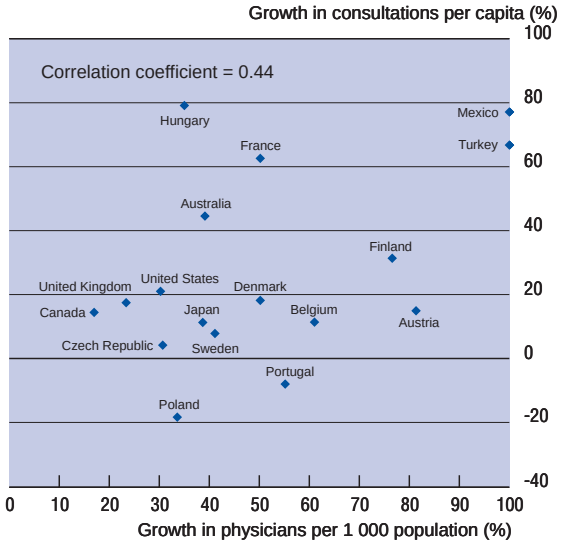


Chart 3.4. **Relationship between changes in physician density and physician consultations, 1980-1996/97**



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Childhood immunisation

Childhood immunisation rates are often used as proxies for health outcomes – changes in health status attributable to interventions. Over the past decades, childhood immunisation has yielded considerable reductions in the rate of several major infectious diseases and has contributed to the reduction of infant and child mortality in both developed and developing countries.

By the late 1990s, most children in OECD countries were vaccinated against diphtheria, tetanus and pertussis (DTP) and measles, with an average of 93.8% of children immunised against DTP and 90.5% immunised against measles (Table 3.2, Charts 3.5 and 3.6). Childhood immunisation rates were particularly high in central and eastern European countries and in Scandinavian countries, with the proportion of children vaccinated against DTP and measles now approaching 100% in these countries.

Charts 3.7 and 3.8 present trends in the immunisation rates for DTP and measles respectively since 1975 in selected OECD countries. In general, childhood immunisation rates have continued to increase over time across most OECD countries, or they have remained stable at a very high level (close to 100%) in countries like the Czech Republic and the Netherlands. In Portugal, the percentage of children vaccinated against measles has increased from 31% in 1975 to 96% in 1998, while the proportion of those immunised against DTP has gone up from 51% in 1975 to 98% in 1998. It is likely that this rapid progress in immunisation rates has played a significant role in the spectacular reduction in child mortality there (Section 1). There has also been a remarkable improvement in immunisation coverage in Turkey since the mid-1980s and in Mexico over the last decade.

Definition and deviations

Childhood immunisation refers to two measures: the percentage of 1-year-old children vaccinated against diphtheria, tetanus and pertussis combined (DTP), and the proportion of 1-year-old children vaccinated against measles.

The age of complete immunisation differs across countries due to different immunisation schedules. Immunisation data are: for 2-year-olds for measles in Australia, for ages 18-24 months for DTP in Belgium, and for both DTP and measles for 2-year-olds in Canada and Finland, for ages 14-15 months in the Netherlands and 19-35 months in the United States.

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Chart 3.5. **Diphtheria, tetanus and pertussis immunisation rates for young children, latest year available**

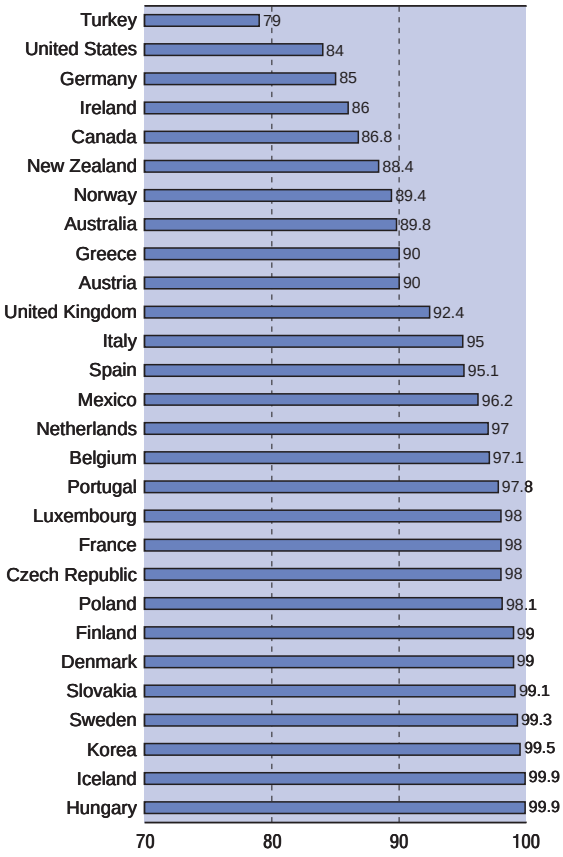


Chart 3.6. **Measles immunisation rates for young children, latest year available**

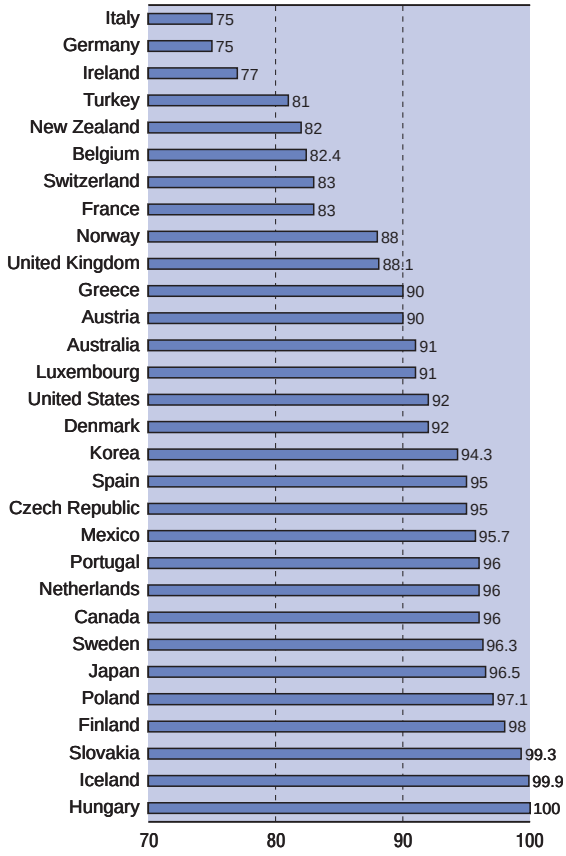


Chart 3.7. **Trends in the proportion of children vaccinated against diphtheria, tetanus and pertussis**

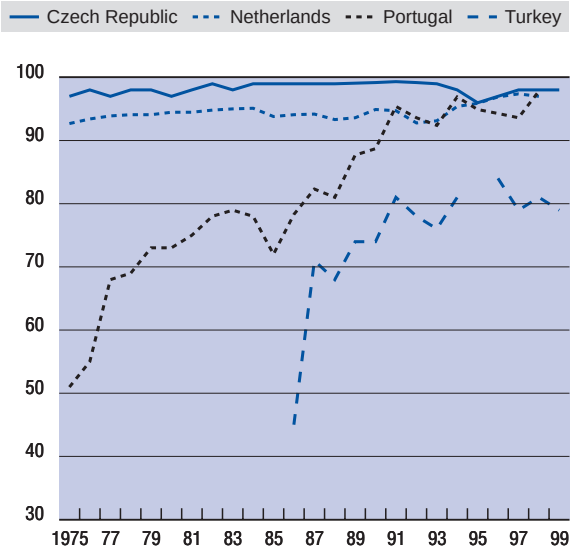
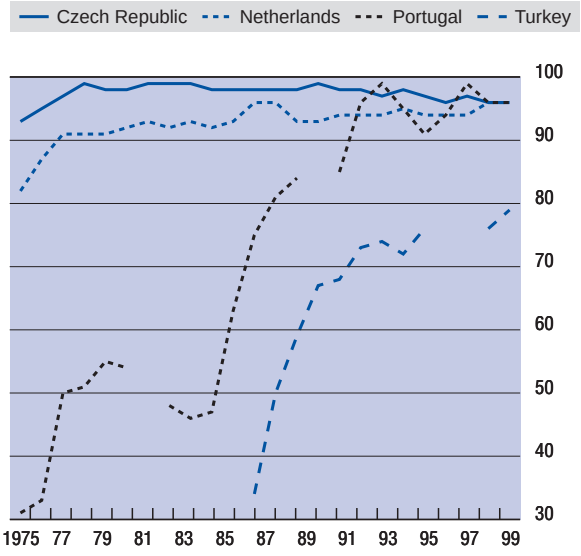


Chart 3.8. **Trends in the proportion of children vaccinated against measles**



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Admissions to hospitals and nursing homes

Admission rates to hospitals and nursing homes – involving at least one overnight stay in a bed – are one of the main indicators of health system activity.

Tables 3.3 and 3.4 and Charts 3.9 and 3.10 show that inpatient and acute-care admissions respectively vary considerably across OECD countries with an OECD average of 169 and 161 per 1 000 population respectively in 1998.

Inpatient admissions per 1 000 population have, since 1970, increased on average for a group of OECD countries for which we have data (Chart 3.11 and Table 3.3). Trends in acute-care admissions have been more stable, on average (Table 3.4, Chart 3.12). The averages conceal considerable variations in trends. Canadians experienced a reduction in the rates of inpatient admissions, falling from about one admission for every sixth person in 1970 to one admission for every tenth person in 1998. The United States was the only other country to experience a decline.

It is important to point out that these trends are not necessarily indicative of an overall fall in hospital utilisation. Day cases are not counted as inpatients because they do not involve an overnight stay. They have increased sharply in many countries. In the United States, about half of all surgical operations are now carried out on a day care basis. The Secretariat is now trying to collect data on day cases.

In the United Kingdom, it has been suggested that the quality of primary-care practice could be related to admission rates for chronic diseases, lower admission rates indicating better preventive care (Aveyard, 1997). However, the interpretation of admissions as an indicator of quality of care is not straightforward, as other external factors such as the socio-economic characteristics of the population and morbidity are important determinants (Giuffrida *et al.*, 1999). Hospital policies and financial incentives facing hospitals (reimbursement systems) also affect admission rates.

Definition and deviations

Inpatient admissions measure the number of patients who were admitted and stayed at least one night in inpatient institutions, including nursing homes. Day cases such as same-day surgery are excluded.

Acute-care admissions are admissions for which the principal clinical intent is to do one or more of the following: manage labour (obstetrics), cure illness or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce severity of illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, perform diagnostic or therapeutic procedures.

Some countries still define acute-care admissions by a length of stay criterion following earlier OECD guidance.

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Chart 3.9. **Inpatient admissions per 1 000 population, late 1990s**

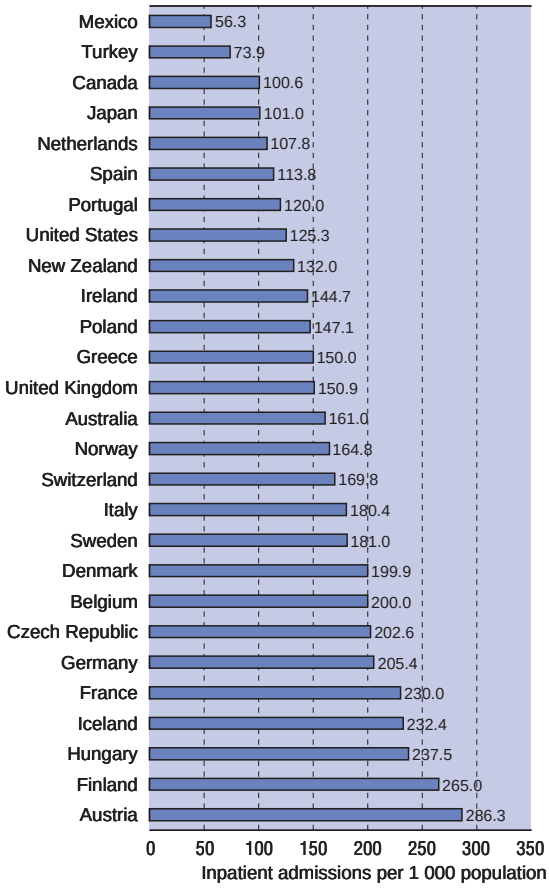


Chart 3.10. **Acute-care admissions per 1 000 population, late 1990s**

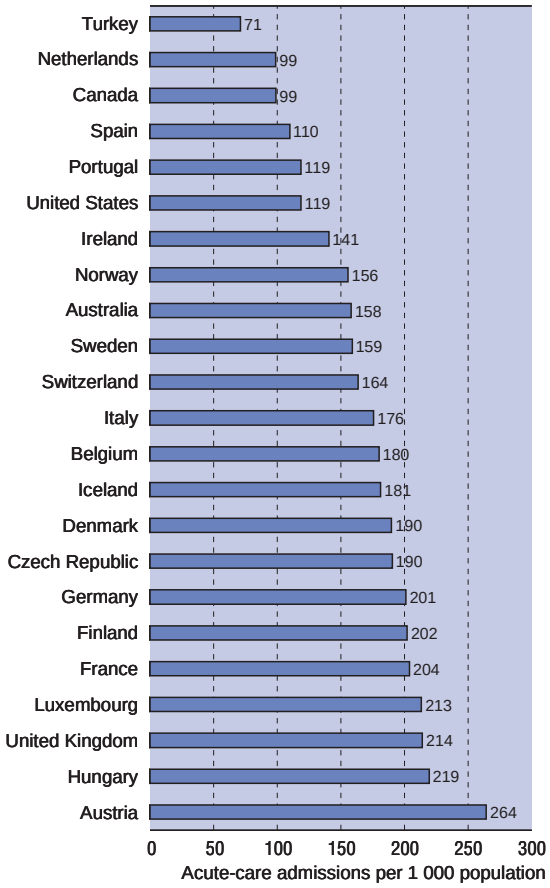


Chart 3.11. **Inpatient care admissions per 1 000 population, 1970-1998**

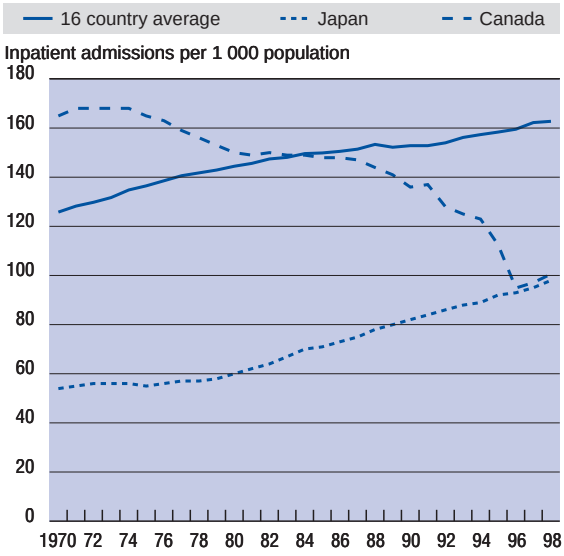
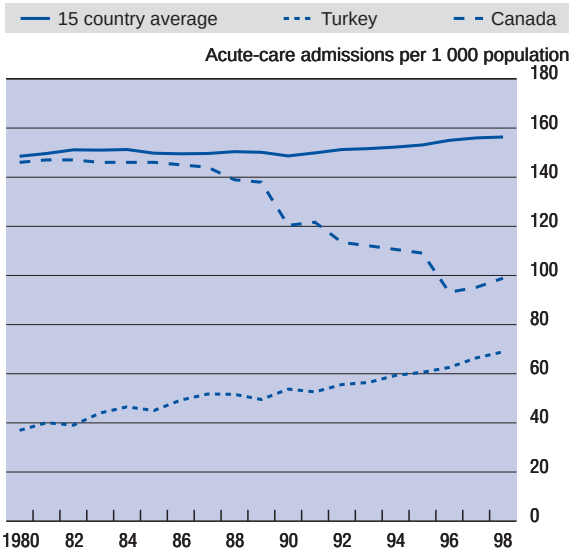


Chart 3.12. **Acute-care admissions per 1 000 population, 1980-1998**



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Average length of stay in acute care

The average length of stay (ALOS) in hospital has often been treated as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per episode. However, length of stay should only be used with caution as an indicator of efficiency. If the stay is too short, there may be adverse effect for treatments or for the comfort and recovery of the patient. In addition, if a falling length of stay leads to a rising readmission rate, costs may fall little or even rise. Also, a shorter stay can transfer costs to other parts of the health sector or onto patients and their families. While the evidence on the impact of reductions in length of stay on the quality of services delivered is unclear, recent research in the United States suggests that the extent of cost savings resulting from length of stay reductions is small. It is the number of patients and not the number of days of hospitalisation that appears to be driving costs (Carey, 2000).

Chart 3.13 and Table 3.5 show that wide disparities exist across OECD countries in terms of average length of stay for acute care. In the late 1990s, acute-care ALOS varied from 4.5 days in Finland and 4.9 days in New Zealand to 10.7 days in Germany and 11.4 days in Switzerland. One national study suggests that patient characteristics (age, severity of illness, income, education, etc.) and hospital characteristics (workload, physician characteristics) are major determinants of average length of stay (Martin and Smith, 1996). The evidence presented here suggests that additional factors may come into play in international comparisons.

Chart 3.14 shows that acute-care ALOS has been falling steadily over time for the majority of OECD countries, with the average for 19 countries decreasing from 11 days in 1980 to less than 8 days by the end of 1990s.

Falling acute length of stay has helped to bring about falling acute bed numbers across many OECD countries in the past two decades. The number of acute beds required depends positively both on the admission rate and on average length of stay. Admission rates have been fairly stable across many OECD countries in the past 20 years (Table 3.4). Hence, falling acute length of stay has been associated mainly with falling acute bed numbers (Chart 3.15). The correlation coefficient is 0.51. Turkey is an exception; its admission rate has been increasing faster than length of stay has been falling. Consequently acute beds per 1 000 population have been rising in Turkey.

It may be possible to improve the comparability of the data across countries by focussing on particular diseases or conditions. Chart 3.16 presents levels and trends in acute-care ALOS for normal delivery (obstetrics) in a number of OECD countries. There are striking variations in ALOS between countries. However, in all those for which we can make comparisons over time, there have been sharp reductions in length of stay. Length of hospitalisation for maternity care has become a key issue in some countries where some patients have complained about premature discharge.

Definition

Acute average length of stay (ALOS) refers to the average number of days (with an overnight stay) that patients spend in an acute-care inpatient institution and is measured by dividing the total number of days stayed for all patients in acute-care inpatient institutions during a year by the number of admissions.

Acute care is where the principal clinical intent is to do one or more of the following: manage labour (obstetric), cure illness or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce severity of illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, perform diagnostic or therapeutic procedures.

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Chart 3.13. **Average length of stay in acute care, late 1990s**

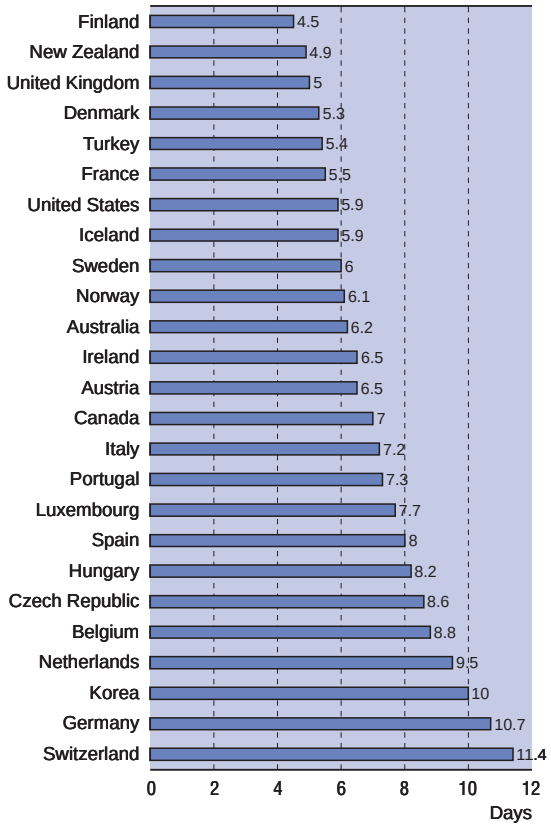


Chart 3.14. **Average length of stay in acute care, 1980-1998**

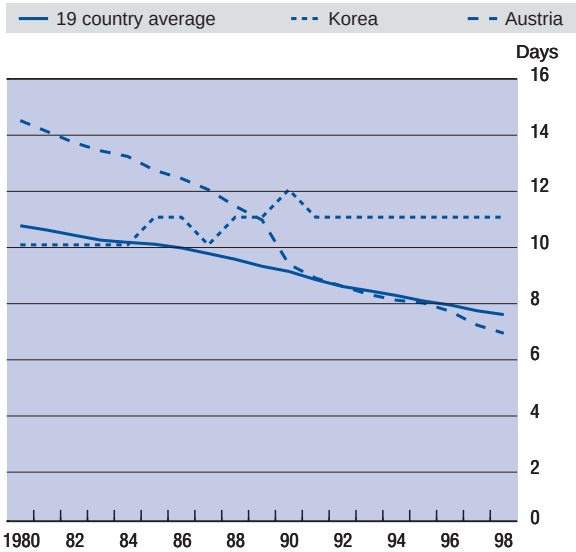
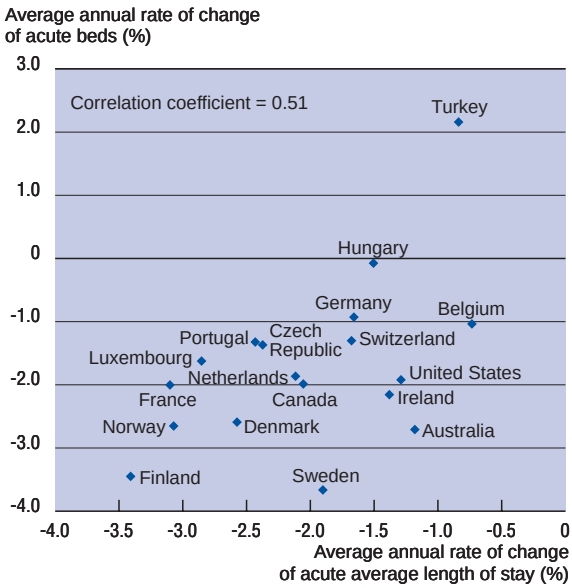
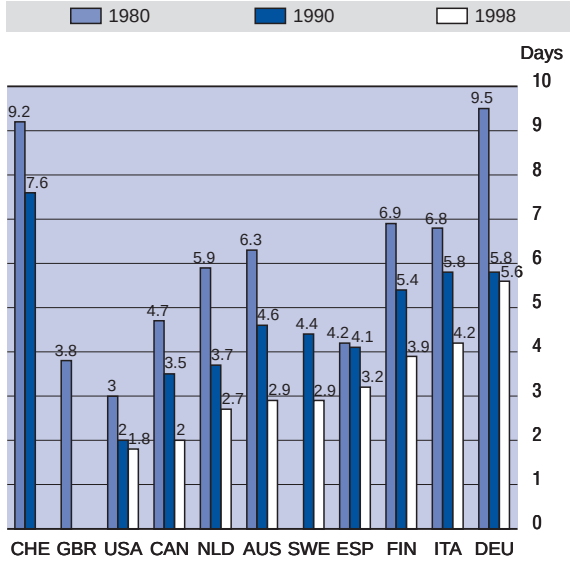


Chart 3.15. **Average annual rates of change of acute average length of stay and acute beds per 1 000 population, 1980-1998**[1]



1. Belgium rates are 1980-1997.

Chart 3.16. **Average length of stay for normal delivery**[1]



1. Data for 1980 refers to 1981 for the Netherlands; 1990 data refers to 1988 for Germany and 1998 data refers to 1997 for Germany.

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4. EXPENDITURE ON HEALTH

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Health expenditure

Rising health expenditure has been a cause of concern in most if not all OECD countries for several decades. Much of the reason for that is that on average around three quarters of the funding of health expenditure is public. Hence, rising health expenditure has added to the burden of taxes and social contributions. Chart 4.1 (see also Table 4.1) shows how health expenditure per capita, converted to US$ using purchasing power parity (PPP) exchange rates, varied across OECD countries in 1998.[1] Average spending was about $1 700 per capita but there was a more than tenfold variation in the range.

Chart 4.2 shows how real[2] health expenditure per capita grew in the 18 countries (listed below in Table 4.1) for which we have complete health expenditure data from 1970-1998. Reported health expenditure grew fastest in Norway over this period.

Chart 4.3 shows growth in real health expenditure per capita expressed as index numbers for an average across 19 countries and for Norway and Denmark which had the highest and lowest growth in per capita health expenditure, respectively, between 1970 and 1998 among countries which do not report a break in their expenditure series.

Chart 4.4 shows the annual rate of change of health expenditure per capita for the same 19 country average. It suggests that on average there has been a fall in the rate of growth of health expenditure in these countries over 28 years. The average annual growth rate in the 1970s, sometimes referred to as the decade of "cost explosion" in health care, was 5.8%. In the following decade it was 3.3%. Between 1990 and 1998 it was 2.9%.

There is a suggestion, here, that OECD countries have experienced increasing success with their cost-containment endeavours over time. Previous work at the OECD has identified some of the reforms by which OECD countries succeeded in containing costs following the 1970s (OECD, 1992 and 1994*a*). These included such measures as the adoption of global budgets by many public insurers and the ascendancy of managed care in the United States.

Definition and deviations

Total expenditure on health is the amount spent on health care goods and services plus capital investment in health care infrastructure. This includes outlays by both public and private sources (including households) on medical services provided by hospitals, nursing homes, outpatient facilities, ambulance services, home health care providers, laboratories, pharmacies and other retailers of therapeutic goods. Also included are outlays on public health and prevention programmes and administration. Excluded are health-related expenditure such as training, research, environmental health programmes and water and sanitation projects.

Currently, comprehensive health expenditure estimates for 12 countries are derived from National Health Accounts (NHA) and comply, for the most part, with the set of classifications and boundaries outlined in the System of Health Accounts (OECD, 2000). These countries are Australia, Canada, the Czech Republic, Denmark, Finland, France, Germany, Iceland, Korea, the Netherlands, New Zealand, and the United States. For countries with no NHA, proxy estimates are reported to the OECD based on health spending identified in the National Accounts. Estimates derived from NHA generally result in higher quality reporting to *OECD Health Data* than is the case in the absence of NHA. Typically, problems are due to underestimation. In Austria, Sweden, and the United Kingdom, the boundary between health and social care is drawn differently, thus lowering spending estimates. For Belgium, Ireland and the United Kingdom, private expenditure is suspected to be underestimated. Luxembourg's close social and economic integration with neighbouring countries results in severe estimation problems with health expenditure. There are significant breaks in the expenditure series for Belgium, Portugal and Sweden.

1. For an explanation of "purchasing power parity" conversion rates see Annex 2.
2. For a note on "real" comparisons of health expenditure, see Annex 2.

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Chart 4.1. **Health expenditure per capita (US$ economy-wide PPP), 1998**

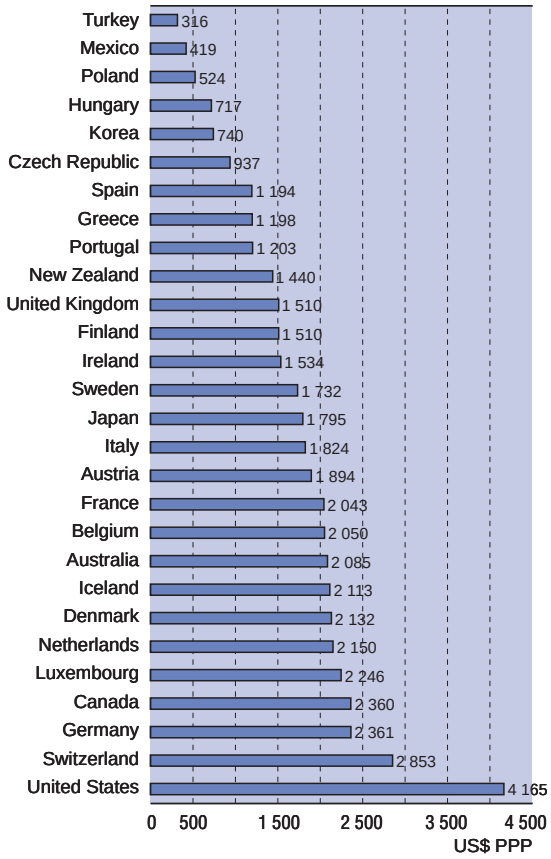
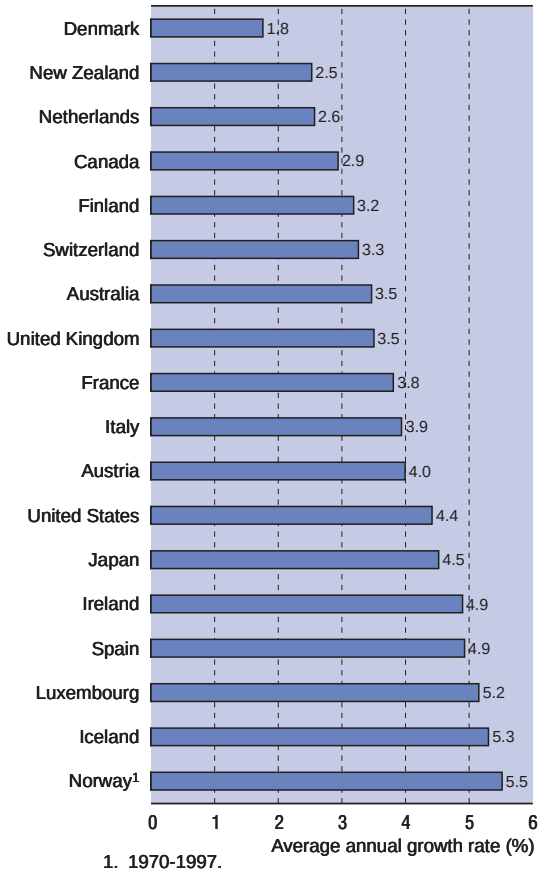


Chart 4.2. **Average annual growth rate, real health expenditure per capita, 1970-1998**



1. 1970-1997.

Chart 4.3. **Real health expenditure per capita, deflated by GDP prices, 1970-1998**

Index 1970 = 100

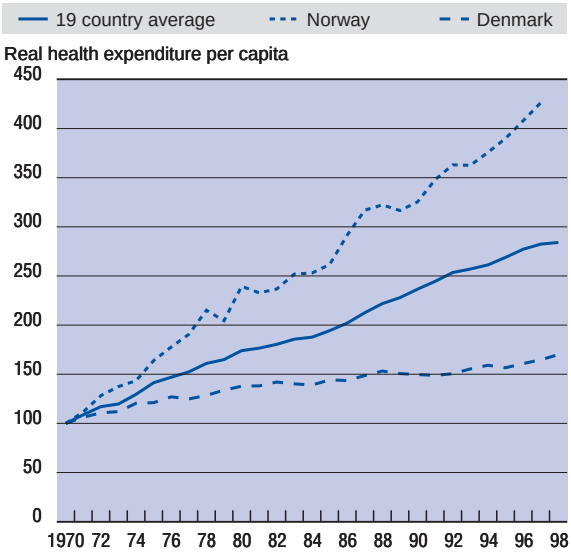
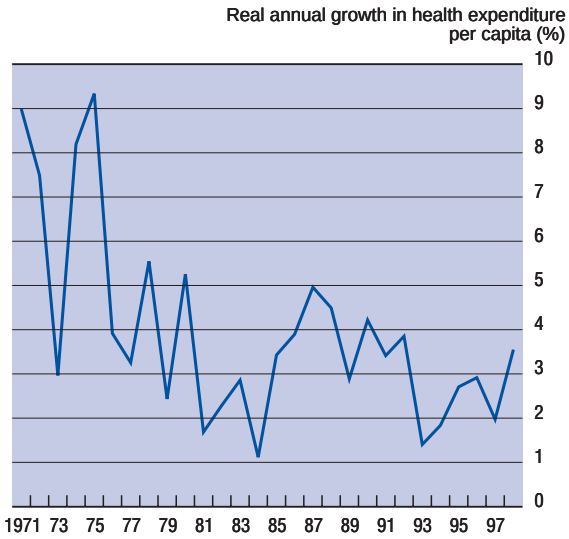


Chart 4.4. **Annual growth in real health expenditure per capita, 19 country average, 1970-1998**



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Health expenditure in relation to Gross Domestic Product

With issues of affordability and cost containment in mind, it is important to examine how health expenditure per capita varies with Gross Domestic Product (GDP) per capita between countries and over time. If health expenditure per capita rises faster than GDP per capita it will mean that there is a reduced share of GDP for other desirable goods and services.

Chart 4.7 shows a well-known relationship which suggests that per capita health expenditure is determined partly by per capita GDP. A logarithmic relationship has been fitted which means that the slope of the line can be interpreted as the "income elasticity" of health expenditure. The "income elasticity" of health expenditure, here, can be thought of as the responsiveness of health expenditure to changes in national income and is defined as the percentage change in health expenditure per capita divided by the percentage change in GDP per capita. The calculated elasticity is about 1.3. That corresponds broadly with other estimates of income elasticity from international comparisons (Gerdtham and Jonsson, 2000). A pure income elasticity relates the rise in the volume of health care to the rise in income. However, the estimate here probably includes a relative price effect as well as a volume effect because health expenditure in national currency units has been converted to US$ using economy-wide purchasing power parity (PPP) exchange rates, rather than health care-specific PPPs (see Annex 2). That means that any differences in the relative prices of health services across countries will be included in the estimated health expenditure differences. Health services are labour intensive, so there is a tendency for the relative price of health care to be higher where living standards are higher, at least across countries using similar health technology.

Chart 4.5 (see also Table 4.2) shows how expenditure on health varied as a percentage of GDP across OECD countries in 1998. The United States had the highest share at 12.9%.

Chart 4.6 shows the change in the health expenditure share of GDP across OECD countries between 1970 and 1998. The largest changes, as reported to the OECD, were in the United States and Switzerland at 6.0% and 5.0% per year, respectively.

Chart 4.8 shows what has happened to the average share of health expenditure in GDP for 20 OECD countries between 1970 and 1998. It shows, also, the shares for the countries with the highest and the lowest change in share – the United States and Denmark, respectively. It can be seen that the rate of rise in the average share stabilised in the 1990s. This was partly as a result of the slackening in the rate of growth of health expenditure (Chart 4.4) and partly as a result of strong economic growth in the OECD area at the time (Table 6.3). It remains to be seen whether such stabilisation will be maintained in the face of continuing technical change in health care, population ageing (see Section 6) and any slowdown in economic growth.

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Chart 4.5. **Expenditure on health as a percentage of Gross Domestic Product, 1998**

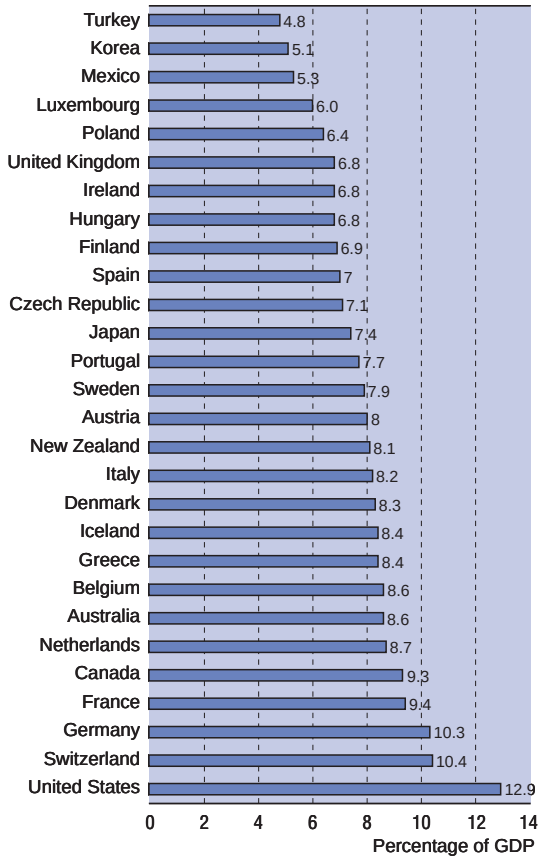
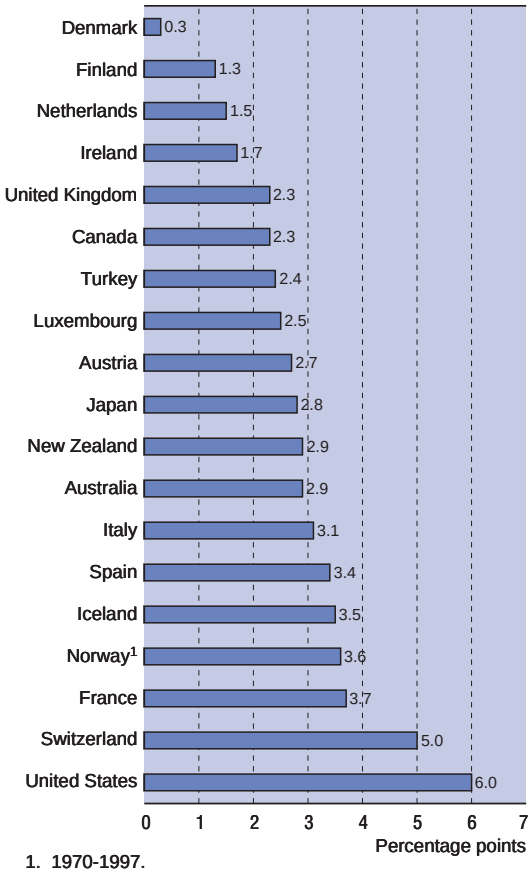


Chart 4.6. **Change in health expenditure as a share of Gross Domestic Product, 1970-1998**



1. 1970-1997.

Chart 4.7. **Per capita Gross Domestic Product and per capita health expenditure, 1998**

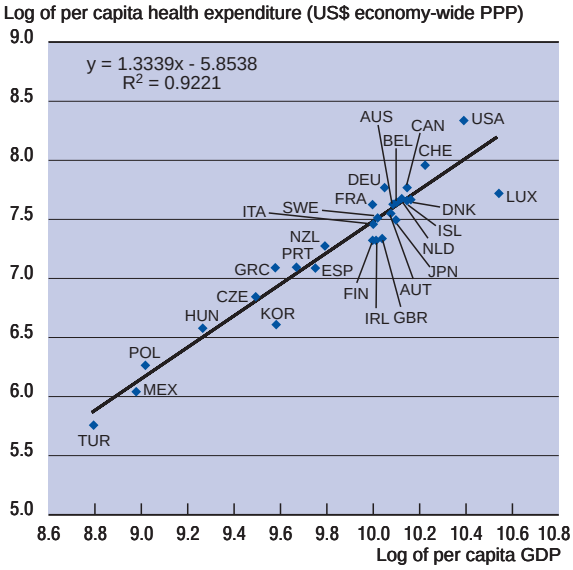
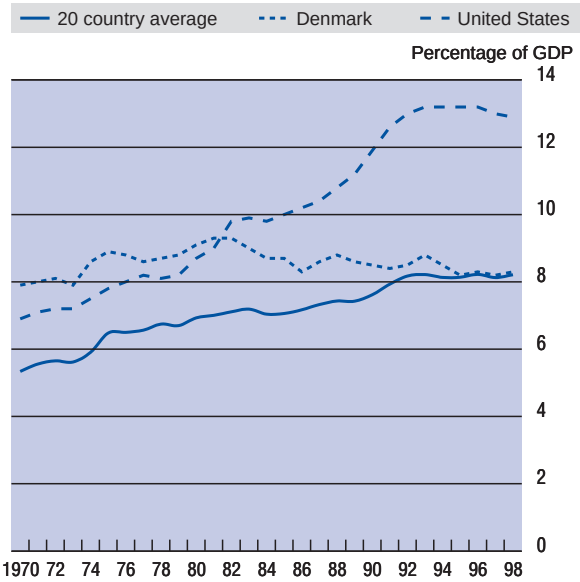


Chart 4.8. **Health expenditure as a percentage of Gross Domestic Product, 1970-1998**



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Responsibility for financing health care

The source of funding for health care and, in particular, the public/private mix of funding, remains a matter for periodic policy debate in most OECD countries. Public funding, which means compulsory financing, mainly from taxes or social security contributions, has been popular in most OECD countries because it provides health insurance with community-wide risk pooling. It can allow payment for health care to be matched to ability to pay and treatment to be matched to need. Private health expenditure, which means voluntary funding, mainly by out-of-pocket payments or private health insurance, remains important for a variety of reasons including the fact that governments are not willing to pay for all health care and in some countries the voluntary principle is valued highly in its own right.

Chart 4.9 compares the public share of health expenditure in the 27 countries for which data have been reported in 1998. Luxembourg and the Czech Republic reported the highest public share of health expenditure in 1998, at 92.4% and 91.9% respectively. The United States had the lowest public share at 44.8%.

The public/private mix of funding has shown signs of changing in recent decades in many OECD countries. Chart 4.10 shows the various changes in the public share between 1970 and 1998 in 21 countries. Only three of these countries had a change in share greater than 10 percentage points. There was a small increase in the average public share over the whole period from about 72% in 1970 to about 75% in 1998 (see Table 4.3).

Chart 4.11 suggests that to a large extent there has been some convergence in the public share of health spending among a number of OECD countries. Countries with a low share in 1970, such as the United States, Turkey, and Spain, have seen their public share increase. Countries with a high share in 1970, such as Norway, the United Kingdom and Italy, have seen their public share decline.

Definition

Public funding for health care is financing by central, state or local government, by social security schemes and by public investment in heath facilities. Private funding is finance by out-of pocket payments, by private health insurance, by charities, by companies' funding of occupational health care and by private investment in health facilities. Private funding may take on certain aspects of social insurance – as in the employer-led health insurance schemes in the United States.

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Chart 4.9. **Public funding as a percentage of total health expenditure, 1998**

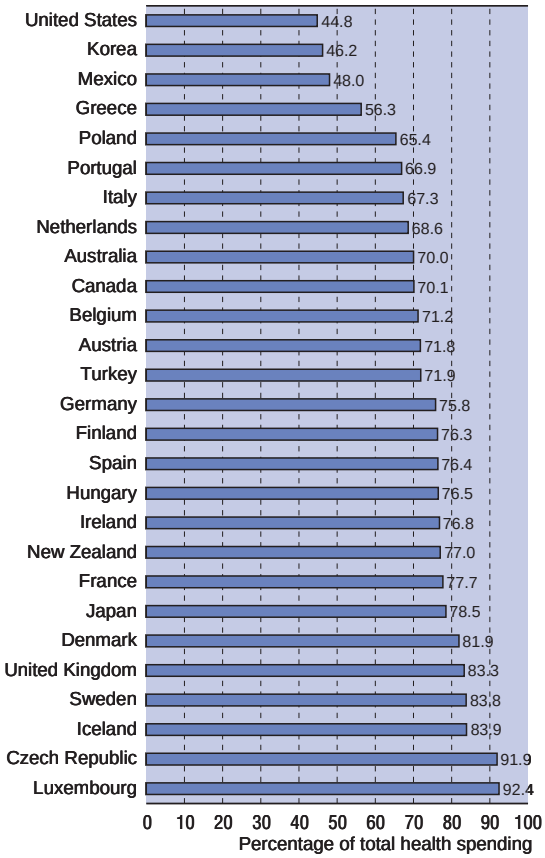
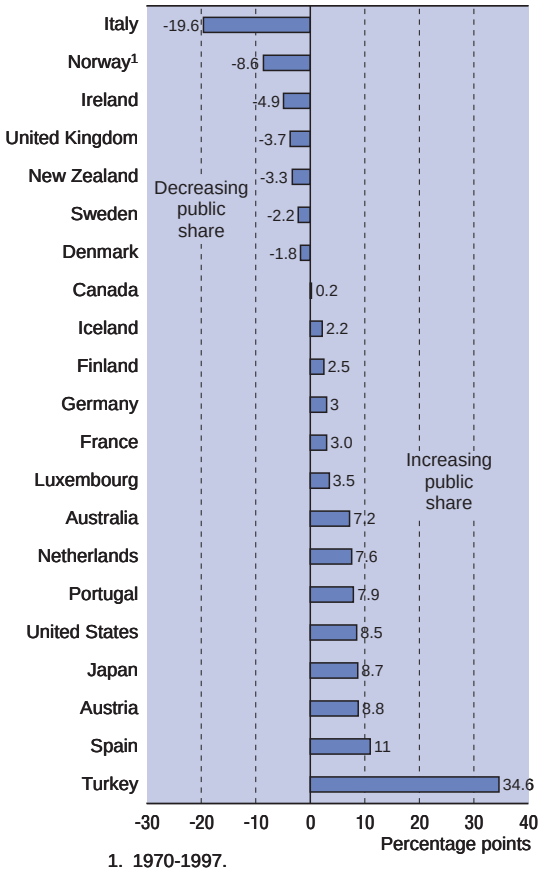
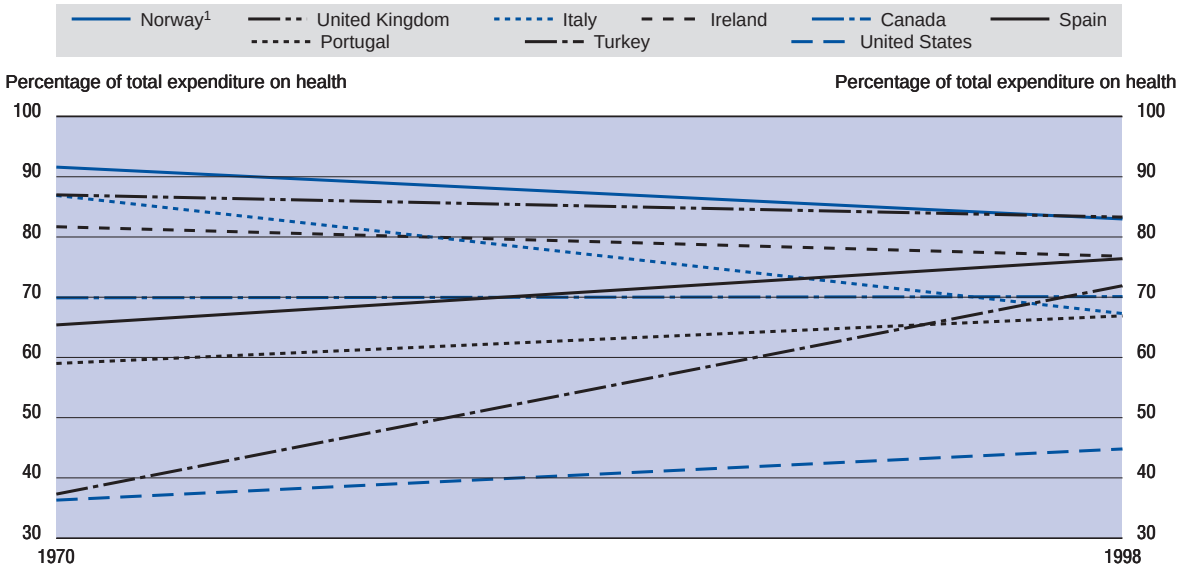


Chart 4.10. **Change in the public share of expenditure on health, 1970-1998**



1. 1970-1997.

Chart 4.11. **Public share of health expenditure, in 1970 and 1998 (with linear interpolation)**



1. 1970-1997.

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Pharmaceutical expenditure

Many new drugs have been introduced in recent decades which have brought significant benefits to the health of OECD populations. Perhaps as a consequence, pharmaceutical expenditure has been rising as a share of total health expenditure in recent years (see Table 4.5).

In 1998, average pharmaceutical expenditure per capita for a group of 25 countries was US$256, across OECD countries (Table 4.4).

Chart 4.12 suggests that among 25 countries, France was the highest spending country, with pharmaceutical expenditure per capita of US$447 in 1998. The lowest spending country was Korea with spending of US$102 per capita.

Looking at changes over time, Chart 4.15 suggests an almost threefold variation in the real growth rate of pharmaceutical spending across 13 countries in 1970-1998. The average rate of growth was 3.6% per annum (Table 4.4).

Chart 4.14 suggests that on average real pharmaceutical expenditure per capita has increased continuously in real terms, between 1970 and 1997. Average real expenditure per capita for a group of 14 countries rose by a factor of 2.6 over this period. The growth rates of pharmaceutical expenditure in Iceland and Ireland are also shown on Chart 4.14 as examples of countries with rates of growth faster and slower than average.

Chart 4.13 shows how health expenditure as a share of total health expenditure varied across OECD countries in 1997/98. The average share in 1998 was 14.1% (Table 4.5). The average percentage share declined between 1970 and 1980, but it has risen significantly since 1990. The share is lower in countries with relatively high levels of GDP per capita and higher in countries with relatively low levels of GDP per capita. It is lowest in Switzerland, Norway and Denmark and is highest in Hungary, Portugal and the Czech Republic. (For more detail, see Jacobzone, 2000*b*.)

Definition

Pharmaceutical expenditure includes expenditure on prescription medicines and self-medication, often referred to as over-the-counter (OTC) products. It also includes pharmacists' remuneration when the latter is separate from the price of medicines. Pharmaceuticals consumed in hospitals are excluded.

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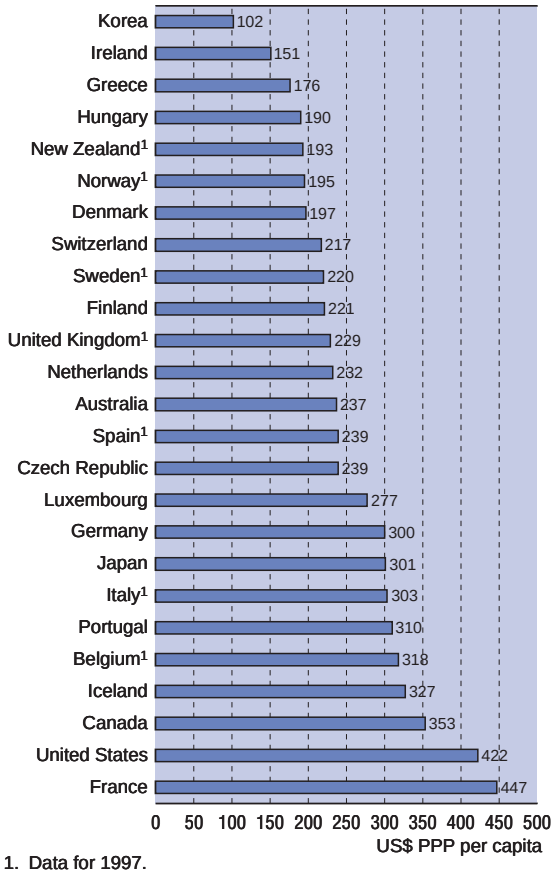
Chart 4.12. **Total expenditure on pharmaceuticals per capita (US$ PPP), 1998**



1. Data for 1997.

Chart 4.13. **Expenditure on pharmaceuticals as a share of total health expenditure, 1997/98**

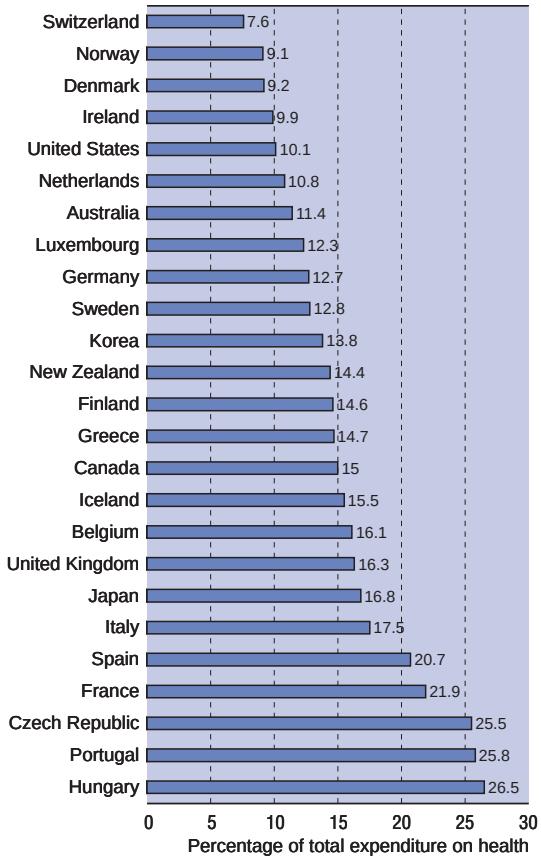


Chart 4.14. **Real expenditure per capita on pharmaceuticals, 1970-1997**

Index 1970 = 100

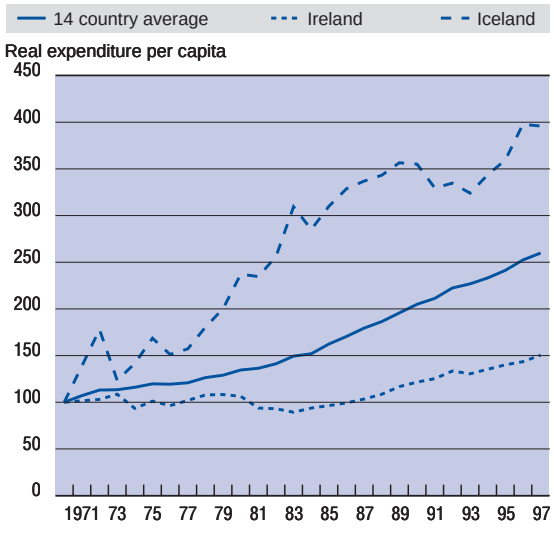
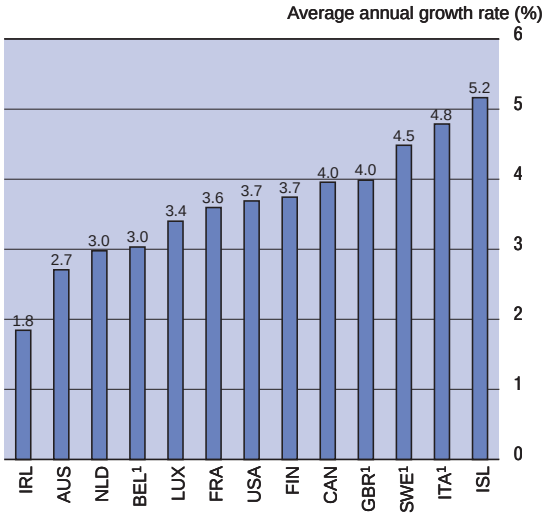


Chart 4.15. **Real growth rate of pharmaceutical expenditure per capita, 1970-1998**



1. 1970 to 1997.

5. NON-MEDICAL DETERMINANTS OF HEALTH

Tobacco consumption 50
Alcohol consumption 52
Body weight 54

Tobacco consumption

Smoking is the largest avoidable risk to health in OECD countries. It is a major risk factor for at least two of the leading causes of premature mortality in OECD countries, cancers and circulatory diseases. Although tobacco consumption has declined over the last few decades in most OECD countries, only a few countries (*e.g.*, Portugal, Sweden and the United States) have reduced the proportion of daily smokers among the adult population below 20% by year 2000 (Table 5.1).

Charts 5.1 and 5.2 show that the proportion of women and men who report smoking daily varies greatly across OECD countries. There remains a substantial gender gap in smoking prevalence in most countries, with men continuing to report smoking much more than women. This gender gap is particularly pronounced in Japan, Korea and Turkey. There is also a large gender gap in Portugal, with smoking rates among Portuguese men being not too far from the OECD average. It is the very low smoking rates among Portuguese women which explain the overall low prevalence of smoking in that country.

Looking at trends over time, Chart 5.3 illustrates a general pattern of a narrowing gap in smoking rates between men and women observed across most OECD countries, using the example of the United States and Japan. In Japan in particular, the proportion of men who report being regular smokers came down from over 80% in the 1960s to 54% in 1999. By comparison, reported smoking rates among Japanese women has gone down only marginally, from 16% to 15%, over that period. In Sweden (not shown on this chart), there has also been a very rapid decline in tobacco smoking among men over the last two decades – from 41% of men who report smoking daily in 1977 to only 19% in 1999. This has resulted in a closing of the gender gap in cigarette smoking prevalence in Sweden.

Chart 5.4 shows the correlation between tobacco consumption (as measured by grams per capita) and deaths from lung cancer across OECD countries, using a 20-year time lag. As might be expected, higher tobacco consumption at the national level is generally related with higher mortality rates from lung cancer 20 years later. Recent econometric analysis of the determinants of premature mortality, using *OECD Health Data*, provides additional evidence that higher levels of smoking (and also of alcohol consumption) are associated with higher levels of premature mortality after controlling for other determinants of health such as occupation, GDP per capita and health expenditure per capita (Or, 2000*a*).

Definition

The proportion of daily smokers is defined as the percentage of the population aged 15 years and over reporting that they smoke every day.

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Chart 5.1. **Percentage of females who report smoking daily, latest year available**

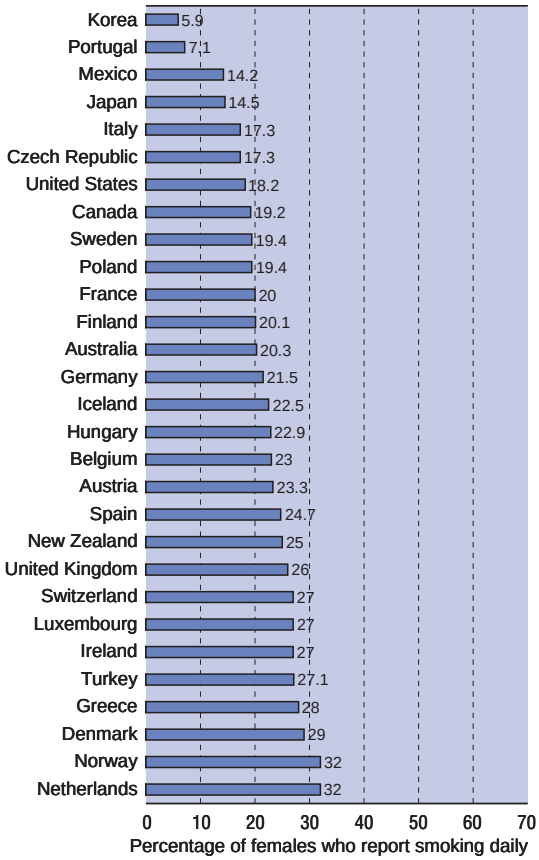


Chart 5.2. **Percentage of males who report smoking daily, latest year available**

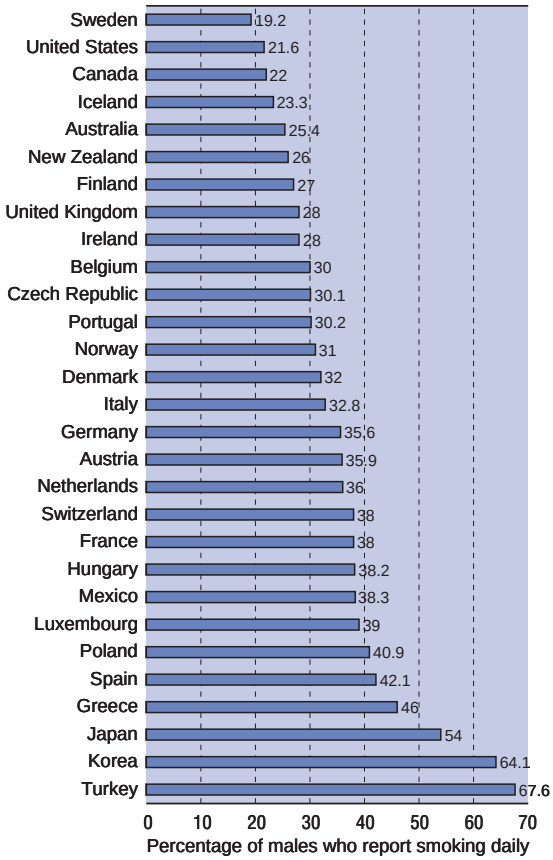


Chart 5.3. **Percentage of daily smokers, males and females, in Japan and the United States, late 1960s to late 1990s**

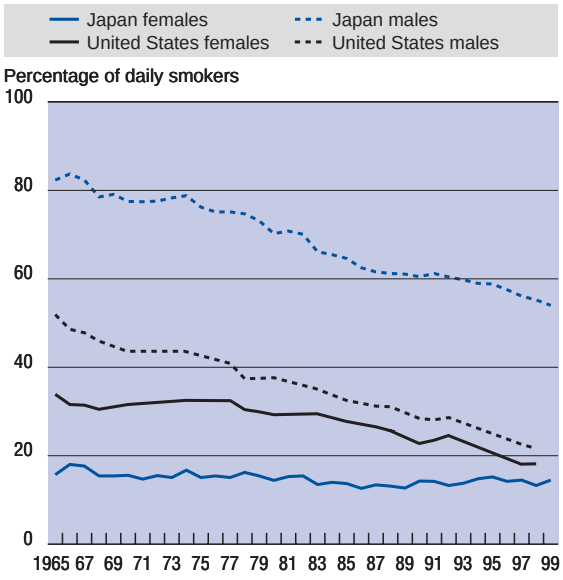
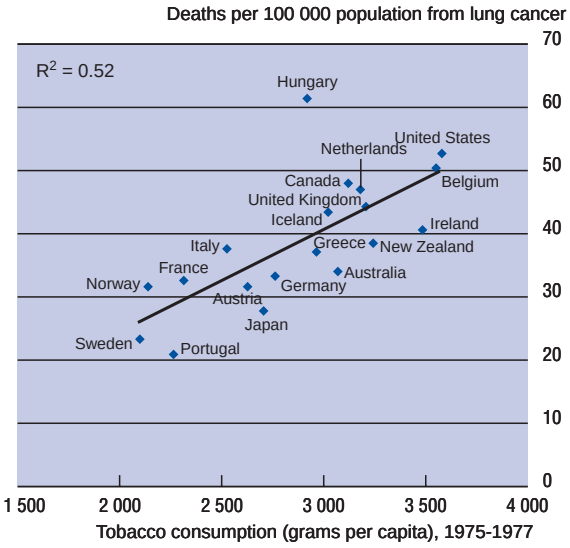


Chart 5.4. **Tobacco consumption, 1975-77 and subsequent deaths from lung cancer, 1995-97**



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Alcohol consumption

Excessive alcohol consumption is considered a major risk factor for accidents (both fatal and non-fatal) and a number of diseases, such as liver cirrhosis and cancers of the digestive system.

In most OECD countries, alcohol consumption per person aged 15 years over (as measured by sales of pure alcohol in litres) rose during the 1960s and the 1970s, but subsequently started to decline over the last two decades. Overall, among the 25 countries for which data are available from 1960 to 1998, the average annual consumption of alcohol first increased from 7.5 litres per adult in 1960 to 11.1 litres in 1980, and then gradually declined to about 9.9 litres in 1998 (Charts 5.6 and 5.7, and Table 5.2).

There is considerable diversity in the pattern of alcohol consumption across OECD countries (Chart 5.5). In Turkey, the average consumption per adult in 1998 was only 1.6 litres, compared with an OECD average of 9.9 litres per capita and 15.6 litres in France (1996 data), the highest level among OECD countries (leaving aside Luxembourg for which actual consumption is likely over-estimated by the fact that national sales include a significant amount of consumption by tourists/foreigners and cross-border traffic of alcohol beverages). Among high income countries, the level of alcohol consumption is relatively low in Iceland, Norway and Sweden; all of these countries have in place integrated alcohol control policies (*e.g.* restrictions on sales to people under 20 years, regulation of hours of sale and venues, a high-price policy achieved through high levels of excise duty, and substantial bans on advertising of wines and spirits). In the past 20 years, many other OECD countries have introduced policies aimed at reducing overall alcohol consumption, combating high-risk behaviour, and supporting accessible and effective treatment for people with harmful alcohol consumption and those with alcohol dependence.

In southern European countries, alcohol consumption has also decreased steadily over time. France, Spain and Portugal have all recorded substantial declines in consumption per adult from their peak levels of two or three decades ago, although consumption levels continue to be relatively high.

Chart 5.8 shows that countries with relatively high levels of alcohol consumption tend to experience higher death rates from liver cirrhosis than countries with lower levels of consumption, using a 5-year time lag (the same relationship can also be observed using a 10-year or a 20-year lag period). The trend in death rates from liver cirrhosis over the last 30 years in each country also follows quite closely the pattern of alcohol consumption described above. For example, in France, the standardised death rate from liver cirrhosis for men has fallen sharply from a peak of 48.6 per 100 000 in 1965 to 20 per 100 000 in 1995 along with the steady decline in alcohol consumption over this time. Cirrhosis death rates peaked in Italy, Spain, and Portugal in the mid-1970s, but they have declined sharply since then, in line with the decline in alcohol consumption in these countries.

Definition and deviation

Alcohol consumption is defined as annual sales of pure alcohol in litres per person aged 15 years and over.

The methodology to convert alcohol drinks to pure alcohol may differ across countries. Some countries report consumption for the population 14 years and over (Italy), 16 years and over (Sweden) or 20 years and over (Japan). For some countries, national sales do not reflect accurately actual consumption, as black markets, consumption by tourists and border traffic of alcoholic beverages may create a significant gap between sales and actual consumption.

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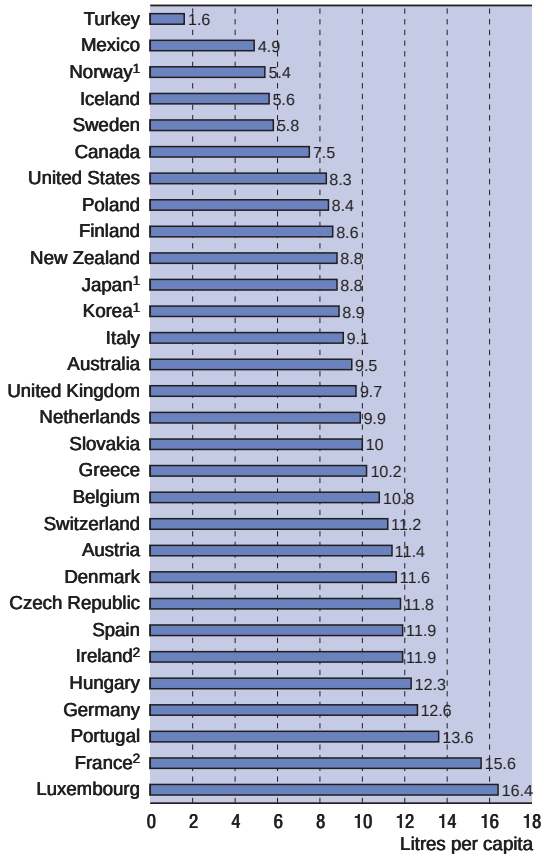
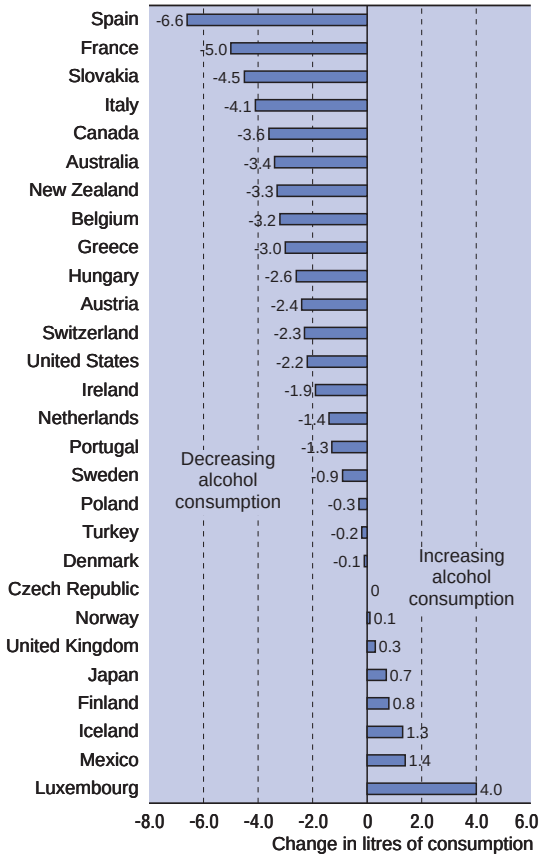
Chart 5.5. **Alcohol consumption, litres per capita (population aged 15 years and over), 1998**



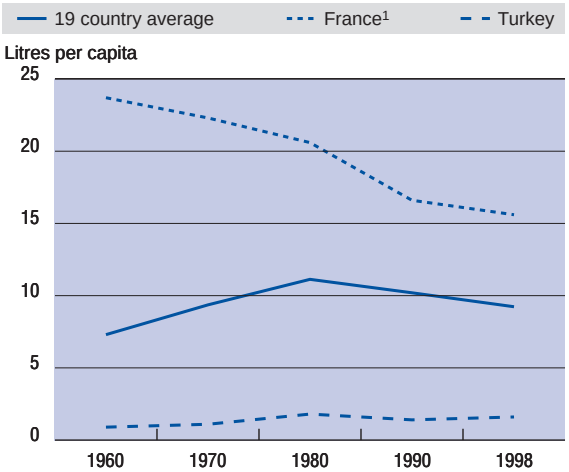
1. Data is for 1997. 2. Data is for 1996.

Chart 5.6. **Changes in alcohol consumption per capita (population aged 15 years and over), 1980-1998[1]**



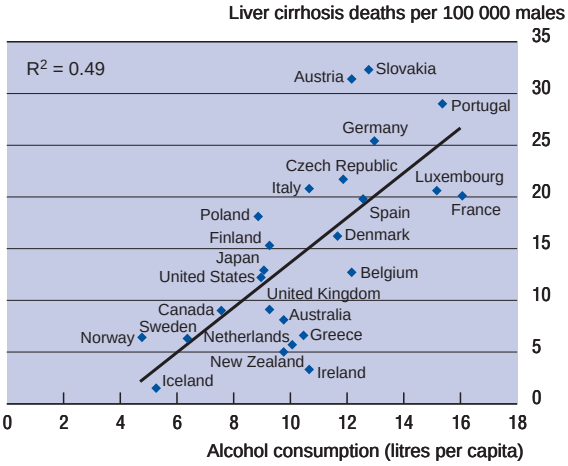
1. 1996 or 1997 data have been used in some cases.

Chart 5.7. **Alcohol consumption in litres per population 15 years and over, 1960-1998**



1. 1998 data refers to 1996.

Chart 5.8. **Liver cirrhosis deaths in 1997 per 100 000 (males) and alcohol consumption, 1992[1]**



1. Some data are for 1996 or 1995 which corresponds with a lagged 5-year period for 1991 and 1990 respectively.

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Body weight

Unlike many other risk factors, problems of obesity are growing in all OECD countries for which historical data are available. Some of the main factors behind the growth in numbers of overweight people in OECD countries include unhealthy diets combined with a lack of physical exercise. Obesity increases the risk of suffering from several chronic diseases such as diabetes, cardiovascular diseases and musculoskeletal diseases.

Charts 5.9 and 5.10 (and Table 5.3) show that the prevalence of obesity in the population aged 15 years and over varies greatly across OECD countries. For women, it ranges from a low of 2.7% in Korea to a high of 25.1% in the United States. Other countries that have a large proportion of people with a Body Mass Index (BMI) over 30 include the United Kingdom, Hungary, Australia and Iceland, where about one out of five people (men and women combined) aged 15 years and over are defined as obese (please note that in the case of Iceland, the data refer only to people aged 45-64 years old). By contrast, most Scandinavian countries (Denmark, Sweden and Norway) and some continental European countries (the Netherlands and Switzerland) have a lower proportion of their population suffering from obesity (between 6% and 8% for men and women combined).

Obesity is more common among women than among men in two-thirds of OECD countries. The gap in obesity rates between women and men is particularly large in the United States, the United Kingdom and New Zealand. Evidence from various countries also indicates that obesity problems tend to be more common among men and women in lower socio-economic groups compared to people with higher levels of education or income.

There has been an increase over time in obesity problems in all countries for which trend data are available (Chart 5.11). This trend rise has been particularly strong in countries like Australia and the United Kingdom. The prevalence of obesity has increased for both men and women, and has affected all age groups.

Obesity is easier to prevent than to treat. This suggests the need for public health authorities to take steps to curb the growth of obesity rates in OECD countries through preventive measures, including the promotion of better nutrition and greater physical activity at all ages. There might also be a need to increase the effort for early detection of children and young adults at risk of potential weight problems.

Definition

The Body Mass Index (BMI) is a single number that evaluates an individual's weight status in relation to height (weight/height^2, with weight in kilograms and height in metres). Individuals with a BMI over 30 are defined as being obese.

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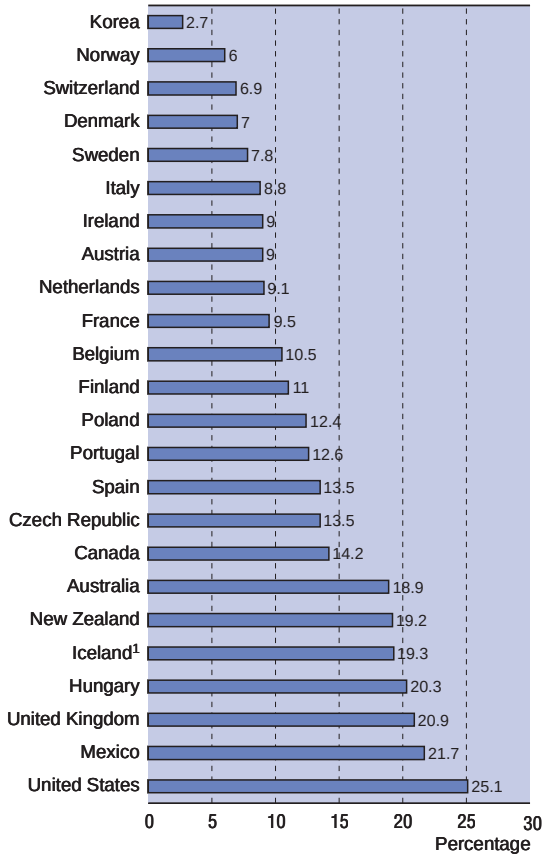
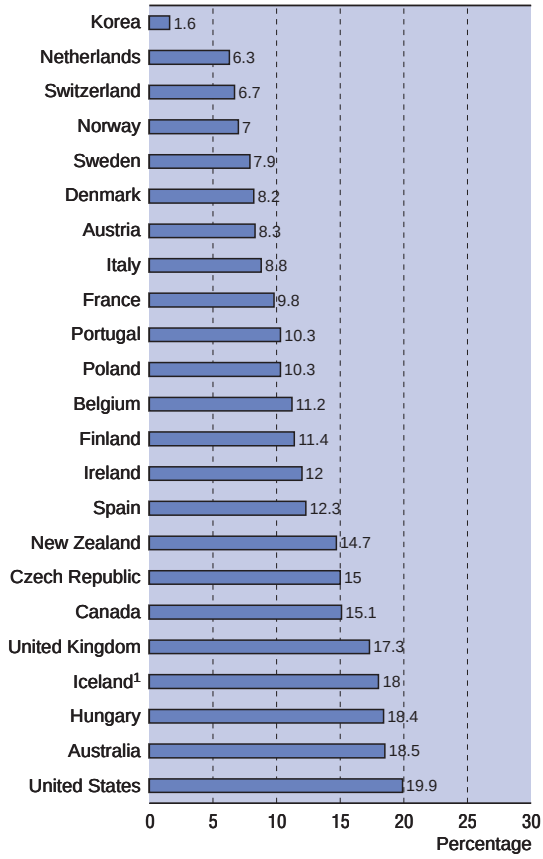
Chart 5.9. **Percentage of females aged 15 years and over with Body Mass Index over 30 (obese population), latest year available**



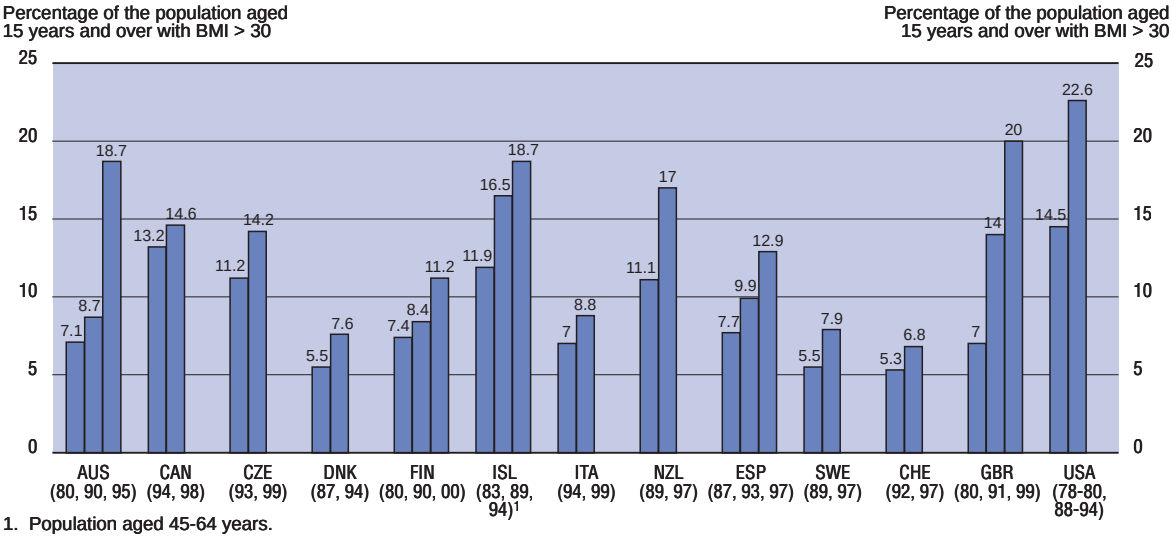
1. Data refer only to people aged 45-64 years old.

Chart 5.10. **Percentage of males aged 15 years and over with Body Mass Index over 30 (obese population), latest year available**



1. Data refer only to people aged 45-64 years old.

Chart 5.11. **Trend in the prevalence of obesity among the adult population**



1. Population aged 45-64 years.

6. DEMOGRAPHIC AND ECONOMIC CONTEXT

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Total population

Growth in the population, along with changes in the population age structure, is one of the determinants of the demand for health care.

Overall, the total population across all 30 OECD countries has increased from 850 million people in 1970 to almost 1 120 million people in 2000 (Table 6.1). Looking at the distribution by broad geographic region, the population of OECD countries now includes 520 million people in Europe (including Turkey), 400 million people in North America and 200 million people in Asia and Oceania. The United States continues to be by far the most populous OECD country, followed by Japan, Mexico and Germany. The countries with the smallest population are Iceland and Luxembourg, with both countries having a population of less than half a million people (Chart 6.1).

Population growth in most OECD countries slowed down considerably over the last decades. By the year 2000, the average population growth across the OECD area was 0.5% per year (Chart 6.3). This compares with average growth rates of 0.9% per year in the 1970s. The decline in population growth across OECD countries is due mainly to a persistent decline in fertility rates.

Average OECD population growth rates mask important variations across countries. Some countries have seen, and continue to see, their population grow at a very rapid pace, while other countries have had roughly stable, or even declining, populations. Among OECD countries, Mexico experienced the fastest population growth over the last three decades (Chart 6.2 and Table 6.1), although this growth rate has tended to come down over time. Turkey also experienced rapid population growth since 1970. On the other hand, population growth in Hungary has been much lower than the OECD average; it has in fact been negative over the last 30 years. This reflects both relatively low fertility rates and very high mortality rates in Hungary in the last three decades.

Looking ahead, population projections from the United Nations show that the slowdown in overall population growth across OECD countries is expected to continue over the next decades. Declining fertility rates along with increases in longevity will mean that the proportion of young people will continue to decline generally in OECD countries, while the share of elderly people will continue to increase. It is projected that by 2020, there will be more people aged 65 and over than there will be young people aged 0 to 15 in all OECD countries taken together (Chart 6.4).

Definition

Total population is defined as all nationals present in or temporarily absent from the country and foreigners permanently settled in the country.

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Chart 6.1. **Total population in thousands, 2000**

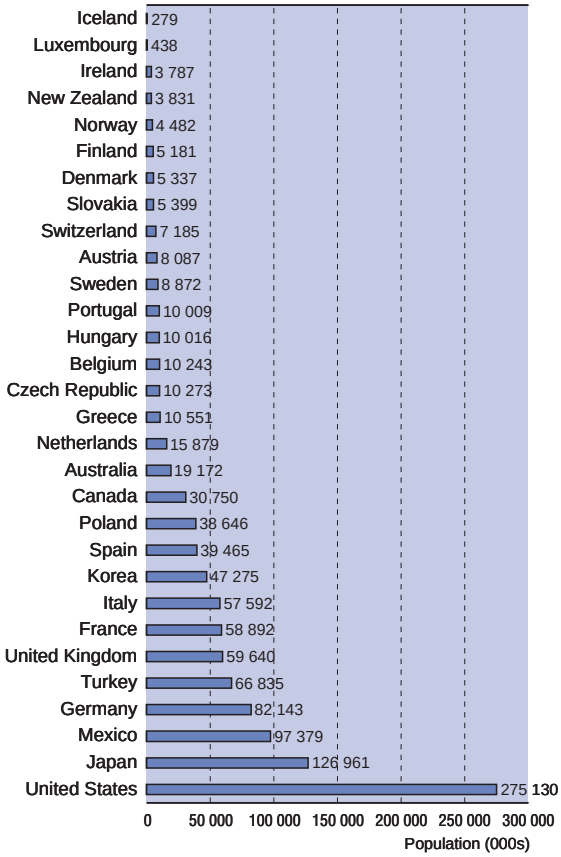


Chart 6.2. **Population growth rates, 1970-2000**

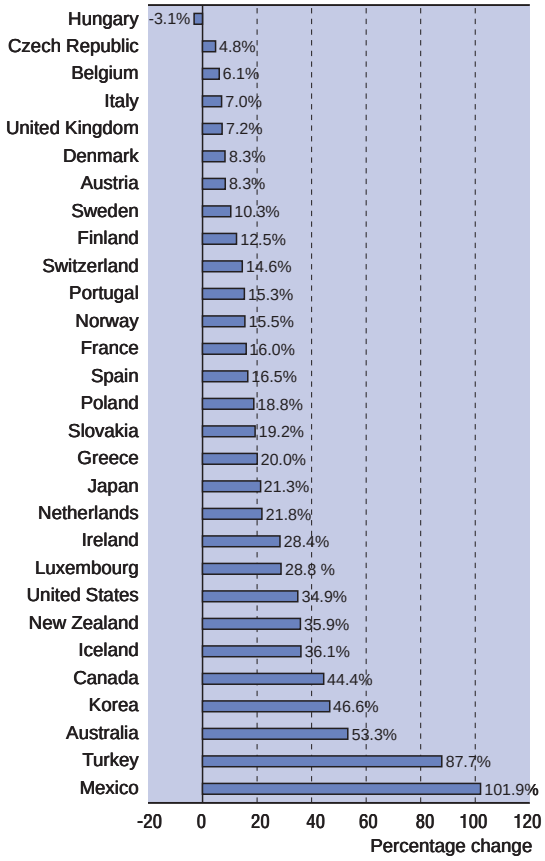
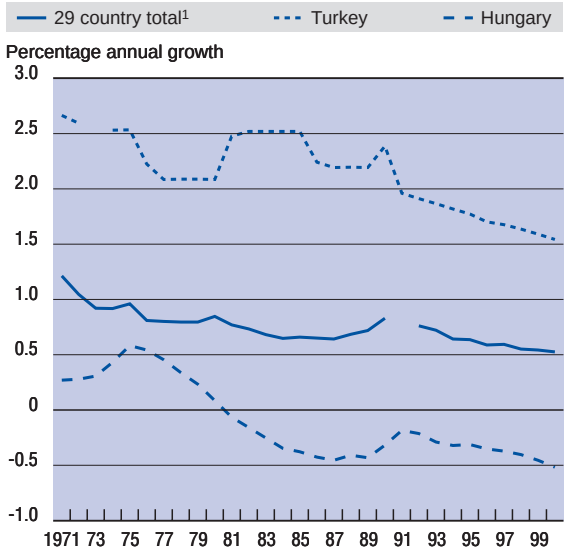
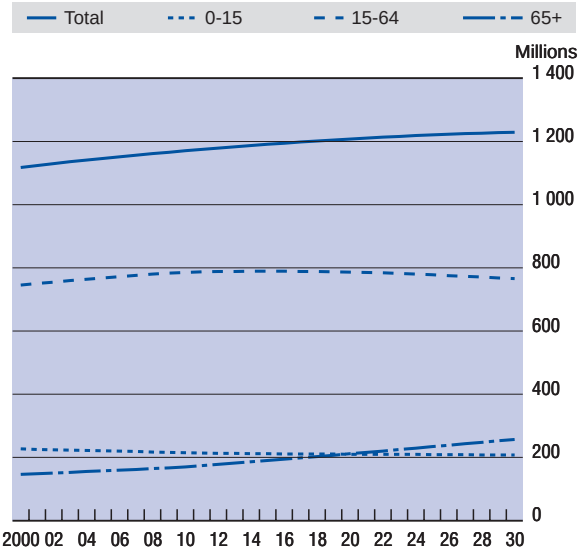


Chart 6.3. **Annual rate of population growth, 1970-2000**



1. Note that the 1990-91 growth rate is not shown due to the impact of German reunification in 1991; Mexico is excluded due to incomplete time series data.

Chart 6.4. **Population growth projections for total OECD area by selected age groups, 2000-2030**



Source: United Nations, *World Population Prospects 1950-2050* (2000 revision).

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Share of the population aged 65 and over

The rising share of elderly members of the population in most OECD countries can be expected to continue to affect demands for health care and long-term care services.

Over the last 40 years, the proportion of people aged 65 years and over has increased steadily in almost all OECD countries (Chart 6.7). On average (unweighted), the share of the population aged 65 years and over has increased from 8.9% in 1960 to 13.8% in 1999 for the 26 OECD countries with complete time series. There has also been a strong growth in the share of the very old population (the population 80 years and over), with their share of the population increasing from 1.3% in 1960 to 3.0% in 1999 (*OECD Health Data 2001*).

Japan has experienced the fastest growth in its share of elderly population in recent decades, with the percentage of people over 65 coming close to tripling in the last 40 years (Table 6.2 and Chart 6.7). The share of the elderly population has also more than doubled over the last 40 years in Finland, Greece, Korea, Poland and Spain. By contrast, in Ireland, the proportion of people aged 65 and over has remained more or less stable over the last forty years, due to relatively high birth rates, particularly in the 1960s and the 1970s.

As it stands, there are large variations across OECD countries in the percentage of the population over 65 years of age, as exemplified by "young" OECD countries such as Mexico, Turkey and Korea and "older" countries such as Sweden, Italy and Greece (Chart 6.5).

Older people, and particularly very old people, tend to require more health care and long-term care than younger people. *OECD Health Data* provides data on health expenditure by age for about half of the OECD countries. Chart 6.6 shows that per capita expenditure for those aged 65 and over are, on the whole, two to five times greater than for the population under 65. These ratios are even greater for people aged 75 and over. Although there appears to be significant variations across countries in the relative amount of resources spent on providing health care to older people, it should be borne in mind that cross-country comparisons are limited by the different methodologies and data sources used to obtain these estimates.

There is growing evidence from several countries that a high proportion of health expenditure is consumed in the last few years prior to death, as opposed to being evenly spread over all years of life after 65 years of age. In the United States, it has been estimated that the 5% of Medicare beneficiaries who died in 1988 accounted for 29% of total Medicare payments (Lubitz and Riley, 1993, cited in Zweifel *et al.*, 1999). Similarly, in Canada, recent results indicate that about one third of health expenditure are incurred by people in their last year of life, regardless of their age (Pollock, 2001). And in Switzerland, results based on longitudinal data also found that health care expenditure tend to be concentrated in the last two years before death (Zweifel *et al.*, 1999). Therefore, a large part of the observed greater health care expenditure for people above a certain age may be explained largely by the high "cost of dying" and the higher probability of people at, say, 75 years of age to be in the last year or last two years of their life in comparison with people in younger age groups. These results are important since they imply that if life expectancy among the elderly population continues to improve in the years ahead, these should help postpone pressures on health care expenditure arising from population ageing.

Although the macroeconomic effect of population ageing on health care expenditure may be less than what is often anticipated, health care systems in OECD countries will need to continue to adjust to a population that will be older. An on-going challenge in several OECD countries is to create better linkages in the delivery and funding of health care and long-term care services for the oldest and most disabled segment of populations (Jacobzone *et al.*, 2000*a*).

Definition

The population aged 65 years and over divided by the total population.

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Chart 6.5. **Share of the population aged 65+, 1999**

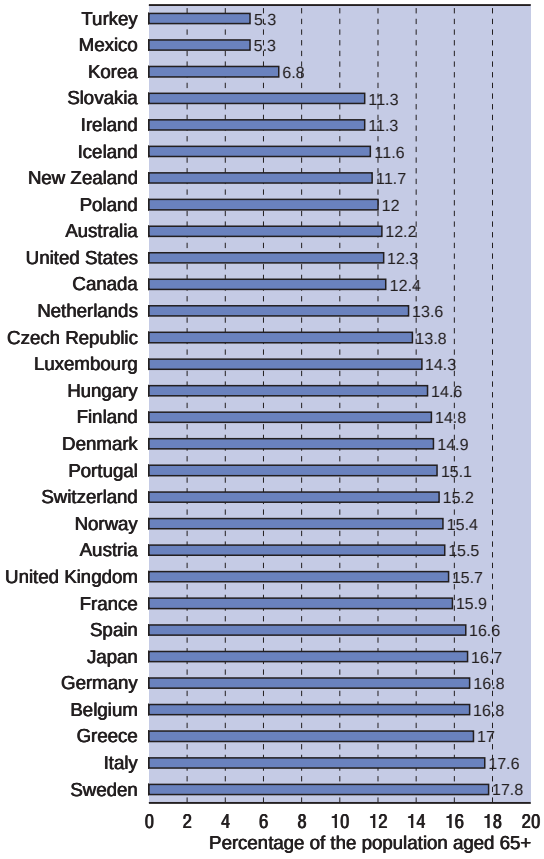


Chart 6.6. **Per capita health expenditure by age group, population 65+ and 75+ compared with 0-64 population, 1990s**

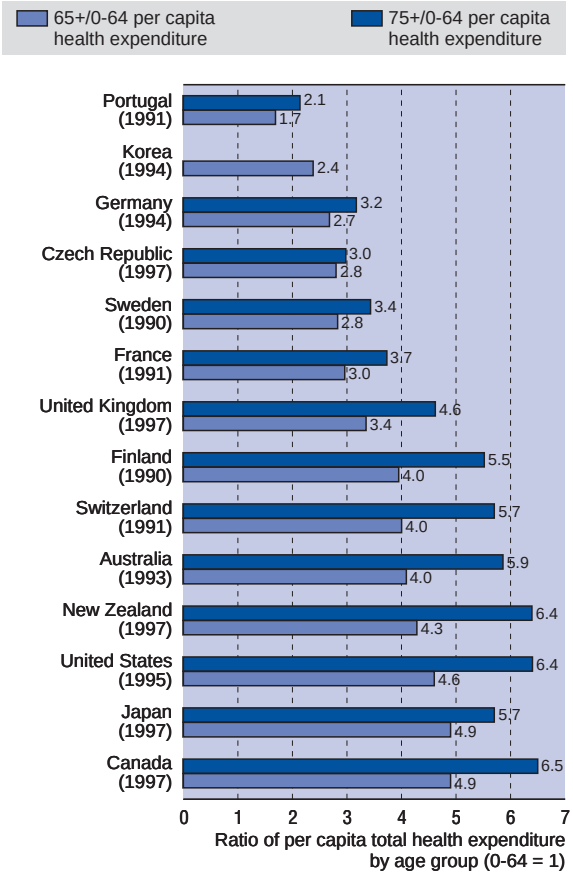
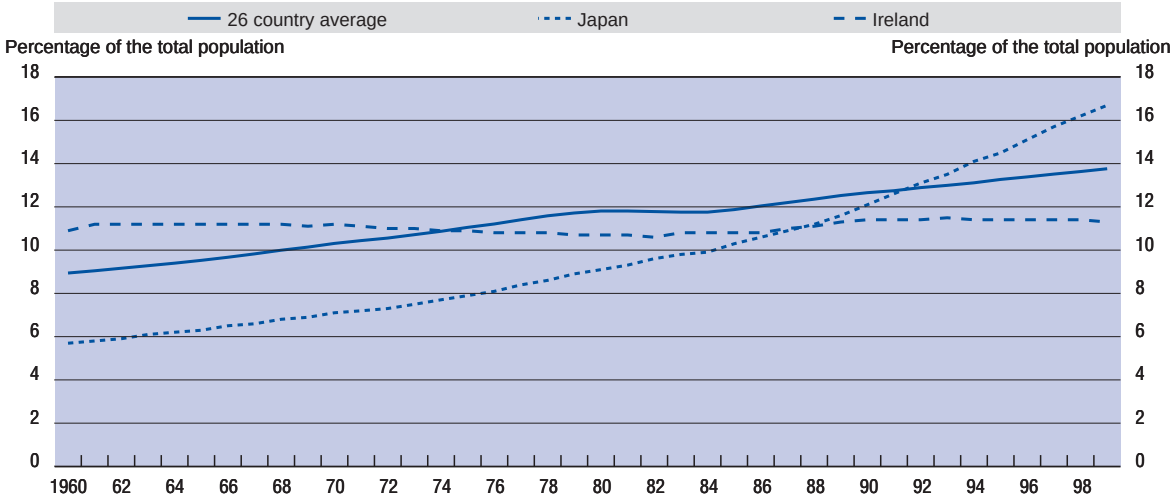


Chart 6.7. **Share of the population aged 65 or more years**



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Gross Domestic Product per capita and income distribution

Another major determinant of the demand for and the supply of health services and indeed, of health status itself, is national income per capita.

At the end of the 1990s, the level of GDP per capita (converted to US$, using economy-wide purchasing power parity rates) continues to vary considerably across OECD countries. It ranged from a high of $41 656 per capita in Luxembourg to a low of $6 335 in Turkey (Chart 6.8).

Looking at trends over time, for the 24 OECD countries with complete time series, real GDP per capita (GDP per capita deflated by national GDP price indices) has increased on average by 2.4% per year between 1970 and 1999, although there were a lot of variations from year-to-year and from country-to-country (Table 6.3). The rate of growth in GDP per capita across these 24 OECD countries has slowed down slightly over the last three decades, from an average of 3% per year in the 1970s to 2.4% in the 1980s and 2% in the 1990s.

Over the 1970-1999 period, Korea registered the highest growth rate in real GDP per capita, with an average growth rate of 6.0% per year (Chart 6.9). Real GDP per capita also increased strongly over that period of time in Ireland, Iceland, Luxembourg, Portugal, Norway and Mexico.

Rising prosperity increases the demand for health services for any given level of morbidity. It also makes it easier to increase the resources available for health care by enhancing household disposable income and the taxable capacity of a country. It is these forces which lie behind the striking positive relationship between GDP per capita and health expenditure per capita as displayed in Section 4 (Chart 4.7). A direct relationship can also be observed between GDP per capita and mortality. Or (2000*a*) suggests that a 10% increase in GDP per capita is associated on average with a reduction of 3.5% to 4.5% in premature mortality in OECD countries, after allowing for other determinants of health status.

While average income per capita affects the population's health status, the distribution of the national income also matters. At the individual level, inequalities in income are associated with inequalities in health status, although questions remain about causality links. In recent years, there has also been a growing literature on possible links between the overall level of income inequality in a society and the health of its population, either at the national, regional or municipal level (Wilkinson, 1992; Lynch *et al*., 1998; and Lynch *et al*., 2000). A recent analysis of income distribution in 19 OECD countries shows that, in the mid-1990s, income inequality (as measured by the Gini coefficient, after taxes and transfers) was the lowest in Nordic countries (Forster, 2000). It was the highest in those OECD countries with the lowest income per capita, such as Mexico and Turkey (Chart 6.10). Looking at trends over time, the distribution of income has widened at least slightly in several countries between the mid-1980s and the mid-1990s. However, in some other countries, income inequality has decreased slightly over that period (Denmark, Ireland and Sweden).

Definition

Gross Domestic Product (GDP) is defined as total domestic expenditure plus exports, less imports of goods and services. Real GDP is then nominal GDP deflated by GDP prices.

Income distribution is measured by the Gini coefficient. The Gini coefficient is derived from the Lorenz curve, which plots cumulative shares of population, from the poorest upwards, against the cumulative share of incomes that they receive. If incomes were equally distributed, the plot would trace a 45° line ("line of perfect equality"). At the other extreme – if the richest unit received all income – the Lorenz curve would lie along the horizontal axis, and then along the vertical axis at the 100 per cent income share ("line of perfect inequality"). The Gini coefficient is defined as the area between the Lorenz curve and the 45° line, taken as the ratio of the whole triangle. Therefore, it will yield a value of 0 in the first extreme case ("perfect equality") and 1 in the latter case ("perfect inequality"). An increase in the Gini coefficient thus represents an increase in inequality.

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Chart 6.8. **Gross Domestic Product per capita (US$ economy-wide PPPs), 1999**

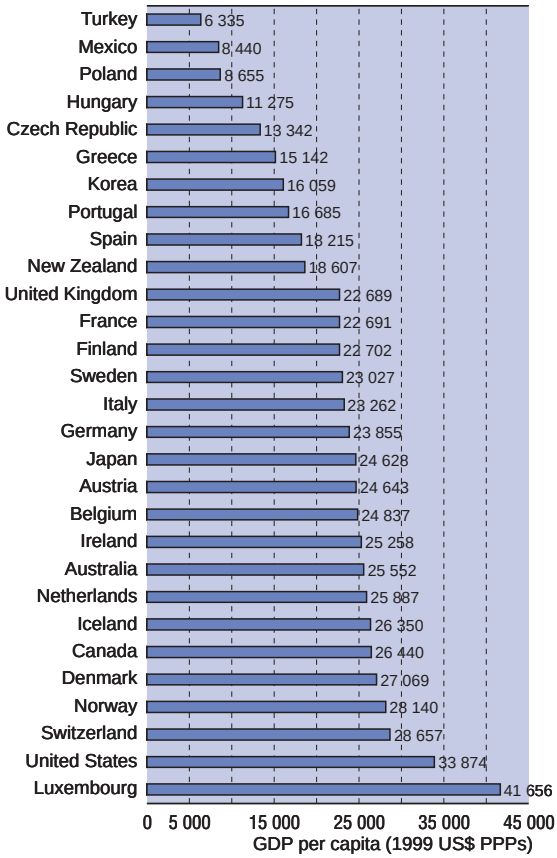


Chart 6.9. **Average annual growth rates, real Gross Domestic Product per capita, 1970-1999**

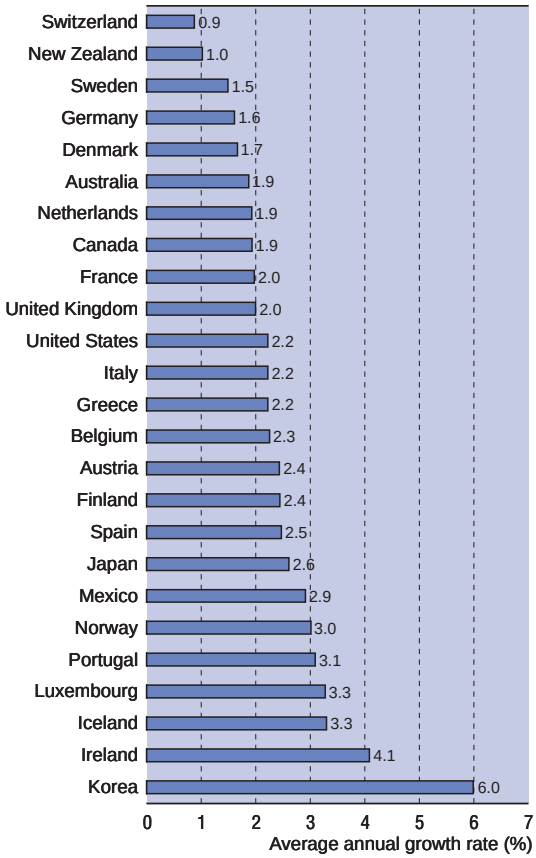
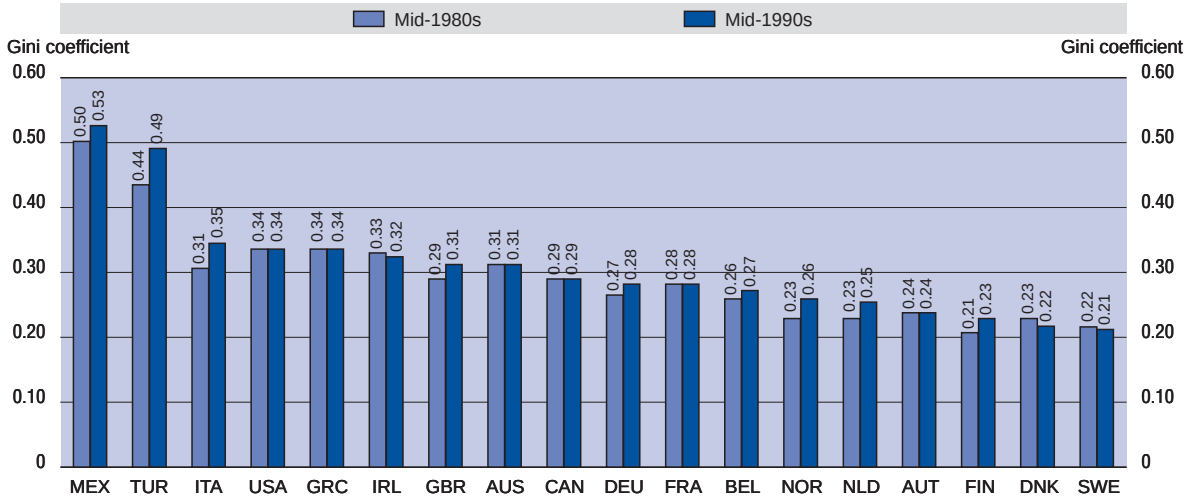


Chart 6.10. **Trends in income inequality, mid-1980s to mid-1990s**



Source: Forster (2000).

Annex 1

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Table 1.1. **Female life expectancy at birth, 1960-1998***

	Year**								% change*** 1960-1998
	1960	1970	1980	1990	1995	1996	1997	1998	
Australia	73.9	74.2	78.1	80.1	80.8	81.1	81.3	81.5	10.3
Austria	71.9	73.4	76.1	78.9	80.1	80.2	80.6	80.9	12.5
Belgium	73.5	74.2	76.8	79.1	80.2	80.2	81.8	81.1	10.3
Canada	74.3	76.4	79.1	80.4	81.3	81.4	81.4	n.a.	9.6
Czech Republic	73.4	73.0	73.9	75.4	76.6	77.3	77.5	78.1	6.4
Denmark	74.1	75.7	77.3	77.7	77.8	78.0	78.4	78.6	6.1
Finland	71.6	74.2	77.8	78.9	80.2	80.5	80.5	80.8	12.8
France	73.6	75.9	78.4	80.9	81.9	82.0	82.3	82.2	11.7
Germany	72.4	73.6	76.6	79.0	79.8	79.9	80.3	80.5	11.2
Greece	70.7	73.6	76.6	79.4	79.4	79.4	79.4	79.4	12.3
Hungary	70.1	72.1	72.7	73.7	74.5	74.7	75.1	75.2	7.3
Iceland	75.0	76.3	79.7	80.3	80.6	80.6	81.3	81.5	8.7
Ireland	71.8	73.2	75.0	77.6	78.6	78.5	78.6	79.1	10.2
Italy	72.3	74.9	77.4	80.0	81.0	81.3	81.6	n.a.	12.9
Japan	70.2	74.7	78.8	81.9	82.9	83.6	83.8	84.0	19.7
Korea	53.7	66.1	70.5	75.9	77.4	n.a.	78.1	n.a.	45.4
Luxembourg	71.9	73.9	75.1	78.5	79.4	80.0	79.8	80.5	12.0
Mexico	59.5	63.6	70.0	74.0	75.9	76.3	76.6	77.0	29.4
Netherlands	75.4	76.5	79.2	80.1	80.4	80.4	80.6	80.7	7.0
New Zealand	73.9	74.6	76.3	78.3	79.5	79.6	80.1	80.4	8.8
Norway	75.8	77.3	79.2	79.8	80.8	81.1	81.0	81.3	7.3
Poland	70.6	73.3	74.4	75.5	76.4	76.6	77.0	77.3	9.5
Portugal	67.2	71.0	76.6	77.9	78.2	78.5	78.7	78.8	17.3
Slovakia	72.7	72.9	74.7	75.4	76.3	76.8	76.7	76.7	5.5
Spain	72.2	75.1	78.6	80.5	81.6	81.8	82.0	82.2	13.9
Sweden	74.9	77.1	78.8	80.4	81.3	81.5	81.8	81.9	9.3
Switzerland	74.1	76.2	78.8	80.9	81.7	81.9	82.3	82.5	11.3
Turkey	50.3	56.3	60.3	69.0	70.3	70.5	70.8	71.0	41.2
United Kingdom	74.2	75.2	77.0	78.5	79.4	79.5	79.7	79.7	7.4
United States	73.1	74.7	77.4	78.8	79.2	79.4	79.4	79.4	8.6
Weighted OECD average	70.5	73.0	75.9	78.3	79.1	79.4	79.6	79.7	13.1
Unweighted OECD average	70.9	73.3	76.0	78.2	79.1	79.3	79.6	79.8	12.5

n.a.: not available.

* Note that each country calculates its own life expectancy, using life table methodologies that can vary. These differences in methodology can affect the comparability of the life expectancy measures provided, as different life table methods can change a nation's life expectancy estimates by a fraction of a year.

** Note that data for:
1960 refers to 1951-1960 for Iceland.
1960 refers to 1961 for Canada and Italy.
1970 refers to 1971 for Canada, Finland, Italy and Korea.
1970 refers to 1966-1970 for Iceland.
1980 refers to 1981 for Canada, Korea and Portugal.
1990 refers to 1991 for Korea.

*** The percentage change refers to the period 1960 to 1998 or the latest year available.

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Table 1.2. **Male life expectancy at birth, 1960-1998***

	Year**								% change*** 1960-1998
	1960	1970	1980	1990	1995	1996	1997	1998	
Australia	67.9	67.4	71.0	73.9	75.0	75.2	75.6	75.9	11.8
Austria	65.4	66.5	69.0	72.3	73.5	73.9	74.3	74.7	14.2
Belgium	67.7	67.8	70.0	72.4	73.6	73.5	74.7	74.8	10.5
Canada	68.4	69.3	71.9	73.8	75.3	75.7	75.8	n.a.	10.8
Czech Republic	67.9	66.1	66.8	67.6	69.7	70.4	70.5	71.1	4.7
Denmark	70.3	70.8	71.2	72.0	72.6	72.9	73.3	73.7	4.8
Finland	64.9	65.9	69.2	70.9	72.8	73.0	73.4	73.5	13.3
France	67.0	68.4	70.2	72.7	73.9	74.2	74.6	74.6	11.3
Germany	66.9	67.2	69.9	72.7	73.3	73.6	74.1	74.5	11.4
Greece	67.5	70.1	72.2	74.6	74.6	74.6	74.6	74.6	10.5
Hungary	65.9	66.3	65.5	65.1	65.3	66.6	66.4	66.1	0.3
Iceland	70.7	70.7	73.7	75.7	76.5	76.2	76.4	77.0	8.9
Ireland	68.5	68.5	69.5	72.1	73.0	73.2	73.4	73.5	7.3
Italy	67.2	69.0	70.6	73.5	74.6	75.0	75.3	n.a.	12.1
Japan	65.3	69.3	73.4	75.9	76.4	77.0	77.2	77.2	18.2
Korea	51.1	59.0	62.3	67.7	69.6	n.a.	70.6	n.a.	38.2
Luxembourg	66.1	67.0	68.0	72.3	72.9	73.0	74.1	73.7	11.5
Mexico	56.2	59.7	64.0	68.8	71.3	71.7	72.0	72.4	28.8
Netherlands	71.5	70.8	72.5	73.8	74.6	74.7	75.2	75.2	5.2
New Zealand	68.7	68.3	70.0	72.4	74.2	74.3	74.9	75.2	9.5
Norway	71.3	71.0	72.3	73.4	74.8	75.4	75.4	75.5	5.9
Poland	64.9	66.6	66.0	66.5	67.6	68.1	68.5	68.9	6.2
Portugal	61.7	65.3	67.7	70.9	71.0	71.2	71.4	71.7	16.2
Slovakia	68.4	66.7	66.8	66.6	68.4	68.9	68.9	68.6	0.3
Spain	67.4	69.6	72.5	73.4	74.4	74.5	74.6	74.8	11.0
Sweden	71.2	72.2	72.8	74.8	75.9	76.5	76.7	76.9	8.0
Switzerland	68.7	70.3	72.3	74.0	75.3	75.7	76.2	76.5	11.4
Turkey	46.3	52.0	55.8	64.4	65.7	65.9	66.2	66.4	43.4
United Kingdom	68.3	68.6	71.0	72.9	74.1	74.3	74.6	74.8	9.5
United States	66.6	67.1	70.0	71.8	72.5	72.7	73.6	73.9	11.0
Weighted OECD average	65.0	66.6	69.1	71.6	72.7	73.0	73.5	73.7	13.3
Unweighted OECD average	66.2	67.4	69.5	71.7	72.8	73.1	73.5	73.7	11.4

n.a.: not available.

* Note that each country calculates its own life expectancy, using life table methodologies that can vary. These differences in methodology can affect the comparability of the life expectancy measures provided, as different life table methods can change a nation's life expectancy estimates by a fraction of a year.

** Note that data for:
1960 refers to 1951-1960 for Iceland.
1960 refers to 1961 for Canada and Italy.
1970 refers to 1971 for Canada, Finland, Italy and Korea.
1970 refers to 1966-1970 for Iceland.
1980 refers to 1981 for Canada and Korea.
1990 refers to 1991 for Korea.

*** The percentage change refers to 1960 to 1998 or the latest year available.

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Table 1.3. **Female life expectancy at age 65, 1960-1998***

	Year**								% change*** 1960-1998
	1960	1970	1980	1990	1995	1996	1997	1998	
Australia	15.6	15.6	17.9	19.0	19.5	19.6	19.8	20.0	28.2
Austria	14.7	14.9	16.3	18.0	18.7	18.8	19.1	19.3	31.3
Belgium	14.8	15.3	16.9	18.3	19.6	19.7	19.8	19.8	33.8
Canada	16.1	17.5	18.9	19.6	20.1	20.2	20.1	n.a.	24.8
Czech Republic	14.5	14.2	14.3	15.2	16.1	16.4	16.6	16.9	16.6
Denmark	n.a.	16.5	17.6	17.9	17.6	17.7	17.9	17.9	n.a.
Finland	13.7	14.4	16.8	17.7	18.6	18.7	18.9	19.1	39.4
France	15.6	16.8	18.2	19.9	20.6	20.7	20.8	n.a.	33.3
Germany	14.6	15.0	16.7	18.0	18.5	18.6	18.9	19.0	30.1
Greece	15.1	15.3	16.7	18.0	18.4	18.6	18.7	18.7	23.8
Hungary	13.8	14.3	14.6	15.3	15.8	15.9	n.a.	n.a.	15.2
Iceland	n.a.	n.a.	19.1	19.3	19.4	19.1	19.5	19.8	n.a.
Ireland	n.a.	n.a.	n.a.	16.9	17.4	n.a.	n.a.	n.a.	n.a.
Italy	15.3	16.2	17.1	18.6	19.4	19.7	20.2	n.a.	32.0
Japan	14.1	15.3	17.7	20.0	20.9	21.5	21.8	22.0	56.0
Korea	n.a.	14.6	15.1	16.4	17.0	n.a.	17.3	n.a.	n.a.
Luxembourg	14.5	14.9	16.0	18.3	19.2	n.a.	n.a.	n.a.	n.a.
Mexico	14.4	15.0	16.5	17.7	18.3	18.4	18.6	18.7	29.9
Netherlands	15.3	16.1	18.0	18.6	18.7	18.6	18.8	18.8	22.9
New Zealand	15.6	16.0	17.0	18.3	19.0	19.0	19.4	19.5	25.0
Norway	16.0	16.7	18.0	18.6	19.1	19.5	19.4	19.6	22.5
Poland	14.9	15.3	15.5	16.1	16.6	16.5	16.8	17.0	14.1
Portugal	n.a.	n.a.	16.5	17.0	17.8	17.7	17.7	17.9	n.a.
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	15.3	15.9	17.9	19.2	19.9	20.0	20.2	20.3	32.7
Sweden	n.a.	16.8	17.9	19.0	19.7	19.7	19.9	20.0	n.a.
Switzerland	n.a.	n.a.	18.3	19.6	20.2	20.3	20.6	20.6	n.a.
Turkey	12.1	12.6	12.8	14.0	14.2	14.2	14.3	14.3	18.2
United Kingdom	15.0	16.0	16.9	17.8	18.3	18.3	18.5	n.a.	23.3
United States	15.8	17.0	18.3	18.9	18.9	18.9	19.2	19.1	20.9
Weighted 21 country average	15.1	16.0	17.4	18.6	19.1	19.2	19.5	19.6	29.5
Unweighted 21 country average****	14.9	15.5	16.8	17.9	18.5	18.7	18.9	19.0	27.6

n.a.: not available.

* Note that each country calculates its own life expectancy, using life table methodologies that can vary. These differences in methodology can affect the comparability of the life expectancy measures provided, as different life table methods can change a nation's life expectancy estimates by a fraction of a year.

** Note that data for:
1960 refers to 1961 for Canada, Italy and Luxembourg.
1970 refers to 1971 for Canada, Finland, Italy, Korea and Luxembourg.
1980 refers to 1979 for Luxembourg.
1980 refers to 1981 for Canada and Korea.
1980 refers to 1982 for Switzerland.
1990 refers to 1991 for Korea.

*** The percentage change refers to 1960 to 1998 or early 1960s to late 1990s where 1960 or 1998 data is unavailable.

**** The 21 country average includes all OECD countries except Denmark, Iceland, Ireland, Korea, Luxembourg, Portugal, Slovakia, Sweden and Switzerland.

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Table 1.4. **Male life expectancy at age 65, 1960-1998***

	Year**								% change*** 1960-1998
	1960	1970	1980	1990	1995	1996	1997	1998	
Australia	12.5	11.9	13.7	15.2	15.7	15.8	16.1	16.3	30.4
Austria	12.0	11.7	12.9	14.4	15.2	15.3	15.4	15.6	30.0
Belgium	12.4	12.1	13.0	14.0	15.1	15.3	15.5	15.6	25.8
Canada	13.6	13.8	14.6	15.6	16.2	16.3	16.3	n.a.	19.9
Czech Republic	12.5	11.1	11.2	11.6	12.7	13.1	13.2	13.4	7.2
Denmark	n.a.	13.7	13.7	14.1	14.2	14.2	14.5	14.7	n.a.
Finland	11.5	11.4	12.6	13.7	14.5	14.6	15.0	14.9	29.6
France	12.5	13.0	13.6	15.6	16.1	16.1	16.3	n.a.	30.4
Germany	12.4	12.0	13.0	14.3	14.7	14.9	15.2	15.3	23.4
Greece	13.5	13.9	14.6	15.7	16.1	16.1	16.2	16.2	20.0
Hungary	12.3	12.0	11.6	12.0	12.1	12.1	n.a.	n.a.	–1.6
Iceland	n.a.	n.a.	15.8	16.1	16.5	16.2	16.2	16.4	n.a.
Ireland	n.a.	n.a.	n.a.	13.3	13.7	n.a.	n.a.	n.a.	n.a.
Italy	13.4	13.3	13.3	14.9	15.5	15.7	15.8	n.a.	17.9
Japan	11.6	12.5	14.6	16.2	16.5	16.9	17.0	17.1	47.4
Korea	n.a.	10.2	10.6	12.6	13.3	n.a.	13.6	n.a.	n.a.
Luxembourg	12.5	12.1	12.3	14.2	14.7	n.a.	n.a.	n.a.	n.a.
Mexico	13.8	14.2	15.3	16.4	17.2	17.3	17.4	17.6	27.5
Netherlands	13.9	13.3	13.7	14.1	14.4	14.4	14.7	14.7	5.8
New Zealand	13.0	12.4	13.2	14.7	15.4	15.5	15.9	16.1	23.8
Norway	14.5	13.8	14.3	14.6	15.5	15.5	15.5	15.7	8.3
Poland	12.7	12.5	12.0	12.4	12.9	12.9	13.1	13.4	5.5
Portugal	n.a.	n.a.	12.9	13.8	14.4	14.3	14.3	14.4	n.a.
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	13.1	13.3	14.8	15.5	16.0	16.1	16.2	16.3	24.4
Sweden	n.a.	14.2	14.3	15.3	16.0	16.1	16.2	16.3	n.a.
Switzerland	n.a.	n.a.	14.6	15.4	16.1	16.3	16.6	16.7	n.a.
Turkey	11.2	11.5	11.7	12.5	12.6	12.7	12.7	12.7	13.4
United Kingdom	11.9	12.0	12.9	14.0	14.7	14.8	15.0	n.a.	26.1
United States	12.8	13.1	14.1	15.1	15.6	15.7	15.9	16.0	25.0
Weighted 21 country average	12.6	12.7	13.7	14.9	15.4	15.6	15.7	15.9	25.8
Unweighted 21 country average****	12.7	12.6	13.4	14.4	15.0	15.1	15.3	15.4	20.8

n.a.: not available.

* Note that each country calculates its own life expectancy, using life table methodologies that can vary. These differences in methodology can affect the comparability of the life expectancy measures provided, as different life table methods can change a nation's life expectancy estimates by a fraction of a year.

** Note that data for:
1960 refers to 1961 for Canada, Italy and Luxembourg.
1970 refers to 1971 for Canada, Finland, Italy, Korea and Luxembourg.
1980 refers to 1979 for Luxembourg.
1980 refers to 1981 for Canada and Korea.
1980 refers to 1982 for Switzerland.
1990 refers to 1991 for Canada and Korea.

*** The percentage change refers to 1960 to 1998 or the latest year available.

**** The 21 country average includes all OECD countries except Denmark, Iceland, Ireland, Korea, Luxembourg, Portugal, Slovakia, Sweden and Switzerland.

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Table 1.5. **Infant mortality, deaths per 1 000 live births, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1960-1999
Australia	20.2	17.9	10.7	8.2	5.7	5.8	5.3	5.0	5.7	–3.2
Austria	37.5	25.9	14.3	7.8	5.4	5.1	4.7	4.9	4.4	–5.3
Belgium	31.2	21.1	12.1	8.0	7.0	6.0	6.1	5.6	5.3	–4.4
Canada	27.3	18.8	10.4	6.8	6.0	5.6	5.5	n.a.	n.a.	–4.2
Czech Republic	20.0	20.2	16.9	10.8	7.7	6.0	5.9	5.2	4.6	–3.7
Denmark	21.5	14.2	8.4	7.5	5.1	5.6	5.2	4.7	4.2	–4.1
Finland	21.0	13.2	7.6	5.6	4.0	3.9	3.9	4.1	3.6	–4.4
France	27.5	18.2	10.0	7.3	4.9	4.8	4.7	4.6	4.3	–4.6
Germany	33.8	23.6	12.6	7.0	5.3	5.0	4.8	4.7	4.6	–5.0
Greece	40.1	29.6	17.9	9.7	8.1	7.2	6.4	5.7	5.9	–4.8
Hungary	47.6	35.9	23.2	14.8	10.7	10.9	9.9	9.7	8.5	–4.3
Iceland	13.0	13.2	7.7	5.9	6.1	3.7	5.5	2.6	2.4	–4.2
Ireland	29.3	19.5	11.1	8.2	6.3	5.5	6.2	6.2	5.5	–4.2
Italy	43.9	29.6	14.6	8.2	6.2	5.9	5.6	5.3	5.1	–5.4
Japan	30.7	13.1	7.5	4.6	4.3	3.8	3.7	3.6	3.4	–5.5
Korea	n.a.	45.0	17.0	10.0	n.a.	7.7	n.a.	n.a.	n.a.	n.a.
Luxembourg	31.5	24.9	11.5	7.3	5.5	4.9	4.2	5.0	4.7	–4.8
Mexico	74.0	68.0	40.0	24.0	17.0	17.0	16.4	15.8	14.5	–4.1
Netherlands	17.9	12.7	8.6	7.1	5.5	5.7	5.0	5.2	5.2	–3.1
New Zealand	22.6	16.7	13.0	8.4	6.7	7.3	6.8	n.a.	n.a.	–3.2
Norway	18.9	12.7	8.1	7.0	4.1	4.1	4.1	4.0	3.9	–4.0
Poland	54.8	36.7	25.5	19.3	13.6	12.2	10.2	9.5	8.9	–4.6
Portugal	77.5	55.5	24.3	11.0	7.5	6.9	6.4	5.9	5.5	–6.6
Slovakia	28.6	25.7	20.9	12.0	11.0	10.2	8.7	8.8	8.3	–3.1
Spain	43.7	28.1	12.3	7.6	5.5	5.5	5.0	5.7	4.9	–5.5
Sweden	16.6	11.0	6.9	6.0	4.1	4.0	3.6	3.5	3.4	–4.0
Switzerland	21.1	15.1	9.1	6.8	5.0	4.7	4.8	4.8	4.6	–3.8
Turkey	189.5	145.0	117.5	57.6	44.4	42.2	40.0	38.5	37.5	–4.1
United Kingdom	22.5	18.5	12.1	7.9	6.2	6.1	5.9	5.7	5.8	–3.4
United States	26.0	20.0	12.6	9.2	7.6	7.3	7.2	7.2	n.a.	–3.3
29 country weighted average	39.6	29.5	19.6	12.5	9.7	9.3	8.9	8.7	8.4	–3.9
29 country unweighted average***	37.6	27.7	17.5	10.7	8.2	7.7	7.3	7.0	6.7	–4.3

n.a.: not available.
* Note that Korean data for 1980 and 1990 refers to 1981 and 1991 respectively.
** Growth rate refers to the average annual growth rate and is for 1960 to 1999 or the latest year available.
*** 29 country average is for all countries excluding Korea.

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Table 1.6. **Female potential years of life lost, all causes, 1960-1997**

	Year*							% change 1960-1997**
	1960	1970	1980	1990	1995	1996	1997	
Australia	6 683.0	6 291.0	4 194.6	3 268.9	2 809.5	2 726.6	2 736.3	–59.1
Austria	8 782.0	6 551.0	4 908.5	3 422.5	2 885.1	2 826.0	2 647.1	–69.9
Belgium	7 354.0	6 012.0	4 759.8	3 554.2	3 100.3	n.a.	n.a.	–57.8
Canada	7 176.0	5 803.0	4 341.9	3 325.2	2 953.6	2 861.8	2 780.1	–61.3
Czech Republic	n.a.	n.a.	n.a.	4 351.9	3 695.3	3 331.6	3 378.2	n.a.
Denmark	6 071.0	4 996.0	4 426.7	3 999.9	3 619.9	3 492.7	n.a.	–42.5
Finland	6 668.0	4 988.0	3 746.8	3 300.1	2 663.2	2 538.9	n.a.	–61.9
France	6 665.0	5 280.0	4 200.8	3 170.6	2 869.1	2 761.7	2 659.1	–60.1
Germany	8 312.5	6 288.1	4 661.4	3 325.9	2 977.8	2 908.5	2 802.5	–66.3
Greece	8 308.4	6 003.5	4 364.9	3 122.6	2 745.4	2 721.0	2 635.3	–68.3
Hungary	9 458.0	7 994.0	6 602.8	6 191.1	5 437.6	5 229.5	4 966.8	–47.5
Iceland	5 042.1	3 933.9	2 956.8	2 964.8	3 294.2	2 353.0	n.a.	–53.3
Ireland	8 017.5	6 559.7	4 761.2	3 606.5	3 253.6	3 035.7	n.a.	–62.1
Italy	9 695.0	6 648.0	4 140.1	2 987.9	2 703.7	2 725.0	2 547.8	–73.7
Japan	9 975.0	5 577.0	3 303.8	2 441.4	2 379.7	2 198.8	2 181.9	–78.1
Korea	n.a.	n.a.	n.a.	3 972.3	3 492.0	3 334.3	3 141.7	n.a.
Luxembourg	n.a.	7 123.0	5 258.4	3 787.3	2 782.5	3 130.8	2 848.0	n.a.
Mexico	26 491.0	21 379.0	11 036.0	8 029.2	6 451.3	n.a.	n.a.	–75.6
Netherlands	5 203.0	4 636.0	3 541.7	3 145.9	2 876.5	2 901.1	2 812.9	–45.9
New Zealand	6 957.0	6 242.0	5 447.7	4 212.8	3 780.4	3 759.0	3 511.0	–49.5
Norway	5 115.0	4 054.0	3 230.8	3 110.4	2 510.1	2 555.7	2 628.3	–48.6
Poland	10 379.0	7 494.0	6 005.4	5 057.8	4 469.0	4 268.6	n.a.	–58.9
Portugal	16 992.0	11953.0	6 036.6	4 379.4	3 627.4	3 625.1	3 631.6	–78.6
Slovakia	n.a.	n.a.	n.a.	n.a.	4 054.5	3 857.6	3 915.6	n.a.
Spain	8 930.0	5 665.0	3 833.4	3 127.3	2 725.5	2 666.1	2 492.6	–72.1
Sweden	5 256.9	4 203.6	3 391.0	2 954.9	2 336.4	2 303.5	n.a.	–55.6
Switzerland	6 129.8	4 786.4	3 671.4	3 128.3	2 795.9	n.a.	n.a.	–54.4
Turkey	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	6 504.0	5 582.0	4 695.7	3 528.8	3 092.1	3 055.4	2 995.4	–53.9
United States	7 686.0	6 888.0	5 157.0	4 338.3	4 067.4	3 969.8	3 871.6	–49.6
Weighted 22 country average	8 295.6	6 281.2	4 536.4	3 603.1	3 289.3	3 196.3	3 101.6	–62.6
Unweighted 22 country average***	7 903.5	6 074.1	4 452.3	3 590.1	3 185.3	3 067.4	2 934.2	–62.9

n.a.: not available.
* Data for 1960 refers to 1961 for Greece.
Data for 1970 refers to 1971 for Spain.
Data for 1995 refers to 1994 for Switzerland.
** 1997 or latest year available.
*** The 22 country average includes:
Australia, Austria, Canada, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, Sweden, United Kingdom, United States.

Table 1.7. **Male potential years of life lost, all causes, 1960-1997**

	Year*							% change 1960-1997**
	1960	1970	1980	1990	1995	1996	1997	
Australia	10 692.0	10 836.0	7 863.6	5 988.3	5 121.9	5 097.4	4 920.4	–54.0
Austria	14 384.0	11972.0	9 723.1	6 792.8	6 044.5	5 708.2	5 432.6	–62.2
Belgium	12 165.0	10 354.0	8 552.9	6 474.8	6 182.5	n.a.	n.a.	–49.2
Canada	11 539.0	10 018.0	8 079.9	6 135.9	5 279.7	5 007.3	4 817.5	–58.3
Czech Republic	n.a.	n.a.	n.a.	9 598.6	7 826.8	7 312.4	7 334.3	n.a.
Denmark	8 765.0	7 944.0	7 258.9	6 545.7	5 860.3	5 686.7	n.a.	–35.1
Finland	12 828.0	11 476.0	9 434.4	7 701.5	6 242.0	6 116.5	n.a.	–52.3
France	11 152.0	9 833.0	8 710.2	7 132.7	6 305.8	6 068.6	5 760.2	–48.3
Germany	12 902.0	10 871.0	8 547.2	6 251.8	5 877.6	5 695.3	5 498.5	–57.4
Greece	10 945.0	9 042.2	7 180.3	5 632.8	5 604.9	5 560.7	5 372.0	–50.9
Hungary	13 361.0	12 851.0	12 379.0	13 200.0	12 751.0	11 606.0	11 303.0	–15.4
Iceland	8 447.3	9 162.4	7 154.9	5 633.7	4 861.1	4 051.8	n.a.	–52.0
Ireland	10 603.0	9 465.7	7 910.4	6 031.4	5 616.5	5 676.4	n.a.	–46.5
Italy	13 686.0	10 567.0	7 700.9	5 985.0	5 439.7	5 163.1	4 856.3	–64.5
Japan	13 769.0	9 043.0	5 814.5	4 544.5	4 355.8	4 111.2	3 995.9	–71.0
Korea	n.a.	n.a.	n.a.	8 700.7	8 012.1	7 751.5	7 241.1	n.a.
Luxembourg	n.a.	12 125.0	7 833.5	7 010.8	5 841.9	6 095.7	5 152.4	n.a.
Mexico	30 877.0	26 583.0	18 023.0	12 946.0	11 084.0	n.a.	n.a.	–64.1
Netherlands	7 946.0	7 880.0	6 247.7	5 209.9	4 626.1	4 581.9	4 314.8	–45.7
New Zealand	10 451.0	10 361.0	8 417.0	7 360.2	6 066.9	5 971.0	5 836.9	–44.1
Norway	8 524.0	8 006.0	6 732.2	5 953.9	4 867.4	4 554.7	4 547.4	–46.7
Poland	15 468.0	12 858.0	12 739.0	11 757.0	10 526.0	9 961.4	n.a.	–35.6
Portugal	22 471.0	17 511.0	11 612.0	9 065.2	8 330.6	8 301.2	7 964.6	–64.6
Slovakia	n.a.	n.a.	n.a.	n.a.	9 287.0	8 858.0	8 926.0	n.a.
Spain	12 490.0	9 235.0	7 131.0	6 822.0	6 203.5	6 136.4	5 545.3	–55.6
Sweden	7 827.1	6 984.7	6 204.2	5 062.4	4 011.2	3 773.0	n.a.	–51.8
Switzerland	10 387.0	8 795.5	7 026.7	6 168.8	5 565.4	n.a.	n.a.	–46.4
Turkey	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	10 216.0	8 986.0	7 535.7	5 890.5	5 119.9	5 040.9	4 896.6	–52.1
United States	12 714.0	12 197.0	9 554.2	8 260.1	7 752.5	7 267.5	6 851.6	–46.1
Weighted 22 country average	12 617.0	10 673.7	8 394.2	6 998.0	6 424.5	6 120.2	5 822.9	–53.8
Unweighted 22 country average***	11 871.8	10 322.7	8 360.5	6 952.6	6 221.1	5 960.8	5 705.3	–51.9

n.a.: not available.
* Data for 1960 refers to 1961 for Greece.
Data for 1970 refers to 1971 for Spain.
Data for 1995 refers to 1994 for Switzerland.
** 1997 or latest year available.
*** The 22 country average includes:
Australia, Austria, Canada, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, Sweden, United Kingdom, United States.

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Table 1.8. **Percentage of population who report their health as "good" or better, 1990s**

	Year	Population 15 and over			Population 65 and over		
		Males	Females	Total	Males	Females	Total
Australia	1995	83.6	83.3	83.5	62.5	65.1	63.9
Austria	1991	72.5	70.1	71.2	n.a.	n.a.	36.4
Belgium	1997	81.6	74.9	78.3	56.7	49.8	53.3
Canada	1998	91.2	89.7	90.4	75.0	78.5	77.0
Czech Republic	1999	57.7	50.4	54.0	36.7	23.8	29.5
Denmark	1994	82.9	75.6	79.1	62.3	52.9	56.9
Finland	1999	67.6	70.0	68.9	n.a.	n.a.	n.a.
France	1995	90.5	85.0	88.0	n.a.	n.a.	n.a.
Germany	1998	68.3	64.0	66.1	49.7	45.1	47.4
Greece		n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2000	48.1	38.9	43.2	n.a.	n.a.	n.a.
Iceland	1998	81.3	82.3	81.8	52.1	58.4	54.9
Ireland	1998	84.9	86.3	85.7	n.a.	n.a.	61.6
Italy	1999	61.0	50.6	55.6	22.2	16.9	19.1
Japan	1998	47.2	42.0	44.5	32.0	26.1	28.6
Korea	1998	48.7	40.8	44.7	43.5	34.1	37.9
Luxembourg		n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Mexico	1994	n.a.	n.a.	67.1	n.a.	n.a.	n.a.
Netherlands	1999	80.6	73.5	77.0	64.6	50.0	56.1
New Zealand	1997	87.3	88.2	87.8	74.7	76.4	75.6
Norway	1998	81.1	78.2	79.6	66.3	59.4	62.3
Poland	1996	48.2	40.2	43.7	13.4	6.6	9.2
Portugal	1999	38.5	27.1	31.3	15.7	6.9	10.4
Slovakia	1998	48.6	40.7	44.4	n.a.	n.a.	n.a.
Spain	1997	72.4	64.7	68.4	47.0	38.6	42.1
Sweden	1997	80.1	75.7	77.8	62.3	54.8	58.2
Switzerland	1997	86.2	80.4	83.2	76.1	65.6	69.8
Turkey		n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	1999	75.3	75.0	75.1	57.4	56.1	56.7
United States	1998	91.4	90.0	90.7	73.2	72.3	72.7

n.a.: not available.

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Table 2.1. **Practising physicians per 1 000 population, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1960-1999
Australia	1.1	1.2	1.8	2.3	2.5	2.5	2.5	2.5	n.a.	2.2
Austria	1.4	1.4	1.6	2.2	2.7	2.8	2.9	3.0	3.0	2.0
Belgium	1.3	1.5	2.3	3.3	3.5	3.6	3.7	3.7	3.8	2.8
Canada	1.2	1.5	1.8	2.1	2.1	2.1	2.1	2.1	2.1	1.5
Czech Republic	1.7	1.9	2.3	2.8	2.9	2.9	3.0	3.0	3.0	1.5
Denmark	1.2	1.4	2.2	3.1	3.3	3.3	3.3	3.3	3.4	2.7
Finland	0.6	0.9	1.7	2.4	2.8	2.8	3.0	3.0	3.1	n.a.
France	1.0	1.3	2.0	2.6	2.9	3.0	3.0	3.0	n.a.	2.9
Germany	1.4	1.6	2.3	3.1	3.4	3.4	3.4	3.4	n.a.	2.4
Greece	1.3	1.6	2.4	3.4	3.9	4.0	4.1	4.2	n.a.	3.1
Hungary	1.5	2.0	2.3	2.9	3.0	3.1	3.1	3.1	3.2	2.0
Iceland	1.2	1.4	2.1	2.8	3.0	3.1	3.3	3.3	n.a.	2.7
Ireland	n.a.	n.a.	n.a.	1.6	2.1	2.1	2.1	2.2	2.3	n.a.
Italy	0.7	1.1	2.6	4.7	5.4	5.5	5.8	5.8	5.9	n.a.
Japan	1.0	1.1	1.3	1.7	1.8	1.8	1.9	1.9	n.a.	1.7
Korea	n.a.	n.a.	0.5	0.8	1.1	1.2	1.2	1.3	1.3	n.a.
Luxembourg	1.0	1.1	1.7	2.0	2.8	2.9	3.0	3.0	3.1	2.9
Mexico	n.a.	n.a.	0.8	1.1	1.6	1.6	1.6	1.6	1.7	n.a.
Netherlands	1.1	1.2	1.9	2.5	n.a.	n.a.	n.a.	2.9	3.1	2.7
New Zealand	1.1	1.1	1.6	1.9	2.1	2.1	2.2	2.2	2.3	1.9
Norway	1.2	1.4	2.0	3.1	2.8	2.8	2.5	2.7	2.8	2.2
Poland	1.0	1.4	1.8	2.1	2.3	2.4	2.4	2.3	2.3	2.2
Portugal	0.8	0.9	2.0	2.8	3.0	3.0	3.1	3.1	3.2	3.6
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	1.2	1.3	2.3	3.8	2.5	2.9	2.9	2.9	3.1	2.5
Sweden	1.0	1.3	2.2	2.9	3.1	3.1	3.1	3.1	3.1	2.9
Switzerland	1.3	1.4	2.4	3.0	3.2	3.2	3.3	3.3	3.4	2.5
Turkey	0.3	0.4	0.6	0.9	1.1	1.1	1.2	1.2	1.2	3.6
United Kingdom	0.8	0.9	1.3	1.4	1.6	1.6	1.7	1.7	1.8	2.1
United States	1.4	1.6	2.0	2.4	2.6	2.6	2.7	2.7	n.a.	1.7
25 country average***	1.1	1.3	1.9	2.6	2.8	2.9	2.9	2.9	3.0	2.6

n.a.: not available.
* Note that physician data for 1960 refers to 1961 for Canada.
Data for 1970 refers to 1971 for Australia, Belgium and New Zealand.
Data for 1980 refers to 1981 for Australia and Korea.
Data for 1990 refers to 1991 for Australia.
** Growth rate refers to the average annual growth rate and is for the period 1960 to 1999 or the latest available year.
*** The 25 country average includes: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Japan, Luxembourg, New Zealand, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States.

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Table 2.2. **Practising certified nurses per 1 000 population, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1980-1999
Australia	6.1	4.3	7.1	8.5	8.4	8.4	8.1	n.a.	n.a.	0.8
Austria	2.5	3.4	5.4	7.2	8.6	8.7	8.8	8.9	9.0	2.7
Belgium	n.a.	n.a.	5.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Canada	n.a.	4.9	6.3	8.1	7.9	7.7	7.7	7.5	7.5	0.9
Czech Republic	n.a.	n.a.	6.7	8.1	8.2	8.1	8.1	8.1	8.2	1.1
Denmark	n.a.	n.a.	5.1	6.8	7.1	7.2	7.2	7.2	7.3	1.9
Finland	2.6	6.0	8.3	10.2	12.4	13.0	13.5	14.0	14.4	2.9
France	n.a.	3.0	4.6	5.4	5.9	5.9	6.0	n.a.	n.a.	1.6
Germany	1.7	2.4	6.2	8.9	9.0	9.5	9.5	9.6	n.a.	2.5
Greece	n.a.	1.8	2.4	3.4	3.7	3.7	3.6	n.a.	n.a.	2.4
Hungary	1.7	2.7	3.7	4.5	4.8	4.9	5.0	5.0	5.0	1.6
Iceland	2.4	4.9	9.6	13.3	13.8	13.8	13.8	n.a.	n.a.	2.2
Ireland	n.a.	n.a.	n.a.	11.3	14.2	14.8	15.3	15.9	16.5	n.a.
Italy	1.1	2.1	4.1	4.7	4.6	4.4	4.5	4.6	n.a.	0.6
Japan	2.0	2.6	4.2	6.0	n.a.	7.4	n.a.	7.8	n.a.	3.5
Korea	n.a.	n.a.	n.a.	n.a.	1.2	1.2	1.3	1.3	1.4	n.a.
Luxembourg	n.a.	n.a.	n.a.	n.a.	6.7	7.0	7.1	7.0	7.1	n.a.
Mexico	n.a.	n.a.	0.3	0.7	1.1	1.1	1.1	1.1	1.2	7.6
Netherlands	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	11.5	12.5	12.7	n.a.
New Zealand	n.a.	n.a.	6.1	9.3	9.8	9.8	9.0	9.7	9.6	2.4
Norway	n.a.	n.a.	9.3	13.2	n.a.	14.9	n.a.	n.a.	n.a.	3.0
Poland	2.1	3.0	4.4	5.5	5.5	5.6	5.6	5.5	5.1	0.8
Portugal	0.7	1.5	2.3	2.8	3.4	3.5	3.7	3.8	n.a.	2.8
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	0.9	0.8	3.3	4.1	3.0	3.5	3.5	3.2	3.6	0.5
Sweden	3.1	4.3	7.0	9.2	10.2	n.a.	n.a.	n.a.	n.a.	2.5
Switzerland	n.a.	5.1	9.9	14.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Turkey	n.a.	0.2	0.6	0.8	1.0	1.0	1.1	1.1	1.1	3.2
United Kingdom	3.5	3.9	4.3	5.2	5.0	4.5	4.5	5.0	4.5	0.2
United States	2.9	3.7	5.6	7.2	8.1	8.2	8.2	8.3	n.a.	2.2

n.a.: not available.
* Note that nurse data for 1960 refers to 1961 for Australia.
Data for 1970 refers to 1971 for Australia and France.
Data for 1980 refers to 1981 for Australia, Belgium and Norway.
Data for 1990 refers to 1991 for Australia and Germany.
** Growth rate refers to the average annual growth rate and is for the period 1980 to 1999 or latest year available.

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Table 2.3. **Inpatient beds per 1 000 population, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1980-1998
Australia	11.4	11.7	12.3	9.2	8.7	8.5	8.3	8.5	n.a.	–2.0
Austria	10.8	10.8	11.2	10.2	9.3	9.2	9.1	8.9	8.7	–1.3
Belgium	n.a.	8.3	9.4	8.0	7.4	7.3	7.3	n.a.	n.a.	–1.5
Canada	6.2	7.0	6.8	6.3	4.8	4.5	4.4	4.1	n.a.	–2.8
Czech Republic	8.6	9.1	11.3	11.3	9.5	9.2	9.0	8.9	8.7	–1.3
Denmark	8.1	8.1	8.1	5.6	4.9	4.7	4.6	4.5	n.a.	–3.2
Finland	11.5	15.1	15.6	12.5	9.3	9.2	7.9	7.8	7.5	–3.8
France	9.6	9.2	11.1	9.7	8.9	8.8	8.6	8.5	n.a.	–1.5
Germany	10.5	11.3	11.5	10.4	9.7	9.6	9.4	9.3	n.a.	–1.2
Greece	5.8	6.2	6.2	5.1	5.0	5.0	5.0	n.a.	n.a.	–1.3
Hungary	6.9	7.9	9.1	10.1	8.9	8.9	8.1	8.2	8.3	–0.6
Iceland	9.8	12.9	14.8	16.7	14.6	n.a.	n.a.	n.a.	n.a.	–0.1
Ireland	n.a.	n.a.	13.0	10.5	10.1	10.1	n.a.	n.a.	n.a.	–1.6
Italy	8.9	10.5	9.7	7.2	6.2	6.5	5.8	5.5	n.a.	–3.1
Japan	9.0	12.5	13.7	16.0	16.2	16.2	16.4	16.5	16.4	1.0
Korea	n.a.	n.a.	1.7	3.1	4.4	4.6	4.8	5.1	5.5	6.3
Luxembourg	11.8	12.6	12.8	11.7	8.2	8.2	8.1	8.0	n.a.	–2.6
Mexico	n.a.	n.a.	0.7	0.8	1.2	1.2	1.1	1.1	1.1	2.5
Netherlands	11.0	11.4	12.3	11.5	11.3	11.2	11.3	11.3	11.3	–0.5
New Zealand	11.7	10.8	10.2	8.5	6.2	6.1	6.1	6.2	n.a.	–2.7
Norway	n.a.	n.a.	16.5	16.4	15.1	15.0	14.7	14.5	14.4	–0.7
Poland	4.6	5.2	5.6	5.7	5.5	5.5	5.4	5.3	5.1	–0.3
Portugal	5.4	6.3	5.2	4.6	4.1	4.1	4.1	4.0	n.a.	–1.4
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	4.4	4.7	5.4	4.3	3.9	3.9	n.a.	n.a.	n.a.	–2.0
Sweden	14.2	15.3	15.1	12.4	4.9	4.4	4.0	3.8	3.7	n.a.
Switzerland	n.a.	n.a.	n.a.	19.9	n.a.	n.a.	18.3	18.1	n.a.	n.a.
Turkey	1.7	2.0	2.2	2.1	2.5	2.5	2.5	2.5	2.6	0.7
United Kingdom	10.7	9.6	8.1	5.9	4.7	4.5	4.4	4.2	4.1	–3.6
United States	9.2	7.9	6.0	4.9	4.1	4.0	3.9	3.7	3.6	–2.6
25 country average***	n.a.	n.a.	8.9	8.0	7.2	7.1	7.0	6.9	n.a.	–1.4

n.a.: not available.
* 1960 data refers to 1961 for Denmark, 1962 for France and Spain.
1970 data refers to 1972 for France.
1990 data refers to 1991 for Australia, Norway and Switzerland.
** Growth rate refers to the average annual growth rate from 1980 to 1998 or the latest available year. Sweden is excluded due to a break in the series.
*** The 25 country average includes all countries except Iceland, Ireland, Slovakia, Sweden, Switzerland.

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Table 2.4. **Acute-care beds per 1 000 population, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1980-1998
Australia	n.a.	6.0	6.4	4.4	4.2	4.1	4.0	3.9	n.a.	–2.7
Austria	n.a.	n.a.	n.a.	7.0	6.6	6.5	6.4	6.3	6.2	n.a.
Belgium	6.0	4.7	5.5	4.9	4.7	4.6	4.6	4.6	n.a.	–1.0
Canada	n.a.	n.a.	4.6	4.0	3.4	3.1	3.1	3.2	n.a.	–2.0
Czech Republic	8.8	9.1	8.6	8.5	7.2	6.9	6.8	6.7	6.6	–1.4
Denmark	n.a.	5.5	5.3	4.1	3.6	3.5	3.4	3.3	n.a.	–2.6
Finland	3.9	4.8	4.9	4.3	4.0	3.7	2.7	2.6	2.5	–3.5
France	n.a.	n.a.	6.2	5.2	4.6	4.5	4.4	4.3	n.a.	–2.0
Germany	7.3	7.5	7.7	7.5	6.9	6.7	6.6	6.5	n.a.	–0.9
Greece	n.a.	n.a.	4.7	4.0	4.0	4.0	4.0	n.a.	n.a.	–0.9
Hungary	4.6	5.6	6.6	7.1	7.0	7.0	6.4	6.5	6.4	–0.1
Iceland	n.a.	n.a.	n.a.	4.3	3.8	n.a.	n.a.	n.a.	n.a.	n.a.
Ireland	n.a.	n.a.	4.3	3.2	3.1	3.1	3.0	2.9	2.9	–2.2
Italy	n.a.	n.a.	7.6	6.1	5.1	5.5	5.2	4.9	n.a.	–2.4
Japan	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Korea	n.a.	n.a.	n.a.	2.7	3.8	4.0	4.2	4.4	4.9	n.a.
Luxembourg	n.a.	n.a.	7.4	6.9	5.7	5.6	5.6	5.5	n.a.	–1.6
Mexico	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Netherlands	5.1	5.5	5.2	4.3	3.8	3.7	3.7	3.7	3.6	–1.9
New Zealand	n.a.	n.a.	n.a.	8.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Norway	n.a.	n.a.	5.2	3.8	3.3	3.3	3.3	3.2	3.2	–2.7
Poland	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	3.6	4.2	4.2	3.6	3.3	3.4	3.4	3.3	n.a.	–1.3
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.	3.4	3.1	3.2	n.a.	n.a.	n.a.	n.a.
Sweden	n.a.	n.a.	5.1	4.1	3.0	2.8	2.7	2.6	2.5	–3.7
Switzerland	8.0	7.0	7.1	6.5	5.5	5.5	5.8	5.6	n.a.	–1.3
Turkey	n.a.	1.3	1.5	2.0	2.1	2.1	2.1	2.2	2.2	2.2
United Kingdom	n.a.	n.a.	3.5	2.7	2.4	2.4	2.4	2.4	n.a.	–2.1
United States	3.6	4.2	4.4	3.7	3.3	3.3	3.2	3.1	3.0	–1.9
21 country average***	n.a.	n.a.	5.5	4.8	4.3	4.2	4.1	4.0	n.a.	–1.7

n.a.: not available.
* 1970 data refers to 1972 for Denmark.
1990 data refers to 1991 for Australia.
** Growth rate is for 1980-1998 or the latest year available in the late 1990s.
*** 21 country average includes all OECD countries except Austria, Iceland, Japan, Korea, Mexico, New Zealand, Poland, Slovakia and Spain.

Table 3.1. **Number of consultations with doctors per capita, 1960-1998**

	Year*								% change 1980-1997**
	1960	1970	1980	1990	1995	1996	1997	1998	
Australia	2.7	3.1	4.0	6.1	6.6	6.6	6.5	6.4	62.5
Austria	4.3	5.2	5.4	5.9	6.3	6.3	6.2	6.5	14.8
Belgium	n.a.	6.0	7.1	7.7	8.0	8.0	7.9	7.9	11.3
Canada	4.0	4.3	5.6	6.7	6.5	6.4	6.4	6.4	14.3
Czech Republic	9.3	9.9	12.4	11.8	12.5	13.2	12.9	12.4	4.0
Denmark	n.a.	n.a.	5.0	5.7	5.7	5.7	5.9	6.0	18.0
Finland	n.a.	2.4	3.2	3.9	4.1	4.3	4.2	4.2	31.3
France	n.a.	3.1	4.0	5.8	6.4	6.5	n.a.	n.a.	62.5
Germany	n.a.	n.a.	n.a.	5.3	6.4	6.5	n.a.	n.a.	n.a.
Greece	n.a.	5.2	5.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	n.a.	n.a.	10.5	11.7	14.8	17.5	18.8	19.7	79.0
Iceland	n.a.	n.a.	n.a.	5.1	5.1	5.2	5.2	n.a.	n.a.
Ireland	n.a.	n.a.	5.8	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Italy	3.9	6.3	8.0	6.8	n.a.	n.a.	n.a.	n.a.	n.a.
Japan	n.a.	13.6	14.4	15.2	15.8	16.0	n.a.	n.a.	11.1
Korea	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Luxembourg	n.a.	n.a.	n.a.	n.a.	n.a.	2.9	2.9	2.8	n.a.
Mexico	n.a.	n.a.	1.3	1.7	2.1	2.2	2.3	2.3	76.9
Netherlands	n.a.	n.a.	4.9	5.5	5.7	5.4	5.9	5.7	20.4
New Zealand	n.a.	n.a.	3.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Norway	n.a.	n.a.	n.a.	3.8	n.a.	n.a.	n.a.	n.a.	n.a.
Poland	3.3	4.9	6.5	5.8	5.4	5.2	5.3	5.4	–18.5
Portugal	1.0	1.5	3.7	3.0	3.2	3.2	3.4	3.4	–8.1
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	2.6	4.7	6.2	n.a.	n.a.	n.a.	n.a.	n.a.
Sweden	n.a.	1.9	2.6	2.8	3.0	2.9	2.8	n.a.	7.7
Switzerland	n.a.	6.3	5.6	11.0	n.a.	n.a.	n.a.	n.a.	n.a.
Turkey	n.a.	n.a.	1.2	1.0	1.7	1.8	2.0	2.1	66.7
United Kingdom	n.a.	n.a.	5.2	6.1	6.1	6.1	n.a.	5.4	17.3
United States	n.a.	4.6	4.8	5.5	5.8	5.8	n.a.	n.a.	20.8
18 country average***	n.a.	n.a.	5.7	6.2	6.7	6.8	6.9	n.a.	22.6

n.a.: not available.
* 1960 data refers to 1962 for Canada.
1970 data refers to 1971 for Japan and Sweden, 1972 for Canada.
1990 data refers to 1991 for Germany, Italy, Norway and Switzerland and 1989 for Spain.
** The percentage changes are 1980 to 1997 or latest year available.
*** The 18 country average includes: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Hungary, Japan, Mexico, Netherlands, Poland, Portugal, Sweden, Turkey, United Kingdom, United States.

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Table 3.2. **Proportion of young children vaccinated against diphtheria, tetanus and pertussis (DTP) and measles**

		DTP	Measles
Australia	2000	89.8	91
Austria	1997	90	90
Belgium	1999	97.1	82.4
Canada	1997	86.8	96
Czech Republic	1999	98	95
Denmark	1999	99	92
Finland	1999	99	98
France	1998	98	83
Germany	1997	85	75
Greece	1997	90	90
Hungary	1999	99.9	100
Iceland	1999	99.9	99.9
Ireland	1999	86	77
Italy	1999	95	75
Japan	1999	n.a.	96.5
Korea	1994	99.5	94.3
Luxembourg	1997	98	91
Mexico	1998	96.2	95.7
Netherlands	1998	97	96
New Zealand	1999	88.4	82 (1992)
Norway	1999	89.4	88
Poland	1999	98.1	97.1
Portugal	1998	97.8	96
Slovakia	1999	99.1	99.3
Spain	1999	95.1	95
Sweden	1999	99.3	96.3
Switzerland	1991	n.a.	83
Turkey	1999	79	81
United Kingdom	1999	92.4	88.1
United States	1998	84	92
OECD average		93.8	90.5

n.a.: not available.

Table 3.3. **Inpatient care admissions, per 1 000 population**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1970-1998
Australia	n.a.	n.a.	n.a.	172.0	166.0	162.0	163.0	161.0	n.a.	n.a.
Austria	141.0	155.0	195.0	234.0	247.0	251.0	266.0	278.0	286.3	2.1
Belgium	n.a.	93.0	135.6	186.0	196.4	200.0	n.a.	n.a.	n.a.	3.0
Canada	150.0	165.0	150.0	136.0	112.4	94.9	97.1	100.6	n.a.	–1.8
Czech Republic	n.a.	n.a.	204.4	193.2	210.2	222.8	211.1	205.4	202.6	n.a.
Denmark	n.a.	144.0	183.3	200.4	198.1	198.3	198.7	199.9	n.a.	1.2
Finland	131.0	182.0	210.0	224.0	254.0	269.0	267.0	266.0	265.0	1.4
France	n.a.	149.0	193.0	232.0	227.0	225.0	231.0	231.0	230.0	1.7
Germany	132.6	154.0	188.3	199.7	218.5	197.3	200.3	205.4	n.a.	1.0
Greece	70.0	105.0	118.0	128.0	150.0	n.a.	n.a.	n.a.	n.a.	1.4
Hungary	138.0	166.0	188.0	218.0	234.0	242.0	245.0	236.0	237.5	1.3
Iceland	n.a.	163.8	222.3	287.1	232.4	n.a.	n.a.	n.a.	n.a.	1.4
Ireland	n.a.	n.a.	159.9	149.7	149.7	151.0	149.2	147.9	144.7	n.a.
Italy	94.0	157.0	181.5	155.0	162.3	184.7	183.7	180.4	n.a.	0.5
Japan	37.0	54.0	60.0	82.0	92.0	93.0	95.0	98.0	101.0	2.2
Korea	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Luxembourg	116.0	134.0	166.0	199.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Mexico	n.a.	n.a.	38.1	39.4	55.1	57.7	61.4	55.5	56.3	n.a.
Netherlands	n.a.	100.0	117.2	108.9	111.2	111.4	110.2	107.8	n.a.	0.3
New Zealand	79.0	93.0	133.0	139.0	141.0	138.0	136.0	132.0	n.a.	1.3
Norway	n.a.	132.0	155.0	156.0	150.0	153.0	158.7	162.3	164.8	0.7
Poland	n.a.	n.a.	122.0	121.0	133.0	136.0	135.0	138.0	147.1	n.a.
Portugal	47.8	69.0	89.0	108.0	113.0	113.6	118.0	120.0	n.a.	2.0
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	93.0	97.0	109.0	113.8	n.a.	n.a.	n.a.	n.a.
Sweden	134.0	166.0	183.0	195.0	185.0	181.0	n.a.	n.a.	n.a.	0.3
Switzerland	124.0	131.0	126.0	139.0	n.a.	n.a.	174.7	169.8	n.a.	0.9
Turkey	34.0	42.3	39.0	65.7	62.9	65.1	69.1	71.6	73.9	1.9
United Kingdom	92.6	112.3	125.3	144.8	153.6	149.1	150.5	150.9	n.a.	1.1
United States	139.1	155.7	171.2	135.4	126.7	125.6	125.6	124.9	125.3	–0.8
19 country average***	n.a.	127.4	148.6	161.0	165.4	166.2	168.8	169.2	n.a.	1.0

n.a.: not available.
* Note that 1960 data refers to 1961 for Greece.
1970 data refers to 1972 for France.
1980 data refers to 1982 for Mexico.
1990 data refers to 1991 data for Australia.
** Growth rate refers to the average annual growth rate and is for 1970 to 1998 or the latest year.
*** The 19 country average includes: Austria, Belgium, Canada, Denmark, Finland, France, Germany, Hungary, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Sweden, Switzerland, Turkey, United Kingdom, United States.

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Table 3.4. **Acute-care admissions per 1 000 population**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1980-1998
Australia	145.0	181.0	202.0	168.0	162.0	159.0	159.0	158.0	n.a.	–1.4
Austria	n.a.	n.a.	n.a.	216.0	231.0	234.0	246.0	258.0	264.2	n.a.
Belgium	n.a.	n.a.	141.9	168.8	180.0	180.0	n.a.	n.a.	n.a.	1.6
Canada	n.a.	n.a.	146.0	120.4	109.1	93.2	95.2	98.9	n.a.	–2.1
Czech Republic	n.a.	n.a.	188.6	179.8	196.3	198.6	199.2	193.5	190.4	0.1
Denmark	n.a.	143.0	170.7	190.4	188.2	188.1	188.7	189.7	n.a.	0.6
Finland	110.9	156.8	145.0	163.0	200.0	210.0	208.0	203.0	202.0	1.9
France	n.a.	n.a.	175.0	209.0	203.0	203.0	205.0	205.0	204.0	0.9
Germany	119.4	135.0	163.0	175.8	191.5	193.4	196.1	201.0	n.a.	1.2
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	121.0	147.0	168.0	191.0	205.0	211.0	212.0	218.0	219.4	1.5
Iceland	n.a.	n.a.	n.a.	176.4	181.2	n.a.	n.a.	n.a.	n.a.	n.a.
Ireland	n.a.	n.a.	154.6	146.5	146.2	147.7	145.6	144.3	140.5	–0.4
Italy	88.0	151.0	177.0	150.0	157.9	180.3	179.6	175.7	n.a.	0.0
Japan	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Korea	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Luxembourg	n.a.	n.a.	153.0	184.0	n.a.	n.a.	n.a.	213.3	n.a.	1.9
Mexico	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Netherlands	80.0	97.0	112.3	102.9	103.1	102.8	101.3	98.8	n.a.	–0.7
New Zealand	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Norway	n.a.	123.0	143.0	148.0	145.0	145.0	150.1	153.5	155.6	0.4
Poland	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	46.3	67.0	86.3	106.0	111.0	112.0	116.0	118.6	n.a.	1.8
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.	96.0	106.8	110.0	n.a.	n.a.	n.a.	n.a.
Sweden	n.a.	144.0	156.0	166.0	162.0	159.0	n.a.	n.a.	n.a.	0.1
Switzerland	n.a.	n.a.	130.0	139.0	n.a.	n.a.	168.1	163.6	n.a.	1.5
Turkey	n.a.	n.a.	37.0	53.7	60.6	62.5	66.5	68.9	71.1	3.5
United Kingdom	n.a.	n.a.	111.0	168.0	212.0	214.0	n.a.	n.a.	n.a.	4.2
United States	127.6	143.4	159.3	125.1	117.9	117.3	118.0	117.8	118.7	–1.7
19 country average***	n.a.	n.a.	145.6	151.1	158.2	159.9	161.1	161.0	n.a.	0.6

n.a.: not available.
* Note that 1980 data refers to 1981 for Belgium.
1990 data refers to 1991 for Australia.
** Growth rate refers to the average annual growth rate from 1980 to 1998 or the latest year.
*** 19 country average includes: Australia, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Netherlands, Norway, Portugal, Sweden, Switzerland, Turkey, United Kingdom, United States.

Table 3.5. **Acute average length of stay, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1980-1998
Australia	11.5	8.7	7.7	6.5	6.5	6.4	6.3	6.2	n.a.	–1.2
Austria	n.a.	n.a.	14.5	9.3	7.9	7.6	7.1	6.8	6.5	–4.1
Belgium	n.a.	15.6	10.0	8.7	9.4	9.2	8.8	n.a.	n.a.	–0.7
Canada	n.a.	n.a.	10.2	8.6	7.2	7.1	7.0	7.0	n.a.	–2.1
Czech Republic	15.0	15.0	13.6	12.0	10.2	9.6	9.1	8.8	8.6	–2.4
Denmark	n.a.	12.5	8.5	6.4	5.7	5.6	5.4	5.3	n.a.	–2.6
Finland	12.5	12.8	8.8	7.0	5.5	5.3	5.0	4.7	4.5	–3.4
France	20.0	16.0	9.9	7.0	5.9	5.8	5.6	5.6	5.5	–3.1
Germany	20.6	17.7	14.5	14.1	11.4	11.4	11.0	10.7	n.a.	–1.7
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	11.3	11.2	11.2	9.9	8.6	8.5	7.6	8.5	8.2	–1.5
Iceland	n.a.	n.a.	n.a.	7.0	5.9	n.a.	n.a.	n.a.	n.a.	n.a.
Ireland	n.a.	n.a.	8.5	6.7	6.6	6.5	6.5	6.6	6.5	–1.4
Italy	n.a.	n.a.	n.a.	9.5	8.4	8.0	7.3	7.2	n.a.	n.a.
Japan	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Korea	n.a.	n.a.	10.0	12.0	11.0	11.0	11.0	11.0	10.0	0.5
Luxembourg	n.a.	n.a.	13.0	11.0	9.8	9.8	n.a.	7.7	n.a.	–2.9
Mexico	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Netherlands	20.1	18.8	14.0	11.2	9.9	9.8	9.6	9.5	n.a.	–2.1
New Zealand	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	5.5	4.9	n.a.	n.a.
Norway	n.a.	14.8	10.9	7.8	6.5	6.3	6.4	6.2	6.1	–3.1
Poland	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	19.0	15.3	11.4	8.4	7.9	7.9	7.5	7.3	n.a.	–2.4
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.	9.6	8.8	8.0	n.a.	n.a.	n.a.	n.a.
Sweden	n.a.	11.0	8.5	6.5	5.2	5.0	6.1	6.0	n.a.	–1.9
Switzerland	n.a.	n.a.	15.5	13.4	12.0	12.0	11.9	11.4	n.a.	–1.7
Turkey	n.a.	n.a.	6.3	6.0	5.7	5.6	5.5	5.4	5.4	–0.9
United Kingdom	n.a.	n.a.	8.5	5.7	5.1	5.0	n.a.	n.a.	n.a.	–3.3
United States	7.6	8.2	7.6	7.3	6.5	6.2	6.1	6.0	5.9	–1.3
20 country average***	n.a.	n.a.	10.7	9.0	8.0	7.8	7.6	7.5	n.a.	–2.0

n.a.: not available.
* 1960 data refers to 1962 for France and 1961 for Portugal.
1990 data refers to 1991 for Australia and Italy.
** Growth rate refers to the average annual growth rate and is from 1980 to 1998 or the latest year available.
*** The 20 country average includes: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Korea, Luxembourg, Netherlands, Norway, Portugal, Sweden, Switzerland, Turkey, United States.

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Table 4.1. **Real health expenditure per capita, average annual growth rates**

	Year*							US$ PPP** 1998
	1970-1979	1980-89	1990-94	1995-96	1996-97	1997-98	1970-98	
Australia	4.4	2.7	3.1	3.8	3.7	6.8	3.5	2 085
Austria	7.9	1.3	3.9	3.5	–7.5	4.4	4.0	1 894
Belgium	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2 050
Canada	3.0	4.1	1.8	–1.7	2.4	6.2	2.9	2 360
Czech Republic	n.a.	n.a.	7.2	1.4	0.2	–0.4	n.a.	937
Denmark	2.9	1.0	1.6	2.8	2.3	3.3	1.8	2 132
Finland	4.6	4.5	–2.5	5.3	1.1	–0.3	3.2	1 510
France	5.7	3.6	2.8	0.4	0.1	2.3	3.8	2 043
Germany	6.3	2.0	1.1	4.5	0.1	0.0	3.4	2 361
Greece	n.a.	2.7	4.4	2.0	1.5	–1.2	n.a.	1 198
Hungary	n.a.	n.a.	n.a.	–3.4	1.0	5.3	n.a.	717
Iceland	9.8	5.5	0.1	4.0	1.5	8.6	5.3	2 113
Ireland	7.8	–0.4	6.3	3.3	7.5	4.2	4.9	1 534
Italy	4.9	3.2	1.3	2.0	5.3	0.9	3.9	1 824
Japan	6.9	2.7	4.4	3.2	5.6	–2.1	4.5	1 795
Korea	n.a.	n.a.	5.4	12.0	5.4	–5.3	n.a.	740
Luxembourg	7.6	4.2	4.2	3.7	–1.7	4.5	5.2	2 246
Mexico	n.a.	n.a.	13.0	–3.8	5.9	3.0	n.a.	419
Netherlands	3.4	1.8	2.4	1.7	1.1	3.6	2.6	2 150
New Zealand	3.3	2.5	2.0	1.5	4.1	6.1	2.5	1 440
Norway	8.3	3.2	3.7	4.6	4.5	n.a.	5.5	2 149
Poland	n.a.	n.a.	3.8	13.1	1.8	9.8	n.a.	524
Portugal	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1 203
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	7.4	4.2	2.6	2.9	3.3	4.0	4.9	1 194
Sweden	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1 732
Switzerland	4.1	2.9	2.0	4.6	2.9	4.0	3.3	2 853
Turkey	n.a.	–0.8	0.1	21.8	14.1	16.3	n.a.	316
United Kingdom	4.0	3.3	4.8	3.2	–1.4	4.1	3.5	1 510
United States	4.5	5.3	3.9	2.2	2.5	2.4	4.4	4 165
19 country average***	5.6	3.0	2.6	2.9	2.0	3.3	3.8	1 696

n.a.: not available.
* 1970 data refers to 1971 for Australia and Denmark and 1972 for the Netherlands. 1998 refers to 1997 for Norway.
** Expenditure per capita expressed in economy-wide PPPs.
*** 19 country average is for those 19 countries that have a relatively complete set of data for the years 1970-1998 and have not reported major breaks in their series. They include: Australia, Austria, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Spain, Switzerland, United Kingdom, United States. There are suggestions of breaks in the expenditure series for Belgium, Portugal and Sweden. Average per capita health expenditure (US$ PPPs) is for 29 countries except Slovakia.

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Table 4.2. **Health expenditure as a percentage of Gross Domestic Product, 1970-1998**

	Year*						Change 1970-1998
	1970	1980	1990	1992	1997	1998	
Australia	5.7	7.0	7.9	8.2	8.3	8.6	2.9
Austria	5.3	7.6	7.1	7.5	7.9	8.0	2.7
Belgium	4.0	6.4	7.4	7.9	8.6	8.6	n.a.
Canada	7.0	7.1	9.0	10.1	9.0	9.3	2.3
Czech Republic	n.a.	3.8	5.0	5.4	7.1	7.1	n.a.
Denmark	8.0	9.1	8.5	8.5	8.2	8.3	0.3
Finland	5.6	6.4	7.9	9.1	7.3	6.9	1.3
France	5.7	7.4	8.6	9.1	9.4	9.4	3.7
Germany	6.3	8.8	8.7	9.7	10.5	10.3	4.0
Greece	5.6	6.5	7.5	7.2	8.7	8.4	n.a.
Hungary	n.a.	n.a.	n.a.	7.7	6.8	6.8	n.a.
Iceland	4.9	6.1	7.9	8.1	8.0	8.4	3.5
Ireland	5.1	8.4	6.7	7.6	6.9	6.8	1.7
Italy	5.1	7.0	8.1	8.4	8.3	8.2	3.1
Japan	4.6	6.5	6.1	6.3	7.4	7.4	2.8
Korea	n.a.	n.a.	4.8	4.7	5.0	5.1	n.a.
Luxembourg	3.5	5.9	6.1	6.1	5.9	6.0	2.5
Mexico	n.a.	n.a.	4.4	5.6	5.3	5.3	n.a.
Netherlands	7.2	8.0	8.5	8.9	8.7	8.7	1.5
New Zealand	5.2	6.0	7.0	7.6	7.6	8.1	2.9
Norway**	4.4	7.0	7.8	8.2	8.0	n.a.	3.6
Poland	n.a.	n.a.	5.3	6.6	6.1	6.4	n.a.
Portugal	2.7	5.6	6.2	7.0	7.5	7.7	n.a.
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	3.6	5.4	6.6	7.1	7.0	7.0	3.4
Sweden	6.9	9.1	8.5	8.5	8.1	7.9	n.a.
Switzerland	5.4	7.3	8.3	9.3	10.2	10.4	5.0
Turkey	2.4	3.3	3.6	3.8	4.2	4.8	2.4
United Kingdom	4.5	5.6	6.0	6.9	6.7	6.8	2.3
United States	6.9	8.7	11.9	13.0	13.0	12.9	6.0
20 country average***	5.3	6.9	7.6	8.2	8.1	8.2	2.9

n.a.: not available.
* Note that 1970 data for Australia, Denmark refer to 1971, and 1972 for the Netherlands.
** Change for 1970-1997.
*** 20 country average is for only those 20 countries that have a relatively complete set of data for the years 1970-1998 and have not reported any major breaks in their series. They include: Australia, Austria, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Spain, Switzerland, Turkey, United Kingdom, United States. There are suggestions of breaks in the expenditure series for Belgium, Portugal and Sweden. The average includes interpolated data for 1970 from Australia, Denmark, and the Netherlands; and extrapolated data for 1998 from Norway.

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Table 4.3. **Public funding as a percentage of health expenditure, 1970-1998**

	Year*				Change 1970–1998
	1970	1980	1990	1998	
Australia	62.8	62.8	67.4	70.0	7.2
Austria	63.0	68.8	73.5	71.8	8.8
Belgium	n.a.	n.a.	n.a.	71.2	n.a.
Canada	69.9	75.6	74.6	70.1	0.2
Czech Republic	96.6	96.8	96.2	91.9	n.a.
Denmark	83.7	87.8	82.7	81.9	–1.8
Finland	73.8	79.0	80.9	76.3	2.5
France	74.7	78.8	78.2	77.7	3.0
Germany	72.8	78.7	76.2	75.8	3.0
Greece	42.6	55.6	62.7	56.3	n.a.
Hungary	n.a.	n.a.	n.a.	76.5	n.a.
Iceland	81.7	88.2	86.6	83.9	2.2
Ireland	81.7	81.6	71.7	76.8	–4.9
Italy	86.9	80.5	78.1	67.3	–19.6
Japan	69.8	71.3	77.6	78.5	8.7
Korea	n.a.	n.a.	36.6	46.2	n.a.
Luxembourg	88.9	92.8	93.1	92.4	3.5
Mexico	n.a.	n.a.	40.8	48.0	n.a.
Netherlands	61.0	69.2	67.7	68.6	7.6
New Zealand	80.3	88.0	82.4	77.0	–3.3
Norway**	91.6	85.1	82.8	n.a.	–8.6
Poland	n.a.	n.a.	91.7	65.4	n.a.
Portugal	59.0	64.3	65.5	66.9	7.9
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	65.4	79.9	78.7	76.4	11.0
Sweden	86.0	92.5	89.9	83.8	–2.2
Turkey	37.3	27.3	61.0	71.9	34.6
United Kingdom	87.0	89.4	84.3	83.3	–3.7
United States	36.3	41.5	39.6	44.8	8.5
21 country average***	71.8	75.4	75.8	75.2	3.1

n.a.: not available.
* Note that 1970 data refer to 1971 for Australia and Denmark, and 1972 for the Netherlands.
** Change for 1970-1997.
*** The 21 country average includes only those 21 countries that have a relatively complete set of data for the years 1970-1998: Australia, Austria, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Turkey, United Kingdom, United States. The average includes interpolated data for 1970 from Australia, Denmark, and the Netherlands; and extrapolated data for 1998 from Norway. Note that data for Switzerland are not presented as the boundary definition of public financing for health in Switzerland which differs considerably from the OECD definition.

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Table 4.4. **Real per capita expenditure on pharmaceuticals, average annual growth rates**

	Year*							US$ PPP** 1998
	1970-1979	1980-89	1990-94	1995-96	1996-97	1997-98	1970-98	
Australia	–3.0	3.7	8.5	5.7	3.0	7.7	2.7	237
Austria	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Belgium	3.3	2.6	5.6	–1.0	3.4	n.a.	3.0	318
Canada	–0.1	7.2	5.0	–0.1	7.9	9.1	4.0	353
Czech Republic	n.a.	n.a.	11.6	1.3	–0.8	0.6	n.a.	239
Denmark	n.a.	2.4	5.8	0.8	3.5	6.0	n.a.	197
Finland	3.5	3.0	6.3	7.8	4.1	–1.7	3.7	221
France	1.2	4.3	4.0	0.3	1.5	5.2	3.6	447
Germany	4.1	2.8	–2.4	5.4	–1.6	4.3	2.5	300
Greece	2.5	–1.1	8.2	5.5	–2.4	–15.6	n.a.	176
Hungary	n.a.	n.a.	61.3	1.9	1.1	6.1	n.a.	190
Iceland	8.0	4.6	–0.8	10.7	–0.5	3.4	5.2	327
Ireland	0.9	1.1	2.7	2.6	4.8	10.8	1.8	151
Italy	5.0	6.5	0.0	5.4	6.4	n.a.	4.8	303
Japan	n.a.	n.a.	4.0	2.6	–1.2	–17.6	n.a.	301
Korea	n.a.	n.a.	2.3	1.4	–9.8	–23.0	n.a.	102
Luxembourg	4.4	5.1	–0.9	–0.7	7.9	1.7	3.4	277
Mexico	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Netherlands	–0.1	3.9	5.7	1.8	0.7	8.5	3.0	232
New Zealand	n.a.	4.7	5.5	0.0	2.7	n.a.	n.a.	193
Norway	3.6	0.3	8.9	4.7	5.9	n.a.	n.a.	195
Poland	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	18.0	6.2	6.0	7.6	4.9	1.8	n.a.	310
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	2.4	3.7	5.3	6.5	n.a.	n.a.	239
Sweden	4.7	3.3	8.6	7.5	–1.5	n.a.	4.5	220
Switzerland	n.a.	n.a.	–0.1	3.2	3.5	3.2	n.a.	217
Turkey	n.a.	n.a.	11.6	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	2.9	4.1	7.9	5.7	2.0	n.a.	4.0	229
United States	1.0	5.4	2.0	5.8	6.5	8.2	3.7	422
14 country average***	2.6	4.1	3.7	4.1	3.2	n.a.	3.6	256

n.a.: not available.
* 1970 data refer to 1971 for Australia and New Zealand and 1972 for the Netherlands.
** 1998 data refers to 1997 for Belgium, Italy, New Zealand, Norway, Spain, Sweden, United Kingdom.
*** The 14 country average includes only those 14 countries for which a relatively complete set of data is available for the years 1970-1997: Australia, Belgium, Canada, Finland, France, Germany, Iceland, Ireland, Italy, Luxembourg, Netherlands, Sweden, United Kingdom, United States. The average includes interpolated data for 1970 (Australia and the Netherlands). Norway has been excluded from the average due to a break in the data series between 1979 and 1980. Average per capita pharmaceutical expenditure (US$ PPP) is for the 25 countries with data which includes all OECD countries except Austria, Mexico, Poland, Slovakia and Turkey.

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Table 4.5. **Pharmaceutical expenditure as a share of total health expenditure, 1970-1998**

	Year*			
	1970	1980	1990	1998**
Australia	13.6	7.9	8.9	11.4
Austria	n.a.	n.a.	n.a.	n.a.
Belgium	28.1	17.4	15.5	16.1
Canada	11.3	8.5	11.4	15
Czech Republic	n.a.	n.a.	21	25.5
Denmark	n.a.	6	7.5	9.2
Finland	12.6	10.7	9.4	14.6
France	23.2	15.9	20	21.9
Germany	16.2	13.4	14.3	12.7
Greece	25.5	18.8	14.5	14.7
Hungary	n.a.	n.a.	n.a.	26.5
Iceland	16.1	15.9	15.7	15.5
Ireland	22.2	10.9	11.1	9.9
Italy	14.5	13.7	18.3	17.5
Japan	n.a.	n.a.	21.4	16.8
Korea	n.a.	n.a.	25.7	13.8
Luxembourg	19.7	14.5	14.9	12.3
Mexico	n.a.	n.a.	n.a.	n.a.
Netherlands	9.8	7.4	9.1	10.8
New Zealand	n.a.	11.9	13.8	14.4
Norway	7.8	8.7	7.2	9.1
Poland	n.a.	n.a.	n.a.	n.a.
Portugal	13.4	19.9	24.9	25.8
Slovakia	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	21	17.8	20.7
Sweden	6.6	6.5	8	12.8
Switzerland	n.a.	n.a.	8.2	7.6
Turkey	n.a.	n.a.	20.5	n.a.
United Kingdom	14.7	12.8	13.6	16.3
United States	12.4	9.1	9.2	10.1
14 country average***	15.8	11.8	12.8	14.1

n.a.: not available.
* 1970 data refer to 1971 for Australia and 1972 for the Netherlands.
** 1998 data refers to 1997 for Belgium, Italy, New Zealand, Norway, Spain, Sweden, United Kingdom.
*** The 14 country average includes only those 14 countries for which a relatively complete set of data is available for the years 1970-1998: Australia, Belgium, Canada, Finland, France, Germany, Iceland, Ireland, Italy, Luxembourg, Netherlands, Sweden, United Kingdom, United States. The average includes interpolated data for 1970 (Australia and the Netherlands). Norway has been excluded from the average due to a break in the data series between 1979 and 1980.

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Table 5.1. **Self-reported proportion of daily smokers, persons 15 years and over, latest year available**

		Daily smokers		
		Females (%)	Males (%)	Total (%)
Australia	1998	20.3	25.4	22.8
Austria	1997	23.3	35.9	29.3
Belgium	1998	23.0	30.0	26.0
Canada	1999	19.2	22.0	20.5
Czech Republic	1999	17.3	30.1	23.5
Denmark	2000	29.0	32.0	31.0
Finland	1999	20.1	27.0	23.2
France	1992	20.0	38.0	29.0
Germany	1995	21.5	35.6	26.0
Greece	1994	28.0	46.0	37.0
Hungary	2000	22.9	38.2	30.1
Iceland	2000	22.5	23.3	22.9
Ireland	1998	27.0	28.0	27.0
Italy	1999	17.3	32.8	24.7
Japan	1999	14.5	54.0	34.0
Korea	1998	5.9	64.1	33.5
Luxembourg	1998	27.0	39.0	32.0
Mexico	1993	14.2	38.3	25.1
Netherlands	1999	32.0	36.0	34.0
New Zealand	1999	25.0	26.0	26.0
Norway	2000	32.0	31.0	32.0
Poland	1996	19.4	40.9	29.6
Portugal	1995	7.1	30.2	18.1
Slovakia		n.a	n.a	n.a
Spain	1997	24.7	42.1	33.1
Sweden	1999	19.4	19.2	19.3
Switzerland	1997	27.0	38.0	33.0
Turkey	1995	27.1	67.6	47.0
United Kingdom	1998	26.0	28.0	27.0
United States	1998	18.2	21.6	19.9
29 country average*		21.8	35.2	28.2

n.a.: not available.
* All OECD countries excluding Slovakia.

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Table 5.2. **Alcohol consumption (in litres) per population 15 years and over, 1960-1999**

	Year*									% growth rate**
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1960-1998
Australia	9.4	11.6	12.9	10.5	9.6	9.6	9.7	9.5	n.a.	0.0
Austria	10.9	13.9	13.8	12.6	11.9	11.8	11.5	11.4	11.4	0.1
Belgium	8.9	12.3	14.0	12.1	11.1	11.0	10.8	10.8	n.a.	0.5
Canada	7.2	8.7	11.1	9.2	7.4	7.2	7.3	7.5	n.a.	0.1
Czech Republic	n.a.	n.a.	11.8	11.3	11.6	11.7	12.0	11.8	11.9	n.a.
Denmark	5.5	8.6	11.7	11.7	12.1	12.2	12.2	11.6	11.6	2.0
Finland	2.7	5.8	7.9	9.5	8.3	8.2	8.5	8.6	8.7	3.1
France	23.7	22.3	20.6	16.6	15.7	15.6	n.a.	n.a.	n.a.	–1.2
Germany	7.5	13.4	12.7	13.8	13.0	12.7	12.9	12.6	12.6	n.a.
Greece	n.a.	7.1	13.2	10.7	10.6	10.4	10.5	10.2	10.5	n.a.
Hungary	8.2	11.5	14.9	13.9	12.2	12.5	12.3	12.3	11.7	1.1
Iceland	2.5	3.8	4.3	5.2	4.8	4.9	5.1	5.6	5.9	2.2
Ireland	7.1	10.6	13.8	10.5	12.1	11.9	n.a.	n.a.	n.a.	1.4
Italy	16.6	18.2	13.2	10.9	10.4	10.5	9.4	9.1	9.0	–1.6
Japan	n.a.	6.9	8.1	8.9	8.6	8.5	8.8	n.a.	n.a.	n.a.
Korea	n.a.	n.a.	n.a.	9.1	9.0	9.1	8.9	n.a.	n.a.	n.a.
Luxembourg	13.1	15.6	12.4	14.7	14.8	14.2	14.0	16.4	15.0	0.6
Mexico	n.a.	n.a.	3.5	4.9	5.1	5.2	4.7	4.9	4.8	n.a.
Netherlands	3.7	7.7	11.3	9.9	9.8	9.8	10.0	9.9	10.1	2.6
New Zealand	5.3	9.8	11.8	10.1	9.4	9.2	8.5	8.5	8.5	1.3
Norway	3.4	4.7	5.3	5.0	4.8	5.0	5.4	n.a.	n.a.	1.3
Poland	6.3	8.0	8.7	8.3	8.2	8.0	8.0	8.4	8.6	0.8
Portugal	17.2	13.9	14.9	16.1	14.6	14.1	13.7	13.6	13.2	–0.6
Slovakia	6.9	12.8	14.5	13.4	10.3	10.7	10.8	10.0	10.1	1.0
Spain	9.6	16.1	18.5	13.5	11.4	11.1	12.1	11.9	11.7	0.6
Sweden	4.8	7.2	6.7	6.4	6.2	6.0	5.9	5.8	6.1	0.5
Switzerland	12.1	14.2	13.5	12.9	11.4	11.3	11.2	11.2	n.a.	–0.2
Turkey	0.9	1.1	1.8	1.4	1.7	1.6	1.6	1.6	1.6	1.5
United Kingdom	n.a.	7.1	9.4	9.7	9.2	9.6	9.9	9.7	10.1	n.a.
United States	7.8	9.5	10.5	9.5	8.4	8.5	8.5	8.3	8.6	0.2
25 country average***	8.3	10.7	11.8	10.7	10.0	9.9	9.9	9.9	n.a.	0.5

n.a.: not available.
* Note that data for 1960 refers to 1961 for Greece, Iceland, Poland, Portugal and Spain.
Data for 1970 refers to 1971 for Poland.
Data for 1980 refers to 1981 for Luxembourg and Poland.
** Growth rate refers to the average annual growth rate and is from 1960 to 1998 or latest year available.
*** The 25 country average includes all countries except Czech Republic, Japan, Korea, Mexico and United Kingdom.

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Table 5.3. **Percentage of the population aged 15 years and over with Body Mass Index over 30, latest year available**

		Females	Males	Total
Australia	1995	18.9	18.5	18.7
Austria	1991	9.0	8.3	8.5
Belgium	1997	10.5	11.2	10.8
Canada	1998	14.2	15.1	14.6
Czech Republic	1999	13.5	15.0	14.2
Denmark	1994	7.0	8.2	7.6
Finland	2000	11.0	11.4	11.2
France	2000	9.5	9.8	9.6
Germany		n.a.	n.a.	n.a.
Greece		n.a.	n.a.	n.a.
Hungary	2000	20.3	18.4	19.4
Iceland*	1994	19.3	18.0	18.7
Ireland	1998	9.0	12.0	10.0
Italy	1999	8.8	8.8	8.8
Japan		n.a.	n.a.	n.a.
Korea	1998	2.7	1.6	2.2
Luxembourg		n.a.	n.a.	n.a.
Mexico	1999	21.7	n.a.	n.a.
Netherlands	1997	9.1	6.3	7.6
New Zealand	1997	19.2	14.7	17.0
Norway	1998	6.0	7.0	6.0
Poland	1996	12.4	10.3	11.4
Portugal	1995	12.6	10.3	11.5
Slovakia		n.a	n.a	n.a.
Spain	1997	13.5	12.3	12.9
Sweden	1997	7.8	7.9	7.9
Switzerland	1997	6.9	6.7	6.8
Turkey		n.a.	n.a.	n.a.
United Kingdom	1999	20.9	17.3	20.0
United States	1991	25.1	19.9	22.6

n.a.: not available.
* Data refer only to people aged 45-64 years old.

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Table 6.1. **Total population (in thousands) in OECD countries, 1970-2000**

	Year									% growth rate 1970-2000
	1970	1980	1990	1995	1996	1997	1998	1999	2000	
Australia	12 507	14 695	17 065	18 072	18 311	18 524	18 730	18 967	19 172	53.3
Austria	7 467	7 549	7 718	8 047	8 059	8 072	8 078	8 092	8 087	8.3
Belgium	9 651	9 847	9 967	10 157	10 158	10 181	10 203	10 227	10 243	6.1
Canada	21 297	24 516	27 701	29 354	29 672	29 987	30 248	30 493	30 750	44.4
Czech Republic	9 805	10 327	10 362	10 331	10 316	10 304	10 294	10 283	10 273	4.8
Denmark	4 929	5 123	5 141	5 228	5 262	5 284	5 301	5 319	5 337	8.3
Finland	4 606	4 779	4 986	5 108	5 125	5 140	5 153	5 171	5 181	12.5
France	50 772	53 880	56 709	57 844	58 026	58 208	58 398	58 620	58 892	16.0
Germany*	60 651	61 566	63 254	81 661	81 895	82 052	82 029	82 087	82 143	35.4
Greece	8 793	9 642	10 089	10 454	10 465	10 498	10 516	10 532	10 551	20.0
Hungary	10 337	10 707	10 365	10 229	10 193	10 155	10 114	10 068	10 016	–3.1
Iceland	205	228	255	267	269	271	274	277	279	36.1
Ireland	2 950	3 401	3 503	3 601	3 626	3 661	3 705	3 745	3 787	28.4
Italy	53 822	56 434	56 719	57 301	57 397	57 512	57 569	57 593	57 592	7.0
Japan	104 665	117 060	123 611	125 570	125 864	126 166	126 486	126 686	126 961	21.3
Korea	32 241	38 124	42 869	45 093	45 545	45 991	46 430	46 858	47 275	46.6
Luxembourg	340	365	384	413	416	421	427	433	438	28.8
Mexico	48 225	66 847	81 250	90 164	92 159	93 938	95 676	97 586	97 379	101.9
Netherlands	13 039	14 150	14 947	15 460	15 523	15 607	15 703	15 808	15 879	21.8
New Zealand	2 820	3 144	3 363	3 656	3 714	3 761	3 792	3 811	3 831	35.9
Norway	3 879	4 086	4 241	4 359	4 381	4 405	4 431	4 462	4 482	15.5
Poland	32 526	35 578	38 119	38 588	38 618	38 650	38 666	38 654	38 646	18.8
Portugal	8 680	9 766	9 896	9 916	9 927	9 946	9 968	9 989	10 009	15.3
Slovakia	4 528	4 984	5 298	5 364	5 374	5 383	5 391	5 395	5 399	19.2
Spain	33 864	37 527	38 851	39 210	39 270	39 323	39 371	39 418	39 465	16.5
Sweden	8 043	8 311	8 559	8 827	8 841	8 846	8 851	8 858	8 872	10.3
Switzerland	6 270	6 385	6 712	7 041	7 072	7 089	7 110	7 144	7 185	14.6
Turkey	35 605	44 439	56 203	61 646	62 695	63 745	64 789	65 819	66 835	87.7
United Kingdom	55 633	56 330	57 561	58 606	58 801	59 009	59 237	59 501	59 640	7.2
United States	203 984	227 225	249 464	262 803	265 229	267 784	270 248	272 691	275 130	34.9
OECD total	852 134	947 015	1 025 162	1 084 370	1 092 203	1 099 913	1 107 188	1 114 587	1 119 729	31.4

* Note that German populations include reunified Germany from 1991 onwards.

Table 6.2. **Share of the population aged 65 and over, 1960-1999**

	Year									% growth rate
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1960-1999
Australia	8.5	8.3	9.6	11.1	11.9	12.0	12.1	12.2	12.2	43.5
Austria	12.2	14.1	15.4	15.1	15.1	15.3	15.4	15.4	15.5	27.0
Belgium	12.0	13.4	14.4	14.9	16.1	16.1	16.4	16.5	16.8	40.0
Canada	7.6	8.0	9.4	11.3	12.0	12.1	12.2	12.3	12.4	63.2
Czech Republic	9.6	12.1	13.5	12.5	13.2	13.4	13.5	13.7	13.8	43.8
Denmark	10.6	12.3	14.4	15.6	15.3	15.1	15.0	14.9	14.9	40.6
Finland	7.3	9.1	12.0	13.4	14.2	14.4	14.6	14.7	14.8	102.7
France	11.6	12.9	13.9	14.1	15.2	15.4	15.6	15.8	15.9	37.1
Germany	10.8	13.2	15.5	15.3	16.1	16.3	16.5	16.6	16.8	55.6
Greece	8.1	11.1	13.1	14.0	15.6	15.8	16.2	16.6	17.0	109.9
Hungary	n.a.	n.a.	n.a.	n.a.	14.1	14.2	14.4	14.5	14.6	n.a.
Iceland	8.1	8.9	9.9	10.6	11.3	11.5	11.5	11.5	11.6	43.2
Ireland	10.9	11.2	10.7	11.4	11.4	11.4	11.4	11.4	11.3	3.7
Italy	n.a.	n.a.	13.2	14.9	16.6	17.0	17.3	17.6	17.6	n.a.
Japan	5.7	7.1	9.1	12.1	14.5	15.1	15.7	16.2	16.7	193.0
Korea	2.9	3.1	3.8	5.1	5.9	6.1	6.3	6.6	6.8	134.5
Luxembourg	10.8	12.6	13.6	13.4	14.1	14.2	14.3	14.3	14.3	32.4
Mexico	n.a.	3.7	3.8	4.2	4.7	4.9	5.3	5.1	5.3	n.a.
Netherlands	9.0	10.2	11.5	12.8	13.2	13.3	13.4	13.5	13.6	51.1
New Zealand	8.7	8.4	9.7	11.1	11.5	11.5	11.6	11.6	11.7	34.5
Norway	10.9	12.9	14.8	16.3	15.9	15.8	15.7	15.6	15.4	41.3
Poland	5.8	8.2	10.1	10.1	11.1	11.3	11.6	11.8	12.0	106.9
Portugal	n.a.	n.a.	11.6	13.4	14.6	14.8	15.0	15.1	15.1	n.a.
Slovakia	6.7	9.2	10.4	10.3	10.9	11.0	11.1	11.2	11.3	68.7
Spain	8.1	9.4	11.2	13.6	15.3	15.6	15.9	16.3	16.6	104.9
Sweden	11.8	13.7	16.3	17.8	17.5	17.5	17.4	17.4	17.8	50.8
Switzerland	10.2	11.4	13.7	15.0	14.7	14.8	15.0	15.1	15.2	49.0
Turkey	3.7	4.4	4.7	4.0	4.7	4.8	5.0	5.2	5.3	43.2
United Kingdom	11.7	13.0	15.0	15.7	15.7	15.7	15.7	15.7	15.7	34.2
United States	9.2	9.8	11.2	12.4	12.5	12.4	12.4	12.4	12.3	33.7
Weighted 26 country average	9.3	10.5	11.9	12.9	13.6	13.8	14.0	14.1	14.3	53.3
Unweighted 26 country average*	8.9	10.3	11.8	12.7	13.3	13.4	13.5	13.6	13.8	53.8

n.a.: not available.
* The 26 countries include all OECD countries except for Hungary, Italy, Mexico and Portugal.

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Table 6.3. **Gross Domestic Product per capita, average annual growth rates, 1970-1999 and levels in 1999 in US$ PPP**

	Percentage change from previous period, in constant prices								GDP per capita (US$ PPP)*
	1970-79	1980-89	1990-94	1995-96	1996-97	1997-98	1998-99	1970-99	1999
Australia	1.5	1.9	2.0	2.4	3.5	3.4	3.1	1.9	25 552
Austria	3.6	1.9	1.1	1.9	1.1	3.2	2.6	2.4	24 643
Belgium	3.0	1.9	0.8	1.2	3.2	2.1	2.5	2.3	24 837
Canada	3.1	1.9	0.3	0.5	3.2	2.4	3.8	1.9	26 440
Czech Republic	n.a.	n.a.	–2.5	4.6	0.1	–1.0	–2.1	n.a.	13 342
Denmark	1.8	1.6	1.5	1.8	3.1	2.3	2.0	1.7	27 069
Finland	3.0	3.0	–2.2	3.6	6.0	5.0	3.8	2.4	22 702
France	2.9	1.9	0.5	0.7	1.6	2.8	2.5	2.0	22 691
Germany	2.8	2.0	–1.8	0.5	1.1	2.1	1.5	1.6	23 855
Greece	4.2	1.3	0.2	2.2	3.2	2.9	3.2	2.2	15 142
Hungary	n.a.	n.a.	–2.8	1.7	5.0	5.3	4.9	n.a.	11 275
Iceland	7.0	1.8	–0.5	4.5	4.0	3.4	3.0	3.3	26 350
Ireland	3.4	2.7	2.8	7.0	9.7	7.2	8.6	4.1	25 258
Italy	3.0	2.3	0.6	0.9	1.8	1.7	1.7	2.2	23 262
Japan	3.4	3.3	1.2	4.8	1.4	–2.8	0.1	2.6	24 628
Korea	6.9	7.3	6.0	5.7	4.0	–7.5	9.6	6.0	16 059
Luxembourg	2.0	4.3	4.4	2.2	5.9	3.6	6.0	3.3	41 656
Mexico	n.a.	n.a.	1.4	2.9	4.7	3.1	1.6	2.9	8 440
Netherlands	2.3	1.4	1.3	2.6	3.2	3.1	2.9	1.9	25 887
New Zealand	0.7	1.4	1.1	1.1	0.7	–0.8	3.8	1.0	18 607
Norway	4.1	2.1	3.1	4.3	4.1	1.5	0.1	3.0	28 140
Poland	n.a.	n.a.	0.8	6.0	6.7	4.7	4.0	n.a.	8 655
Portugal	3.7	2.9	1.5	3.3	4.2	3.8	2.9	3.1	16 685
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	2.7	2.4	0.8	2.3	3.8	4.2	3.9	2.5	18 215
Sweden	1.6	1.8	–0.8	0.9	2.0	3.5	4.1	1.5	23 027
Switzerland	0.8	1.4	–1.3	–0.2	1.5	2.1	1.0	0.9	28 657
Turkey	n.a.	–0.9	0.2	5.2	5.7	1.4	–6.5	n.a.	6 335
United Kingdom	2.3	2.7	0.9	2.2	3.2	2.3	1.7	2.0	22 689
United States	2.5	2.4	1.2	2.6	3.6	3.4	2.6	2.2	33 874
24 country average**	3.0	2.4	1.0	2.5	3.3	2.3	3.2	2.4	21 861

n.a.: not available.
* GDP per capita using economy-wide PPP rates.
** 24 country average is an average of all OECD countries except Czech Republic, Hungary, Mexico, Poland, Turkey and Slovakia. The average GDP per capita (US$ PPP) in 1999 includes all countries except Slovakia for which data is unavailable.

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Annex 2

COMPARISONS OF HEALTH EXPENDITURE ACROSS COUNTRIES AND OVER TIME: CONVERTING NATIONAL CURRENCIES TO A COMMON MONETARY UNIT AND CORRECTING FOR PRICE INFLATION

Introduction

Raw data on total health expenditure are difficult to interpret across countries and across time without adjustment, for differences in national currency units, and differences in spending power of national currencies over time due to price inflation.

Currency conversion

To make useful comparisons of health expenditure across countries, it is necessary to convert data in national currency units to a common currency, such as the US dollar by using a suitable currency conversion rate, and to divide the results by the population to obtain health spending per capita. The most reliable conversion rates are based on purchasing power parity (PPP). The PPP rate is formed by pricing the same, fixed basket of goods and services across different countries in the national currency of each country. For example, if an identical basket of goods and services cost 500 French Francs (FF) in France and US$100 in the US, then the PPP conversion rate would be calculated at five FF to one US$. If actual expenditure on such baskets are then compared across countries using the PPP conversion rates, the differences will reflect differences in the volume of goods and services consumed in each country.

The only PPP conversion rates published in *OECD Health Data 2001* are economy-wide (GDP) PPPs, which are based on a broad basket of goods and services, chosen to be representative of all economic activity. Health expenditure in this report is converted using those economy-wide PPPs. The use of economy-wide PPPs means that the resulting variations in health expenditure across countries will reflect not only variations in the volume of health services but also any variations in the prices of health services, relative to GDP prices, across countries.

Real health expenditure

To make useful comparisons over time, it is necessary to deflate (remove inflation from) nominal health expenditure by suitable price indices and to divide by the population to derive real spending per capita. The result is a ratio which is not affected by inflation. Economy-wide (GDP) price indices have been used as deflators in this report.

Alternatively, annual health expenditure can be expressed as a share of annual, national Gross Domestic Product (GDP).

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Annex 3

MAIN FIELDS COVERED IN *OECD HEALTH DATA 2001*

Part 1. Health status

Mortality
- *Life expectancy*
- *Causes of mortality*
- *Maternal and infant mortality*
- *Potential years of life lost*

Morbidity
- *Perceived health status*
- *Health expectancy (Disability-free life expectancy)*
- *Infant health*
- *Congenital anomalies*
- *Dental health*
- *Communicable diseases*
- *Cancer*
- *Injuries*
- *Absence from work due to illness*

Part 2. Health care resources

In-patient beds

Medical technology

Health employment

Education in medical science and health-related fields

Part 3. Health care utilisation

In-patient utilisation

Average length of stay
- *Average length of stay: in-patient and acute care*
- *Average length of stay by diagnostic categories*
- *Average length of stay by case mix*
- *Discharge rates by diagnostic categories*
- *Discharge rates by case mix*

Surgical procedures
- *Total surgical procedures*
- *Surgical procedures by ICD-CM*
- *Surgical procedures by case mix*
- *Transplants*

Ambulatory care activity

Other medical care activity

Part 4. Expenditure on health

National expenditure on health
- *Total expenditure on health*
- *Expenditure on personal health care*
- *Expenditure on collective health care*
- *Prevention and public health*
- *Expenditure on health administration and insurance*
- *Expenditure on health-related functions*

Expenditure on medical services
- *Total expenditure on medical services*
- *Expenditure on in-patient care*
- *Expenditure on out-patient care*
- *Expenditure on ancillary services*
- *Expenditure on home health care services*

Medical goods dispensed to out-patients
- *Total expenditure on medical goods*
- *Pharmaceuticals and other medical non-durables*
- *Therapeutic appliances and other medical durables*

Expenditure by age groups

Direct expenditure by disease

Trade in medical goods

Price index

Part 5. Financing and remuneration

Health expenditure by sources of funds

Health professions' incomes

Medical services' fees

Part 6. Social protection

Social expenditure

Health care coverage

Part 7. Pharmaceutical market

Pharmaceutical industry activity

Pharmaceutical consumption

Pharmaceutical sales

Part 8. Non-medical determinants of health

Life styles and behaviour
- *Food consumption*
- *Alcohol consumption*
- *Tobacco consumption*
- *Body weight and composition*

Environment: air quality

Part 9. Demographic references

General demographics

Population age structure

Labour force

Education and training

Part 10. Economic references

Macroeconomic references

Monetary conversion rates

A full list of indicators can be found at *www.oecd.org/els/health/*

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