

**Health at a Glance – OECD Indicators 2003**  
**Briefing note (Germany)**  
*[No media use until 16 October 2003]*

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### **Health Spending<sup>1</sup>**

Total health expenditure (public and private) as a percentage of GDP accounted for 10.7% of GDP in **Germany** in 2001, the third highest share in the OECD, over two percentage points higher than the average of 8.4% in OECD countries (Chart 3.4). Only the United States and Switzerland allocated more of their GDP to health (13.9% and 10.9% respectively).

Moreover, **Germany** is one of the top four spenders in terms of total health spending per capita, with spending of 2,808 USD (adjusted for purchasing power parity), one third higher than the OECD average of 2,117 USD in 2001 (Chart 3.1). It should be noted that differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

For **Germany**, it is interesting to note that the addition of comprehensive long-term care insurance to health care in 1995/1996 has not resulted in above average health expenditure growth over the last decade. Cost-containment measures have led to expenditure increase in real terms of 2.0% between 1992 and 2001, which is substantially lower than the OECD average of 3.2% for the same period of time (Chart 3.9).

The rise in pharmaceutical spending has been one of the factors behind the recent rise in total health spending in **Germany** as well as in several other OECD countries. Cost-containment measures reduced the share of spending on prescription drugs to a low of 10.5% in 1995. Pharmaceutical spending have been growing faster than overall spending since then, bringing the share of spending on prescription drugs back to 12.3% in 2001 (close to where it was in 1992). In 2001, **Germany** was among the top spenders on pharmaceuticals, after the United States, France, Italy, and Canada (Chart 3.13).

### **Public and private financing**

The public sector is the main source of health funding in all OECD countries. In **Germany** the share of public funding remained relatively stable over time (Table 3.8). Out-of-pocket spending has been growing somewhat from 9.8% in 1992 to 10.6% in 2001. Germany is among the countries with a relatively large share of funding coming from private health insurance (more than 10%), besides Canada, France, the Netherlands and the United States (Table 3.9).

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<sup>1</sup> Data on expenditures relate generally to 2001 (the latest year for which comparable data are available in most countries)

## Resources and activities in the health sector

Relatively high health expenditure in **Germany** can at least partially be explained by a comparatively high activity level. Hospital discharge rates in **Germany** are substantially higher than the OECD average (Chart 2.25). The frequency of expensive treatment, such as cardiovascular surgeries, is also relatively high (Chart 2.37).

To maintain relatively high activity levels, Germany also has above average levels of resources, albeit not at a wide margin. For example, there are 3.3 physicians per 1000 in the **German** population, about 10% higher than the OECD average. The number of acute care beds is also high in **Germany** in comparison with the OECD average and has only during the 1990s started to fall significantly.

The average length of stay in hospitals has decreased over time in OECD countries, but there remain notable variations across countries. With an average 9.6 days, **Germany** has among the longest length-of-stay for acute care (Charts 2.29, 2.31 and 2.32). Length of stay seems to decrease in OECD countries with the introduction of case-based payment mechanisms. But shorter stays tend to be more service intensive and at the same time more costly per day. Shorter length of stay in hospitals also requires adequate resources of post-acute care in an ambulatory setting. Hence the longer length of stay in Germany is not associated with an unusually high share of expenditure on inpatient services.

## Health Status<sup>2</sup>

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years, adding eight years to the life span on average. For **Germany** both the level and the gains of life expectancy are close to the median of OECD countries, which means that about half of all countries were doing better and the other half less well on this indicator. The same is the true for life expectancy at age 65 (Table 1.2 and 1.3).

## Risk Factors

The proportion of daily smokers among the adult population has shown a marked decline over recent decades across most OECD countries, especially for men. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. In **Germany**, the percentage of men who are daily smokers among adults has fallen from an above average value in 1980 to around an average value in OECD countries in 1999 (Table 4.1). Like in other countries, tobacco consumption has decreased at a much slower pace for women than men, albeit from a significantly below OECD average level in 1980.

**Germany** reports a higher consumption of alcohol per person (10.5 litres) than the OECD average of 9.6 litres per person. This number has gone down 22% since 1970, when alcohol consumption was substantially above the OECD average (Table 4.2). However, the number of deaths due to liver cirrhosis is quite high in comparison with other OECD countries. **Germany** ranks third behind Austria and the Slovak Republic in liver cirrhosis deaths.

At the same time, obesity rates have increased in recent decades in all OECD countries for which trend data is available (Chart 4.11). There remain however notable differences in obesity rates across countries. The obesity rate among adults in **Germany** (as measured by a body mass index level of 30 or greater) was 11.5% in 1999 (Table 4.3). The time lag between the onset of obesity and increases in related chronic

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<sup>2</sup> Data on indicators of health status and risk factors relate generally to 2000, and to 1999 for Germany.

diseases (such as diabetes) suggest that the rise in obesity that has occurred in Germany and other OECD countries, will have substantial implications for future incidence of health problems and related spending.

**Panorama de la santé – Les indicateurs de l’OCDE 2003**  
**Notes de présentation (France)**  
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### **Les dépenses de santé <sup>1</sup>**

Les dépenses de santé totales (publiques et privées) représentaient en **France** 9.5% du PIB en 2001, soit environ un point de pourcentage de plus que la moyenne des pays de l’OCDE (graphique 3.4). Les dépenses de santé par rapport au PIB en **France** restent cependant moins élevées qu’aux États-Unis (qui enregistre le niveau le plus élevé avec 13.9%), en Suisse, en Allemagne et au Canada.

La **France** se situe aussi au-dessus de la moyenne des pays de l’OCDE en termes de dépenses totales de santé par habitant, avec des dépenses de 2 561 USD (ajustées sur la base de la parité de pouvoir d’achat des monnaies) par rapport à une moyenne de 2 117 USD pour l’ensemble des pays de l’OCDE (graphique 3.1). Là encore, les dépenses de santé par habitant en **France** restent cependant bien en dessous des dépenses de santé aux États-Unis, qui s’élèvent à 4 887 USD par habitant. Les différences de dépenses de santé entre les pays peuvent refléter des différences de prix, de volume et/ou de qualité des services et des produits médicaux consommés.

Au cours des années 1990, les dépenses de santé par habitant en **France**, en terme réels (c’est-à-dire hors inflation), ont augmenté en moyenne de 2.2% par année, un chiffre moins élevé que la moyenne observée dans les pays de l’OCDE durant cette période (tableau 3.4). Toutefois, la hausse des dépenses de santé en **France** s’est accélérée en 2000 et 2001, atteignant une croissance en termes réels de 3.7% en moyenne sur ces deux années.

L’augmentation des dépenses pour les médicaments a été l’un des facteurs de la hausse des dépenses totales de santé en France comme dans plusieurs autres pays de l’OCDE. Entre 1990 et 2001, la part des dépenses en produits pharmaceutiques est passée de 16.9% du total des dépenses de santé en **France** à 21%, soit une des plus fortes augmentations parmi les pays de l’OCDE (graphique 3.15). En 2001, seuls les États-Unis dépensaient plus par habitant que la **France** au chapitre des médicaments (graphique 3.13). La plupart des pays de l’OCDE ont tenté de maîtriser la croissance des dépenses pharmaceutiques au cours de la dernière décennie en recourant à une panoplie de mesures. L’une des plus courantes a été d’accroître la participation des consommateurs aux coûts des produits pharmaceutiques. Ainsi, en **France** comme dans d’autres pays de l’OCDE, le nombre de médicaments non remboursés a augmenté, principalement pour les médicaments dits « de confort » ou dont la valeur thérapeutique n’est pas prouvée. On a aussi augmenté la participation des consommateurs aux coûts de nombreux autres médicaments.

### **Le financement des dépenses de santé**

Le financement public représente la principale source de financement des dépenses de santé dans tous les pays de l’OCDE, à l’exception de la Corée, des États-Unis et du Mexique. En **France**, 76% des dépenses

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<sup>1</sup> Les données financières sont, en règle générale, pour l’année 2001.

de santé sont financées par des fonds publics, un niveau un peu plus élevé que la moyenne des pays de l'OCDE (graphique 3.11). Parmi les pays européens, la part du financement public des dépenses de santé est plus élevée en **France** que dans des pays comme l'Espagne, la Belgique et les Pays-Bas, mais plus faible que dans la plupart des pays nordiques (le Danemark, la Suède et la Norvège).

En ce qui concerne les dépenses pharmaceutiques, la prise en charge privée de ces dépenses est, en règle générale, plus élevée que pour les services aux patients hospitalisés et aux patients externes, car les taux de remboursement sont plus faibles et une grande part des produits pharmaceutiques n'est pas couverte par les régimes publics d'assurances. En **France**, 66% des dépenses pharmaceutiques en 2001 étaient financées par des sources publiques, un niveau plus élevé que pour la moyenne des pays de l'OCDE (tableau 3.12). Alors qu'entre 1990 et 2001 la part du secteur public dans le financement des dépenses pharmaceutiques a diminué dans plusieurs pays européens (Allemagne, Italie, Pays-Bas, Suède), elle a augmenté en **France**, de même qu'au Danemark, en Australie et au Canada.

### Les ressources et les activités du secteur de la santé

La **France** compte 3.3 médecins par millier d'habitants, un chiffre plus élevé que la moyenne de 2.9 médecins par millier d'habitants pour la moyenne des pays de l'OCDE (tableau 2.1). La proportion de femmes médecins a fortement augmenté dans la plupart des pays de l'OCDE. Dans certains pays (Finlande, Pologne et République tchèque), les femmes sont désormais plus nombreuses que les hommes à exercer ce métier (graphique 2.4). En **France**, un médecin sur quatre était une femme en 1985, une proportion qui est passée à plus de un sur trois en 2000.

Par ailleurs, la **France** compte 6.7 infirmières par millier d'habitants, un nombre moins élevé que la moyenne des pays de l'OCDE (tableau 2.2). Il est à noter cependant que les infirmières auxiliaires (aides-soignantes) ne sont pas comptabilisées pour la France, alors qu'elles le sont dans la plupart des autres pays.

En **France**, le nombre de lits d'hôpitaux pour soins aigus est de 4.6 lits par milliers d'habitants, un nombre un peu plus élevé que la moyenne des pays de l'OCDE (graphique 2.9). Comme dans la plupart des autres pays développés, le nombre de lits d'hôpitaux disponibles par habitant a diminué au cours des 20 dernières années (tableau 2.3). La réduction du nombre de lits d'hôpitaux dans la plupart des pays de l'OCDE a coïncidé avec une réduction de la durée moyenne des séjours à l'hôpital et une augmentation du recours à la chirurgie de jour.

Bien que la durée moyenne des séjours à l'hôpital ait diminué dans les pays de l'OCDE, on observe toujours des variations importantes entre les pays. Par exemple en **France**, la durée moyenne de séjour suite à un accouchement normal est d'environ 5 jours alors qu'elle n'est que de 2 jours au Canada, aux États-Unis et en Nouvelle Zélande (graphique 2.32). En ce qui concerne la durée moyenne de séjour suite à un infarctus aigu du myocarde, elle est de 7.5 jours en **France**, comparée à 5.7 jours aux États-Unis (la moyenne la plus basse) et à 15 jours en Autriche (la moyenne la plus élevée) (graphique 2.31).

La durée moyenne de séjour à l'hôpital est fréquemment utilisée comme indicateur d'efficacité des systèmes de santé. Toutes choses étant égales par ailleurs, un séjour plus court diminue le coût par épisode de soins. Toutefois, l'utilisation de cet indicateur pour mesurer l'efficacité des soins requiert certaines précautions. Un séjour plus court exige souvent une intensité de services plus élevée et coûte plus cher par journée d'hospitalisation. En outre, un séjour trop court peut compromettre l'efficacité des soins et s'avérer préjudiciable au rétablissement du patient.

La diffusion des technologies médicales modernes est l'un des facteurs principaux de l'augmentation des dépenses de santé dans les pays de l'OCDE. Par exemple, le nombre d'appareils d'imagerie par résonance magnétique (IRM) utilisés pour diagnostiquer de nombreuses maladies a plus que triplé en moyenne dans

les pays de l'OCDE durant les années 1990, passant de 1.7 par million d'habitants en 1990 à 6,5 en 2000. Bien que leur nombre ait aussi augmenté en **France**, le nombre d'IRM par habitant y était moins élevé en 2000 (2,6 par million d'habitants) que dans la majorité des pays de l'OCDE.

### **L'état de santé de la population**

Parallèlement à la croissance des dépenses de santé, la plupart des pays de l'OCDE ont enregistré d'importants gains d'espérance de vie à la naissance au cours des 40 dernières années. En **France**, l'espérance de vie à la naissance a augmenté de 8.7 ans entre 1960 et 2000, ce qui correspond aux gains enregistrés en moyenne dans les pays de l'OCDE (graphique 1.2). En 2000, l'espérance de vie en **France** était de 79 ans, soit deux ans de plus que la moyenne des pays de l'OCDE. Le Japon enregistre l'espérance de vie la plus élevée, avec 81.2 ans, suivi de la Suisse, la Suède et l'Islande avec des espérances de vie atteignant presque 80 ans (tableau 1.1).

En **France**, l'écart d'espérance de vie à la naissance entre les hommes et les femmes est de 7.5 ans, un écart plus élevé que la moyenne des pays de l'OCDE. La **France** se situe au deuxième rang (à égalité avec l'Espagne) pour l'espérance de vie à la naissance des femmes, mais seulement au quinzième rang pour les hommes. Cet écart reflète notamment des taux de mortalité relativement élevés chez les hommes liés à des morts violentes (par exemple, accidents de la route et suicides) et à des maladies associées à une consommation excessive de tabac et d'alcool.

### **Les facteurs de risque**

La proportion d'adultes déclarant fumer quotidiennement a diminué dans la plupart des pays de l'OCDE au cours des deux dernières décennies. En **France**, la proportion d'adultes qui fument quotidiennement est passée de 30% en 1980 à 27% en 2000, une réduction cependant moins importante que dans la plupart des autres pays de l'OCDE. Ainsi, la proportion de fumeurs quotidiens en **France**, qui était moins élevée que la moyenne des pays de l'OCDE en 1980, est maintenant supérieure à cette moyenne (tableau 4.1).

Dans tous les pays de l'OCDE, excepté la Suède et la Norvège, les hommes continuent à fumer davantage que les femmes, mais dans la plupart des pays, la proportion de fumeurs a diminué plus rapidement chez les hommes que chez les femmes depuis 1980. Alors que le pourcentage de femmes qui déclarent fumer quotidiennement a diminué dans la plupart des pays de l'OCDE, il a augmenté en **France** au cours des deux dernières décennies. Mise à part la France, seules la Finlande, la Norvège et l'Espagne ont enregistré une augmentation du pourcentage de femmes qui fument quotidiennement entre 1980 et 2000 (tableau 4.1).

La consommation d'alcool par habitant a diminué dans la plupart des pays de l'OCDE au cours des dernières décennies. En **France**, la consommation globale d'alcool a fortement chuté depuis 1970 (graphique 4.6), même si elle reste plus élevée que la moyenne des pays de l'OCDE (graphique 4.5). En Suède, un des pays de l'OCDE qui enregistre la plus faible consommation d'alcool par habitant, des ventes strictement contrôlées et un niveau de taxe élevé sur l'alcool ont entraîné une baisse globale de la consommation, alors qu'en **France**, en Italie et en Espagne, la baisse de la consommation a coïncidé avec des mesures de contrôle plus strictes, en particulier dans le domaine de la publicité.

Les problèmes d'obésité ont considérablement augmenté au cours des deux dernières décennies dans tous les pays de l'OCDE pour lesquels on dispose de données chronologiques (graphique 4.11). Il existe toutefois des différences notables de prévalence de l'obésité chez les adultes selon les pays. En **France**, le taux d'obésité parmi la population adulte (9% en 2000) reste bien inférieur aux taux enregistrés dans la

plupart des autres pays développés, bien qu'il soit en augmentation<sup>2</sup>. Les taux d'obésité les plus élevés se retrouvent notamment aux États-Unis (31% en 1999), au Royaume-Uni (22% en 2001) et en Australie (21% en 1999)<sup>3</sup>. Le temps de latence entre l'apparition de l'obésité et l'accroissement des maladies chroniques qui y sont liées (comme le diabète et l'asthme) laisse à penser que la forte augmentation de la population obèse dans la plupart des pays de l'OCDE aura, dans l'avenir, des implications considérables en termes de santé et de dépenses de santé.

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<sup>2</sup> Des données récentes d'une enquête SOFRES réalisée pour l'Institut Roche de l'Obésité en collaboration avec l'INSERM indiquent que la prévalence de l'obésité en France est passée à 11.3% en 2003, en hausse par rapport à des taux de 8.2% en 1997 et 9.6% en 2000, enregistrés sur la base d'enquêtes similaires.

<sup>3</sup> Il est à noter cependant que ces données pour les États-Unis, le Royaume-Uni et l'Australie sont plus fiables et précises que celles des autres pays car elles sont fondées sur un examen médical au cours duquel on a mesuré la taille et le poids réel des individus, alors que les données pour les autres pays (incluant la France) sont basées sur de simples déclarations des répondants, ce qui entraîne généralement une sous-estimation des taux d'obésité.

**Health at a Glance – OECD Indicators 2003**  
**Briefing note (United States of America)**  
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### **Health spending<sup>1</sup>**

Total health spending (public and private) accounted for 13.9% of GDP in the **United States** in 2001, the highest share in the OECD and more than five percentage points higher than the average of 8.4% in OECD countries (chart 3.4). By comparison, countries such as Switzerland, Germany and Canada allocate from 10 to 11% of their GDP to health.

The **United States** also ranks far ahead of other OECD countries in terms of total health spending per capita, with spending of 4,887 USD (adjusted for purchasing power parity), more than double the OECD average of 2,117 USD in 2001 (chart 3.1). Switzerland comes just after with spending of 3,248 USD per capita, whereas France spends 2,561 USD per capita. It should be noted that differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

One might distinguish three different periods in terms of health expenditure growth in the **United States** over the past twenty years. The **United States** saw the fastest increase in health spending growth rate over the 1980s, with an increase in real terms by 5.3% per year on average, compared to the OECD average of 3.1% per year. In the 1990s, the growth rate then stabilised to 3.3% per year, identical to the OECD average. Health spending in the **United States** started to rise again more rapidly in 1999-2001, at a rate of 4.4% per year in real terms over this period, a higher growth rate than the 4% on average across OECD countries.

Regarding the allocation of health expenditure in 2001, the **United States** spent 48% of its total health expenditure on out-patient care (including ancillary services and home care), which is the highest share devoted to out-patient care in OECD countries (the average across OECD countries was 31% spent on out-patient services). Most OECD countries allocate a greater portion of their health expenditure to in-patient care (chart 3.3).

The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in the **United States** as well as in several other OECD countries. Between 1990 and 2001, the share of health expenditure spent on pharmaceuticals increased from 9.2% of total health spending to 12.4% (chart 3.15). In 2001, the United States was the top spender on pharmaceuticals (with 605 USD per capita, adjusted for purchasing power parity), followed by France and Italy (chart 3.13).

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<sup>1</sup> Data on expenditures relate generally to 2001 (the latest year for which comparable data are available in most countries).



## Public and private financing

The public sector is the main source of health funding in all OECD countries, except for **the United States**, Mexico and Korea. In the **United States**, only 44% of health spending is funded by government revenues, well below the average of 72% in OECD countries (chart 3.11). The public share of total health spending remains the lowest of OECD countries, compared for instance with the Nordic countries (Denmark, Norway and Sweden) where it reaches more than 80% of total health spending (chart 3.12).

In the **United States**, private insurance accounts for 35% of total health spending, by far the largest share among OECD countries. Beside the **United States**, Canada, France, Germany and the Netherlands also have a relatively large share of funding coming from private insurance (more than 10%).

## Resources and activities in the health sector

Despite the relatively high level of health expenditure in the **United States**, there are fewer physicians per capita than in most other OECD countries. In 1999, the **United States** had 2.7 practising physicians per 1 000 population, below the OECD average of 2.9 (table 2.1). Between 1990 and 2000, the number of doctors per capita remained quite stable, while it continued to increase (at least slightly) in most OECD countries (chart 2.2).

The proportion of female doctors has increased strongly over time as in most other OECD countries. In some countries (Finland, Poland and the Czech Republic), there are now more female doctors than males (chart 2.4). In the **United States**, the proportion of female doctors increased from 6% in 1970 to over 20% in 1999.

There were 8.1 nurses per 1 000 population in the **United States** in 1999, which corresponds exactly to the average across OECD countries. The number of nurses per capita increased in the United States (by a mean average growth rate of 2.8% over the period 1970-1999), as in most countries, but unlike Canada, Australia, Sweden and Poland, which experienced a decline during the 1990s (charts 2.6 and 2.7).

The number of acute care hospital beds in the **United States** in 2000 was 2.9 per 1 000 population, lower than the OECD average of 4.0 beds per 1 000 population (chart 2.9). As in most OECD countries, the number of hospital beds per capita has fallen over the past twenty years, from 4.4 beds per 1 000 population in 1980 to 2.9 in 2000 (table 2.3). This decline has coincided with a reduction in average length of stays in hospitals and an increase in day-surgery patients.

The average length of stays in hospitals has decreased over time in OECD countries, but there remain notable variations across countries. The United States has among the lowest average lengths of stay for most procedures. For instance, in the **United States** the average length of stay for mothers following a normal delivery is 2 days, which is much lower than in most other OECD countries (chart 2.32). The average length of stay following acute myocardial infarction (AMI) is 5.7 days, the lowest among OECD countries (table 2.11). The average length of stay in hospitals is often used as an indicator of efficiency since, 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. Shorter stays tend to be more service intensive and more costly per day. Also, if the stay is too short, there may be adverse effect on health outcomes of for the recovery of the patient.

Although progress has been achieved on childhood immunization, the **United States** has a relatively low overall vaccination coverage, with 82% of children immunised against diphtheria, tetanus and pertussis (DTP) in 2001, whereas more than two-thirds of OECD countries have achieved rates greater than 90% (chart 2.21).

## Health status<sup>2</sup>

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In the **United States**, life expectancy at birth increased by 6.9 years between 1960 and 2000, which is less than the increase of 13.4 years in life expectancy in Japan, or of 8 years in Canada (chart 1.2). In 2000, life expectancy in the **United States** stood at 76.8 years, below the OECD average of 77.2 years. Japan, Switzerland, Iceland, Sweden and Canada were among the top 5 countries registering the highest life expectancy among OECD countries (table 1.1).

Infant mortality rates in the **United States** have fallen greatly over the past few decades, but not as much as in most other OECD countries (table 1.6). It stood at 6.9 deaths per 1 000 live births in 2000, below the median among OECD countries (chart 1.5). It should be noted however that some of the international variation in infant mortality rates is due to variations in registering practices of premature infants (whether they are reported as live births or not). In several countries, such as the **United States**, Canada and the Nordic countries, very premature babies (with relatively low odds of survival) are registered as live births, which increases mortality rates compared with other countries that do not register them as live births. Among OECD countries, infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway), all below 4 deaths per 1 000 live births.

## Risk factors

The proportion of daily smokers among the adult population has shown a marked decline over recent decades across most OECD countries. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. In the **United States**, the proportion of smokers among adults has fallen from 34% in 1980 to 19% in 2000, the lowest rate among OECD countries along with Sweden (chart 4.1 and table 4.1).

At the same time, obesity rates have increased in recent decades in all OECD countries for which trend data is available (chart 4.11). There remain however notable differences in obesity rates across countries. In the **United States**, the obesity rate among adults (31% in 1999) is the highest in OECD countries, with the United Kingdom registering 22% in 2001 and Australia 21% in 1999<sup>3</sup>. Obesity rates in Continental European countries are lower (e.g., 9% of adults in 2000), but are also rising. The time lag between the onset of obesity and increases in related chronic diseases (such as diabetes and asthma) suggest that the rise in obesity that has occurred in the **United States** and other OECD countries, will have substantial implications for future incidence of health problems and related spending.

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<sup>2</sup> Data on indicators of health status and risk factors relate generally to 2000.

<sup>3</sup> It should be noted however that the data for the United States, the United Kingdom and Australia are more reliable and precise than those from other countries since they are based on health examinations whereby actual measures are taken of people's height and weight, while data for other countries are based on health interview surveys, which generally under-estimate the real prevalence of obesity.

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### **Health spending<sup>1</sup>**

Total health spending (public and private) accounted for 7.6% of GDP in the **United Kingdom** in 2001, less than one percentage point below the average of 8.4% in OECD countries (chart 3.4). Health spending as a share of GDP was also lower in the **United Kingdom** than the average among the 15 European Union countries (which was 8.3% of GDP). The United States continued to spend the highest proportion of its GDP on health, reaching 13.9% in 2001, a full three percentage points above the second placed country, Switzerland. Germany, Canada and France followed, spending 10.7%, 9.7% and 9.5% respectively of their GDP on health in 2001.

However, in terms of public expenditure, the **United Kingdom** spent 6.2% of its GDP on health in 2001, compared with 5.9% on average among OECD countries and 6.1% among European Union countries.

The **United Kingdom** ranked slightly below the OECD average in terms of total health expenditure per capita in 2001, with spending of 1 992 USD (adjusted for purchasing power parity) compared with an OECD average of 2 117 USD (chart 3.1). The United States again topped the OECD ranking of health spending per capita, with 4 887 USD per capita. Differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

During the 1990s, health spending per capita in the **United Kingdom** grew in real terms by 3.8% per year on average, a growth rate higher than the OECD average of 3.3% per year (table 3.4) and the European Union average of 3.2%. In the **United Kingdom**, as in many other countries, the past decade consisted of three different periods in terms of health expenditure growth. In the early 1990s, health spending grew fairly rapidly (4.7% per annum on average), coinciding with the introduction of the internal market and GP fund-holding. After relative stagnation in growth during the mid-1990s, health spending has accelerated in recent years, as a result of government commitments to improving the health service. Health spending increased by 4.9% per year in real terms from 1998-2001, second only to Ireland among the European Union countries. The bulk of this growth has been met by increases in public financing, rising by 5.6% on average from 1998 to 2001, compared with OECD-wide public health expenditure growth rate of 4.4% per annum.

### **Public and private financing**

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea. In the **United Kingdom**, 82% of health spending is funded by government revenues,

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<sup>1</sup> Data on expenditures relate generally to 2001 (the latest year for which comparable data are available in most countries).

above the average of 72% in OECD countries (chart 3.11). The share of public spending on health ranges from a low of 44% in the US to over 85% in countries such as Norway and Luxembourg. In France and Germany around 75% of health expenditure is financed through public funds. From a peak of 90% in the mid-1970s the public share of health spending in the **United Kingdom** declined to a low of 80% in the late 1990s, reflecting a steady rise in out-of-pocket payments and take up of private medical insurance over the same period. The government's commitment to increase public health expenditure over recent years has seen the public share increase again.

## **Resources and activities in the health sector**

The **United Kingdom** continues to face acute doctor shortages; there are fewer physicians per capita than in most other OECD countries. Amid efforts to recruit and maintain doctors in the health service, the **United Kingdom** reported 2.0 practising physicians per 1 000 population in 2000, well below the OECD average of 2.9, and the European Union average of 3.3.

In terms of practicing nurses there were 8.8 nurses per 1 000 population in the **United Kingdom** in 2000, in line with the European Union average, and slightly above the average of 8.1 across OECD countries. Following a period of relative stability, the number of nurses started to increase rapidly in the latter half of the 1990s (charts 2.6), when active recruitment policies were introduced to increase the nursing workforce, including from abroad. Reflecting also the relatively low density of UK physicians, the nurse to physician ratio in the **United Kingdom** is relatively high at 4.4, in line with Canada, Australia and New Zealand. At the other end of the scale, Southern European countries report much lower nurse-physician ratios (down to below 1.0 in Greece). These variations raise as much the question as to whether the appropriate skill mix between doctors and nurses in health care delivery is being adopted across countries.

The number of acute care hospital beds in the **United Kingdom** in 2000 was 3.9 per 1 000 population, close to OECD and European Union averages of 4.0 beds per 1 000 population (chart 2.9). In most OECD countries, the number of hospital beds per capita has fallen over recent decades, although comparable data for the **United Kingdom** is only available from 1995. Since then the number of beds in the **United Kingdom** has been stable. The current government's stated policy is to increase acute bed availability in order to reduce blockages caused when beds are not available.

Although the average length of stays in hospitals has decreased over time in OECD countries, there remain notable variations across countries. In the **United Kingdom** the average length of stay for acute care is 6.9 days, the same as the OECD average, but lower than in some other European countries such as Germany and the Netherlands where the average length of stay for acute care is over 9 days (chart 2.29).

During the past decade, there has been rapid growth in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in most OECD countries. In the **United Kingdom**, the number of MRIs per million population increased from 1.0 in 1990 to 4.6 in 2000. Despite this rapid increase, it still ranks around the median with regards to OECD countries (chart 2.15). The number of scanners provides only an indication of the overall availability of such equipment; it does not indicate to what extent the equipment is used.

## Health status<sup>2</sup>

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In the **United Kingdom**, life expectancy at birth increased by 7.0 years between 1960 and 2000, below the average gain of 8.6 years registered across OECD countries, and far less than the increase of 13.4 years in life expectancy in Japan (chart 1.2). In 2000, life expectancy in the **United Kingdom** stood at 77.8 years, just below the median in terms of OECD ranking. Japan, Switzerland, and Sweden register the highest life expectancy in the OECD at 81.2, 79.8 and 79.7 years respectively (table 1.1).

As in other OECD countries, infant mortality rates in the **United Kingdom** have fallen dramatically over the past few decades (table 1.6). It stood at 5.6 deaths per 1 000 live births in 2000, lower than the OECD average of 6.5 but above the corresponding average of European Union countries (chart 1.5). Infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway).

## Risk factors

The proportion of daily smokers among the adult population has shown a marked decline over recent decades across most OECD countries. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. In the **United Kingdom**, the proportion of smokers among adults has fallen from 39% in 1980 to 27% in 2000. It continues to be around the average of OECD countries; the lowest current rates are reported in Sweden, the United States, Canada and Australia, all at fewer than 20% of the adult population (table 4.1).

At the same time, obesity rates have increased in recent decades in all OECD countries for which trend data is available (chart 4.11). There remain however notable differences in obesity rates across countries. In the **United Kingdom**, the obesity rate among adults has tripled over the last twenty years to stand at 22% in 2001. This is higher than in nearly all other OECD countries, but lower than in the United States (31% in 1999) and Mexico (24%, 2000), and comparable to Australia (21% in 1999)<sup>3</sup>. The time lag between the onset of obesity and increases in related chronic diseases (such as diabetes and asthma) suggest that the rise in obesity that has occurred in most OECD countries, including the **United Kingdom**, will have substantial implications for future incidence of health problems and related spending.

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<sup>2</sup> Data on indicators of health status and risk factors generally relate to 2000.

<sup>3</sup> It should be noted however that the data for the United States, the United Kingdom and Australia are more reliable and precise than those from other countries since they are based on health examinations whereby actual measures are taken of people's height and weight, while data for other countries are based on health interview surveys, which generally under-estimate the real prevalence of obesity.