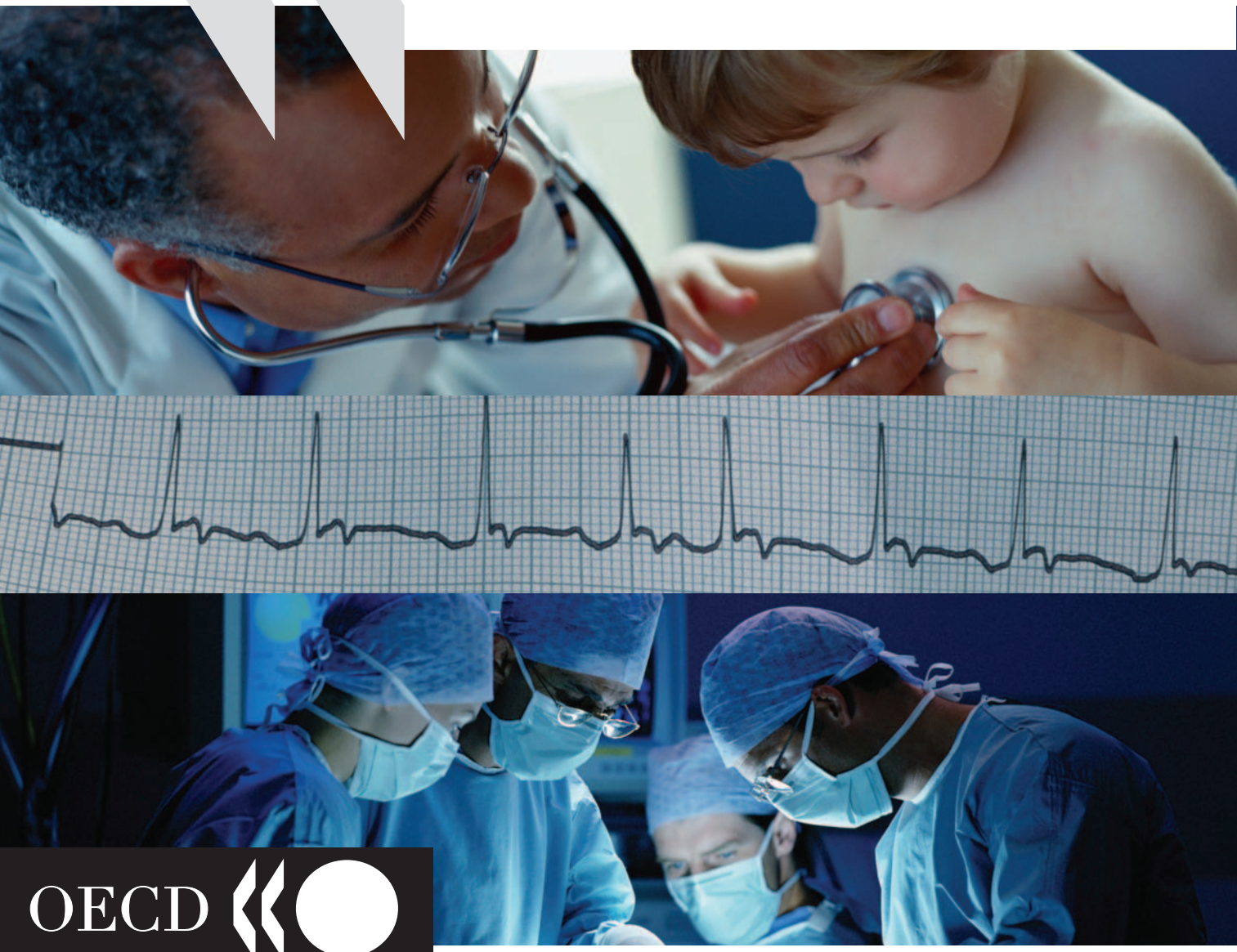
Health at a Glance

OECD INDICATORS 2003



OECD

2003

© OECD, 2003.

© Software: 1987-1996, Acrobat is a trademark of ADOBE.

All rights reserved. OECD grants you the right to use one copy of this Program for your personal use only. Unauthorised reproduction, lending, hiring, transmission or distribution of any data or software is prohibited. You must treat the Program and associated materials and any elements thereof like any other copyrighted material.

All requests should be made to:

Head of Publications Service,
OECD Publications Service,
2, rue André-Pascal,
75775 Paris Cedex 16, France.

Health at a Glance

OECD INDICATORS
2003

OECD

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

Pursuant to Article 1 of the Convention signed in Paris on 14th December 1960, and which came into force on 30th September 1961, the Organisation for Economic Co-operation and Development (OECD) shall promote policies designed:

- to achieve the highest sustainable economic growth and employment and a rising standard of living in Member countries, while maintaining financial stability, and thus to contribute to the development of the world economy;
- to contribute to sound economic expansion in Member as well as non-member countries in the process of economic development; and
- to contribute to the expansion of world trade on a multilateral, non-discriminatory basis in accordance with international obligations.

The original Member countries of the OECD are Austria, Belgium, Canada, Denmark, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The following countries became Members subsequently through accession at the dates indicated hereafter: Japan (28th April 1964), Finland (28th January 1969), Australia (7th June 1971), New Zealand (29th May 1973), Mexico (18th May 1994), the Czech Republic (21st December 1995), Hungary (7th May 1996), Poland (22nd November 1996), Korea (12th December 1996) and the Slovak Republic (14th December 2000). The Commission of the European Communities takes part in the work of the OECD (Article 13 of the OECD Convention).

Publié en français sous le titre :

Panorama de la santé

INDICATEURS DE L'OCDE 2003

© OECD 2003

Permission to reproduce a portion of this work for non-commercial purposes or classroom use should be obtained through the Centre français d'exploitation du droit de copie (CFC), 20, rue des Grands-Augustins, 75006 Paris, France, tel. (33-1) 44 07 47 70, fax (33-1) 46 34 67 19, for every country except the United States. In the United States permission should be obtained through the Copyright Clearance Center, Customer Service, (508)750-8400, 222 Rosewood Drive, Danvers, MA 01923 USA, or CCC Online: *www.copyright.com*. All other applications for permission to reproduce or translate all or part of this book should be made to OECD Publications, 2, rue André-Pascal, 75775 Paris Cedex 16, France.

FOREWORD

Health expenditure has increased in all OECD countries over the past several decades. It now accounts for more than 8% of gross domestic product (GDP) in most countries, with pressures for further growth arising from rapid advances in medical technologies, population ageing and rising public expectations. At the same time, remarkable progress has been achieved in OECD countries over the past four decades in reducing premature mortality and increasing the life expectancy of people at all ages. Governments in OECD countries are pursuing their search for effective health policies that contribute to further improvements in populations' health status while containing the growth in health spending. There is increasing interest in learning lessons from international comparisons of the performance of health systems to inform these public policy discussions.

A key basis for such comparisons is *OECD Health Data*, a comprehensive database on health and health systems in OECD countries. Since 1991, these data have been released annually on a CD-ROM called *OECD Health Data*. The main aim of the present publication, *Health at a Glance*, is to present some of the key indicators from *OECD Health Data 2003* in an easily accessible form.

This is the second edition of *Health at a Glance*. Compared to its predecessor, this second edition provides a richer, more comparable and more up-to-date set of indicators in relation to health status, health care activity and expenditures, and health risks. The publication is designed to describe the main variations across countries and over time in key indicators of health, drawing heavily on graphical illustrations. Care has also been taken to indicate precisely the definition of each indicator and to signal data comparability limitations.

The OECD would like to acknowledge the many individuals and organisations that have contributed to the development of *OECD Health Data* and the preparation of this second edition of *Health at a Glance*. *OECD Health Data* and this publication would not have been possible without the contribution of national data correspondents in the 30 OECD countries. The OECD gratefully acknowledges their effort to report most of the data and qualitative information contained in this publication. The OECD also acknowledges the contribution of other international organisations, especially the World Health Organisation and Eurostat, for sharing some of the data presented in this publication. Particular thanks go to the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) of the United States Department of Health and Human Services for the financial support provided to the collection of *OECD Health Data* over many years.

Health at a Glance was prepared by the Health Policy Unit at the OECD, under the coordination of Gaetan Lafortune and David Morgan, with contributions from Eva Orosz, Uffe Ploug, Pierre Moise and Steven Simoens. The editorial review committee included Elizabeth Docteur, Manfred Huber, Jeremy Hurst and Peter Scherer. Other useful comments in the development of this publication were provided by national data correspondents.

Health at a Glance is only the "tip of the iceberg" of *OECD Health Data*. Readers interested in undertaking further comparative analysis are invited to consult the more extensive data and additional information on sources and methods contained in *OECD Health Data*.

© OECD 2003

TABLE OF CONTENTS

© OECD 2003

© OECD 2003

INTRODUCTION

This second edition of *Health at a Glance* aims to build on the success of the inaugural edition by presenting an expanded set of indicators. In keeping with the original aim and as its name suggests, *Health at a Glance* presents key health indicators in charts and tables. It is designed to provide the basis for a better understanding of a range of factors which affect the health of populations and the performance of health care systems in OECD countries. The publication shows cross-country variations and trends over time in core indicators of health status, health care systems and non-medical determinants of health. It also provides a brief interpretation of these data. The statistical annex at the end of the publication offers additional data on these indicators in a set of more than 50 tables.

The indicators presented in this publication are also available on the CD-ROM, *OECD Health Data 2003*. *OECD Health Data 2003* is a comprehensive database which covers over 1 000 indicators of health and health systems across OECD countries. The database is the product of longstanding collaborative effort between the OECD Health Policy Unit and national statistical offices. It comes with extensive documentation of indicator definitions, national sources and estimation methods. The structure of *Health at a Glance* generally follows the structure of *OECD Health Data*, although some parts of the more encompassing database have been combined for the purpose of this publication. More details on the full content of *OECD Health Data 2003* are available in Annex 3 and at *www.oecd.org/health/healthdata*.

Text and charts

Each indicator in this publication is presented over two pages, which display:

- One page of commentary relating to the indicator, including the OECD definition of the indicator and a note regarding any significant national variation from that definition which might affect data comparability.
- One or two bar charts showing differences between countries in the indicator for the most recent year available.
- One or two charts showing trends over time in the indicator. These might either be a *bar* chart showing two or three data points over time for all countries for which consistent time series are available, or a *trend line* chart showing year-after-year changes usually for the average across OECD countries and a few countries reporting among the lowest or highest growth rates over the period.
- In some cases, an additional chart also shows the relationship between the indicator under review and other variables found in *OECD Health Data*.

Tables

The tables in the statistical annex at the end of this publication contain additional data on each indicator, including OECD averages and, in some cases, medians (see below). Where data for individual countries are not available for the years selected, the tables present data up to the previous or following two years.

Averages across countries are unweighted (*i.e.*, they do not take into account differences in the size of the population of each country). These averages have been calculated only for those countries for which data are available over the complete time series, in order to avoid mixing different groups of countries. The number of countries included in the "OECD average" is mentioned in brackets, and those countries excluded from the average (due to data gaps) are listed in footnotes.

© OECD 2003

All medians, on the other hand, relate to the group of countries for which data is available in a given year. In statistical terms, the median is defined as the number in the middle of a set of numbers. In the tables at the end of this publication, it means therefore that half the countries have values that are greater than the median, and half have values that are less. Compared with averages, medians minimize the influence of outliers (countries with values either much greater or much smaller than others).

Data limitations

Limitations in data comparability are indicated both in the text (in the box related to "Definition and deviations") as well as in footnotes to tables and charts. Please note that particular caution should be exercised when considering time trends for Germany. Data for Germany up to 1990 generally refer to West Germany and data from 1991 refer to unified Germany.

Readers interested in using the data presented in this publication for further analysis and research are encouraged to consult the full documentation of definitions, sources and methods contained in *OECD Health Data 2003*. *OECD Health Data 2003* can be ordered online at SourceOECD (*www.sourceOECD.org*) or through the OECD's online bookshop (*www.oecd.org/bookshop*).

© OECD 2003

1. HEALTH STATUS

© OECD 2003

Life expectancy at birth

Life expectancy at birth remains one of the most frequently used indicators of a population's health status. Over the past 40 years, there have been large gains in life expectancy at birth in OECD countries (Chart 1.2). On average, life expectancy at birth across OECD countries increased by 8.7 years, to reach 77.2 years in 2000, up from 68.5 years in 1960, for the whole population (Table 1.1). The gains in life expectancy were steady over the past four decades on average across countries, averaging 1.8 year from 1960 to 1970 and 2.3 years per decade since then.

Increases in life expectancy have been particularly pronounced in countries which started with a relatively low level in 1960. For instance, in Korea, life expectancy for the whole population increased by 23.1 years between 1960 and 1999 (Chart 1.2 and Table 1.1). These gains occurred during a period when the country experienced rapid economic development. In Turkey, life expectancy at birth increased by almost 20 years over the past four decades, rapidly catching up as well with the OECD average. Similarly, in Mexico, gains in life expectancy totalled almost 16.6 years during the same 40-year period.

In 2000, the country with the highest life expectancy was Japan, with 81.2 years for the whole population, followed by Switzerland, Sweden and Iceland with life expectancy reaching almost 80 years (Table 1.1). In Japan, the remarkable gains in life expectancy at birth over the past decades have been driven by a continuous reduction in infant mortality rates together with rapidly falling death rates from circulatory diseases (see indicators "Infant mortality" and "Ischaemic heart disease mortality").

The gender gap in life expectancy stood at 5.9 years on average across OECD countries in 2000, with life expectancy reaching 80.1 years for women and 74.2 years for men (Chart 1.1; Tables 1.2 and 1.3). This gender gap increased by almost one year on average across countries over the entire period from 1960 to 2000. But this result hides different trends between earlier and later decades. While the gender gap in life expectancy increased substantially in many countries during the 1960s and the 1970s, it narrowed down during the past two decades. From 1980 to 2000, gains in life expectancy were on average across countries higher for men than for women. The narrowing of the male-female gap in life expectancy in many countries since 1980 has been attributed partly to the narrowing in risk factor behaviours (such as smoking) between men and women (Max Planck Institute, 1999).

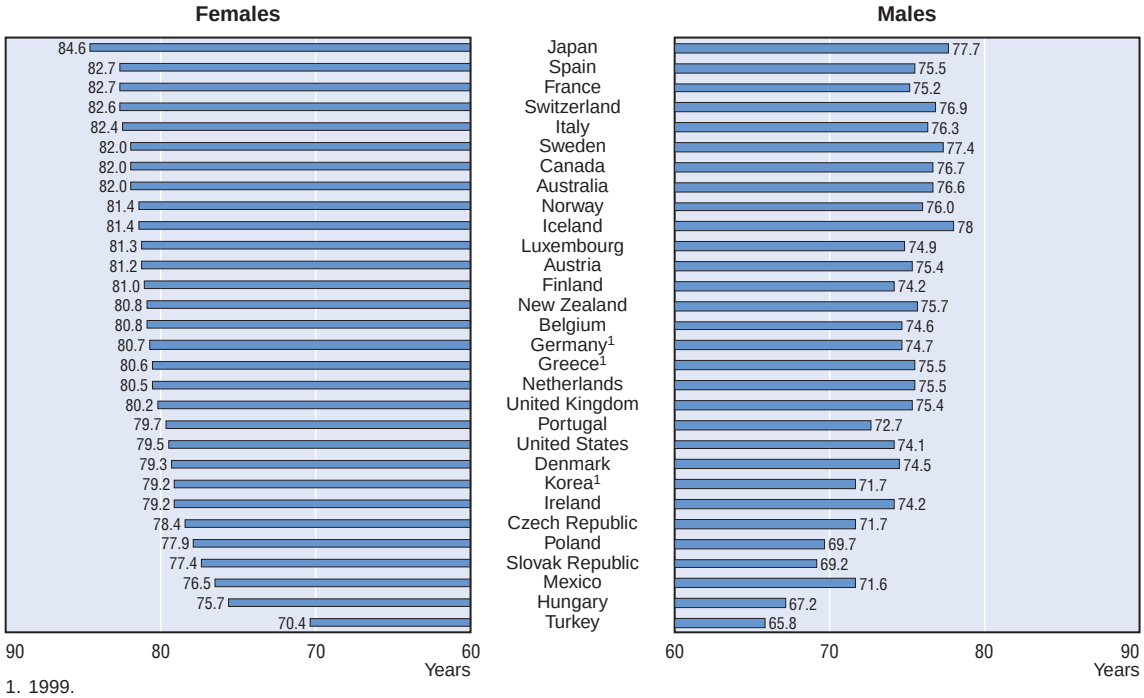
Gains in life expectancy in OECD countries in recent decades have come as a result of a number of important factors, including improvements in living conditions, public health interventions and progress in medical care. Although it is not easy to estimate the relative contribution of each of these factors, Bunker and colleagues estimated that medical care might account for 17-18% of the increases in life expectancy in the United States and Great Britain over the last century as a whole (Bunker *et al.*, 1994; Bunker, 1995, cited in Naylor *et al.*, 2002). Using statistics on health care resources available in *OECD Health Data*, Or found some correlation between variations in life expectancy and in numbers of doctors per capita across countries and over time, controlling for other variables such as GDP per capita (Or, 2000).

Definition and deviations

Life expectancy is the average number of years of life remaining to a person at a particular age, based on a given set of age-specific mortality rates. Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

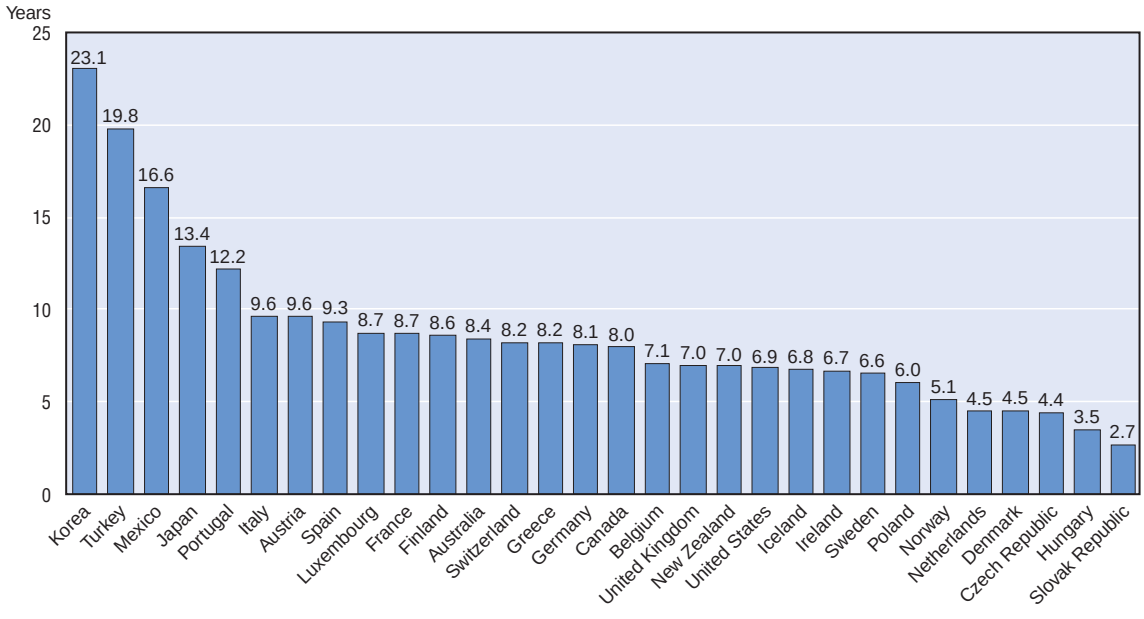
© OECD 2003

Chart 1.1. **Life expectancy at birth, 2000**



1. 1999.

Chart 1.2. **Gains in life expectancy, total population, 1960 to 2000**



See footnotes to Table 1.1.
Source: OECD Health Data 2003.

© OECD 2003

Life expectancy at age 65

Life expectancy at age 65 is often used as an overall indicator of the health of older persons, although it only measures the *quantity* of remaining years of life that a person reaching that age can expect to live (given current patterns of mortality), not the health-related *quality* of life during these years.

Life expectancy at age 65 has been steadily improving for both men and women over the past few decades in most OECD countries (Chart 1.4; Tables 1.4 Table 1.5). On average across OECD countries, life expectancy at age 65 has increased by 3.4 years for women and 2.8 years for men between 1970 and 2000. The gender gap in longevity at age 65 therefore widened slightly during that period. By the year 2000, people at age 65 in OECD countries could expect to live, on average, an additional 18.9 years for women and 15.4 years for men.

Japan registered particularly strong increases in life expectancy at age 65 in recent decades, with gains of more than seven years for women and five years for men between 1970 and 2000 (Chart 1.4). As a result, Japanese women enjoyed the longest, and Japanese men the second longest life expectancy at age 65 in 2000, with respectively 22.4 years and 17.5 years of remaining years of life (Chart 1.3). These gains have been driven largely by a marked reduction in death rates from heart diseases and cerebrovascular diseases (stroke) among elderly people in Japan, along with low mortality rates from cancer. Other OECD countries have also registered significant reductions in mortality from cardiovascular and cerebrovascular diseases among elderly populations over the past decades (OECD, 2003a; Moise, Jacobzone *et al*., 2003; Moon *et al.*, 2003).

Some of the factors explaining the gains in life expectancy at age 65 include advances in medical care combined with greater access to health care, healthier lifestyles and improved living conditions before and after people reach 65.

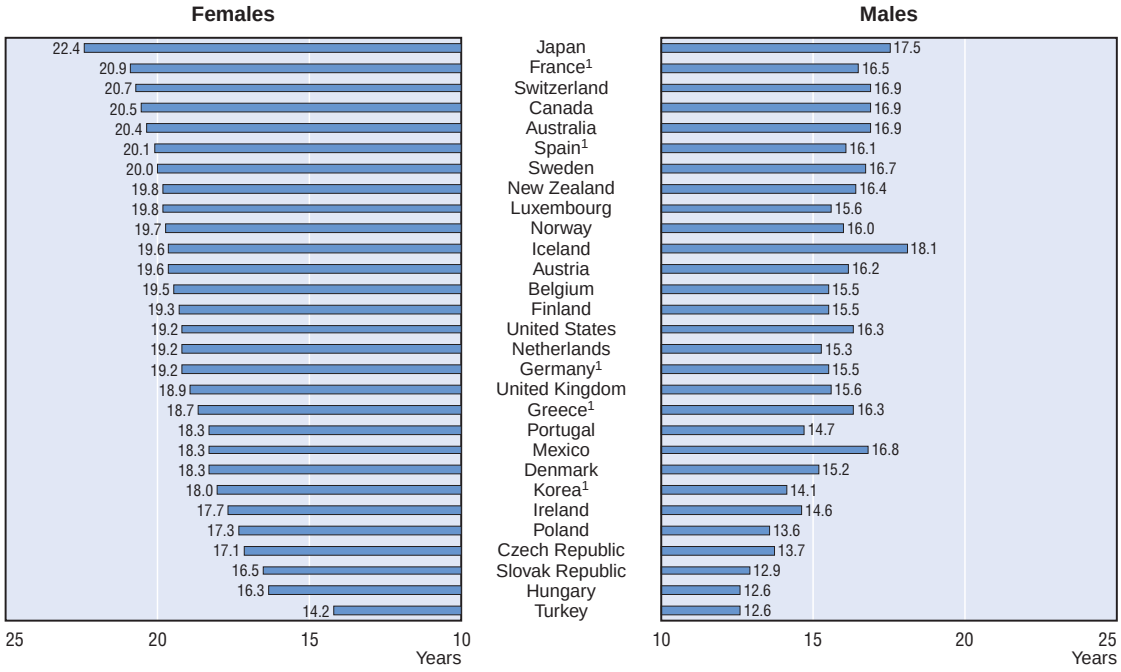
The gains in longevity at older ages, combined with the trend reduction in fertility rates, are leading to a steady rise in the proportion of older persons in most OECD countries (see indicators "Fertility rates" and "Share of the population aged 65 and over").

Definition and deviations

Life expectancy is the average number of years of life remaining to a person at a particular age, based on a given set of age-specific mortality rates. Each country calculates its own life expectancy, using methodologies that can vary somewhat. These differences in methodology can affect the comparability of the life expectancy measures presented here, as different methods can change a country's life expectancy estimates by a fraction of a year.

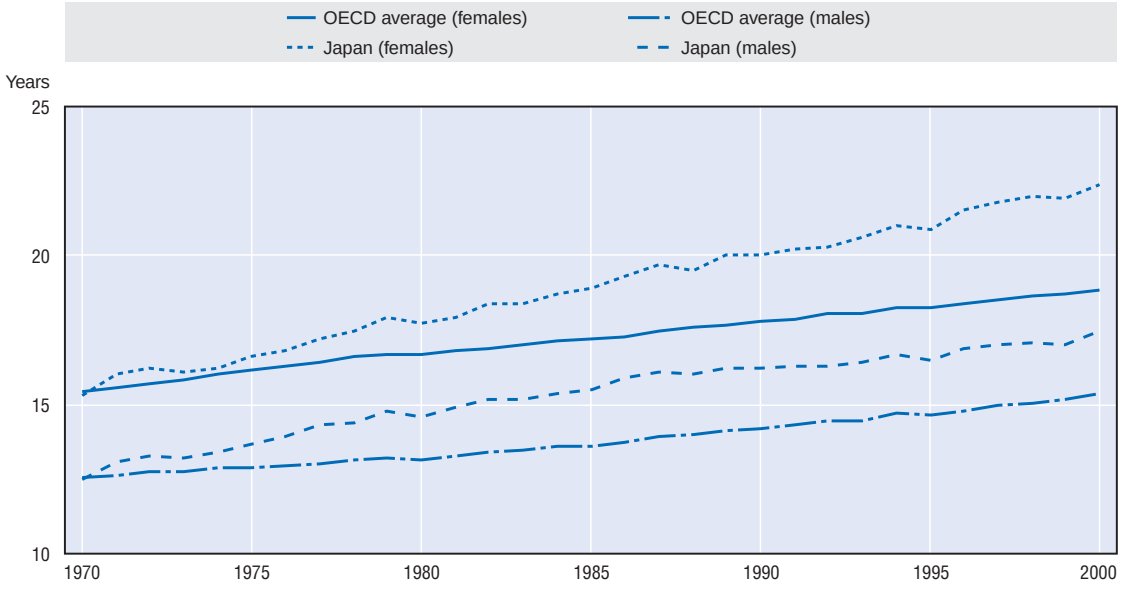
© OECD 2003

Chart 1.3. **Life expectancy at age 65, 2000**



1. 1999.

Chart 1.4. **Trends in life expectancy at age 65, 1970-2000**
OECD average and Japan



See footnotes to Tables 1.4 and 1.5.
Source: OECD Health Data 2003.

© OECD 2003

Infant mortality

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

All OECD countries have achieved remarkable progress in reducing infant mortality rates since 1960. On average across OECD countries, infant mortality rates stood at 6.5 deaths per 1 000 live births in 2000, down from 36.4 per 1 000 live births in 1960 (Table 1.6). Portugal has made much progress, bringing its infant mortality rate down from 77.5 deaths per 1 000 live births in 1960 (more than double the OECD average at that time) to 5.5 by 2000 (below the OECD average) (Charts 1.6 and 1.7). Japan has also gone from a country previously in the bottom half of OECD countries in terms of its ranking on infant mortality in 1960 to be currently one of the countries with the lowest rates, along with historically low Nordic countries (Chart 1.5). Although infant mortality rates remain significantly higher than the OECD average in Mexico and Turkey, substantial reductions have also been achieved in these countries over the past decades.

Infant mortality rates are related to a number of social and economic factors, such as the average income level in a country, the income distribution and the availability and access to health services. Some studies have found an association between cross-country variations in infant mortality rates and 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). Other studies have shown that a higher level of resources does not necessarily result in greater reductions in infant mortality. For instance, the United States has a significantly higher density per population of neonatologists and neonatal intensive care beds than Australia, Canada and the United Kingdom, yet the infant mortality rate in the United States remains higher than in these countries. Other factors such as the high level of teenage pregnancy and the lack of free prenatal and perinatal care in the United States have been put forward as contributory factors underlying the higher observed rates (Thomson *et al.*, 2002).

Neonatal deaths (those deaths occurring in the first four weeks) can account for up to two-thirds of all infant mortality. Most neonatal deaths in developed countries are a result of congenital anomalies or premature birth. With increasing age of motherhood and the rise in multiple pregnancies linked with fertility treatments, the number of premature births has tended to increase. For some countries with historically low infant mortality rates, such as in Nordic countries and Western Europe, this has resulted in a leveling-off or reversal of the downward trend over the past few years.

Definition and deviations

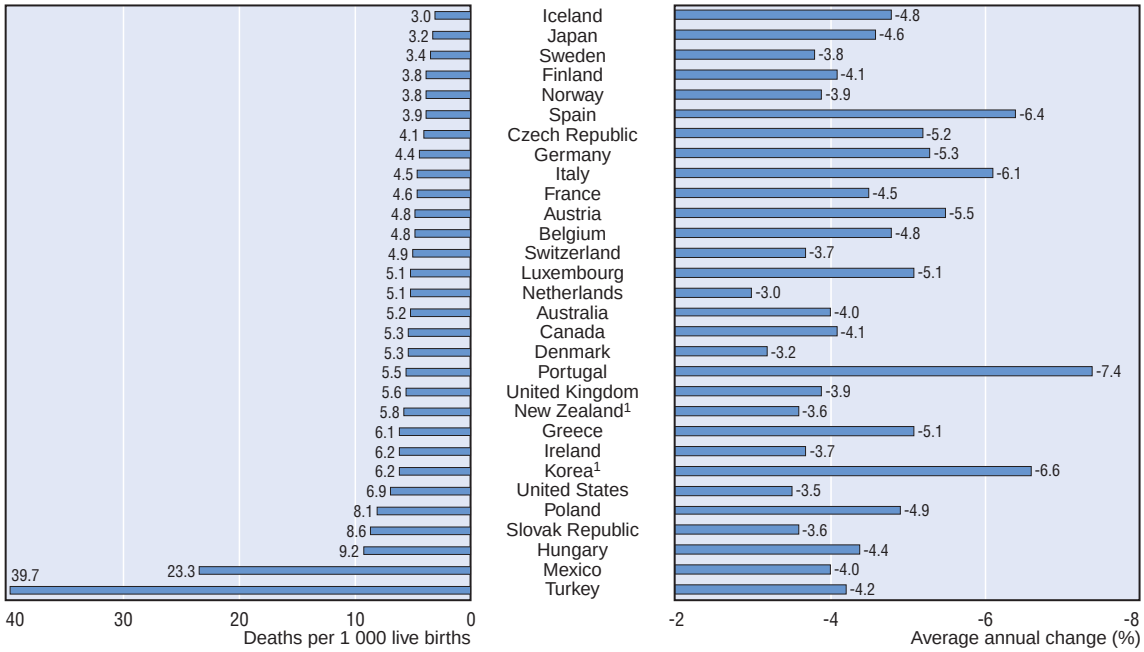
Infant mortality is the number of deaths of children under one year of age expressed per 1 000 live births.

Some of the international variation in infant mortality rates may be due to variations among countries in registering practices of premature infants (whether they are reported as live births or not). In several countries, such as in 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 (Sachs *et al.*, 1995).

© OECD 2003

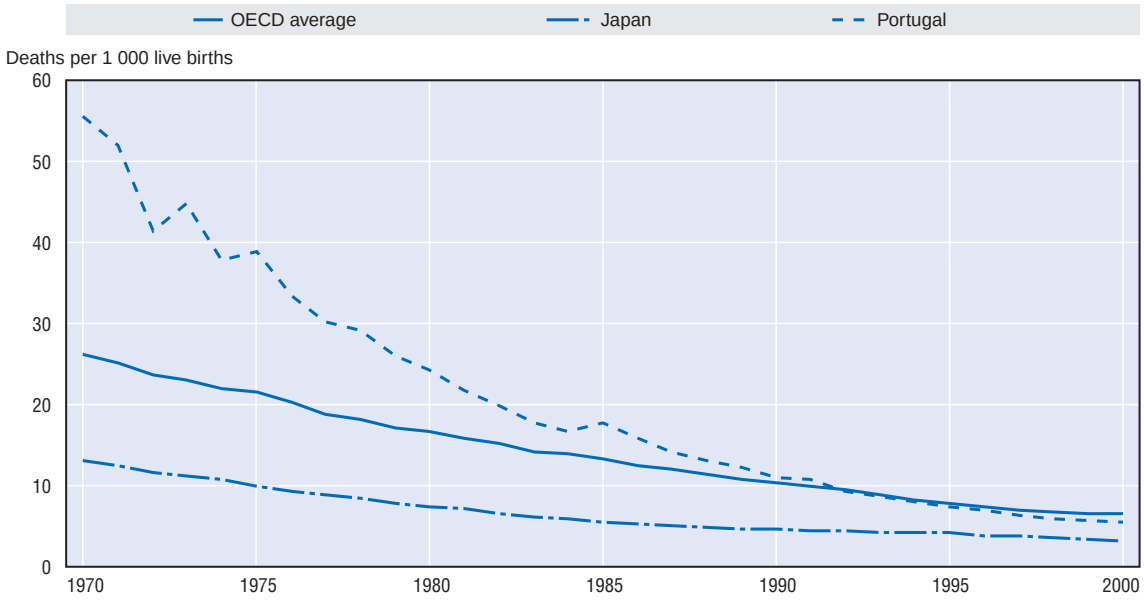
Chart 1.5. **Infant mortality rates, 2000**

Chart 1.6. **Average annual decline in infant mortality rates, 1970-2000**



1. 1999.

Chart 1.7. **Decline in infant mortality rates, 1970-2000**
OECD average, Japan and Portugal



See footnotes to Tables 1.6.
Source: OECD Health Data 2003.

© OECD 2003

Premature mortality

Premature mortality, measured in terms of potential years of life lost (PYLL), focuses on deaths among the younger age groups of the population. PYLL values are heavily influenced by infant mortality and deaths from diseases and injuries affecting children and younger adults. Any decline in what is often interpreted as a measure of untimely or avoidable deaths can be influenced by advances in medical technology, for example, in relation to infant mortality and heart disease mortality, and prevention and control measures, regarding deaths from injuries and communicable diseases.

Across OECD countries, premature mortality has been cut by half on average since the early 1960s (Tables 1.7 and 1.8). The downward trend in infant mortality has been a major factor contributing to the decrease during the earlier years. More recently, the decline in deaths from heart disease among adults has contributed to the overall reduction in premature mortality in many countries (see indicator "Ischaemic heart disease mortality"; for a review of long-term mortality trends in the United States, see Cutler and Meara, 2001).

Japan and Portugal have seen premature mortality rates for both males and females coming down to below a third of their levels in the early 1960s, due partly to a sharp reduction in infant mortality rates. In contrast, some Central and Eastern European countries, particularly Hungary and Poland, have seen only moderate decreases in premature mortality rates for males. As a result, Hungary reported in 2000 the highest level of premature mortality for males among OECD countries, at a level twice the OECD average (Charts 1.8 and 1.10). As in other OECD countries, infant mortality rates in Hungary have dropped. However, the reduction in premature mortality overall has been slowed down by persistent high levels of mortality from circulatory disease (currently over twice the OECD average) and from liver cirrhosis/disease. These are believed to reflect unhealthy lifestyles in relation to alcohol and tobacco consumption among males in Hungary.

For both males and females, Japan and Sweden featured amongst the countries with the lowest levels of premature mortality in 2000 (Chart 1.8). The United States reported premature mortality rates above the OECD average, 21% above in the case of men and 34% above in the case of women (Charts 1.9 and 1.10). In the case of men, around a half (and in women almost a third) of these higher-than-average premature mortality rates can be attributed to deaths resulting from external causes, including accidents, suicides and homicides. Premature death from homicides in the United States, for both men and women, is around four or five times the OECD average.

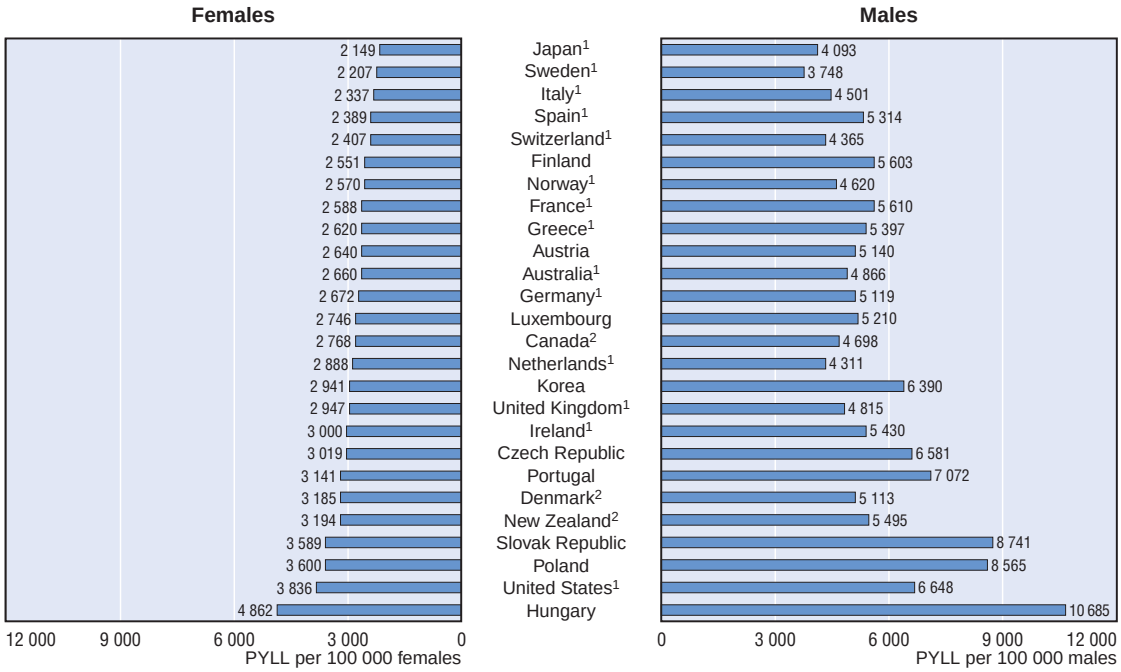
Across the OECD as a whole, the main causes of PYLL before age 70 amongst women are cancer (31%), external causes including accidents and violence (17%), and circulatory diseases (14%). For men, the principal causes are external causes (29%), followed by cancer (20%) and circulatory diseases (19%).

Definition and deviations

Potential years of life lost (PYLL) is a summary measure of premature mortality providing an explicit way of weighting deaths occurring at younger ages. The calculation for PYLL involves adding up age-specific deaths occurring at each age and weighting by the number of remaining years to live until a selected age limit, defined here as the age of 70. For example, a death occurring at 5 years of age is counted as 65 years of PYLL. The indicator is expressed per 100 000 females and males.

© OECD 2003

Chart 1.8. **Potential years of life lost (PYLL), 2000**



1. 1999. 2. 1998.

Chart 1.9. **Trends in PYLL, females, 1960-2000**

OECD average and selected countries

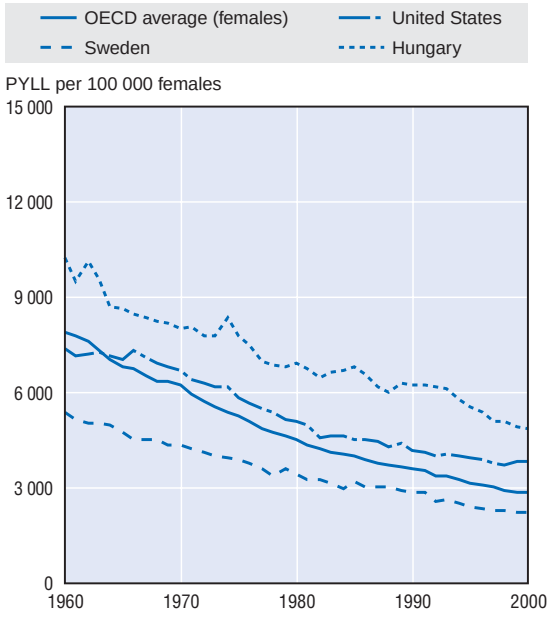
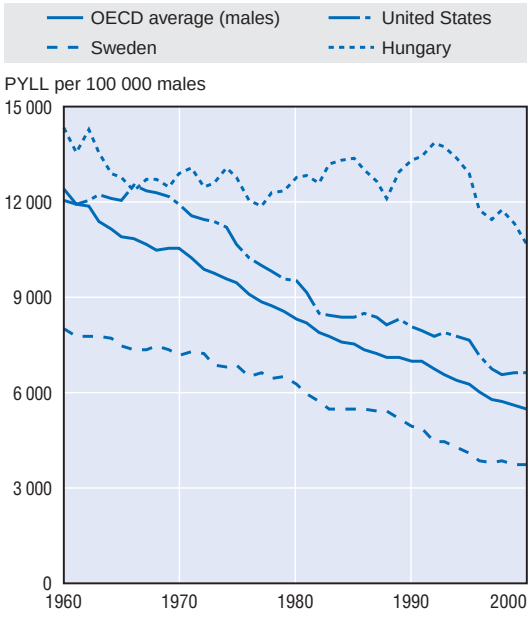


Chart 1.10. **Trends in PYLL, males, 1960-2000**

OECD average and selected countries



See footnotes to Tables 1.7 et 1.8.
Source: OECD Health Data 2003.

© OECD 2003

All cancers, females and males

Cancer is the second leading cause of mortality in most OECD countries, after diseases of the circulatory system. In any given year, deaths from cancer account for some 20 to 30% of all deaths, depending on the country. In several OECD countries *(e.g.,* Australia, Canada, Ireland, Italy, New Zealand, the United Kingdom and the United States), death rates from cancer reached a peak in the 1980s and declined during the 1990s (Table 1.9).

In 2000, mortality rates from cancer (age-standardised) were relatively low in Finland, Switzerland, Sweden, Greece and Japan, with annual death rates from cancer in the range of 145-155 per 100 000 population (Chart 1.11). On the other hand, in Central and Eastern European countries, cancer death rates are higher than in other parts of the OECD, with rates exceeding 200 deaths per 100 000 population in Hungary, the Czech Republic, the Slovak Republic and Poland. Denmark also reports relatively high mortality rates from cancer. Differences in death rates from cancer across countries can be explained both by non-medical factors, such as the population's exposure to risk factors *(e.g.,* smoking), and medical factors, including early diagnosis and effective treatment of different types of cancer.

Mortality rates from cancer are higher for men than for women in all OECD countries (Table 1.9). In 2000, the gender gap in death rates from cancer was particularly high in France, Italy, Japan, Korea, Portugal, the Slovak Republic and Spain, with mortality rates being at least two times higher for men than for women in these countries. The gender gap in cancer mortality rates can be explained at least partly by the greater prevalence of risk factors among men and the lesser availability or use of screening programmes for different types of cancers among men, leading to lower survival rates after diagnosis.

As noted above, in most OECD countries, mortality rates from cancer have declined over the past decade (Chart 1.12). The decline in death rates from cancer was particularly marked in Switzerland, Luxembourg, Austria, Finland, Italy and the United Kingdom, registering a reduction in cancer mortality rates for the whole population of more than 10% during the 1990s. The notable exceptions to this declining pattern were Korea (which started with the lowest level among all OECD countries in 1990) and the Slovak Republic, where death rates from cancers continued to increase between 1990 and 2000.

While mortality rates from cancer started to fall in many countries over the past decade, the number of new cancer cases continued to increase over the 1980s and the 1990s in all countries for which comparable data is available, with the exception of Austria where it began to decline during the 1990s and the United States where it remained stable (Chart 1.14). The rise in the number of new cancer cases over time across OECD countries can be attributed at least partly to the more widespread use of screening tests for various types of cancers. In 2000, the incidence of all cancers was the highest in the Netherlands, Italy, Hungary and Luxembourg, with rates of new cancer cases exceeding 400 per 100 000 population in these countries (Chart 1.13).

The decline in cancer death rates in most countries, despite the increasing number of cancer cases, indicates that substantial progress has been achieved in survival rates from different types of cancers in many OECD countries (see OECD, 2003a, Chapter 4, for survival rates in relation to breast cancer).

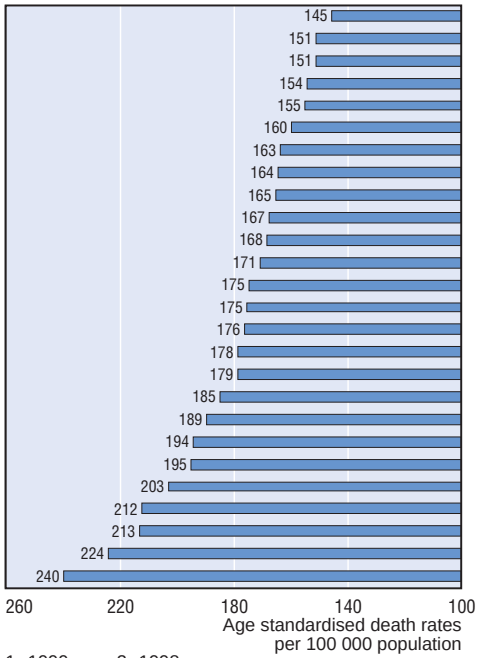
Definition and deviations

Cancer incidence rates are measured as the number of new cancer cases per 100 000 population. Cancer mortality rates are estimated based on the crude number of deaths according to selected causes as provided by the WHO. Detailed information on the coverage and reliability of these causes-of-death data is regularly published by WHO in *World Health Statistics Annuals*. Incidence and mortality rates have been age-standardised to remove variations arising from differences in age structures across countries and over time within each country.

The international comparability of cancer incidence and mortality data can be affected by differences in medical training and practices as well as in death certification procedures across countries.

© OECD 2003

Chart 1.11. **All cancers, mortality rate, total population, 2000**



1. 1999. 2. 1998.

Chart 1.12. **All cancers, percentage change in mortality rate, total population, 1990 to 2000**

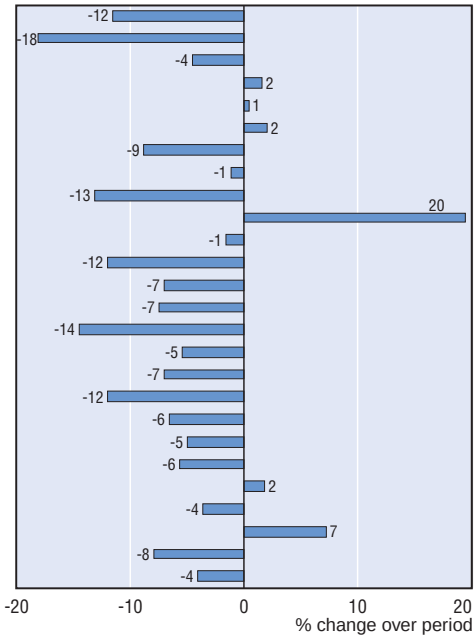
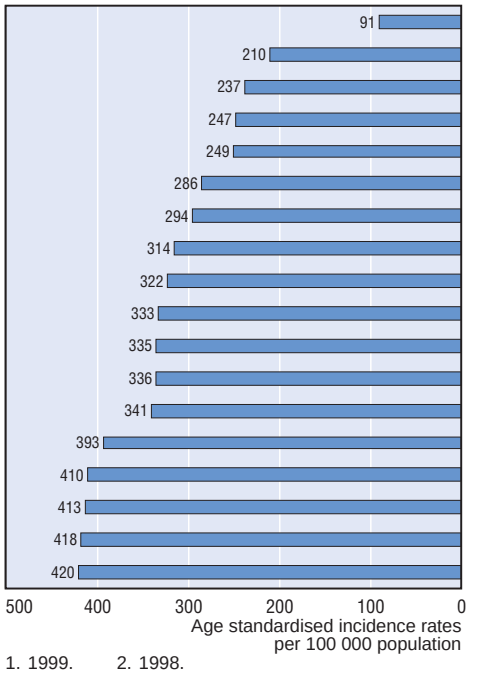
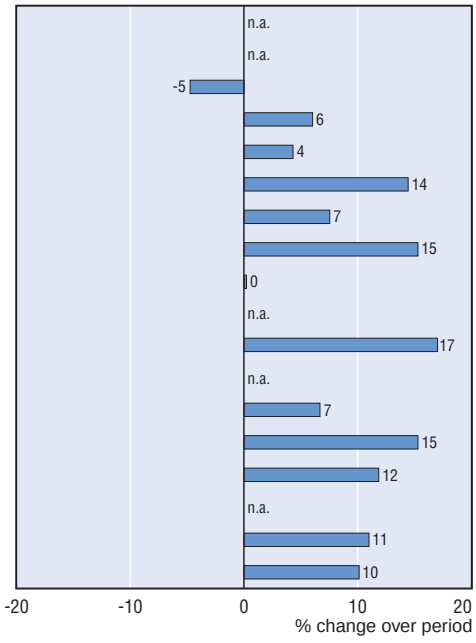


Chart 1.13. **All cancers, incidence rate, total population, 2000**



1. 1999. 2. 1998.

Chart 1.14. **All cancers, percentage change in incidence rate, total population, 1990 to 2000**



See footnotes to Tables 1.9 and 1.10.
Source: OECD Health Data 2003.

© OECD 2003

Cancers among females

Cancer is the second leading cause of death among women in OECD countries after diseases of the circulatory system. Some of the most common cancer sites in women include the breast, cervical, lung and colon (Tables 1.11 and 1.12).

Breast cancer is the most common cancer among women in all OECD countries. In many countries, it accounts for 30% or more of all cancer cases among women, and 15% to 20% of cancer deaths. Breast cancer incidence and mortality vary significantly across countries (Chart 1.15). Relatively high incidence of breast cancer is reported in Luxembourg, the Netherlands, Iceland, Canada and the United States, with rates close to or exceeding 100 cases per 100 000 females. Incidence rates have increased in the 1990s in all OECD countries for which data is available, with the exception of Italy. These increases are largely due to medical improvements in diagnosis and the growing number of women receiving mammography screening, leading to a subsequent rise in the detection of new cases. While there has been a general increase in incidence rates, death rates from breast cancer have declined or remained stable over the past decade in all countries, with the exception of Japan, Korea, France, Greece and the Slovak Republic. In the United States, death rates from breast cancer declined from 29 per 100 000 females in 1990 to 23 in 1999. These lower mortality rates reflect the benefits of improvements in early diagnosis through the increased use of breast cancer screening, resulting in significant increases in the percentage of less advanced cases. Improved survival rates also reflect better treatments. Results from the breast cancer component of the OECD Ageing-Related Diseases project indicate that there are marked variations in survival rates from breast cancer across countries. In the early to mid-1990s, survival rates among the eight countries covered in the study ranged from 74% in England to 84% and 85% in the United States and Japan (OECD, 2003a, Chapter 4; Jee-Hughes and Jacobzone, forthcoming). In the United Kingdom, more advanced stages at diagnosis have been identified as an important factor explaining relatively low survival rates from breast cancer (Sant *et al*., 1998).

Cervical cancer accounts for 2% to 5% of all cancers among women in OECD countries, and 3% of cancer deaths on average across OECD countries. In 2000, death rates from cervical cancer were particularly low in a number of Continental European countries (Italy, Switzerland, Greece, Luxembourg, France and Spain). They were relatively high in Central and Eastern European countries – Poland, the Slovak Republic, Hungary and the Czech Republic – and in Denmark, with rates ranging from five to eight deaths per 100 000 women in 2000 (Chart 1.16). Both the incidence and death rates from cervical cancer declined at least slightly in most OECD countries during the 1990s. This can be explained at least partly by the growing use of screening for cervical cancer (through pap smear tests) which not only detect the early stages of the disease, but also the precursor stages which can be treated even before the disease is formally diagnosed. Pap smear tests are now recommended once every two to three years for women aged 20 to 64 years in several countries. Survival rates from cervical cancer are relatively high if the disease is diagnosed at an early stage.

Colon cancer is the second or third most common form of cancer among women, accounting for 7% to 15% of new cancer cases depending on the country. Colon cancer is associated among other things with nutrition, in particular high consumption of fats and animal proteins and low consumption of fruits, vegetables and fibre (ONS, 2001). In 2000, death rates from colon cancer among women were relatively high in Central and Eastern European countries (the Czech Republic, Hungary and the Slovak Republic) and in Denmark, Norway and New Zealand (Chart 1.18). They were the lowest (but rising) in Korea. In most countries, death rates from colon cancer among women decreased during the 1990s, but they increased in Greece, Japan, Korea, Poland, the Slovak Republic and Spain.

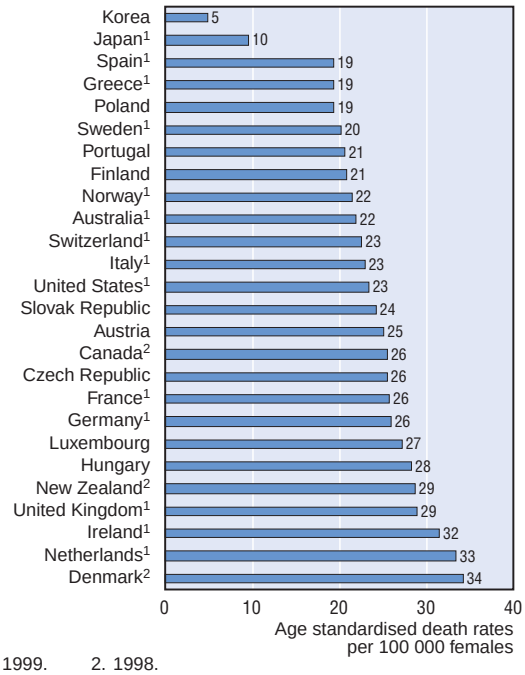
Although the incidence and mortality from lung cancer is much lower among women than for men, it remains the leading cause of cancer deaths among women in several countries including Canada, Denmark and the United States (Chart 1.17). Tobacco smoking is the most important risk factor for lung cancer. The incidence and mortality rates from lung cancer among women increased in nearly all countries during the 1980s and the 1990s, following increases in smoking rates among women in the post-war period. Incidence rates of lung cancer tend to be relatively close to mortality rates for both women and men, due to very low survival rates. For instance, five-year relative survival rates for lung cancer among women and men stood at only 5% in England and Wales for patients diagnosed during the 1986-90 period, and at 15% in Canada and 16% in the United States for cases diagnosed in 1992 (ONS, 2001; and Statistics Canada, 2001).

Definition and deviations

See indicator "All cancers, females and males".

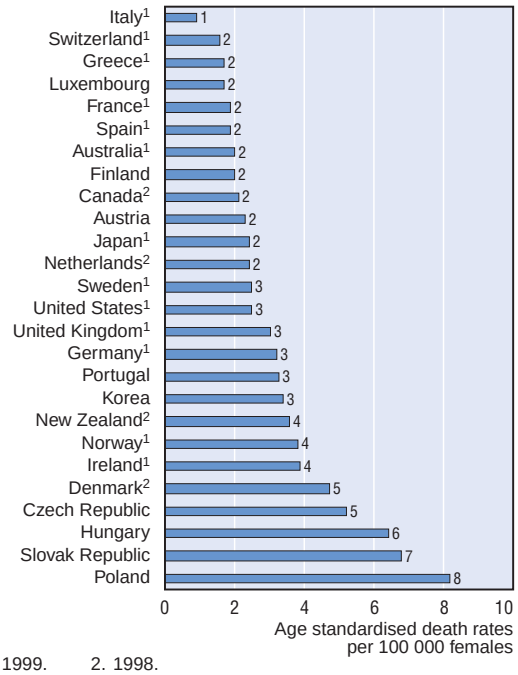
© OECD 2003

Chart 1.15. **Breast cancer, females, mortality rates, 2000**



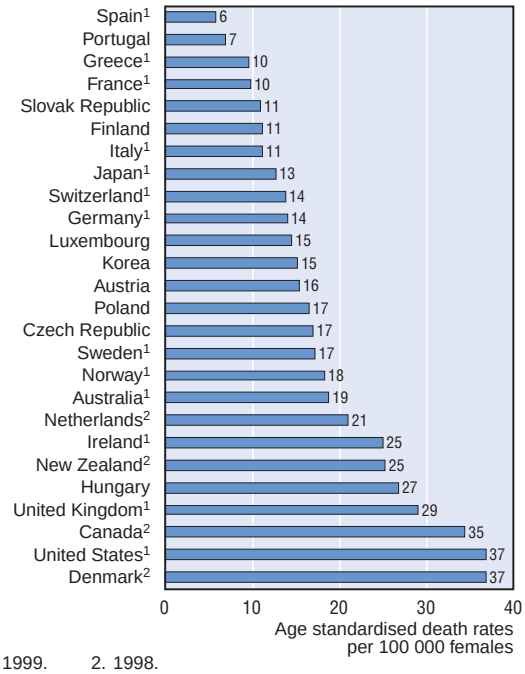
1. 1999. 2. 1998.

Chart 1.16. **Cervical cancer, females, mortality rates, 2000**



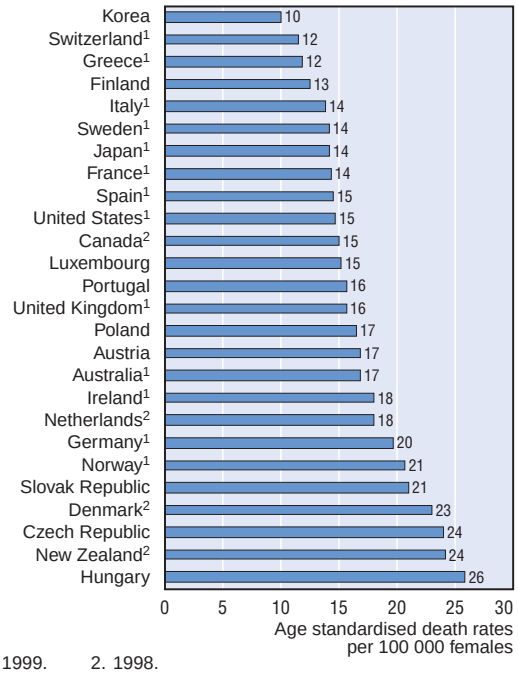
1. 1999. 2. 1998.

Chart 1.17. **Lung cancer, females, mortality rates, 2000**



1. 1999. 2. 1998.

Chart 1.18. **Colon cancer, females, mortality rates, 2000**



1. 1999. 2. 1998.

See footnotes to Tables 1.11 and 1.12.
Source: OECD Health Data 2003.

© OECD 2003

Cancers among males

Cancer is more common among men than women in most OECD countries, and death rates from cancer are higher for men than for women across all OECD countries (see "All cancers, females and males"). The most common cancer sites among men are lung, colon and prostate (Tables 1.13 and 1.14).

Lung cancer is the leading cancer killer among men in all OECD countries except Sweden (where prostate cancer has been the leading cancer killer among men since the 1980s). It accounts for more than 30% of all cancer deaths among men in several countries (Canada, Greece, Hungary, the Netherlands, Poland, and the United States). Tobacco smoking is the most important risk factor for lung cancer. Both the incidence and death rates from lung cancer among men declined over the past decade in many countries, following public health campaigns to reduce tobacco smoking in the 1970s and 1980s. In the United States, the incidence of lung cancer among men fell by 20% during the 1990s while death rates fell by 16%. The decline was even more pronounced in Finland, with incidence rates falling by 38% and death rates by 28% between 1990 and 2000. In 2000, incidence rates and death rates from lung cancer continue to be comparatively high in Central and Eastern European countries – Hungary, Poland, the Czech Republic and the Slovak Republic – as well as in the Netherlands (Charts 1.19 and 1.20). These are all countries where smoking rates among men have traditionally been, and continue to be, relatively high. Death rates from lung cancer among men are the lowest in Sweden, the country with the lowest male smoking rate (see indicator "Tobacco consumption").

Prostate cancer has become the most common cancers among males in many OECD countries, particularly those over 65 years of age, although death rates from prostate cancer remain lower than for lung cancer in all countries except Sweden. The rise in the reported incidence of prostate cancer in the United States in the 1980s and in the 1990s, and in many other countries in the 1990s, is due to a large extent to the greater use of prostate-specific antigen (PSA) diagnostic tests. In the late 1990s or 2000, the reported incidence rate of prostate cancer was the highest in Luxembourg, the United States and Canada, with an age-standardized rate of more than 100 cases per 100 000 men (Chart 1.22). It was the lowest in Korea. Death rates from prostate cancer in 2000 varied from a high of about 40 per 100 000 males in Norway and Sweden, to a low of less than 10 per 100 000 males in Korea and Japan (Chart 1.21). These mortality rates were also relatively low in Greece and Italy. The causes of prostate cancer are not well-understood. Some evidence suggests that environmental and dietary factors might influence the risk of prostate cancer (Institute of Cancer Research, 2003).

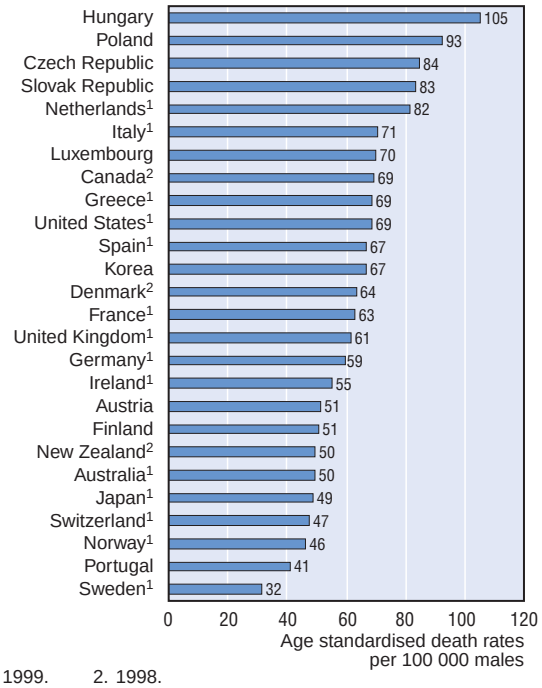
Changes in incidence and death rates from colon cancer among men have shown different patterns across countries over the 1990s (Tables 1.13 and 1.14). In a first group of countries, the incidence rate of male colon cancer has remained relatively stable during the past decade (Australia, Denmark, Finland, New Zealand and Sweden). In a second group of countries, the number of new colon cancer cases has increased between 1990 and 2000 (the Czech Republic, Germany, Iceland, Italy, Luxembourg, the Netherlands, Norway and the United Kingdom), while in a third group of countries (Austria and the United States), the incidence of colon cancer among men declined during the 1990s. Similarly, death rates from colon cancer among men increased over the past decade in some countries (such as Greece, Hungary, Japan and Korea), were stable in others (such as France and Italy), while they fell in many others (including Australia, Austria, Switzerland, the United Kingdom and the United States).

Definition and deviations

See indicator "All cancers, females and males".

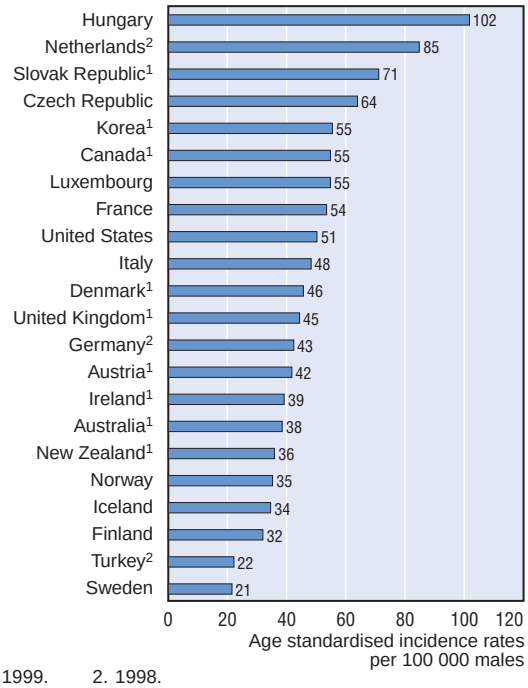
© OECD 2003

Chart 1.19. **Lung cancer, males, mortality rates, 2000**



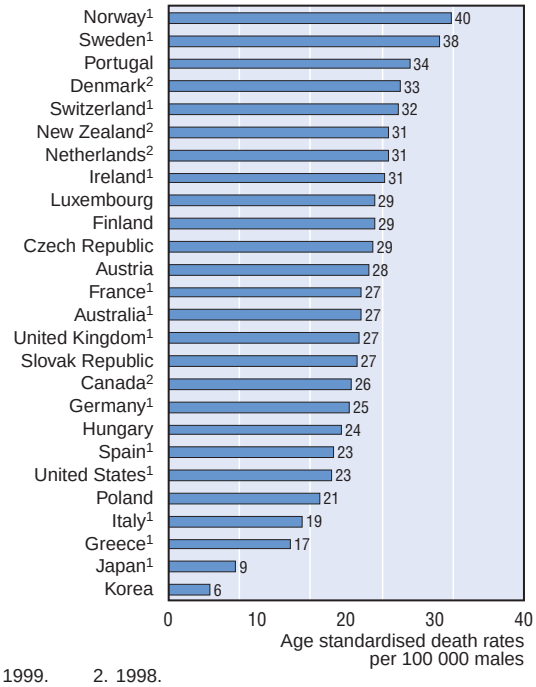
1. 1999. 2. 1998.

Chart 1.20. **Lung cancer, males, incidence rates, 2000**



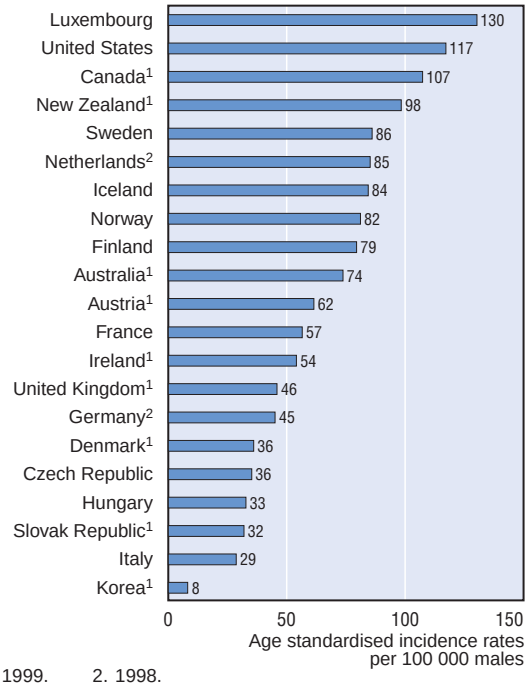
1. 1999. 2. 1998.

Chart 1.21. **Prostate cancer, males, mortality rates, 2000**



1. 1999. 2. 1998.

Chart 1.22. **Prostate cancer, males, incidence rates, 2000**



1. 1999. 2. 1998.

See footnotes to Tables 1.13 and 1.14.
Source: OECD Health Data 2003.

© OECD 2003

Ischaemic heart disease, mortality

Ischaemic heart disease (IHD) is one of the leading causes of mortality for both men and women in OECD countries, responsible for 15% to 25% of all deaths in any given year in many countries. IHD is caused by the accumulation of fatty deposits lining the inner wall of a coronary artery, restricting blood flow to the heart.

IHD mortality varies considerably across OECD countries (Chart 1.23 and Table 1.15). In 2000, the Slovak Republic had the highest mortality rate with 279 deaths per 100 000 population (females and males), a figure almost nine times greater than in Korea (32 per 100 000 population), the country with the lowest mortality rate. There is a regional pattern to the variability in IHD mortality rates. The OECD's two Asian countries, Korea and Japan, have the lowest mortality rates. Five of the six countries with the next lowest IHD mortality rates, France, Spain, Portugal, Italy and Greece, are located in Southern Europe. This suggests that there are underlying risk factors, such as diet, which explain differences in mortality across countries. At the other end of the scale, the three countries with the highest IHD mortality rates are transition countries in Central and Eastern Europe. Next to the Slovak Republic, Hungary had 185 deaths per 100 000 due to IHD and the Czech Republic had 179 in 2000.

A significant gender gap exists with men having much higher IHD mortality rates than women in all countries (Chart 1.23 and Table 1.15). The IHD average mortality rate for males in 2000 was 159 per 100 000 population compared to an average of 77 for females. This gap has persisted since the 1960s. From 1960 to 1980, the gender gap in IHD mortality rates increased in many countries, but in recent years it has narrowed.

Since the 1970s, IHD as a cause of death has been declining in almost all OECD countries (Charts 1.24 and 1.25). The decline has been most remarkable in Australia, Canada, the United States and Portugal, with IHD mortality rates falling by 60% or more. On the other hand, IHD mortality rates increased in two countries which had low rates in 1970, Greece and Spain, as well as in Poland.

There has been much debate about what factors are responsible for declining IHD mortality rates in most OECD countries. Declining tobacco consumption is often cited as a contributing factor in reducing the prevalence of IHD, consequently reducing IHD mortality rates (see indicator "Tobacco consumption"). IHD mortality rates are declining despite a trend towards increased obesity (see "Body weight"). At the same time, significant improvements in medical care for treating IHD have certainly contributed to reducing IHD mortality rates. Trends in the prevalence of IHD risk factors and utilisation rates for IHD treatments vary not only over time but across countries as well, rendering it even more difficult to disentangle the relative contributions of individual factors to reducing IHD mortality. The decade-long WHO-MONICA project concluded that improvements to medical care were more responsible for declining IHD mortality than changes in risk factors (Tunstall-Pedoe *et al.*, 2000).

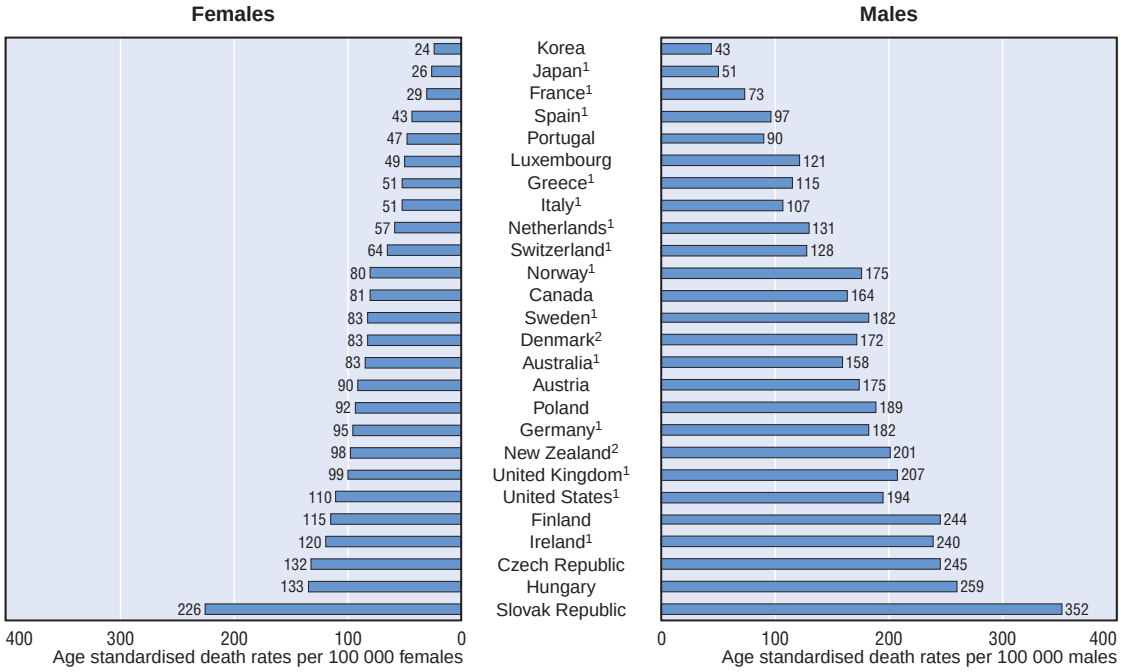
Despite the proven efficacy in clinical trials of revascularisation for treating ischaemic heart disease, it is unclear to what extent increased use of revascularisation procedures has lowered IHD mortality rates. For example, IHD mortality rates are lower in Australia and Canada than in the United States, yet the United States has the highest utilisation rate for revascularisations of any OECD country, almost three times greater than Australia and between three and four times greater than Canada (see indicator "Cardiovascular procedures"). Furthermore, among these three countries utilisation rates for revascularisations have been growing fastest in the United States without larger reductions in IHD mortality rates (Moïse, 2003; Moïse, Jacobzone *et al*., 2003).

Definition and deviations

Ischaemic heart disease mortality rates are estimated based on the crude number of deaths according to selected causes as provided by the WHO. Detailed information on the coverage and reliability of these crude causes-of-death data is regularly published by WHO in *World Health Statistics Annuals*. Mortality rates have been age-standardised by the OECD Secretariat to remove variations arising from differences in age structures across countries and over time within each country.

© OECD 2003

Chart 1.23. **Ischaemic heart disease, mortality rates, 2000**



1. 1999. 2. 1998.

Chart 1.24. **Trends in ischaemic heart disease, females, 1970-2000**

OECD and selected countries

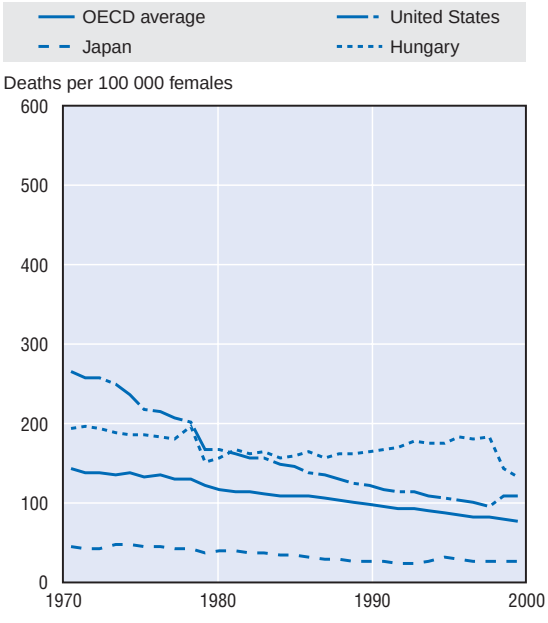
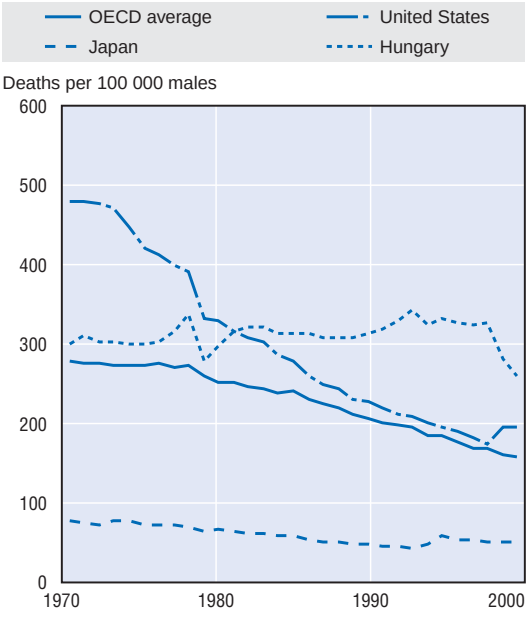


Chart 1.25. **Trends in ischaemic heart disease, males, 1970-2000**

OECD and selected countries



See footnotes to Table 1.15.
Source: OECD Health Data 2003.

© OECD 2003

AIDS, incidence and mortality

The first cases of the Acquired Immunodeficiency Syndrome (AIDS) have been diagnosed two decades ago. The onset of AIDS is normally caused as a result of HIV (human immunodeficiency virus) infection and can manifest itself as any number of different diseases, such as pneumonia and tuberculosis, as the immune system is no longer able to defend the body. There is a time lag between HIV infection, AIDS diagnosis and death due to HIV infection that can be any number of years depending on the treatment administered. Despite worldwide research however, there is no cure presently available.

In 2000, the number of reported new cases of AIDS stood at more than 56 000 across the OECD area as a whole, representing an (unweighted) average incidence rate of 2 per 100 000 population (Table 1.16). Since the first reporting of AIDS cases in the early 1980s, the number of cases rose rapidly to reach an average of more than 4.4 new cases per 100 000 population across OECD countries at its peak in the first half of the 1990s, more than double current incidence rates (Chart 1.28). Public awareness campaigns contributed to steady declines in reported cases through the second half of the 1990s. In addition, the development and greater availability of so-called HAART (highly active antiretroviral treatment) drugs, which reduce or slow down the development of the disease, led to a sharp decrease in incidence between 1996 and 1997 (Montserrat and Hamzaoui, 2002).

The United States has consistently shown the highest AIDS incidence rates among OECD countries, although it is important to note that the case reporting definitions were expanded in 1993 and subsequently differ from the definition used across Europe and other OECD countries. The change in definition also explains the large increase in cases in the United States in 1993. In Europe, Spain reported the highest incidence rates in the first decade following the outbreak, although there has been a sharp decline since 1994 to leave Portugal currently with the highest rate among European countries. On the other hand, Central European and Scandinavian countries report much lower incidence rates of AIDS. Similarly, Japan and Korea show some of the lowest rates among OECD countries (Charts 1.26 and 1.27).

In terms of mortality, AIDS-related death rates mirror incidence rates. The decline in mortality rates since the mid-1990s has tended to be greater than for incidence rates, reflecting the effectiveness of HAART treatment in alleviating some of the symptoms of AIDS.

In more recent years, the overall decline in AIDS cases has slowed down in many countries with a number of countries showing a rise. Also, although the reporting of HIV prevalence is less reliable and needs to be treated with caution, the evidence is that HIV infection has not seen the same decline in numbers, suggesting that the falls observed in AIDS cases is mainly due to the availability of HAART. This recent halt or renewed increase in the number of AIDS cases in many countries has been attributed to complacency regarding the effectiveness of treatment and a waning of public awareness regarding drug use and sexual practice (UNAIDS, 2002).

Definition and deviations

Incidence rate of AIDS is the number of new cases per 100 000 population at year of diagnosis. Note that data for recent years are provisional due to reporting delays, which sometimes can be for several years depending on the country.

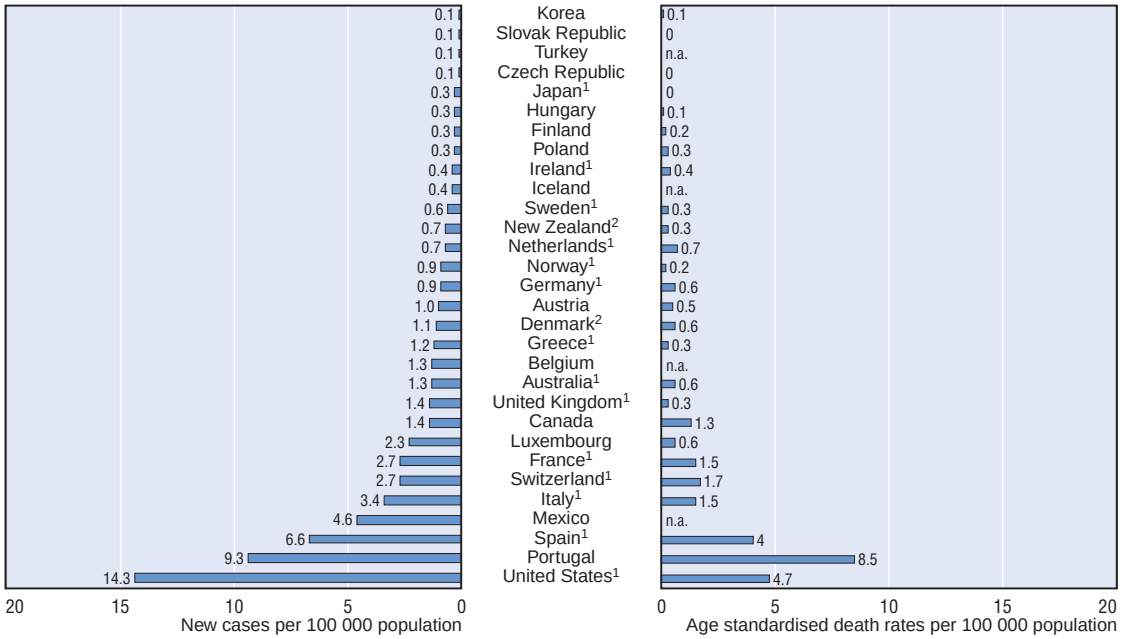
The mortality rate is the number of deaths per 100 000, age-standardized according to the 1980 OECD standard population. Coding practices may differ from country to country, so care should be exercised when conducting cross country comparisons of mortality data.

The United States expanded their AIDS surveillance case definition in 1993 to include T-lymphocyte count criteria. This broadening of the definition led to a large increase in the number of new cases in the United States in 1993 and explains some of the current variations in AIDS incidence between the United States and other OECD countries.

© OECD 2003

Chart 1.26. **AIDS, incidence rates, 2000**

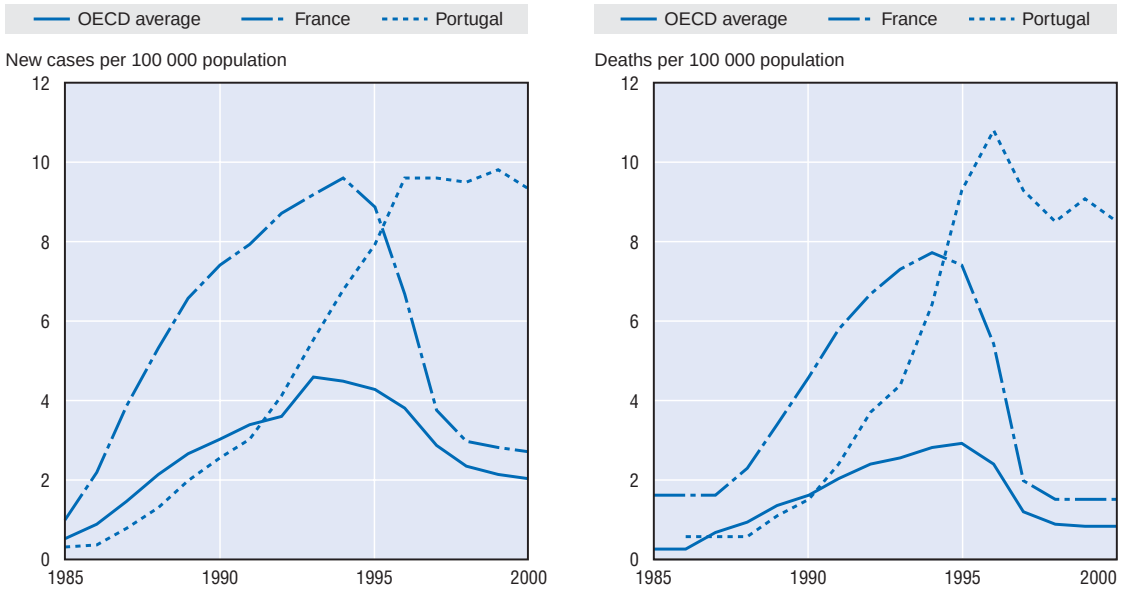
Chart 1.27. **AIDS, mortality rates, 2000**



1. 1999. 2. 1998.

Chart 1.28. **Trends in AIDS incidence rates, 1985-2000**

Chart 1.29. **Trends in AIDS mortality rates, 1985-2000**



See footnotes to Table 1.16.
Source: OECD Health Data 2003.

© OECD 2003

Suicides

Suicides are a significant cause of death in many OECD countries, even though they may be under-reported because of stigma. Suicide rates are often used in international studies as a proxy indicator of a population's mental health status, since suicides are in many cases linked to mental disorders such as depression and schizophrenia, as well as to alcohol or other substance abuse *(e.g.,* Maris, 2002; Henriksson *et al*., 1993; STAKES and European Commission, 2000).

Available data show that suicide rates vary considerably across OECD countries (Chart 1.30 and Table 1.17). They tend to be comparatively low in Southern European countries (Greece, Portugal, Italy and Spain) as well as in the United Kingdom. On the other hand, suicide rates are relatively high in Hungary, Japan and Finland. Caution is required however in making cross-country comparisons of suicide rates, given that the extent of under-reporting may vary from one country to the other.

Over the past 20 years, there has been a decrease in suicide rates in many OECD countries (Chart 1.31 and Table 1.17). The decline was particularly pronounced in some Nordic countries, such as Denmark and Sweden. In Finland, suicide rates increased during the 1970s and the 1980s, but started to decline in the 1990s. Suicide rates also declined during the 1990s in Hungary, although it remained the highest in the OECD area in 2000. Suicide rates in Hungary are especially high for men (four times greater than for women).

In Japan, suicide rates increased markedly among men during the 1990s (rising to a rate of 30 per 100 000 men in 2000, up from 19 per 100 000 in 1990), while suicide rates among women remained stable. Ireland also recorded a substantial increase in suicide rates among men over the past decade.

In general, death rates from suicides are three to four times greater for men than for women across OECD countries (Chart 1.30), and this gender gap has been fairly stable over time in most countries. This gender gap in *completed* suicides is due largely to men using more lethal methods than women. Evidence from several countries suggests that there tends to be much less of a difference between men and women in suicide *attempts* (WHO, 2002a; Statistics Canada, 2002).

The average age of suicide in many countries has tended to decline over time, because of declining suicide rates among the elderly population while the rates among younger age groups have remained more stable (OECD, 2003b).

Preventing suicides is not an easy task, given that suicidal behaviour is not limited to certain population groups. Since suicides are in the vast majority of cases linked with depression, and alcohol and other substance abuse, the early detection of these psycho-social problems by families, social workers and health professionals must be part of suicide prevention campaigns, together with the provision of effective support, treatment and management of these conditions.

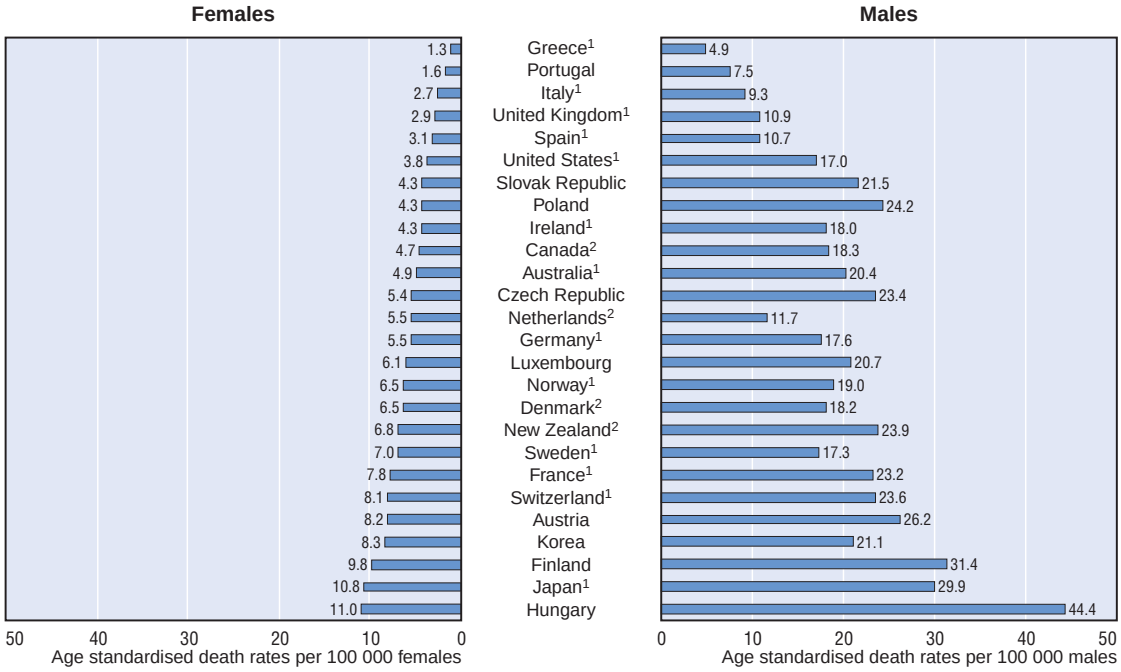
Definition and deviations

Suicide mortality is defined as the number of deaths from suicides per 100 000 population. The crude number of deaths according to causes is extracted from the WHO Mortality Database. Mortality rates have been age-standardised by the OECD Secretariat to remove variations arising from differences in age structures across countries and over time within each country.

The international comparability of death rates from suicide can be affected by reporting differences across countries. A stigma is associated with suicide in many countries, and those recording causes of death may come under pressure to record deaths from suicide as "unknown" or due to other causes. Caution is required therefore in interpreting variations across countries.

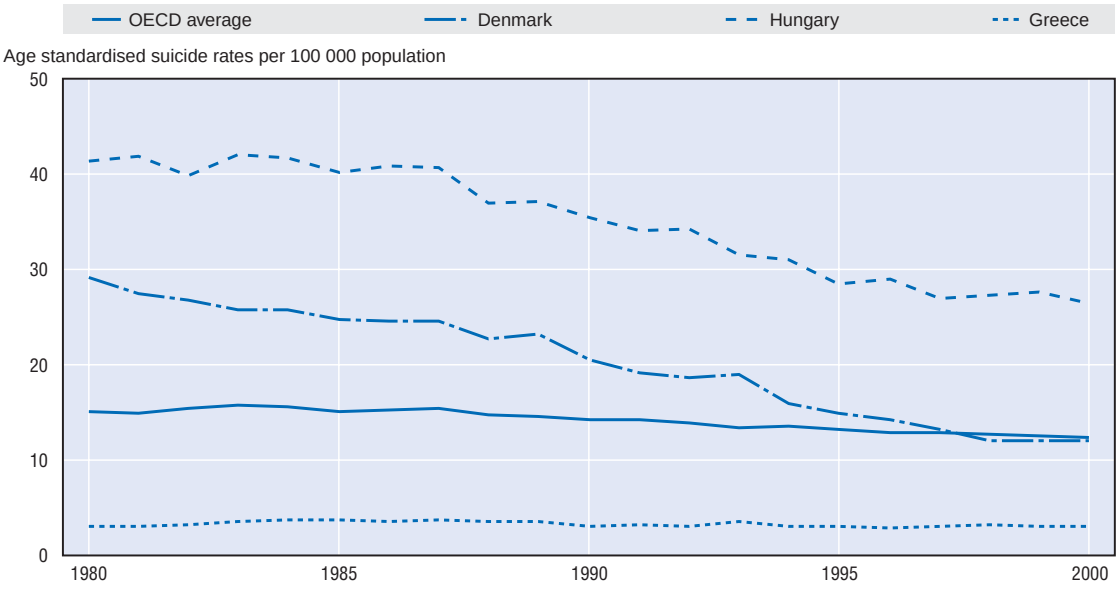
© OECD 2003

Chart 1.30. **Suicides, death rates, 2000**



1. 1999. 2. 1998.

Chart 1.31. **Trends in suicide death rates, total population, 1980-2000**
OECD average and selected countries



See footnotes to Tables 1.17.
Source: OECD Health Data 2003.

© OECD 2003

Self-reported general health

A major challenge in health statistics 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 and comparable general morbidity data are still scarce across the OECD area. An increasing number of countries are conducting regular health interview surveys which allow respondents to report on their health status. A commonly-asked question relates to self-perceived general health, in several cases based on the following question: "How is your health in general? Very good, good, fair, poor or very poor"? Despite the general and subjective nature of this question, indicators of self-rated general health have been found to be a good predictor of people's future health care use and mortality in several countries (for instance, see Miilunpalo *et al*., 1997). For the purpose of international comparisons however, cross-country differences in self-rated general health are often difficult to interpret because responses may be affected by a number of factors, including differences in the formulation of survey questions and responses and cultural factors.

In about half of OECD countries, 75% or more of the adult population (aged 15 and over) report their health to be "good" or better (Chart 1.32 and Table 1.18). The United States, Canada, New Zealand and Ireland have the highest percentage of people assessing their health to be "good" or better, with 85-90% of the adult population reporting being in "good/very good/excellent" health in these countries. At the other end of the scale, the percentage of people reporting being in good health is lowest in Portugal, Japan and Korea, as well as in some Central and Eastern European countries (Slovak Republic, Hungary and Poland). Less than half of the population in these countries report to be in good health. Japan, in particular, stands out as having a relatively low percentage of its population reporting their health to be good or better, despite the fact that it reports the highest life expectancy in the world. People in Japan may be less extreme ("exuberant") in rating their health than people in other countries and may have a greater "central tendency" bias in responding to such survey questions.

Focusing on within-country differences in self-rated general health, in the majority of countries, men are more likely than women to report their health to be good or better. The exceptions are Australia, Finland, Ireland and New Zealand, where a higher percentage of women report being in good health compared to men. 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. Nonetheless, in several countries, two-thirds or more of the population aged 65 and over report being in good health (Australia, Canada, New Zealand, Switzerland and the United States; Chart 1.33 and Table 1.18). Older people might however have lower health expectations and be more likely to rate their health positively compared with younger people under similar health conditions.

Looking at trends over time, self-reported "good" or better health status among the population aged 15 and over has remained generally stable for both men and women in those countries where long time series are available. For the population aged 65 and over, the proportion of older persons reporting their health to be good or better has gone up at least slightly over time in some countries (Finland and the United States), but not in others (the Netherlands and Sweden).

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, poor, very poor". *OECD Health Data* provides figures related to the proportion of people reporting their health to be "good/very good" combined.

Caution is required in making cross-country comparisons of self-reported general health, for at least two reasons. First, there remain some variations in the question and answer categories used to measure self-rated general health across surveys/countries. In particular, the response scale used in countries such as the United States and Canada is *asymmetric* (skewed on the positive side), with the following response categories: "excellent, very good, good, fair, poor". The data reported in *OECD Health Data* refer to respondents answering one of the three positive responses ("excellent, very good or good"). By contrast, in most other countries, the response scale is *symmetric*, with response categories being: "very good, good, fair, poor, very poor". The data reported from these countries refer only to the first two categories ("very good, good"). Such a difference in response categories biases downward the results from those countries using a symmetric scale compared with those using an asymmetric scale.

A second comparability problem arises from the fact that people's overall assessment of their own health is subjective and can be affected by a number of factors beyond their real health status, such as cultural background and national traits.

© OECD 2003

Chart 1.32. **Percentage of population aged 15 and over reporting to be in good health**

Latest year available

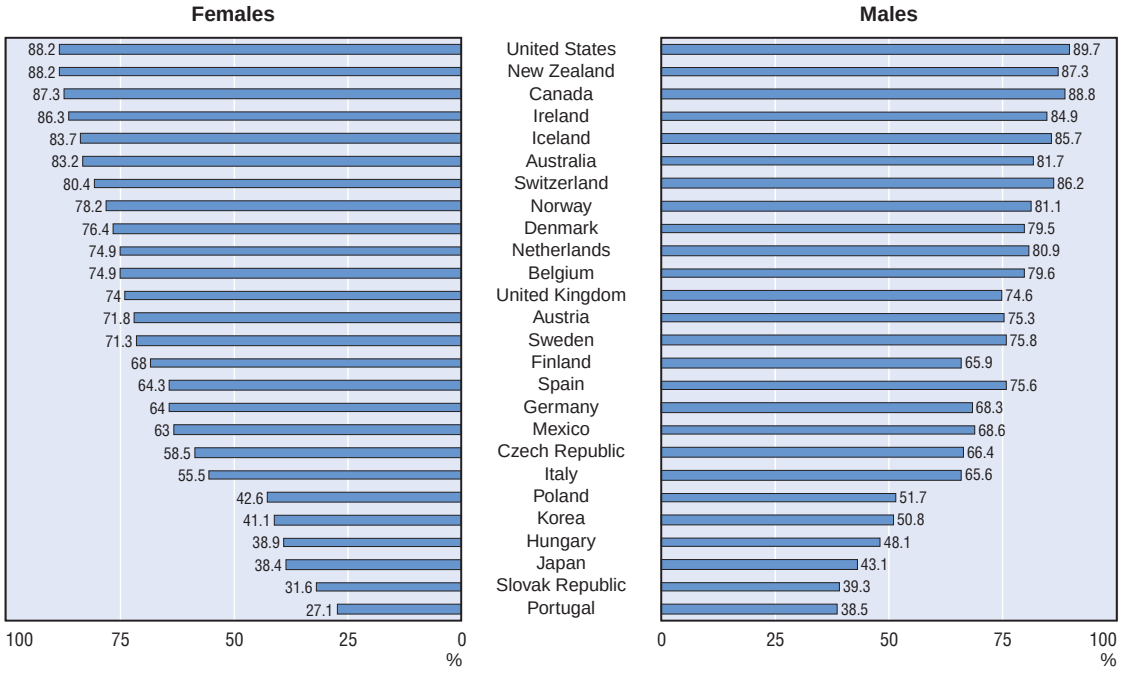
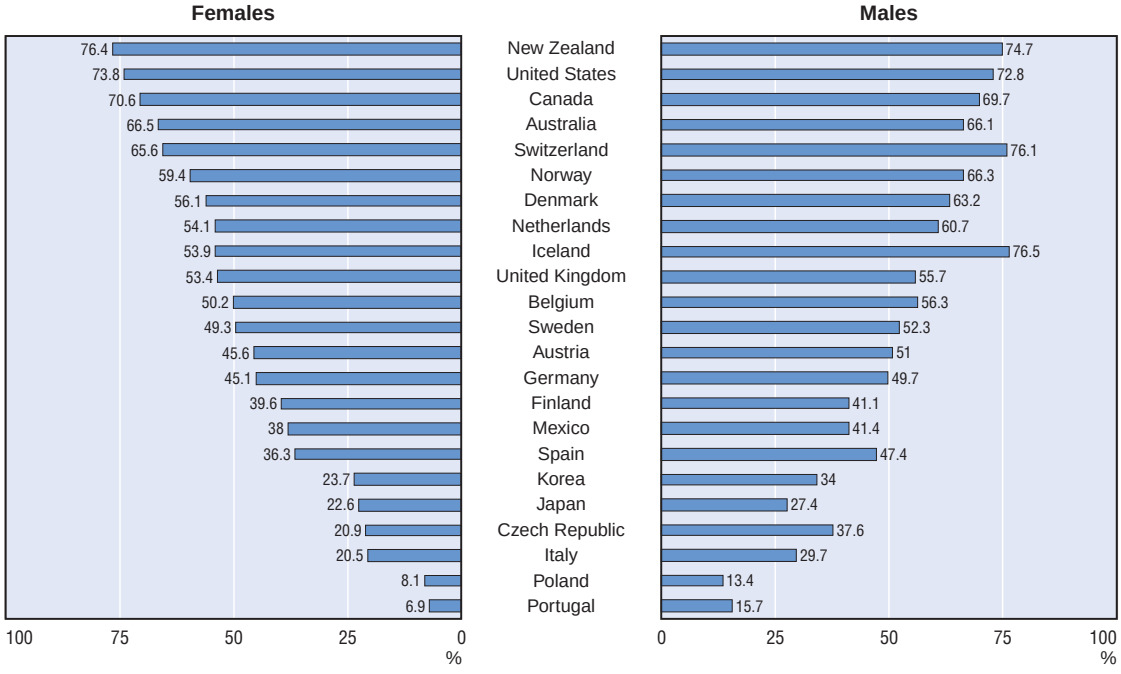


Chart 1.33. **Percentage of population aged 65 and over reporting to be in good health**

Latest year available



See footnotes to Table 1.18 for data comparability limitations.
Source: OECD Health Data 2003.

© OECD 2003

Infant health: low birth weight

Low birth weight significantly increases the risk of mortality within the first year of life and the risk of health and development problems in infancy and in later life.

There may be a number of reasons for the observed increase of low birth weight infants in many OECD countries in recent years (Chart 1.35 and Table 1.19). Firstly, the number of multiple births, with the increased risks of prematurity and low birth weight, has steadily risen in recent years partly due to the increase in fertility treatments. Secondly, during the past 20 years there has been a tendency in many OECD countries for women to delay childbearing until their thirties and later, again shown to increase the risk of low birth weight infants. A third factor is that new medical technology and improved pre-natal care is giving very small foetuses an increased chance of being born alive.

In 2000 (or the latest year available), Korea, Iceland and Sweden report the lowest proportions of low weight births with around 4% of live births defined as low birth weight (less than 2 500 g). Japan, Hungary, Greece and Turkey are at the other end of the scale, with rates of low birth weight infants close to or above 8% (Chart 1.34). The United States and the United Kingdom are close behind with 7.6% of all live births reported as low birth weight infants. These figures compare with an overall OECD unweighted average of 6.3%.

Rather surprisingly perhaps, Japan and Korea sit at opposite ends of the scale in the proportion of low birth weight infants. Japan, historically amongst the group of countries with a low proportion of low birth weight, has seen the greatest increase, rising from around 5% in the late 1970s to well above 8% in recent years. The average birth weight now in Japan is significantly lower than in Korea, which is more comparable to other OECD countries (Chart 1.37). A number of risk factors in the Japanese society have been cited as contributing to this increase in the proportion of low birth weight infants. The rising prevalence in smoking, traditionally a male bastion, amongst younger Japanese women from the 1970s onwards is seen as one of the causes together with a marked move towards later motherhood amongst Japanese women (Jeong and Hurst, 2001; and Ohmi *et al.*, 2001).

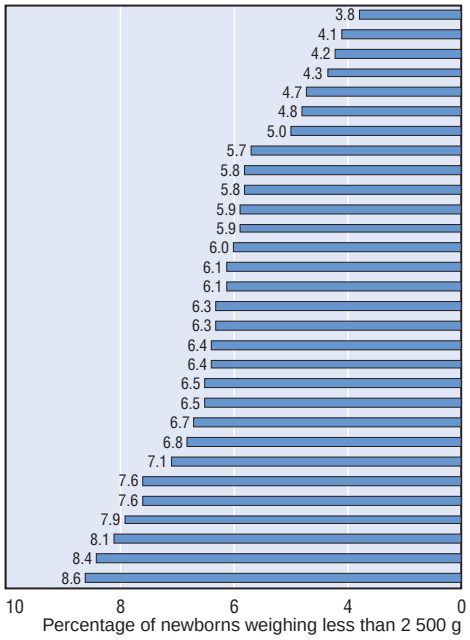
Comparisons of different population groups within countries suggest that the proportion of low birth weight infants might also be influenced by inequality of income and social opportunity. In the United States, there are marked differences between ethnic groups in the proportion of low birth weight infants, with black infants having a rate two-times greater than white infants (Centers for Disease Control, 2002). Similar differences have also been observed amongst the indigenous and non-indigenous populations in Australia and Mexico.

Definition and deviations

Low birth weight is measured by the number of live births weighing less than 2 500 grams as a percentage of total live births. The majority of the data comes from birth registers; however, in the case of the Netherlands the source is a national health interview survey.

© OECD 2003

Chart 1.34. **Low birth weight infants, 2000**



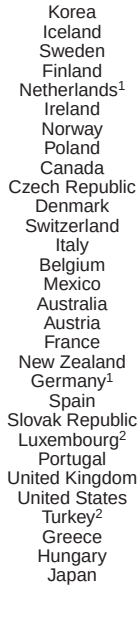
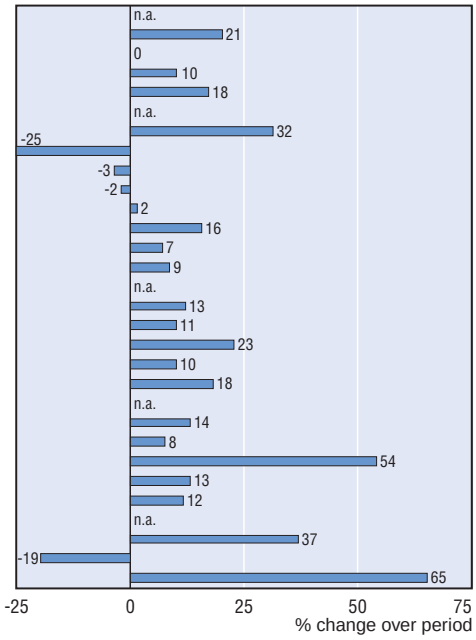


Chart 1.35. **Change in proportion of low birth weight infants, 1980 to 2000**



1. 1999. 2. 1998.

Chart 1.36. **Trends in low birth weight infants, 1980-2000**

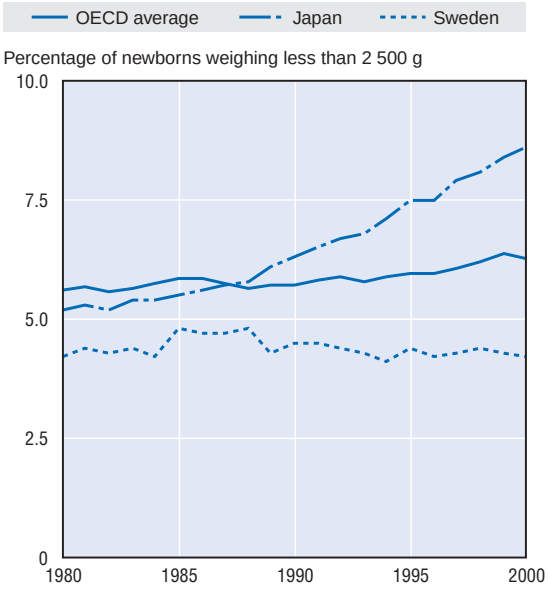
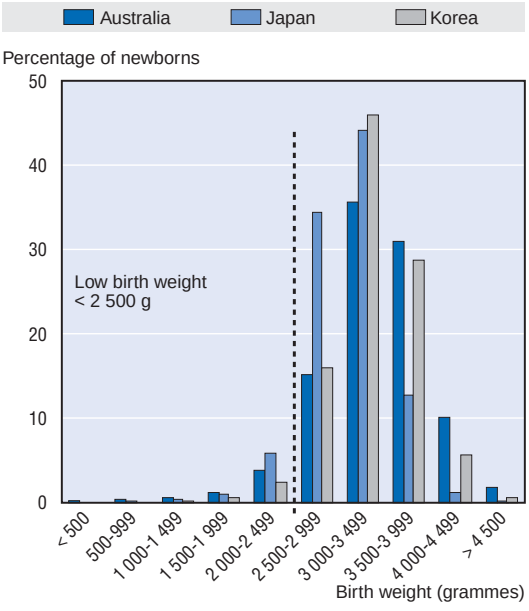


Chart 1.37. **Live births by birth weight, late 1990s**



See footnotes to Table 1.19.

Source: *OECD Health Data 2003 ;* Australian Institute of Health and Welfare; Japan: National Statistical Office; Korea: Ministry of Health and Welfare.

© OECD 2003

2. HEALTH CARE RESOURCES AND UTILISATION

© OECD 2003

Practising physicians

Modern and accessible health care requires a well-trained medical workforce which is able to cater for the population's need for safe, high-quality medical services. This implies an adequate number of practising physicians, with the right qualifications and in the right place when patients need them. The size, distribution and composition of practising physicians is influenced by a number of factors, including restrictions imposed on entry into the medical profession, choice of speciality, demographic characteristics of doctors *(e.g.,* age and gender), remuneration, working conditions, location of practice and migration.

Taking a long-term perspective, the number of physicians per 1 000 population has been rising over time in all OECD countries. On average across OECD countries, the number of doctors per 1 000 population increased from 1.1 in 1960 to 2.9 in 2000 (Chart 2.3 and Table 2.1). In most OECD countries, the bulk of this growth took place in the 1970s and 1980s, although the number of doctors per 1 000 population continued to rise in many countries during the 1990s.

Greece registered particularly strong growth in the number of doctors in recent decades. As a result, it reported the highest doctor-to-population ratios among all OECD countries in 2000 (Charts 2.1 and 2.2). The number of doctors in Greece has consistently been higher than the average among OECD countries, and this gap has widened since 1980 (Chart 2.3). With 4.5 doctors per 1 000 population in 2000, Greece is the only OECD country which reports having more doctors than nurses (see next indicator "Practising nurses").

On the other hand, Japan registered the slowest growth in the number of doctors between 1960 and 2000 among all OECD countries for which historical data are available (Chart 2.3). This is a result of Japanese government policies constraining the growth in the number of doctors in order to avoid a supply that exceeds need (Jeong and Hurst, 2001). This policy has been achieved mainly by fixing strict limits on the number of new entrants in medical schools.

In 2000, there remained substantial variations in doctor-to-population ratios across OECD countries (Chart 2.1 and Table 2.1). Following Greece, countries reporting the highest number of doctors per 1 000 population were Italy, Belgium, Austria, the Slovak Republic and Switzerland, with 3.5 doctors or more per 1 000 population. At the other end of the scale, the number of doctors per 1 000 population was less than 2 in Mexico, Turkey, Korea and Japan, although it increased rapidly in Turkey and Korea since 1980. In Korea, the number of practising physicians is expected to continue to increase rapidly during the present decade as a result of newly established medical schools and higher number of medical students (OECD, 2003c).

The proportion of female doctors has increased strongly over time in most OECD countries (Chart 2.4). In some countries (the Czech Republic, Finland and Poland), there are now more female doctors than males. The growing proportion of female doctors is important not only because some patients prefer to consult a woman doctor, but also because women tend to differ from men in how they participate in the medical workforce. Studies in countries such as Canada have reported that the choice of speciality varies by gender, with female doctors concentrating in primary care and certain specialities, such as paediatrics, psychiatry, obstetrics and gynaecology (Tyrrell and Dauphinee, 1999).

Definition and deviations

Practising physicians are defined as the number of doctors who are actively practising medicine in public and private institutions. The numbers are based on head counts, unless otherwise stated.

Finland, Ireland and the Netherlands provide the number of physicians *entitled* to practise rather than only *practising* physicians (resulting in an upward bias).

© OECD 2003

Chart 2.1. **Practising physicians per 1 000 population, 2000**

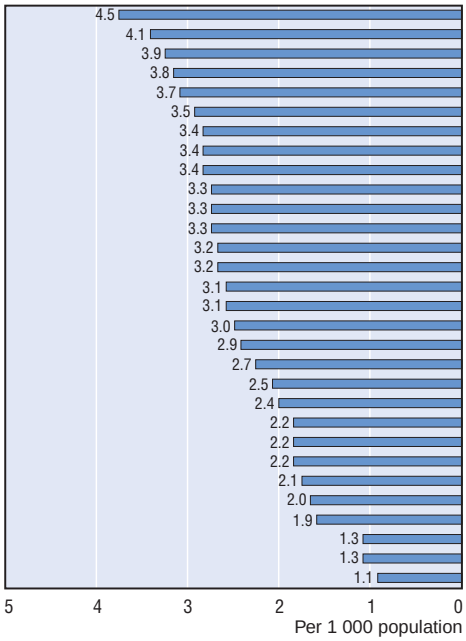


Chart 2.2. **Increase in number of practising physicians per 1 000 population, 1980 to 2000**

1. 1999.

Chart 2.3. **Trends in number of practising physicians, 1960 to 2000**

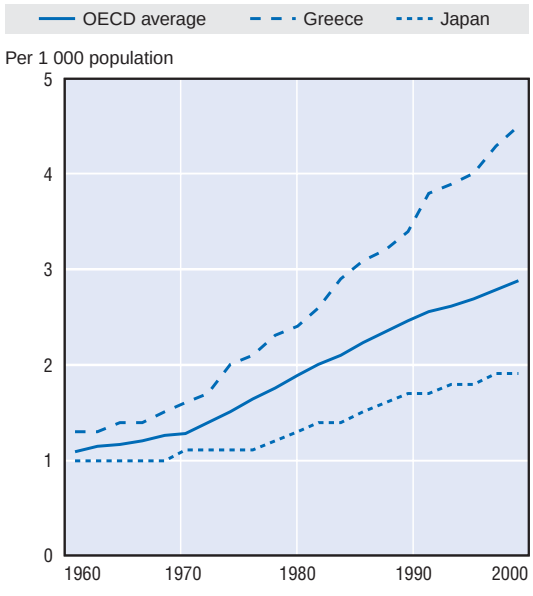
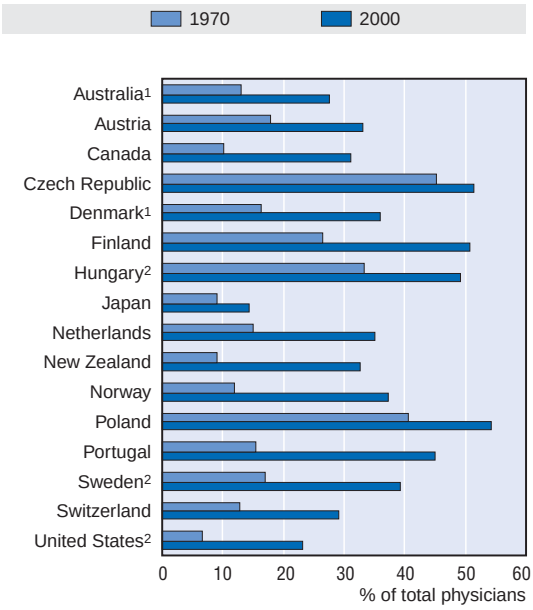


Chart 2.4. **Increasing proportion of female physicians, 1970 to 2000**



See footnotes to Table 2.1.
Source: OECD Health Data 2003.

1. 2001. 2. 1999.

© OECD 2003

Practising nurses

Nurses represent the largest category of health care practitioners in nearly all OECD countries. Adequate nurse staffing of hospitals is key to delivering a high quality of patient care and good patient outcomes (Aiken *et al.*, 2002a, 2002b).

In 2000, there were substantial variations in the number of nurses per 1 000 population across OECD countries (Chart 2.5 and Table 2.2). At the upper end of the scale, Finland, Ireland, Iceland and the Netherlands reported more than 13 nurses per 1 000 population. At the lower end of the scale, there were less than four nurses per 1 000 population in Turkey, Mexico, Korea, Portugal and Greece. The OECD average (18 countries) was 8.2 nurses per 1 000 population in 2000.

Looking at trends over time, the number of nurses per 1 000 population has increased in all OECD countries during the 1970s and the 1980s. In the 1990s, the number of nurses continued to increase in several countries, but it started to decline in Australia, Canada, Poland and Sweden (Charts 2.6 and 2.7; Table 2.2). In Canada, the reduction in the number of nurses per capita was linked to a reduction in enrolment and graduation from nursing schools during the 1990s, together with a reduction in the number of hospital beds (CIHI, 2001).

The ratio of nurses to physicians varies greatly across OECD countries (Chart 2.8). In 2000, it ranged from more than six nurses per physician in Ireland to less than 1 nurse per physician in Greece. The nurse-to-physician ratio continues to be relatively high in Canada and Australia, despite the reduction in nurses per capita during the 1990s in these two countries. It is also higher than average in the United Kingdom and New Zealand. At the other end of the scale, the ratio of nurses to physicians tends to be low in Southern European countries, with Greece reporting a ratio of less than one nurse per doctor followed by Italy and Portugal reporting a ratio of just over one nurse per physician. This raises questions about whether countries are adopting the appropriate skill mix between doctors and nurses in health care delivery.

Definition and deviations

Practising nurses refer to the number of actively practising nurses employed in public and private hospitals, clinics and other health facilities. They generally include registered nurses and nursing assistants. Nursing assistants are however not included in France. Most countries report head counts, while Germany, Mexico and Norway report full-time equivalents (resulting in an under-estimation compared with head-count data provided by other countries). Spain includes only publicly employed nurses (nurses employed in the National Health Service), resulting in an under-estimation. Austria and Italy reports only nurses employed in hospitals; they do not include those working in other health facilities or self-employed nurses (under-estimation). Finland reports all nurses entitled to practise (over-estimation). Canada includes practising registered nurses, plus licensed practical nurses (not all practising), but does not include psychiatric nurses.

© OECD 2003

Chart 2.5. **Practising nurses per 1 000 population, 2000**

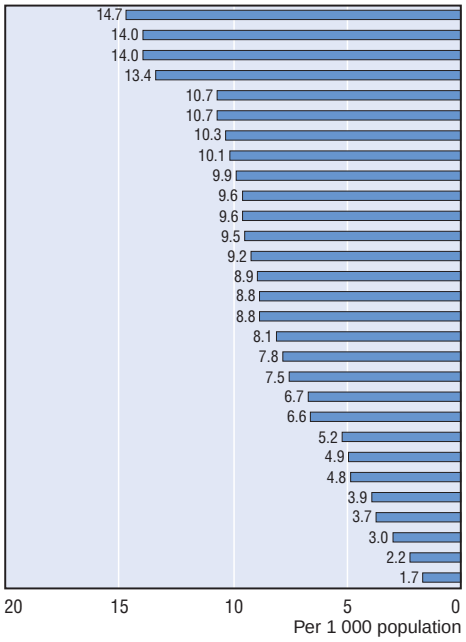
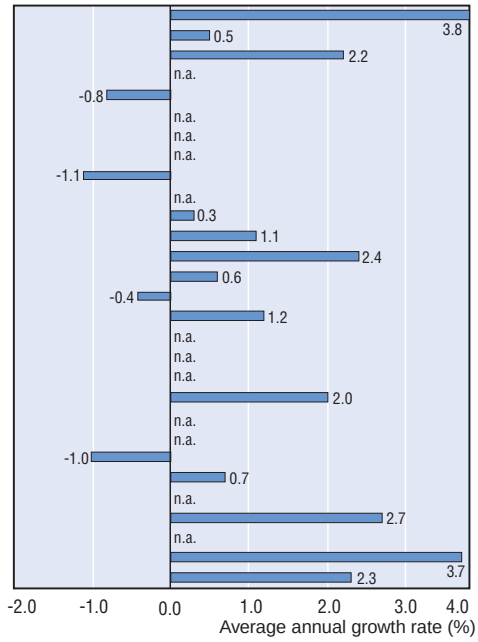


Chart 2.6. **Change in the number of practising nurses per 1 000 population, 1990 to 2000**



1. 1999. 2. 1998.

Chart 2.7. **Trend in practising nurses, 1980 to 2000**

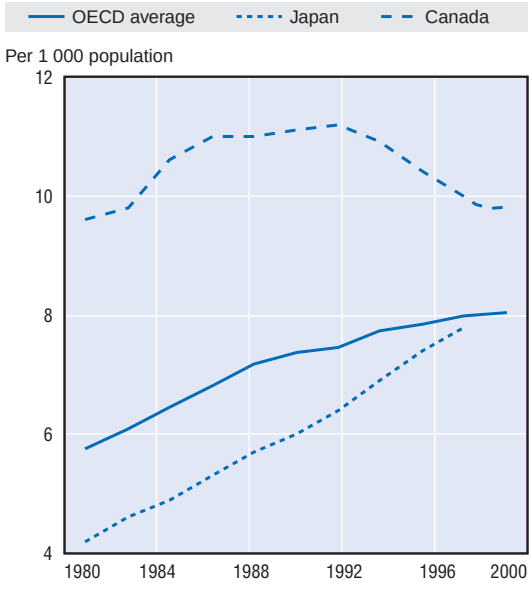
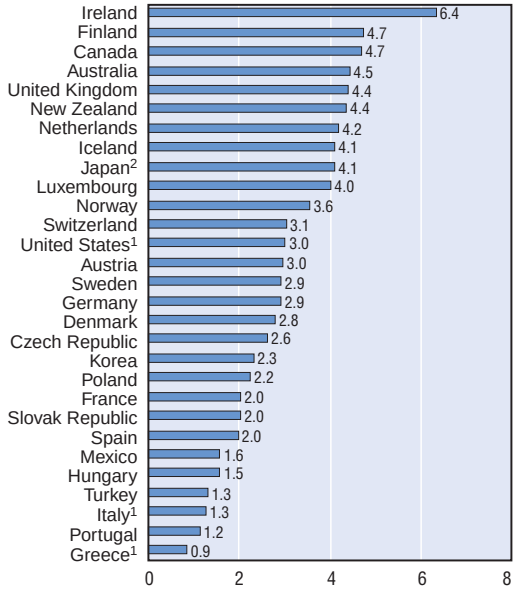


Chart 2.8. **Ratio of practising nurses to practising physicians, 2000**



See footnotes to Table 2.2.
Source: OECD Health Data 2003.

1. 1999. 2. 1998.

© OECD 2003

Acute and long-term care beds

The number of acute care beds in hospitals, and long-term care beds in hospitals or in long-term care institutions, provides a measure of the resources available for health and long-term care. It does not provide however a comprehensive measure of capacity since it does not capture the capacity to furnish outpatient services (such as ambulatory surgeries) or home care services.

The rapid development of new (less invasive) medical technologies, together with growing pressure for cost containment over the past two decades, have led to a decline in the number of acute care beds per capita in most OECD countries (Chart 2.11 and Table 2.3). The number of acute care beds available in hospitals has dropped on average across OECD countries from 5.7 per 1 000 population in 1980 to 4.0 in 2000. The decline in available beds over the past two decades has coincided with a reduction of average length of stays in hospitals and an increase in day-surgery patients (see indicators "Average length of stay in hospitals" and "Surgical procedures").

In 2000, there were some notable variations in the number of acute care beds reported across countries (Chart 2.9 and Table 2.3). At the upper end of the scale, the number of acute care beds available is higher than 6 per 1 000 population in several Continental and Central and Eastern European countries (Luxembourg, the Czech Republic, Germany, Hungary and Austria). It is less than 3 per 1 000 in Mexico, Turkey, Sweden, Finland and the United States. In the United States, there are now 2.9 acute care beds per 1 000 population, down from 4.4 per 1 000 in 1980. During the same period, the proportion of surgical procedures performed on a same-day basis in the United States has more than tripled, and most surgical procedures are now performed without an overnight stay in hospital. Moreover, the average length of stay of those admitted to hospitals has continued to decline (NCHS, 2002).

Turning to long-term care, a policy goal in many OECD countries has been to shift the provision of long-term care from institutions like nursing homes towards community-based care. The objective is to allow the elderly to live independently for a longer time either in their own homes or in special housing arrangements adapted to their needs. This trend is reflected in the decline in the number of long-term care beds relative to the size of the population aged 65 and over in several countries, such as Australia, Denmark, Hungary, Norway and Switzerland over the past decade (Chart 2.12 and Table 2.4). However, in some other countries such as Germany and Japan, there has been an increase in the number of long-term care beds per 1 000 population aged 65 and over. This can be attributed at least partly to enhanced coverage by publicly funded programmes of long-term care in institutions.

Caution is required in making cross-country comparisons of long-term care beds because of differences in institutional settings regarding the provision of long-term care across countries and differences in data coverage and reporting. In Japan, a large number of long-term care beds are provided in hospitals, but these beds are not included in the data reported to *OECD Health Data*. This is because Japan's health information system does not routinely distinguish beds allocated for acute care from those allocated for long-term care in hospitals (Jeong and Hurst, 2001).

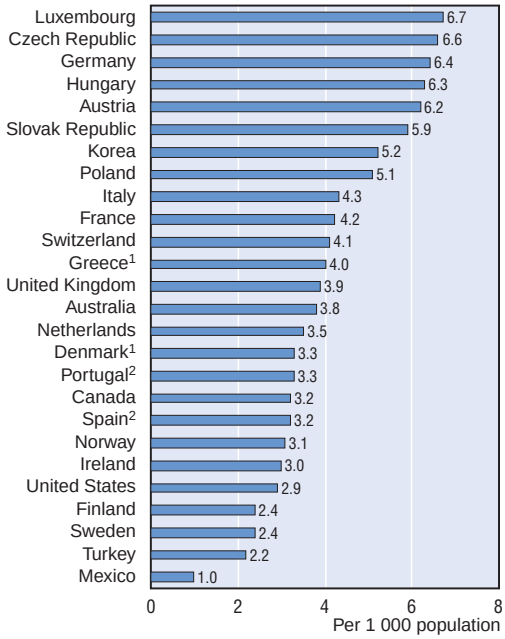
Definition and deviations

Acute care beds are hospital beds available for all types of medical care, exlcuding beds designated for same-day cases and for long-term care.

Long-term care beds are beds for inpatients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence in activities of daily living. These beds can be found in a wide range of institutions providing long-term care, including hospitals and nursing homes. The main defining criteria for inclusion is that a significant part of the care provided should be health services (with the health services often being provided mainly by nurses). In Japan, long-term care beds in hospitals are excluded. Some of the international variation in long-term care beds is due to the difficulty of distinguishing clearly long-term health care from long-term social services in different institutions for elderly dependent persons (or even in different units within an institution).

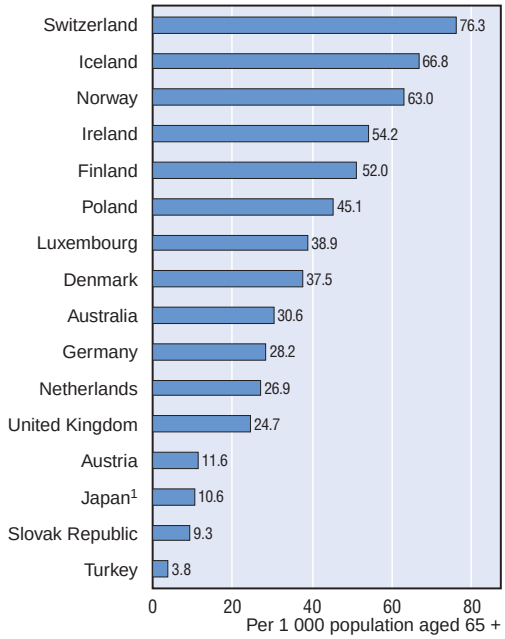
© OECD 2003

Chart 2.9. **Acute care beds per 1 000 population, 2000**



1. 1999. 2. 1998.

Chart 2.10. **Long term care beds per 1 000 population aged 65 and over, 2000**



1. Japan excludes beds in long term care units in hospitals.

Chart 2.11. **Decline in acute care beds, 1980 to 2000**

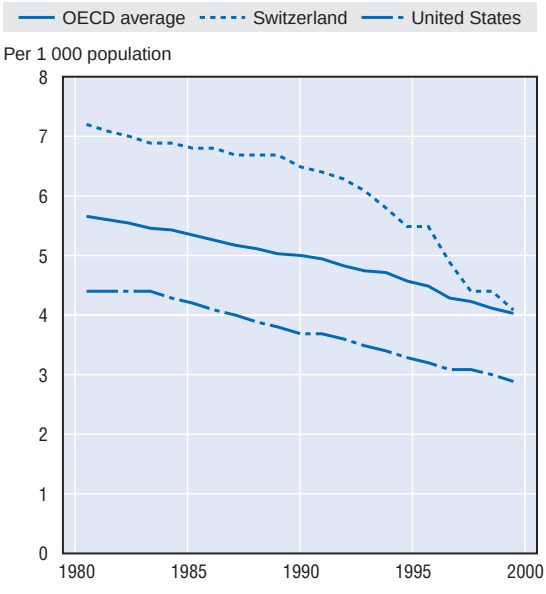
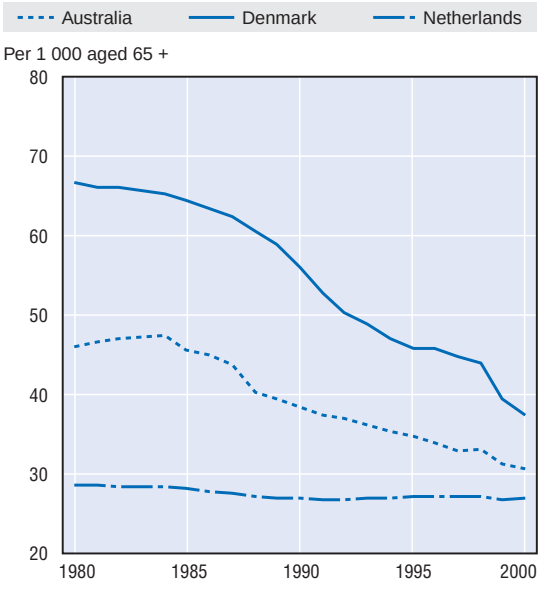


Chart 2.12. **Decline in long term care beds, 1980 to 2000**



See footnotes to Tables 2.3 and 2.4.
Source: OECD Health Data 2003.

© OECD 2003

Diagnostic technologies: computed tomography (CT) and magnetic resonance imaging (MRI) scanners

The diffusion of modern medical technologies is one of the main drivers of rising health expenditures across OECD countries. This section presents data on the availability of two specific technologies which are used to diagnose a wide range of diseases: computed tomography (CT) scanners (also known as "CAT" scans, for computed axial tomography) and magnetic resonance imaging (MRI) units. An advantage of MRI over conventional radiography or CT is that it does not expose patients to ionising radiation.

The availability of CT and MRI scanners continued to increase in most OECD countries during the 1990s (Charts 2.15 and 2.16; Table 2.5). MRI being a newer technology than CT scanners, the number of MRI has increased particularly rapidly over the past decade in OECD countries. On average across countries, the number of MRI scanners per capita more than tripled during the 1990s, rising from 1.7 per million population in 1990 to 6.5 in 2000 (the median was 4.7 MRI per million population in 2000). The number of CT scanners also increased, albeit more moderately, from an average of 10.1 per million population in 1990 to 17.7 in 2000 (with a median of 12.1 per million in 2000).

In 2000, Japan was by far the country with the highest number of CT and MRI scanners per capita, with 84 CT scanners per million population and 23 MRI units. The rapid increase in the number of MRI scanners in Japan has been attributed at least partly to the lack of any formal assessment of efficiency or effectiveness before making decisions to purchase MRI units (Hisashige, 1992). European countries like Switzerland, Finland, Austria and Iceland also have a relatively high number of MRI and CT scanners. At the other end of the scale, Mexico and Poland report the lowest number of CT and MRI scanners per capita. It should be noted that the figures for the United States under-estimate considerably the real number of CT and MRI units in that country, because they refer to the number of hospitals reporting to have at least one scanner rather than the total number of scanners in hospitals and in other locations *(e.g.,* specialised clinics).

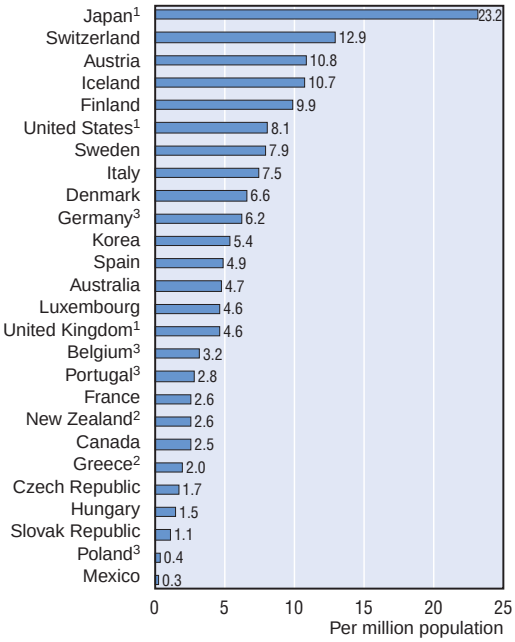
The number of scanners provides an indication of the overall availability of such equipment, but it does not indicate to what extent the equipment is used. A study comparing the use of diagnostic tests in hospitals in Canada and the United States found that American patients received many more CT and MRI tests than Canadians, and this result holds even in hospitals with similar availability of machines. Much of the difference in test use was explained by the more intensive use of available machines for the elderly in the United States than in Canada (Katz *et al.*, 1996).

Definition and deviations

The figures relate to the number of CT and MRI scanners per million population. For the United States, the data refer only to the number of short-term general hospitals which report having at least one CT or MRI scanners. They therefore under-estimate considerably the real number of scanners available in the United States.

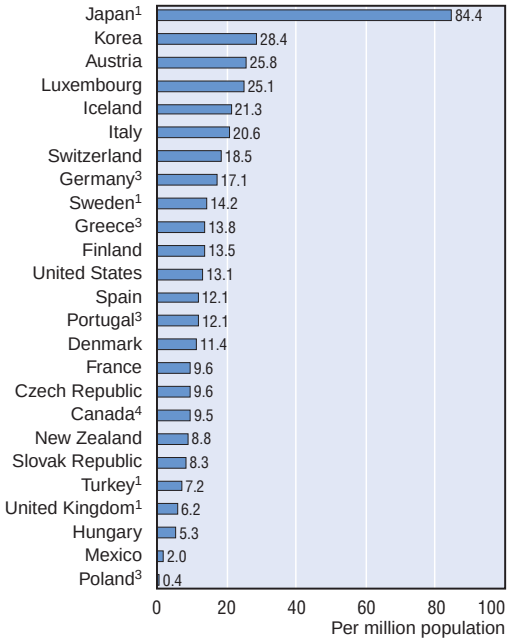
© OECD 2003

Chart 2.13. **MRI units, density per million population, 2000**



1. 1999. 2. 1998. 3. 1997.

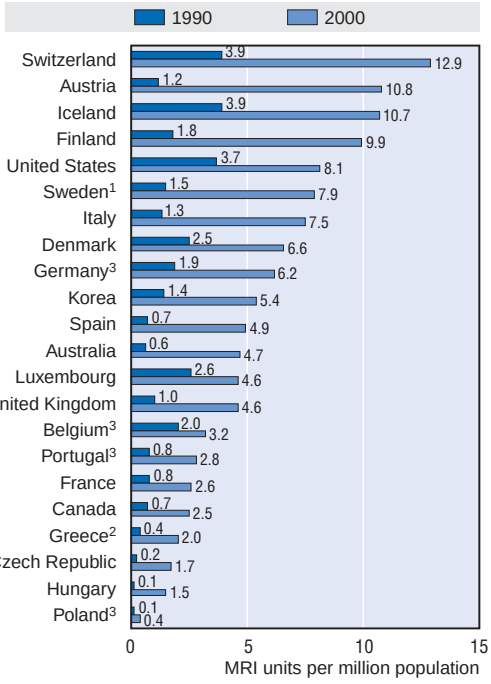
Chart 2.14. **CT scanners, density per million population, 2000**



1. 1999. 2. 1998. 3. 1997. 4. 2001.

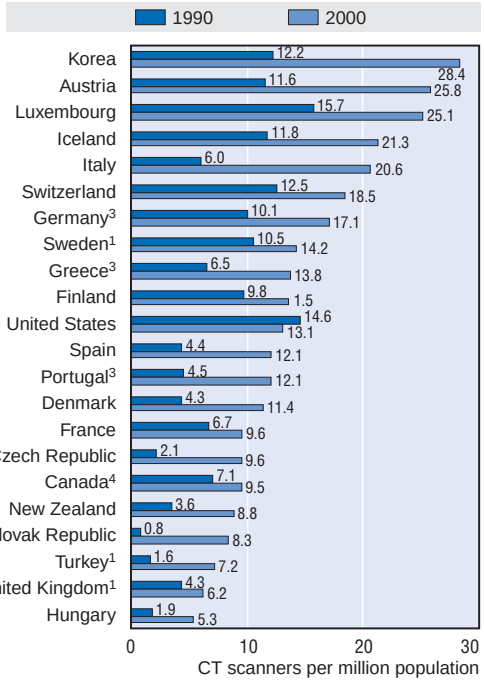
Note: US data is an under estimation as it refers to the number of general hospitals reporting to have at least one CT or MRI unit, rather than the total number of units in all health care facilities.

Chart 2.15. **Diffusion of MRI units, 1990 to 2000**



1. 1999. 2. 1998. 3. 1997.

Chart 2.16. **Diffusion of CT scanners, 1990 to 2000**



1. 1999. 2. 1998. 3. 1997. 4. 2001.

See footnotes to Table 2.5.
Source: OECD Health Data 2003.

© OECD 2003

Consultations with doctors

A large part of patient contacts with health care systems involve a consultation with a doctor either in a doctor's office, primary care clinic or in a hospital outpatient department. The overall number of physician contacts in a given year is influenced, among other things, by the health status of the population, the availability of doctors and the cost of consultations to individuals. Ways of accessing specialists also vary across countries. In some countries *(e.g.,* Belgium, France, Germany, Greece), patients can approach a specialist directly while in others *(e.g.,* Austria, Canada, the Netherlands and the United Kingdom) they are either required or encouraged to approach a general practitioner "gatekeeper" who decides whether they need referral to a specialist. The total number of physician contacts is only a crude measure of the volume of services provided, as services are counted regardless of their duration and complexities.

In 2000, there were considerable differences across countries in the number of consultations with doctors per capita. The average across OECD countries was 5.6 visits per person per year (Table 2.6). It ranged from a low of less than three visits per person per year in countries like Turkey, Mexico, Greece and Sweden, to over ten visits per year in Japan, the Czech Republic and Hungary (Chart 2.17).

The number of doctor visits in Japan has, over the past decade, been much higher than in other OECD countries (Chart 2.19). The high consultation rate in Japan is related at least partly to the fact that doctors not only prescribe but also dispense drugs. In Korea also, the large number of doctor consultations reflects not only a higher propensity for ambulatory care but also, before the reform of July 2000 which separated the physician's role of prescribing drugs from that of dispensing them, of using doctor visits to obtain drugs (OECD, 2003c).

The number of doctor consultations per capita has increased at least slightly in most countries for which data are available between 1990 and 2000, but it has decreased in some others (Chart 2.18). The largest increases have been in countries such as Mexico and Turkey which were building up their physician numbers and services over the past decade (Chart 2.20). It also increased by over 10% in France, Austria and Portugal. The largest decrease in the number of doctor consultations per capita was in the United Kingdom, although the UK data do not include consultations with specialists in the independent sector which might have increased during the past decade. They also exclude consultations with the relatively new "NHS Direct" telephone service.

Many OECD countries ascribe to a standard of equal care for equal need. Evidence from a comparative study of 14 OECD countries (including 12 European Union countries, Canada and the United States), based on household surveys from 1996, suggests that most countries had achieved at that time equity in the number of physician visits across different income groups, after standardising for need (self-reported health status) differences. Significant inequity emerged in only four of the countries studied: Portugal, the United States, Austria, and Greece (Van Doorslaer *et al.*, 2002).

Definition and deviations

Consultations with doctors per capita refer to the number of ambulatory contacts with physicians (both generalists and specialists) divided by the entire population. The number of contacts normally includes: consultations of patients at the physician's office, in primary care clinics and in outpatient departments of hospitals; physician's visits made to a person in institutional settings *(e.g.,* in a hospital or nursing home); and visits made to the patient's home.

The US estimates also include all telephone calls for medical advice, prescription or test results; they are therefore not limited to physician visits. Denmark also includes consultations by telephone, but excludes consultations with specialists. The UK figures do not include consultations of specialists outside hospital outpatient departments nor do they take into account consultations with physicians in the independent sector. The Netherlands do not include contacts for maternal and child care, nor discharge planning visits in hospitals and nursing homes. Portugal and Turkey exclude visits to private practitioners.

© OECD 2003

Chart 2.17. **Doctor consultations per capita, 2000**

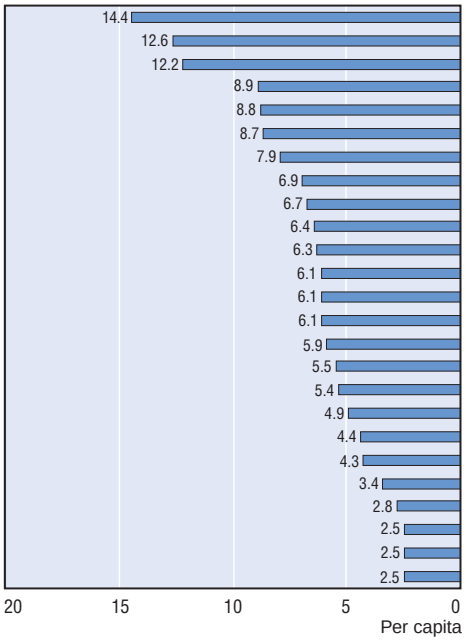
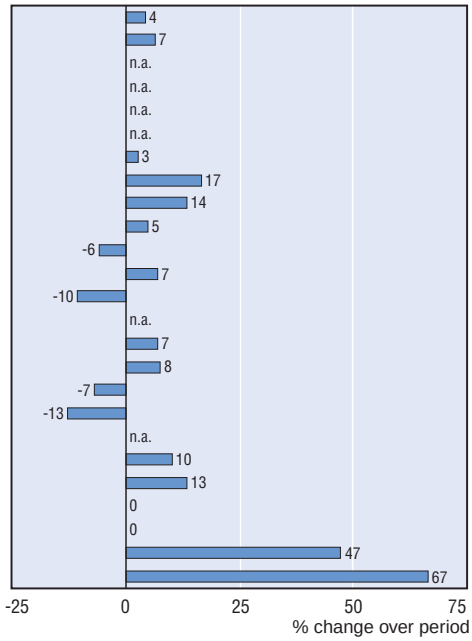


Chart 2.18. **Percentage change in number of doctor consultations per capita, 1990 to 2000**



1. 2001. 2. 1999. 3. 1998.

Chart 2.19. **Trend in numbers of doctor consultations per capita, 1990 to 2000**

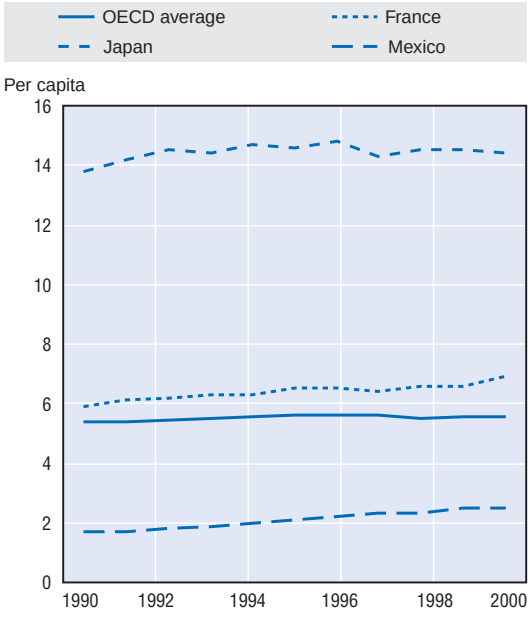
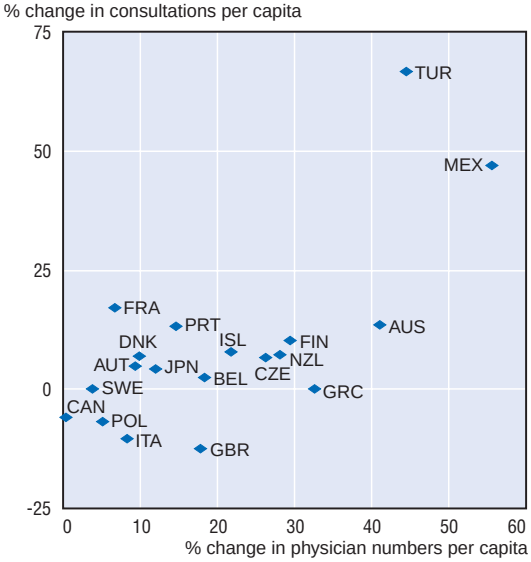


Chart 2.20. **Change in physician numbers and in number of doctor consultations, 1990 to 2000**



See footnotes to Table 2.6.
Source: OECD Health Data 2003.

© OECD 2003

Childhood immunisation

Childhood immunisation is a cornerstone of a nation's preventive medicine programme. High coverage levels have proven to be a cost-effective measure for disease prevention, drastically reducing the rate of childhood disease and cutting infant and childhood mortality.

By 2001, more than two-thirds of OECD countries had achieved rates greater than 90% for childhood immunisation against measles, compared with only a third of countries ten years earlier. Although the current level of immunisation coverage is similar for diphtheria, tetanus and pertussis (DTP) immunisation the uptake of the DTP vaccine has been generally earlier than for the measles vaccine (Table 2.7).

Some countries, for example in Central and Eastern Europe and in Scandinavia, have had long established and effective vaccination programmes achieving practically universal coverage over the past twenty years. Other countries have seen great strides in their immunisation coverage. In Mexico, following a measles outbreak in 1990, national vaccination programmes were launched and coverage reached more than 95% by 2001. There has been a similar increase in the DTP vaccine coverage in Mexico from just over 50% in 1990 to more than 97% in 2001 with no reported cases of diphtheria since 1991 (Pérez-Cuevas *et al.*, 1999). Other countries achieving large increases in coverage over the past twenty years include Portugal and the United Kingdom in the case of DTP, and Italy and Japan in the case of measles. Those countries with relatively low overall vaccination coverage in 2001 included Turkey, Austria, Ireland and the United States (Charts 2.21 and 2.22).

A successful national immunisation programme can be structured in various ways. In certain countries, immunisation may be almost obligatory in order to gain access to future medical care, child-care facilities or schooling. Other countries may adopt a thorough follow-up campaign by health service staff. Mass media communication and promotion is also a useful tool in any immunisation campaign.

The uptake of childhood immunisation can be affected by various factors relating to parents' doubts about the efficacy, safety or necessity of the vaccine. The United Kingdom is a case in point. Following adverse media coverage about a possible link between the combined MMR (measles, mumps and rubella) vaccine and autism, coverage has fallen in recent years and is currently similar to pre-1990 levels. A similar situation occurred in a number of countries in the late 1970s concerning the pertussis vaccine with the resultant upsurge in reported cases of whooping-cough (Streefland, 2001; and Roberts *et al.*, 2002).

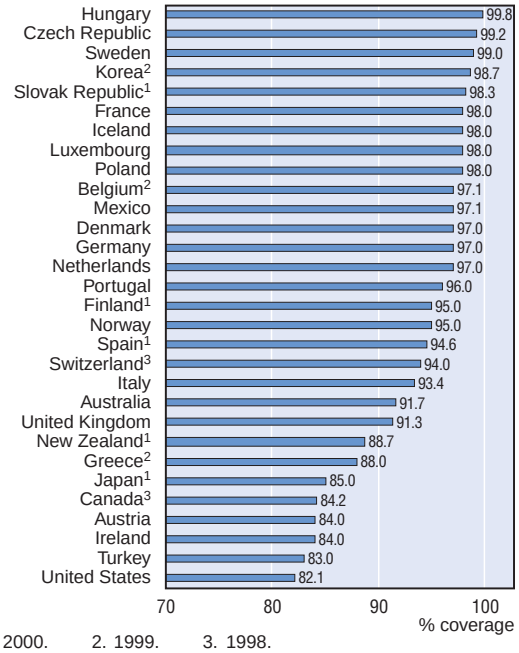
Definition and deviations

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 and Iceland, 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 for ages 19-35 months in the United States.

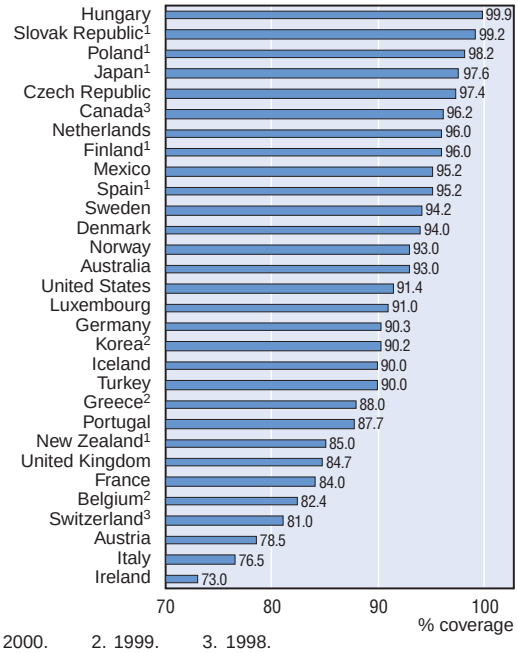
© OECD 2003

Chart 2.21. **Diptheria, tetanus and pertussis, immunisation rates for young children, 2001**



1. 2000. 2. 1999. 3. 1998.

Chart 2.22. **Measles, immunisation rates for young children, 2001**



1. 2000. 2. 1999. 3. 1998.

Chart 2.23. **Trends in immunisation rates of young children against DTP, 1980 to 2000**

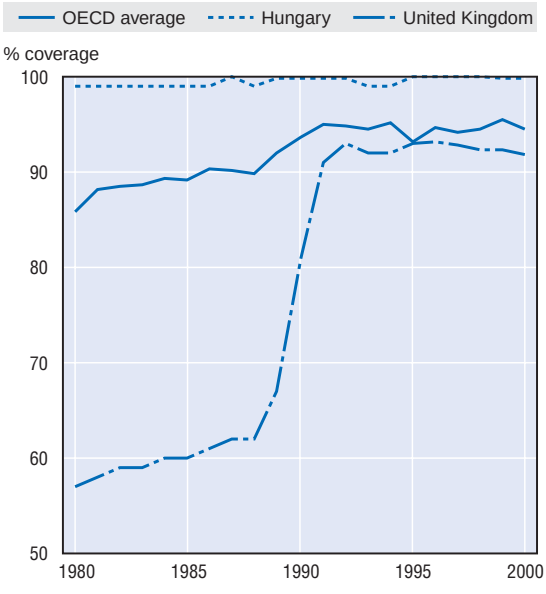
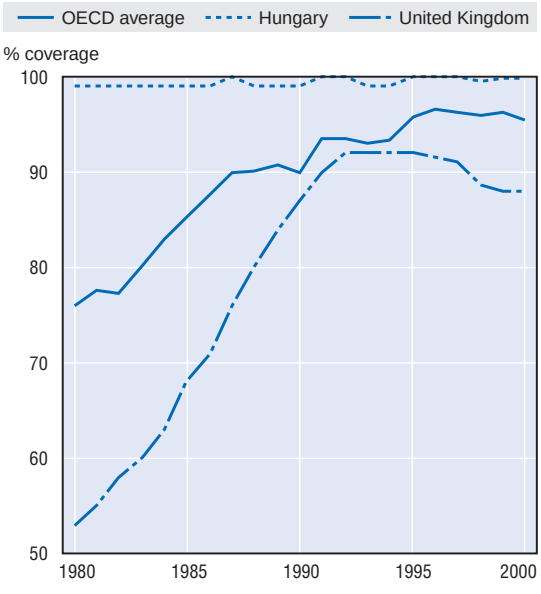


Chart 2.24. **Trends in immunisation rates of young children against measles, 1980 to 2000**



See footnotes to Table 2.7.
Source: OECD Health Data 2003.

© OECD 2003

Hospital discharges

Discharge rates are an important measure of hospital activity. However, they provide only a partial measure of hospital activity since, in most countries, discharge rates do not generally include same-day separations (ambulatory care) which represent a growing proportion of hospital activity. In addition, a comparison of hospital discharge rates within and across countries does not take into account differences in case-mix (the severity of the conditions leading to hospitalization).

Caution is required in making cross-country comparisons in hospital discharge rates, since some countries include same-day separations while most others do not. As expected, those countries reporting same-day separations *(e.g.,* Austria, Hungary, Luxembourg and New Zealand), with the exception of the United States, tend to rank higher in overall hospital discharge rates than those countries which exclude them (Chart 2.25 and Table 2.8). Among those countries which do not include same-day separations, discharge rates in 2000 were high in Finland, France, the Czech Republic and Germany, while they were relatively low in Mexico, Portugal, Turkey, the Netherlands and Canada.

In two of the countries reporting same-day separations in hospital discharges, Austria and New Zealand, discharge rates increased between 1995 and 2000, but in the United States, they decreased slightly (Chart 2.26 and Table 2.8). The increase in discharge rates in Austria and New Zealand can be attributed partly to a rising number of patients treated in ambulatory care units and, more generally, to shorter average length of stay in hospitals (see section on "Average length of stay in hospitals").

In countries where same-day separations are excluded from discharge rates, there is no consistent pattern in changes over time in discharge rates. In most of these countries, discharge rates increased at least slightly during the latter half of the 1990s *(e.g.,* in the Czech Republic, Finland, Germany, Greece, Korea, the Slovak Republic, Spain and Turkey). In other countries, discharge rates remained fairly stable between 1995 and 2000, while in others they fell (in Australia, Canada, the Netherlands, Portugal and Sweden). The reduction in discharge rates in this latter group of countries does not necessarily indicate a fall in hospital activity, since the decline may have been accompanied by a rise in ambulatory care.

Looking at the breakdown by diagnostic category, the main conditions leading to hospital discharges are diseases of the circulatory system, pregnancy and childbirth, diseases of the digestive system and diseases of the respiratory system (Charts 2.27 and Table 2.9). Discharge rates for circulatory diseases have increased over time in many countries (Chart 2.28). This is explained at least partly by the diffusion of new treatments for heart diseases such as revascularisation procedures (see section on "Cardiovascular procedures").

Trends in hospital discharges might be influenced by a number of factors including not only the development and diffusion of new treatments for specific diseases, but also the expansion of ambulatory care, changes in access to hospital services for different population groups and changes in the age structure of the population. Elderly populations account for a disproportionately high percentage of overall hospital discharges. In some countries, there have been changes over time in age-specific discharge rates. In the United States for instance, hospital discharge rates among persons 65 years of age and over increased by 11% from 1990 to 1999 in comparison to a 17% decrease for the 15-44 age group (Centers for Disease Control, 2001). The reasons for this diverging pattern are not clear.

Definition and deviations

Discharge is the release of an inpatient from an acute care institution after admission for a period of hospitalisation. It includes deaths in hospital following inpatient care, and in most countries (but not all) excludes same-day separations. Transfers to other care units within the same institution are also excluded.

There are a number of important differences between countries over the definition of discharges which limit cross-country comparability. Austria, Hungary, Luxembourg, New Zealand and the United States include same-day separations whereas (as noted above) the majority of countries exclude them. Other countries do not cover the whole of the health service. Data for the United Kingdom and Mexico, for example, are restricted to public hospitals. Some countries include discharges related to pregnancy and childbirth while others do not. The source of the information can also differ, although most data come from hospital administrative records.

© OECD 2003

Chart 2.25. **Hospital discharges per 1 000 population, 2000**

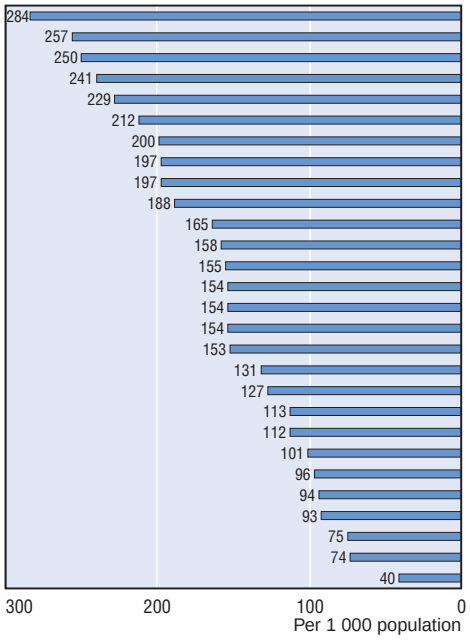
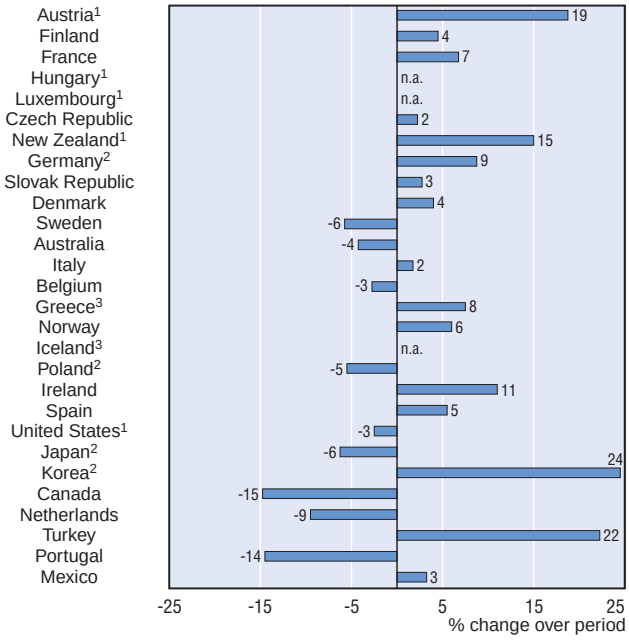


Chart 2.26. **Percentage change in hospital discharges per 1 000 population, 1995 to 2000**



1. Includes same day separations. 2. 1999. 3. 1998.

Chart 2.27. **Hospital discharges by diagnostic category, 2000**

OECD average

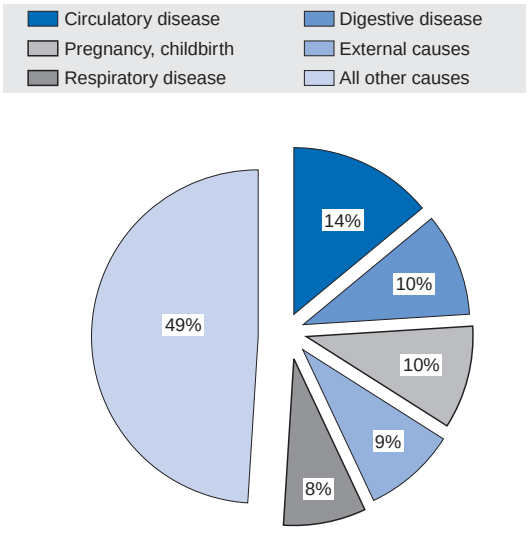
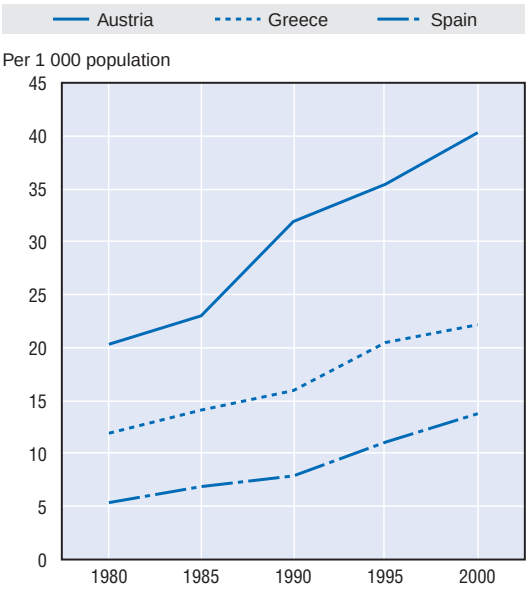


Chart 2.28. **Trends in hospital discharges for circulatory disease, 1980 to 2000**



See footnotes to Table 2.8.
Source: OECD Health Data 2003.

© OECD 2003

Average length of stay in hospitals

The average length of stay in hospitals 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. 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 or for the comfort and recovery of the patient. If a falling length of stay leads to a rising readmission rate, costs per episode of illness may fall little or even rise.

There are large variations across OECD countries in terms of average length of stay (ALOS) for acute care (Chart 2.29 and Table 2.10). In 2000, ALOS for acute care was relatively low (3.5 to 5 days) in Mexico, Nordic countries (Denmark, Finland, Sweden) and New Zealand. It was relatively high (more than 9 days) in Korea, Germany, Switzerland, Luxembourg and the Netherlands. In all countries for which consistent data over time is available, ALOS for acute care has fallen over the past fifteen years, with the exception of Korea. On average across OECD countries, ALOS for acute care decreased from 9.6 days in 1985 to 6.9 days in 2000. ALOS fell particularly quickly between 1985 and 2000 in Nordic countries as well as in several other European countries such as France, Austria, the Czech Republic and Switzerland. The decline in ALOS can be attributed to several factors, including the use of less invasive surgical procedures and the expansion of early discharge programmes enabling patients to return to their home to receive follow-up care. Falling length of stay for acute care has helped to achieve a reduction of acute care beds in many OECD countries during the past two decades (see section on "Acute and long-term care beds").

In Korea, ALOS in acute care hospital beds has consistently been higher than the OECD average and it has not been decreasing over time. This high ALOS in Korea can be explained in part by the lack of beds for long-term care; hence acute care beds may also be used for chronically ill patients. The availability of a large number of hospital beds might also have given Korean hospitals incentives to keep patients longer (OECD, 2003c).

Focusing on ALOS for specific diseases or conditions can remove some of the heterogeneity arising from potentially different mix and severity of acute care conditions across countries. Chart 2.32 presents comparative data on ALOS for normal delivery (obstetrics). There are striking variations in ALOS for normal delivery between countries, ranging from 2 days or less in Mexico, Turkey, Canada, New Zealand and the United States, to more than 5 days in the Slovak Republic, Hungary, the Czech Republic, Austria, Poland, Luxembourg and Belgium. The average across OECD countries was 3.7 days in 2000. In all countries, there has been a reduction in ALOS for normal delivery during the 1990s (Table 2.11). The length of hospitalisation for maternity care has become an important issue in some countries because of concerns about premature discharge.

There has also been a gradual decline in lengths of stay following acute myocardial infarction (AMI) during the 1990s for all countries reporting data, pursuing a trend that started in earlier decades. In 2000, ALOS following AMI was lowest in the United States with 5.7 days, followed by New Zealand, Sweden, Denmark and Australia, with ALOS of 6.5 to 7 days. On the other hand, it was relatively high in Austria, Finland, Poland and Germany, with ALOS of more than 12 days following AMI (Chart 2.31). Care is required however in making these cross-country comparisons since, in countries like Finland, ALOS may include patients originally admitted for AMI but who are no longer receiving acute care and might therefore be considered long-term care patients (Moise, Jacobzone *et al*., 2003).

ALOS has continued to decline in nearly all countries for other important conditions leading to hospitalisation, such as cerebrovascular diseases and pneumonia and influenza (Table 2.11).

Definition and deviations

Average length of stay (ALOS) for acute care refers to the average number of days (with an overnight stay) that patients spend in an acute-care inpatient institution. It is generally 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 or discharges. Data on length of stays should be interpreted with care since differences exist across countries in what is measured that may distort the calculated ALOS.

© OECD 2003

Chart 2.29. **Average length of stay for acute care, 2000**

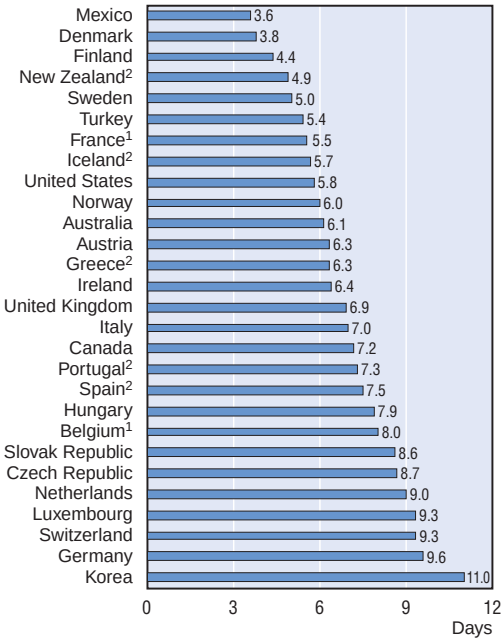
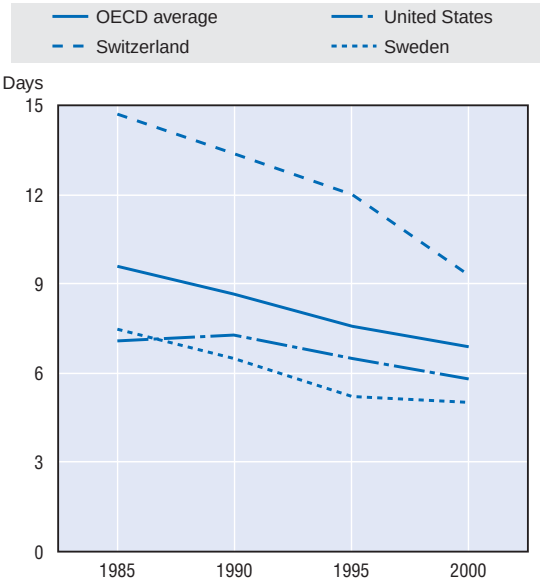
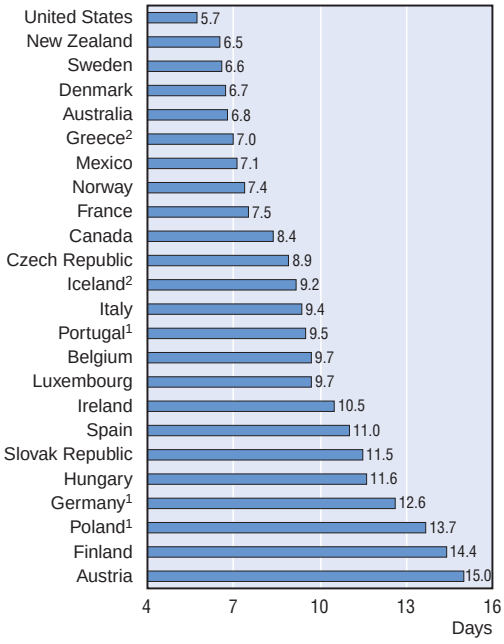


Chart 2.30. **Trend in average length of stay for acute care, 1985 to 2000**



1. 1999. 2. 1998.

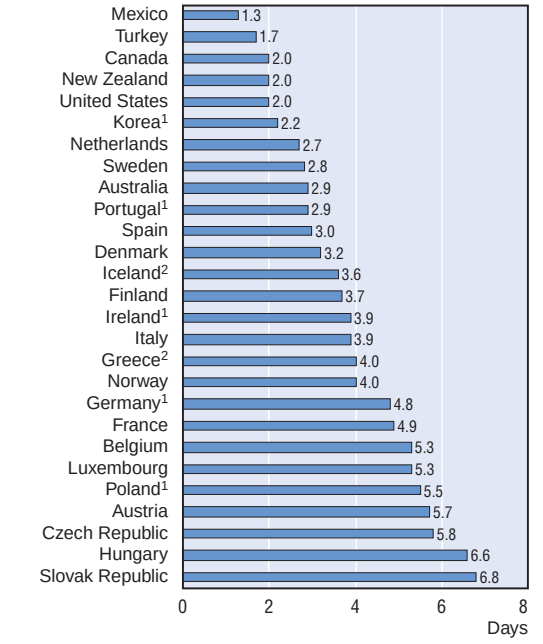
Chart 2.31. **Average length of stay following acute myocardial infarction (AMI), 2000**



1. 1999. 2. 1998.

See footnotes to Tables 2.10 and 2.11.
Source: OECD Health Data 2003.

Chart 2.32. **Average length of stay for normal delivery, 2000**



1. 1999. 2. 1998.

© OECD 2003

Surgical procedures, ambulatory and inpatient

The proportion of surgical acts carried out on an ambulatory (or same-day) basis has been growing in recent years in nearly all OECD countries for which data is available. This rise has been made possible by advances in medical technologies, in particular the diffusion of less invasive surgical interventions. The expansion of day surgery has also been used by hospitals to achieve cost-containment objectives, as ambulatory surgery can offer a less costly alternative to traditional inpatient surgery.

Health information systems in several countries remain incomplete in their coverage of day surgeries, especially those carried out in ambulatory settings outside hospitals *(e.g.,* in private clinics). Therefore, the availability and comparability of data on day surgeries is limited, and caution is required in making cross-country comparisons. Based on currently available data, the rate of surgeries performed on a same-day basis has increased between 1995 and 2000 in all countries with complete data, with the exception of Luxembourg (Chart 2.35 and Table 2.12). In the Netherlands, the proportion of surgeries carried out on an ambulatory basis increased from 39% to 46% between 1995 and 2000.

The volume of inpatient surgical activities (requiring an overnight stay in hospital) varies considerably across OECD countries (Chart 2.33). It ranges from more than 100 per 1 000 population in some European countries (Hungary, Austria, Luxembourg, Italy and Ireland), to less than 50 per 1 000 population in Mexico, Turkey, New Zealand, Canada, the Netherlands and Greece. In several countries (Canada, Finland, the Netherlands, the United States), the rate of inpatient surgical procedures per capita has declined during the 1990s, coinciding with an increase in the rate of ambulatory surgeries (see Table 2.12 for data for Finland and the Netherlands; for Canada, see De Lathouwer and Poullier, 2000; for the United States, see NCHS, 2002).

Looking at trends in total surgical activity rates for those few countries with complete data for inpatient and ambulatory procedures, in most of these countries there has been an increase in aggregate surgical activity rates between 1995 and 2000 (Table 2.12). In Finland, the rise in the total number of surgical interventions was driven by an increase in the number of day surgeries. In other countries such as Ireland, Italy and New Zealand, it was driven by a fairly even increase in both inpatient and ambulatory surgeries. The Netherlands reports a relatively stable aggregate number of surgical procedures, but this is the result of a growing number of ambulatory surgeries offsetting a reduction in the number of inpatient procedures. The increasing number of ambulatory surgeries over the past decade in the Netherlands has been accompanied by a reduction in the number of acute care beds in hospitals (Chart 2.36).

The rate of diffusion of same-day surgeries across countries might be affected by financial incentives to hospitals or doctors to adopt ambulatory surgery programmes. For instance, a *per diem* financing of hospitals may provide no incentive (or disincentive) for the take-up of same-day surgery programmes. Similarly, fixed salary remuneration to physicians may provide less incentive for the adoption of same-day surgery techniques, compared with fee-for-service remuneration. However, the evidence on the impact of such differences in financial incentives across countries is not conclusive. A recent European study found that such financial incentives do not appear to greatly influence the choice of same-day surgeries in the twelve countries studied. Rather, the study found that health care capacity variables, such as the availability of acute care hospital beds, seem to be more important in explaining the variations in the use of same-day surgeries across countries (Kroneman *et al.*, 2001).

Definition and deviations

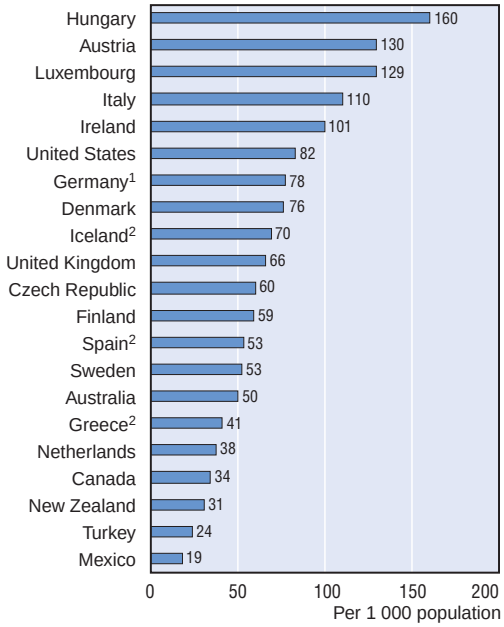
Ambulatory surgery is defined as those patients who are given invasive surgical treatment (usually elective, non-emergency) which are carried out in a dedicated surgical unit and which lead to discharge on the day of the operation. Equivalent terms used in some countries include same-day (or day) surgery and outpatient surgery.

Inpatient surgery refers to those patients who are given invasive surgical treatment, whether on an emergency or elective basis, and who stay over at least one night in an institution.

Data on surgical procedures in some countries may only include those carried out in inpatient institutions (hospitals) and exclude those performed in ambulatory settings *(e.g.,* clinics). Some countries report only the number of patients receiving one or more operations or only the main surgical procedure (*e.g.* Canada), while others report all procedures or up to four procedures per discharged patient in the case of Ireland and the United States. Data from Ireland and the United States also include both surgical and non-surgical procedures (for example, diagnostic procedures such as endoscopies). They therefore over-estimate the volume of surgical procedures compared with data from other countries.

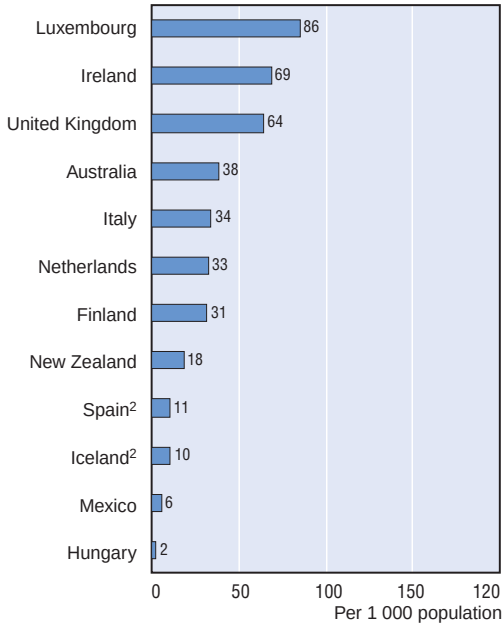
© OECD 2003

Chart 2.33. **Number of inpatient surgical procedures per 1 000 population, 2000**



1. 1999. 2. 1998.

Chart 2.34. **Number of ambulatory surgical procedures per 1 000 population, 2000**



1. 1999. 2. 1998.

Chart 2.35. **Day surgery as a proportion of total surgery, 1995 and 2000**

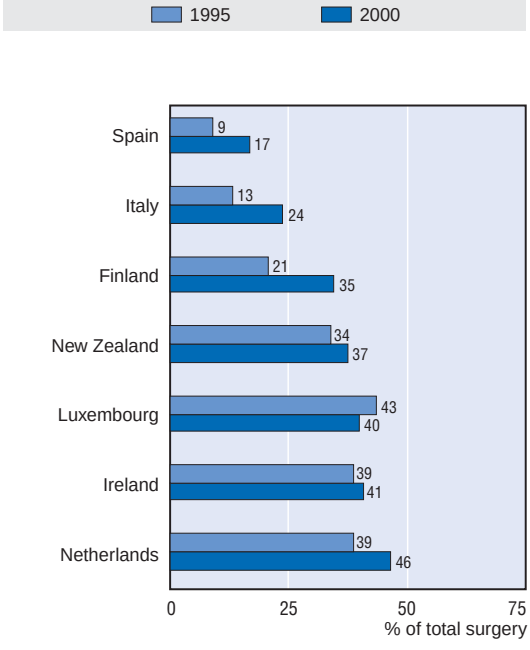
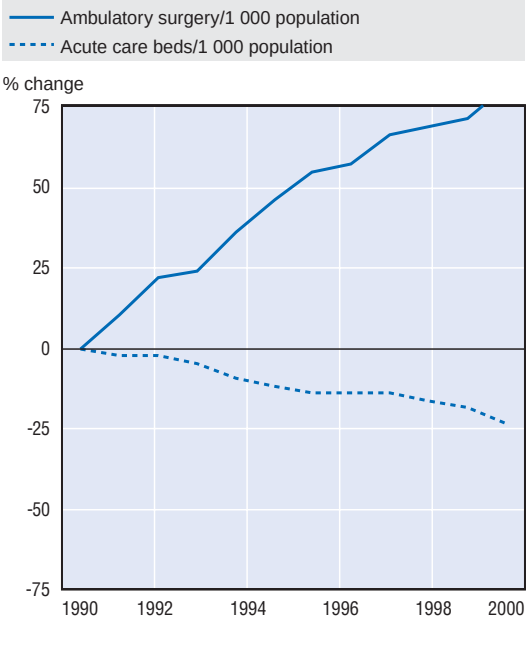


Chart 2.36. **Change in rates of ambulatory surgery and acute care beds, Netherlands, 1990 to 2000**



See footnotes to Table 2.12.
Source: OECD Health Data 2003.

© OECD 2003

Cardiovascular procedures

Coronary artery bypass graft (CABG) surgery and coronary angioplasty are two surgical revascularisation procedures that have revolutionized the treatment of heart disease.

There is considerable variation across countries in the use of both procedures (Charts 2.37 and 2.38; Table 2.13). The United States is the country which makes the heaviest use of these two procedures. In 2000, 205 CABG surgeries and 363 coronary angioplasties per 100 000 population were performed in the United States, in both cases exceeding by a large margin the next highest country. At the other extreme is Mexico, where, for every 100 000 people there were only one CABG and one coronary angioplasties performed in 2000. In no other country reporting data was there less than 15 per 100 000 population of either one of these procedures.

The utilisation of these two revascularisation procedures has been increasing throughout the 1990s (Charts 2.39 and 2.40; Table 2.13). In 1990, the average (unweighted) number of CABG performed was 53 per 100 000 population; by 2000 the average had increased to 78 per 100 000 population (calculated across the same nine countries for which data were available for both years). Over the same period, the average (unweighted) number of coronary angioplasties performed was 33 per 100 000 population in 1990 and 117 per 100 000 population in 2000 (calculated also across the same nine countries for which data were available for both years).

The advent of the intracoronary stent, a wire mesh that greatly reduces the chances of arterial obstruction following angioplasty, has been the major factor in coronary angioplasty replacing CABG as the most widely used means of revascularisation (Moïse, 2003). Coronary angioplasty began to replace CABG around the mid-1990s, around the same time as the first published trials on the efficacy of stents began to appear.

Income is a significant factor influencing the adoption and subsequent diffusion of health technologies throughout health systems, including procedures such as revascularisations. The more affluent countries tend to adopt new technologies earlier (Slade and Anderson, 2001). Coronary angioplasty was first introduced in the late 1970s; by 1990, 114 coronary angioplasties per 100 000 population were performed in the United States, the OECD country with the highest per capita national income after Luxembourg. It was not until 2000 before other countries such as Australia, Canada, Denmark and Sweden, reached that level.

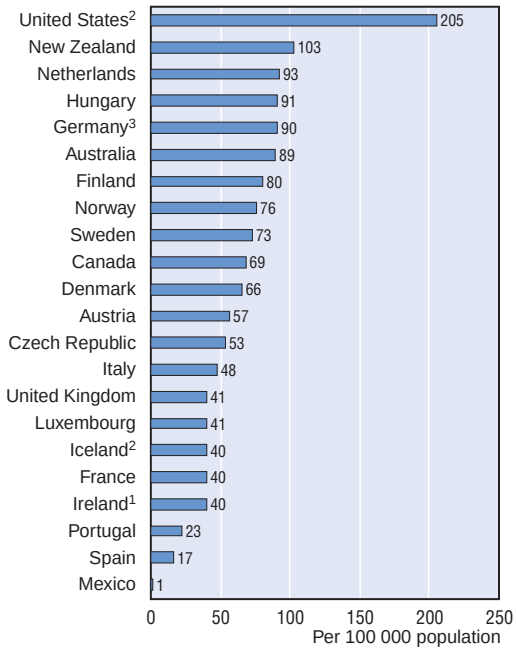
Definition and deviations

CABG surgery is the grafting of veins and/or arteries to bypass an obstructed coronary artery. A CABG may involve bypassing the obstruction of only one coronary artery, but multiple coronary artery bypasses are most common. Coronary angioplasty involves the threading of a catheter with a balloon attached to the tip through the arterial system, usually started in the femoral artery in the leg, into the diseased coronary artery. The balloon is inflated to distend the coronary artery at the point of obstruction.

The data relate to the number of inpatient procedures only. They do not include coronary angioplasties performed on an ambulatory basis (a growing share of overall activity rates in many countries).

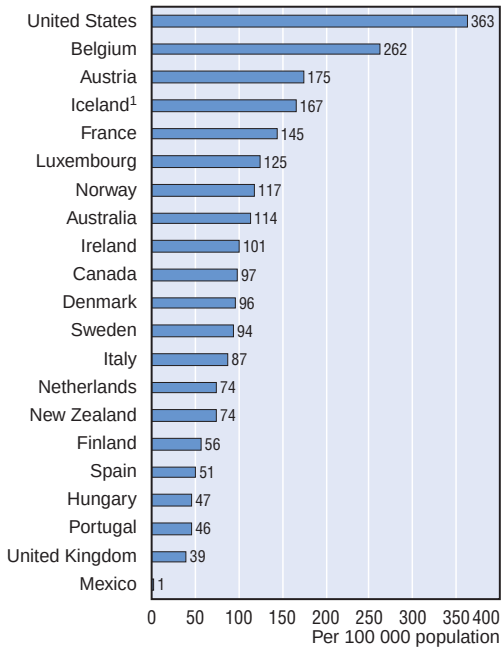
© OECD 2003

Chart 2.37. **Cardiac bypass procedures per 100 000 population, 2000**



1. 2001. 2. 1999. 3. 1998.

Chart 2.38. **Cardiac angioplasty procedures per 100 000 population, 2000**



1. 1999.

Chart 2.39. **Cardiac bypass procedures, 1990 to 2000**

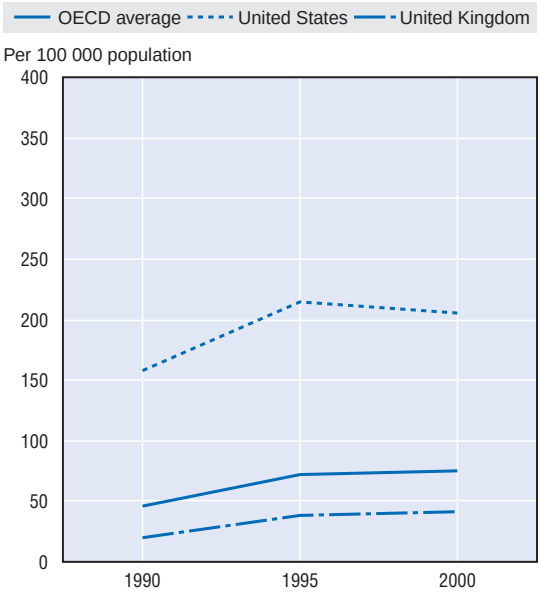
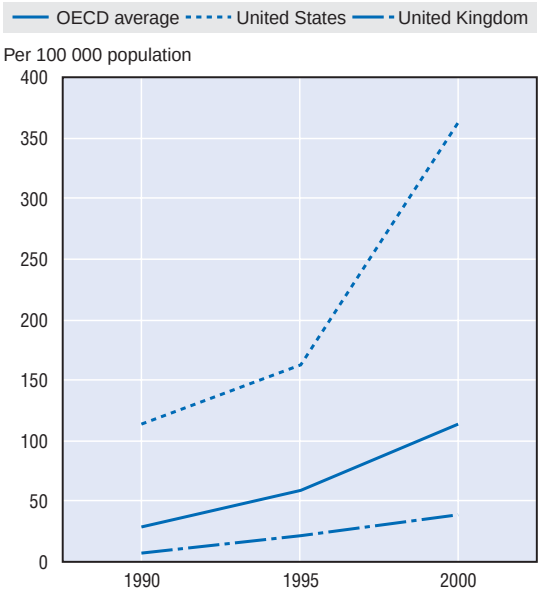


Chart 2.40. **Cardiac angioplasty procedures, 1990 to 2000**



See footnotes to Table 2.13.
Source: OECD Health Data 2003.

© OECD 2003

3. HEALTH EXPENDITURE AND FINANCING

© OECD 2003

Health expenditure per capita

Controlling the growth of health spending (both public and total) is a key policy issue in most OECD countries. The level of health spending varies considerably across countries, reflecting differences in price, volume and quality of medical goods and services consumed.

Health expenditure per capita (converted to USD purchasing power parity, PPP) can be used to compare the overall level of consumption of health goods and services across countries at a given point in time (see Annex 2 for an explanation of "purchasing power parity" conversion). The United States ranks far ahead of other OECD countries in terms of total health spending per capita. It spent 4 887 USD PPP per capita in 2001, 2.3 times more than the OECD average of 2 117 USD PPP (Chart 3.1 and Table 3.1). Following the United States in 2001 was Switzerland and Norway which spent over 3 000 USD PPP, and Germany and Canada with spending of 2 800 USD PPP per capita. At the other end of the scale, Mexico, Poland, the Slovak Republic, Korea and Hungary spent less than 1 000 USD PPP on health in 2001, less than half the average across OECD countries.

In most OECD countries, concern about health cost growth reflects the pressure such growth places on public budgets. Public financing is the main source of funding of health expenditure in all OECD countries, except Korea, Mexico and the United States (see indicator "Sources of financing for health care"). Focussing on public spending on health, only Iceland, Luxembourg and Norway spent more per capita than the United States in 2001 (Chart 3.2), despite the fact that only one-quarter of Americans have public health insurance coverage (Docteur *et al.*, 2003). Public spending on health per capita was lowest in Korea, Mexico and Poland. The overall differences across countries are smaller in public spending than in private spending.

During the 1990s, there have been a number of changes in countries' relative position to the OECD average in both total and public health spending per capita (Table 3.1). For example, in 1990, Sweden spent 30% more per capita than the OECD average, but by 2001 its spending level was only 7% greater than the average. Similarly, in Finland, public spending per capita was 24% above the OECD average in 1990, while in 2001 it was 8% below. Conversely, Ireland's public spending on health used to be 40% below the OECD average in 1990, but it caught up to the average by 2001. Over the past decade, the lower-income OECD countries, with the exception of Hungary, narrowed their gap from the OECD average, both in terms of total and public expenditure on health.

OECD countries allocate their health expenditure in different ways (Chart 3.3). For example, Denmark, the Netherlands and Switzerland allocated 45% or more of their health expenditure on inpatient care in 2001, while countries such as the United States and Canada spent less than 30% on this component of their health system. Hungary and the Slovak Republic spent almost 40% of their total health expenditure on medical goods (including pharmaceuticals), while Denmark, Switzerland and the United States spent less than 15%. In 2001, on average across OECD countries, 38% of total health expenditure was allocated to inpatient care, 31% for outpatient services (including ancillary services and home care), 21% for medical goods (including pharmaceuticals and medical appliances) and the remaining 10% was spent on collective services (administration and prevention programmes).

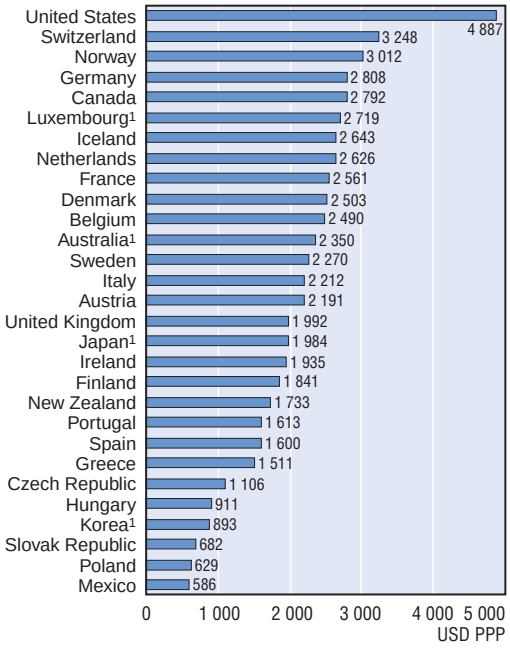
Definition and deviations

Total expenditure on health measures the final consumption of health care goods and services (*i.e.* current health expenditure) plus capital investment in health care infrastructure. This includes spending by both public and private sources (including households) on medical services and goods, public health and prevention programmes and administration. Excluded are health-related expenditure such as training, research and environmental health. The two major components of total current health expenditure are: expenditure on personal health care and expenditure on collective services. Personal health services consist of medical services (including inpatient care, day care, outpatient services, home care and ancillary services) and medical goods (including pharmaceuticals and medical appliances). Expenditure on collective services includes prevention and administration.

Cross-country comparisons of per capita expenditure require a conversion of national currencies into a common currency: USD at purchasing power parity (PPP) conversion rates. The economy-wide (GDP) PPPs are used as the most available and reliable conversion rates. For further information about the definition of health expenditure and comparisons of health expenditure across countries, see Annex 2.

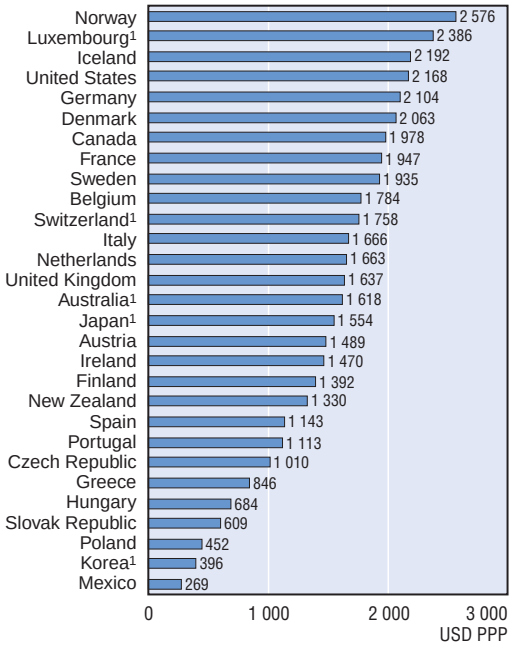
© OECD 2003

Chart 3.1. **Total health expenditure per capita, 2001**
USD PPP



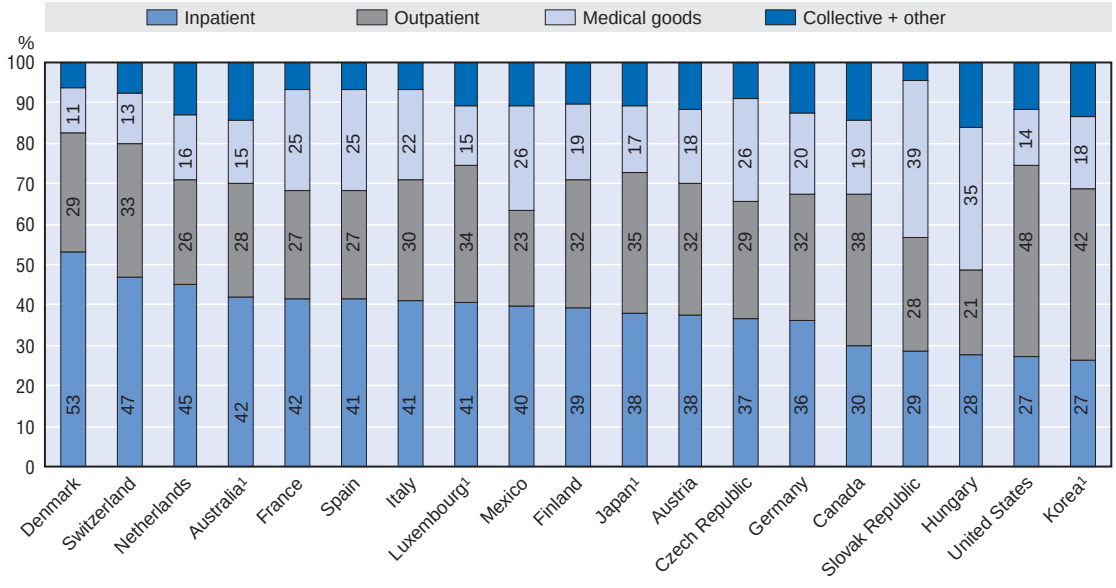
1. 2000.
Note: Data not available for Turkey.

Chart 3.2. **Public expenditure on health per capita, 2001**
USD PPP



1. 2000.

Chart 3.3. **Health expenditure by function of care, 2001**
Percentage of total health expenditure



1. 2000.
See footnotes to Table 3.1.
Source: OECD Health Data 2003.

© OECD 2003

Health expenditure in relation to gross domestic product (GDP)

Health spending represents a growing share of GDP in OECD countries. In 2001, OECD countries devoted on average 8.4% of their GDP to health spending. This proportion varies considerably across countries, ranging from 13.9% in the United States to less than 6% in Luxembourg, the Slovak Republic and Korea (Chart 3.4). Following the United States in terms of highest health spending as a percentage of GDP were Switzerland and Germany which spent, respectively, 10.9% and 10.7% of their GDP on health in 2001.

The health spending to GDP ratio, in itself, does not measure the relative magnitude of the resources used in a health system. Countries having relatively high health expenditure to GDP ratio might have relatively low per capita expenditure, and conversely, countries with relatively low health expenditure to GDP ratio might have relatively high expenditure per capita. For example, Luxembourg and Korea spent a similar share of GDP on health in 2000; however, per capita spending was more than three times higher in Luxembourg than in Korea (Charts 3.4 and 3.1). Similarly, France and Greece both spent around 9.5% of GDP on health in 2001, but health expenditure per capita in France was 70% higher.

Over the past decade, on average across OECD countries, the health expenditure to GDP ratio increased from 7.3% in 1990 to 8.1% in 2000 and up to 8.4% in 2001. However, changes in the ratio of health spending to GDP varied widely across countries (Charts 3.5 and 3.6; Tables 3.2 and 3.3). In some countries, the health expenditure share of GDP decreased between 1990 and 2001 *(e.g.,* in Finland, Hungary and Luxembourg). In other countries, it was almost unchanged in 2001 compared with 1990 *(e.g.,* in Denmark, Ireland and Italy,), while in another group of countries it increased by 2 percentage points or more *(e.g.,* in the Czech Republic, Greece, Portugal, the United States and Switzerland).

In Switzerland, the health expenditure share of GDP increased considerably during the 1990s despite the relatively low growth in health expenditure; this was due to economic growth being even lower than health spending growth (Tables 3.2 and 3.6). On the other hand, in Ireland, health spending increased rapidly during the 1990s (6.2% average annual growth rate in real terms), but this was accompanied by strong economic growth; hence the health expenditure share of GDP increased only modestly.

Differences in the health expenditure share of GDP across OECD countries narrowed during the 1990s, mainly because health expenditure in lower-income OECD countries grew more rapidly than in higher-income countries and more rapidly also than their economic growth (Chart 3.5 and Table 3.6).

Focussing on the most recent year, the health expenditure share of GDP rose considerably in several OECD countries in 2001 compared with 2000, especially in the United States and in countries such as Canada and Finland where it had stabilised during the 1990s (Chart 3.6 and Table 3.2). This was due partly to an economic slowdown and partly to an increase in health expenditure.

Chart 3.7 shows the well known positive association between GDP per capita and health expenditure per capita across OECD countries. This association is stronger however among lower-income countries than for higher-income countries. Among countries with income levels of 25 000 USD PPP and above, there are substantial differences in health expenditure at a given level of GDP (Huber, 1999). For instance, despite having similar level of GDP per capita, Denmark spent 30% more on health than Ireland in 2001, and Germany spent 50% more than Finland.

Definition and deviations

See indicator "Health expenditure per capita" for definition of health expenditure, and indicator "Gross Domestic Product" for definition of GDP.

© OECD 2003

Chart 3.4. **Health expenditure as a percentage of GDP, 2001**

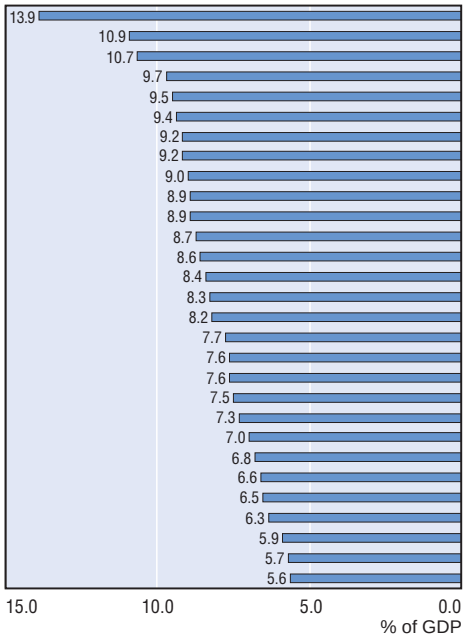
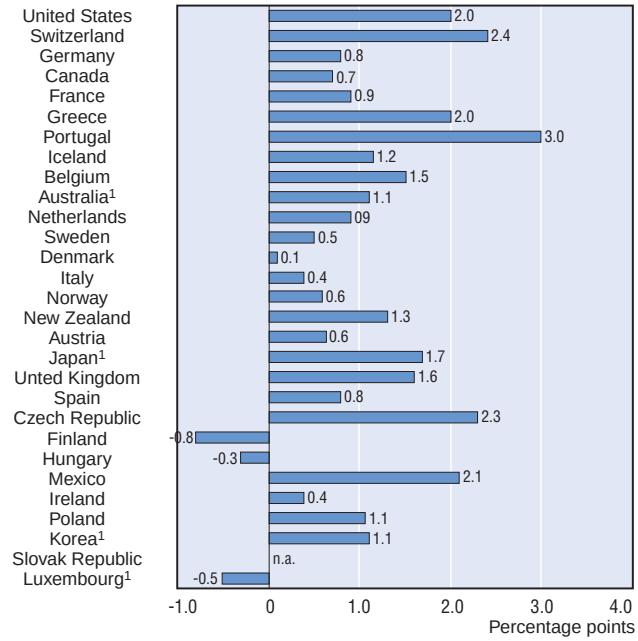


Chart 3.5. **Change in total health expenditure as a percentage of GDP, 1990-2001**



1. 2000.

Chart 3.6. **Health expenditure as a percentage of GDP in selected OECD counries, 1970-2001**

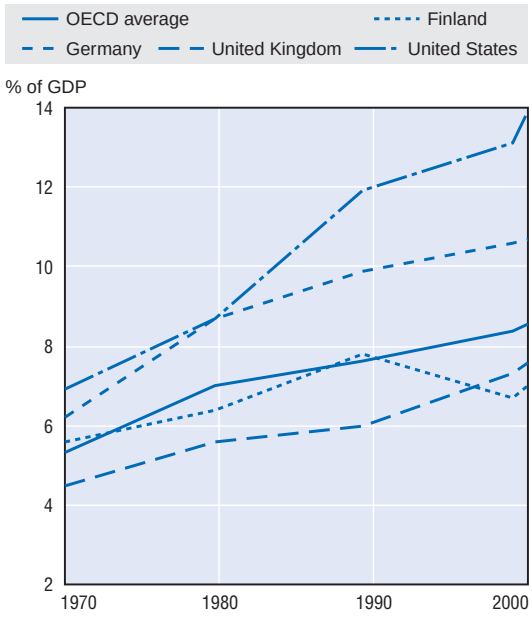
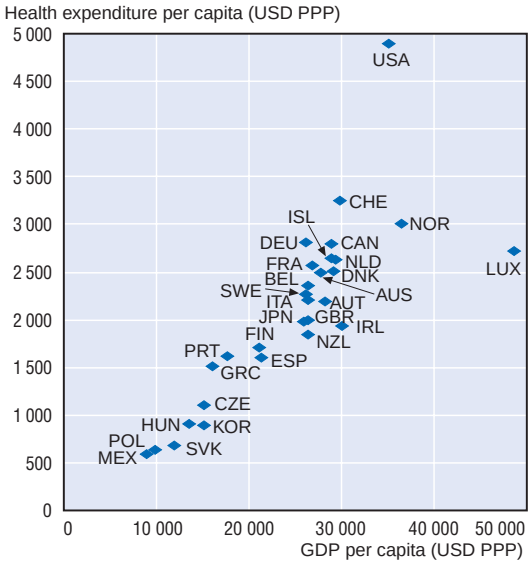


Chart 3.7. **Health expenditure and GDP per capita, 2001**



See notes to Table 3.2.
Source: OECD Health Data 2003.

© OECD 2003

Health expenditure per capita, growth trends

Rising health expenditure has been a cause of concern in most OECD countries for several decades. On average across OECD countries, the average annual growth rate in real health expenditure dropped from 6.2% in the 1970s, to 3.1% in the 1980s and to 3.3% in the 1990s and in the years 2000 and 2001 combined (Chart 3.8; Tables 3.4 and 3.6). Nonetheless, while spending growth slowed considerably over the past two decades, health spending continues to grow at rates exceeding overall economic growth in many OECD countries (see indicator "Health expenditure in relation to GDP").

In many countries, the past decade consisted of three different periods in terms of health expenditure growth rate. The first three years of the decade (1990-1992) saw considerably higher growth than during the mid-1990s. Health expenditure started to rise again rapidly in many countries at the end of the 1990s and in the early part of this decade, reflecting deliberate policies in some countries to relieve pressures arising from cost containment in previous years (Chart 3.9; Tables 3.4 and 3.5).

Overall OECD trends conceal the fact that countries were at different stages of development of their economies and health care systems at the beginning of the 1990s. Four different patterns in health expenditure growth among sub-groups of OECD countries during the 1990s can be distinguished (Chart 3.10 and Tables 3.6 and 3.7).

Several countries *(e.g.,* Korea, Ireland, Portugal) with lower income and lower health expenditure per capita in 1990 experienced high growth in health expenditure during the 1990s. As a result, they narrowed the gap with the OECD average. At the end of the 1990s, health expenditure per capita in these countries was 50-90% higher than in 1990. In most of them, the growth in public expenditure on health was even higher than the increase in total health expenditure, partly due to enhancement of the capacities of publicly financed health systems and partly due to an extension of public coverage.

Several high-income countries also experienced strong growth in health expenditure over the past decade. That was the case for Japan, Norway and the United Kingdom, both for total and public health expenditure, while the United States and Australia saw a strong rise particularly in public expenditure on health (AIHW, 2001; Cowan *et al*., 2001; Docteur and Oxley, 2003; Yutaka, 2002). At the end of the 1990s, health expenditure per capita in these countries was 40-50% higher than in 1990.

Some countries experienced moderate (below average) health expenditure growth during the past decade *(e.g.,* Switzerland, France, Germany). However, health expenditure still grew faster than the economy in these countries, resulting in an increase in the ratio of health spending to GDP. By the end of the 1990s, health expenditure per capita in this group of countries was 15-25% higher than in 1990.

Finally, several countries *(e.g.,* Finland, Hungary, Italy and Sweden) experienced very slow growth both in total and public expenditure on health during the 1990s, following the introduction of cost-containment measures (Häkkinen, 1999; Orosz and Burns, 2000; Anell and Svarvar, 1999). This resulted in a decrease in the ratio of health spending to GDP in Finland and Hungary, and a stabilisation of this ratio in Italy and Sweden. At the end of the 1990s, expenditure on health per capita in these countries was only 5-15% higher than in 1990.

Definition and deviations

See indicator "Health expenditure per capita" for definition of health expenditure. Growth rates are calculated in real terms (based on the 1995 GDP price index).

Average annual growth rate between 1989-1999 shows the (geometric) average of the annual growth indices calculated for the ten years: 1990, 1991, ... 1999. The calculation is made in the same way for the other decades.

© OECD 2003

Chart 3.8. **Real health expenditure per capita, 1970-2001**

Annual average growth rate

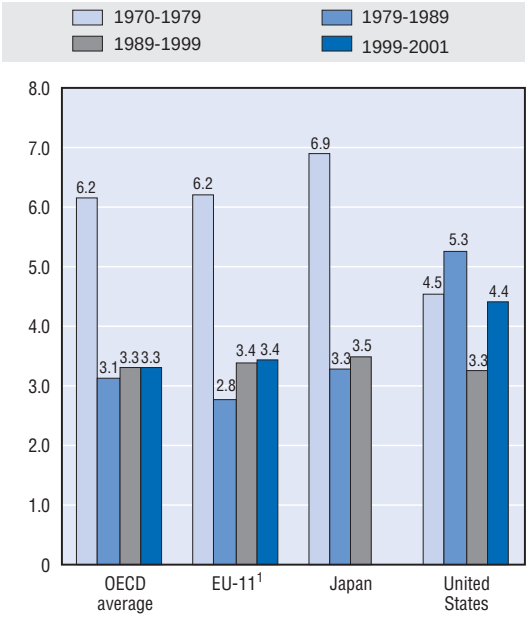
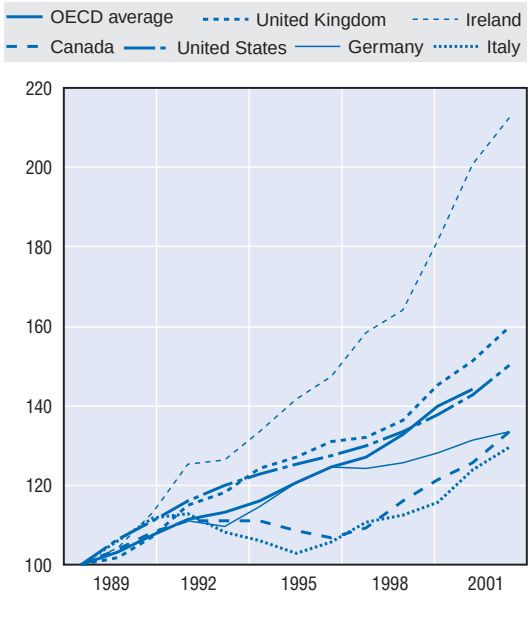


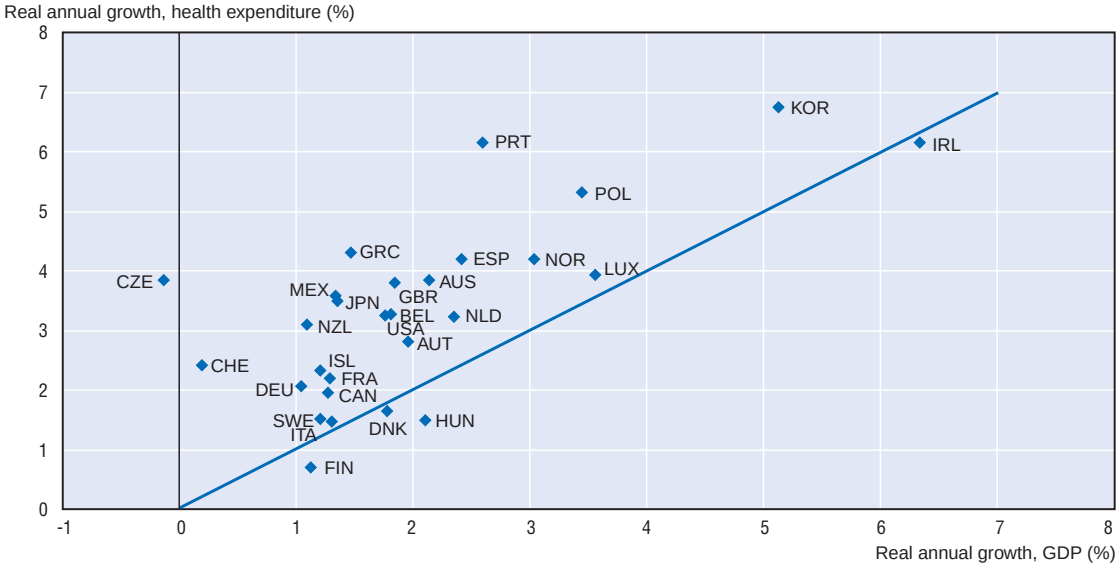
Chart 3.9. **Growth in real health expenditure per capita, 1989-2001**

(1989 = 100)



1. Excludes Belgium, France, Italy and the Netherlands.

Chart 3.10. **Increase in health expenditure per capita and GDP per capita in the 1990s**



See footnotes to Tables 3.4 and 3.6.
Source: OECD Health Data 2003.

© OECD 2003

Sources of financing for health care

Different methods of financing health care can affect the level of health expenditure, the distribution of its burden, and access to services across the population. Health care in all OECD countries is funded from a mix of public and private sources (Chart 3.11; Tables 3.8 and 3.9). Public third-party payment arrangements include expenditure from general government revenues and social contributions in countries with social insurance based funding *(e.g.,* France and Germany), and expenditure from government revenues in countries where central and/or local governments are responsible for financing health services *(e.g.,* Finland, United Kingdom). Private sources consist of out-of-pocket payments of households, third-party payment arrangements that might come in different forms of private health insurance (often funded by employers and subsidised by exemption from the calculation of taxable income by employees), employers' direct health benefits such as occupational health care, and other direct benefits provided by charities and the like.

Chart 3.11 presents countries by order of health expenditure per capita. There is no clear relationship between the level of spending and the share of public expenditure; the latter seems to be more influenced by health policies than by overall levels of health expenditure. However, with one or two exceptions, there is a tendency for the share of out-of-pocket spending to decline as health expenditure per capita rises.

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea (Chart 3.11 and Table 3.8). On average across OECD countries, the public share of health spending increased in the 1970s, but since 1980 it has stabilised and even slightly declined in the 1990s. The public share of health spending stood at 72% on average across OECD countries in 2001. It accounted for more than 80% of total health expenditure in several countries, including the Czech Republic, Denmark and the United Kingdom.

Chart 3.12 suggests that there has been a convergence in the share of public spending over the past three decades. Many countries which started with a relatively high public share in 1970 had a lower public share in 2001 *(e.g.,* the Czech Republic, Norway and the United Kingdom), while several countries which started with a low public share in 1970 have seen this share increase over time *(e.g.,* the United States, Greece and Portugal).

Focussing more closely on developments since 1990, the role of public funding has increased considerably in several lower-income countries which had a relatively low public share a decade ago *(e.g.,* Korea and Portugal). In the United States, the increase in the public share of health spending during the 1990s reflects increases in the level and coverage of Medicare and Medicaid benefits to meet more of the health needs of the elderly and poor, combined with a growth in the proportion of the population eligible for benefits (Docteur *et al*., 2003). In Spain and the Czech Republic, the growth of public spending was also quite strong during the 1990s, but the share of public spending nonetheless declined since it was outpaced by an even faster growth of private spending. While many higher-income OECD countries experienced a moderate decrease in the public share of health spending in the 1990s, there has been a considerable decline in a few countries *(e.g.,* Italy, Finland, Sweden, Hungary).

Private sources accounted for the remaining 28% of health spending on average across OECD countries in 2001. The size and composition of private funding differs considerably however across countries. In the United States, private insurance accounted for 35% of total health spending in 2000 (Table 3.9). Beside the United States, Canada, France, Germany and the Netherlands also have a relatively large share of funding coming from private insurance. The share of private insurance in other countries with available data did not reach 10% of total health expenditure.

The share of out-of-pocket payments was above 30% of total health expenditure in Switzerland, Korea and Mexico, while it was below 10% in the Czech Republic, Luxembourg and the Netherlands. In other countries, it varied between 10% and 30% of total health expenditure. The burden of out-of-pocket spending on households can be measured alternatively by its share of final household consumption (Table 3.10). In several countries, less than 2% of the total consumption of households was spent on out-of-pocket health services in 2000, while in Korea, Mexico and Switzerland, these spending represented more than 4% of total household consumption.

Definition and deviations

The term "sources of financing" can be used in two different ways: financing agents or final sources of funding. The data presented here refer to the first meaning. Financing agents are institutions and entities that pay for or purchase health care. They include institutions that pool health resources collected from different sources as well as entities (households and firms) that pay directly for health care from their own resources. *OECD Health Data* uses the following categories of sources of financing: 1) public expenditure, including general government revenues and social security funds; 2) private expenditure, including out-of-pocket payments of households, private insurance (with two subcategories: private social insurance and other private insurance) and all other private funds (including from non-governmental organisations and companies' funding of occupational health care).

© OECD 2003

Chart 3.11. **Health expenditure by source of funding, 2000**
Countries are ranked by per capita health expenditure

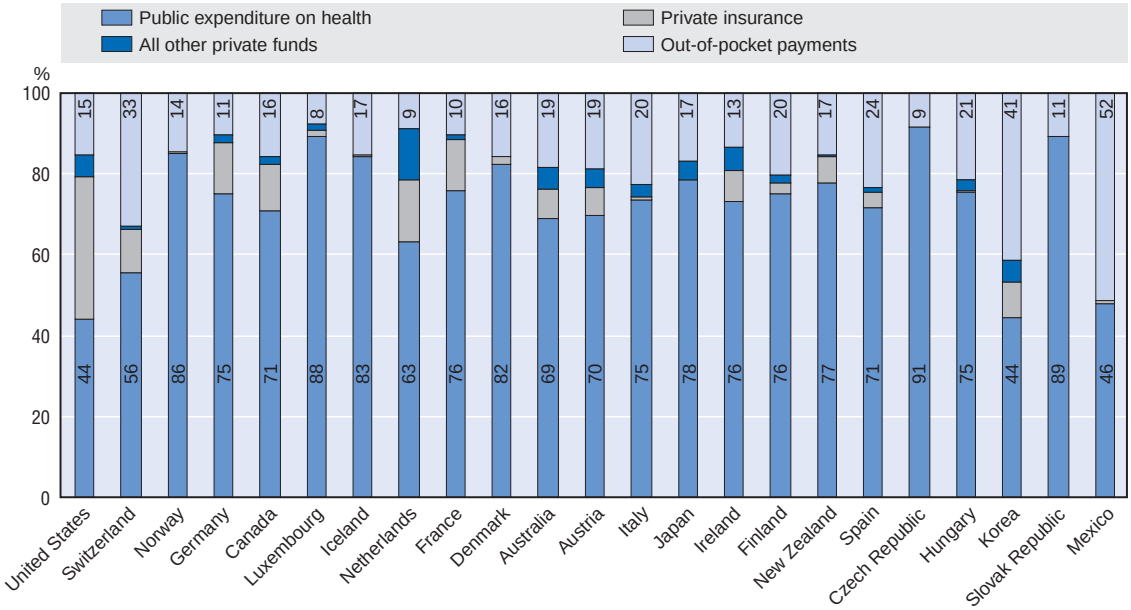
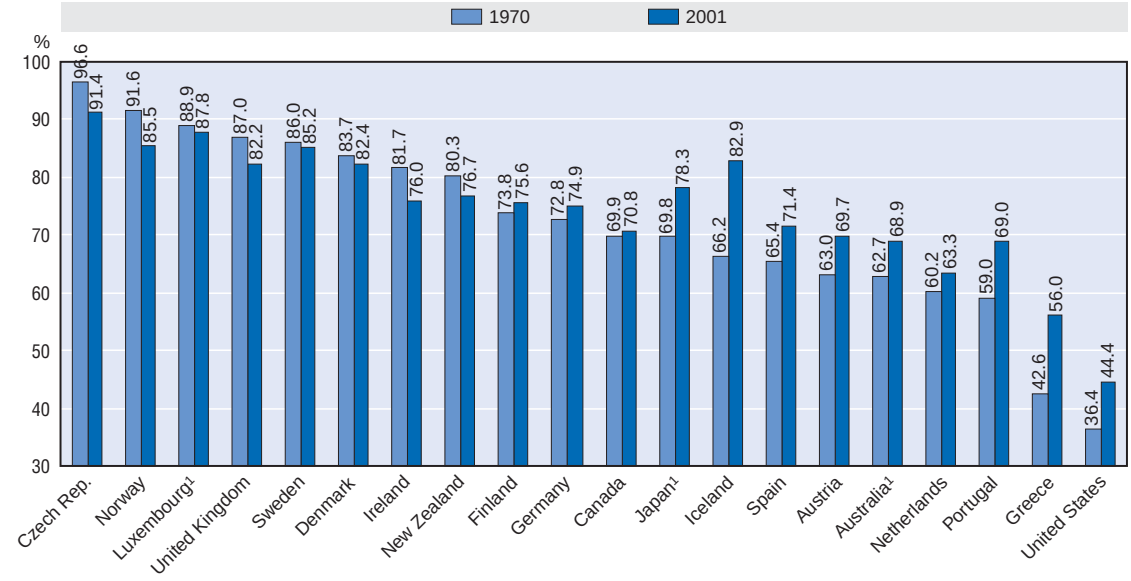


Chart 3.12. **Changes in the public share of health expenditure, 1970 and 2001**



1. 2000.
See footnotes to Tables 3.8 and 3.9.
Source: OECD Health Data 2003.

© OECD 2003

Pharmaceutical expenditure

Pharmaceutical products represent an important and growing share of health expenditure in most countries. The number of new drugs increased considerably during the past decade, and the movement towards new, more expensive products has been one of the main driving forces in increasing pharmaceutical expenditure, thereby contributing to the increase in overall health spending.

In 2001, pharmaceutical expenditure per capita on average across OECD countries was 340 USD PPP (Table 3.11). There are considerable differences in pharmaceutical spending across countries, reflecting differences in volume, structure of consumption and price level. The United States spends the most on pharmaceuticals, with expenditure per capita of 605 USD PPP in 2001. France, Italy, Canada and Germany followed the United States, with spending of more than 400 USD PPP per capita. The lowest spending countries were Korea and Mexico, with spending of 142 and 152 USD PPP per capita respectively (Chart 3.13).

Since 1990, pharmaceutical expenditure has increased in real terms in all OECD countries with available data, albeit at different rates (Chart 3.14). In Sweden and Australia, spending on pharmaceuticals doubled between 1990 and 2001. Pharmaceutical expenditure also increased very rapidly during that time in the United States, Canada, Finland and France. On average across OECD countries, the annual growth rate of pharmaceutical expenditure was 30% higher than that of total health expenditure during the 1990s and 20% higher at the beginning of this decade (Table 3.11). As a result, pharmaceutical expenditure has increased as a share of health spending in most OECD countries between 1990 and 2001 (Chart 3.15).

Lower-income OECD countries tend to spend a greater share of their health expenditure on pharmaceuticals, partly because pharmaceuticals have international market prices while labour costs are usually based on national wage structures. For example, Hungary and the Slovak Republic spent around 30% of total health expenditure on pharmaceuticals, while Denmark and the Netherlands spent only around 10%. The share of health expenditure spent on pharmaceuticals can also be very different in countries having similar health spending per capita. For example, Denmark spends 9% of total expenditure on pharmaceuticals while France spends 21%, although they have roughly the same health spending per capita (Chart 3.15).

Pharmaceutical expenditure tends to be funded from private sources to a greater extent that inpatient and outpatient services, because co-payments tend to be higher on pharmaceuticals and a considerable portion of pharmaceuticals is not covered under public insurance schemes (Table 3.12). On average across OECD countries, 59% of pharmaceutical expenditure was financed by the public sector in 2001 while the remaining 41% was paid from private sources (mainly out-of-pocket payments and private health insurance). The public share of pharmaceutical expenditure decreased in several countries during the 1990s *(e.g.,* Hungary, the Czech Republic, Italy). However, in some other countries *(e.g.,* Australia, Canada, Denmark and France), the proportion of public financing of pharmaceutical expenditure increased. While the public share also increased in the United States (to 19% in 2001), it remained one of the lowest among OECD countries.

Most OECD countries have been applying a mix of tools for controlling pharmaceutical expenditure over the past two decades. An increase in cost-sharing for pharmaceuticals has been a common feature. The number of drugs not reimbursed has increased, mainly for "comfort" drugs or those without proven therapeutic value. The degree of cost-sharing has been increased for many others. In a number of cases, flat-rate payments per prescription have been established. Reference price systems have also been introduced in several countries *(e.g.,* Germany, Denmark, the Netherlands). These arrangements increase cost-sharing for individuals using branded or higher cost products while assuring access to less costly generic drugs. Many OECD countries have increasingly used pharmacoeconomic assessments in order to improve decisions on reimbursement of new drugs and to inform price negotiations (Dickson *et al*., 2003).

Definition and deviations

Pharmaceutical expenditure includes expenditure on prescription medicines and self-medication, often referred to as over-the-counter products. It also includes pharmacists' remuneration when the latter is separate from the price of medicines. Pharmaceuticals consumed in hospitals are excluded. Final expenditure on pharmaceuticals includes wholesale and retail margins and value-added tax.

© OECD 2003

Chart 3.13. **Pharmaceutical expenditure per capita, 2001**
USD PPP

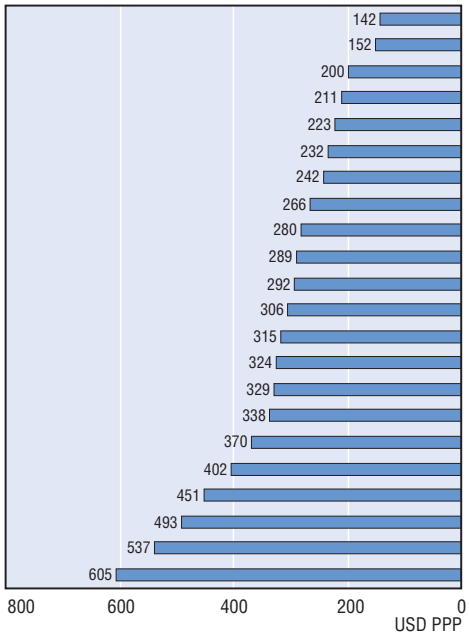
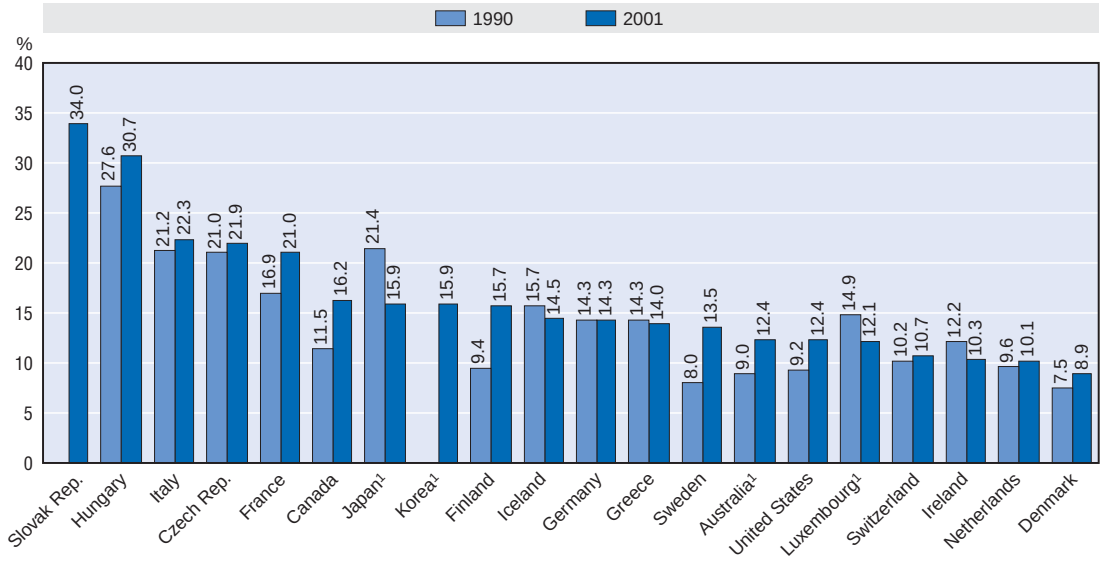


Chart 3.14. **Growth in pharmaceutical expenditure per capita, in real terms, 1990 to 2001**

1. 2000. 2. 1999.

Chart 3.15. **Pharmaceutical expenditure as a percentage of total health expenditure, 1990 and 2001**



1. 2000.
See footnotes to Tables 3.11 and 3.12.
Source: OECD Health Data 2003.

© OECD 2003

4. NON-MEDICAL DETERMINANTS OF HEALTH

© OECD 2003

Tobacco consumption

According to estimates by the World Health Organisation, cigarette smoking is directly responsible for 4.9 million deaths a year worldwide (WHO, 2002b). It is a major risk factor for at least two of the leading causes of premature mortality, cancers and circulatory diseases. In addition, it is a contributory factor for respiratory diseases, and the effect of smoking amongst pregnant women can lead to low birth weight and infant disease.

The proportion of daily smokers among the adult population has shown a marked decline over recent decades across most OECD countries, dropping on average from 36% in 1980 to 26% in 2000 (Table 4.1). Sweden, the United States, Canada and Australia have the lowest percentage of daily smokers, with 20% or less of adults reporting to smoke every day in these countries in 2000 (Chart 4.1). Greece reported the highest rate of 35%.

Smoking prevalence among men continues to be higher than among women in all countries except Sweden and Norway, but smoking rates have declined more rapidly among men than among women in most countries over the past twenty years. In 2000, the gender gap in smoking rates continued to be particularly large in Japan and Korea and, to a lesser extent, in Portugal and Greece (Chart 4.2). In Japan, smoking rates among men nonetheless decreased strongly over the past twenty-five years, from 76% in 1975 to 54% in 2000. The reduction in female smoking rates in Japan has been much more modest (Chart 4.3).

Historically, in the post-war period, most OECD countries have tended to follow a general pattern characterized at first by very high smoking rates among men (above 50%). This was the case for many OECD countries during the 1960s and 1970s, and remains the case for Japan and Korea today. This was generally followed, in the 1980s and the 1990s, by a marked downturn in tobacco consumption, particularly among 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 response to rising rates of tobacco-related diseases (World Bank, 1999).

Smoking prevalence among women has traditionally been much lower than among men, so the overall decline in recent decades was less pronounced. In a number of countries, smoking rates among women have been stable or even increased between 1980 and 2000 in the case of Finland, France, Norway and Spain. In 2000, smoking rates among women was the highest in Norway, Denmark, the Netherlands and Greece, with rates close to or above 30%.

Chart 4.4 shows the correlation between tobacco consumption (as measured by grams per capita) and incidence of lung cancer across OECD countries, using a 15-year time lag (a similar correlation is found using a 10-year or a 20-year time lag). Higher tobacco consumption at the national level is also generally associated with higher mortality rates from lung cancer 10 or 20 years later across OECD countries.

Definition and deviations

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

International comparability is limited due to the lack of standardisation in the measurement of smoking habits in health interview surveys across OECD countries. There remain some variations in the wording of questions, response categories and survey methodologies.

© OECD 2003

Chart 4.1. **Percentage of adult population smoking daily, 2000**

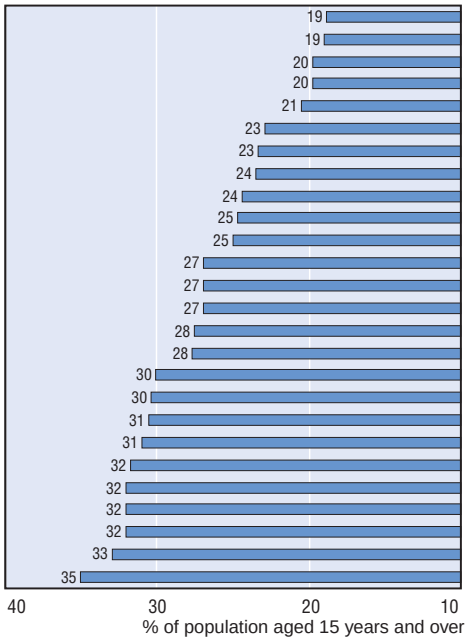
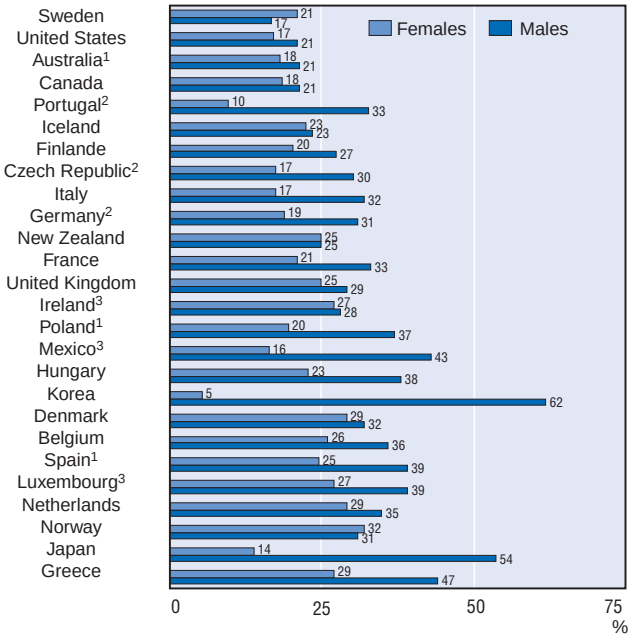


Chart 4.2. **Percentage of females and males smoking daily, 2000**



1. 2001. 2. 1999. 3. 1998.

Chart 4.3. **Trends in daily smoking, females and males, 1975 to 2000**

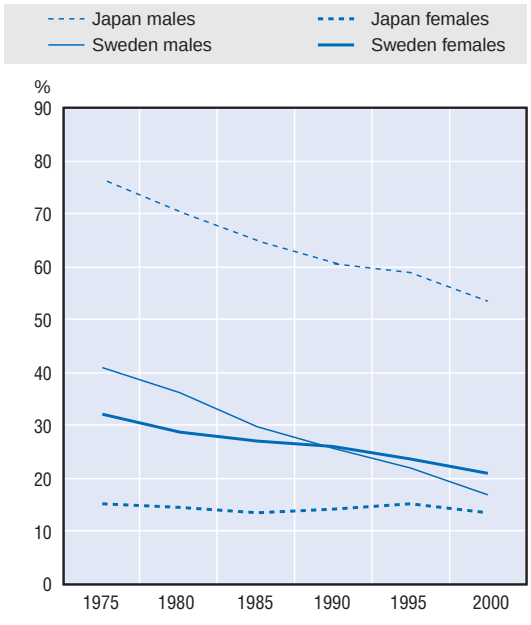
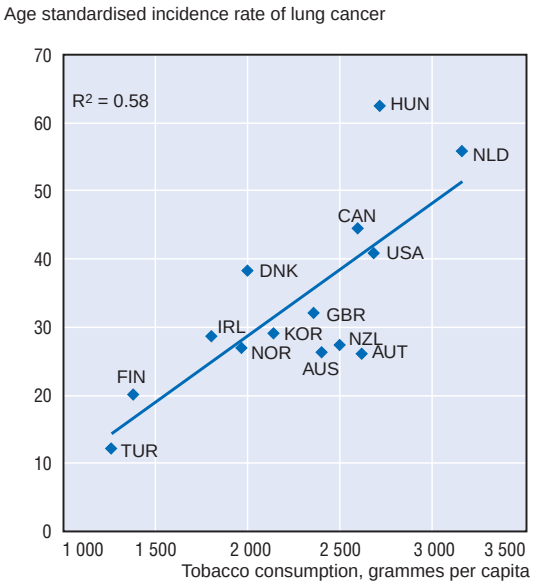


Chart 4.4. **Tobacco consumption, 1985, and incidence of lung cancer, 2000**



See footnotes to Table 4.1.
Source: OECD Health Data 2003.

© OECD 2003

Alcohol consumption

Excessive alcohol consumption is an important cause of loss of healthy life (Ezzati *et al.*, 2002). It can be responsible for many health problems, including damages to the nervous system and liver diseases. Furthermore, alcohol can also be a contributory factor in a range of other causes of death, such as road accidents, violence and suicides.

Alcohol consumption, as measured by annual sales, stood on average across OECD countries at 9.6 litres per adult in 2000 (Table 4.2). There are a lot of variations however in alcohol consumption across countries. Leaving aside Luxembourg (given that total sales in this country might over-estimate by a wide margin the actual consumption by residents due to purchases by non-residents), Ireland, Portugal and Hungary reported the highest consumption of alcohol, with more than 12 litres per adult per year in 2000. At the other end of the scale, Turkey, Mexico and some of the Nordic countries (Norway, Iceland and Sweden) reported relatively low levels of alcohol consumption, ranging from 1.5 to 6.2 litres per capita (Chart 4.5).

Alcohol consumption rose in many countries through the 1960s and the 1970s, to reach a peak of 12 litres per adult on average across OECD countries at the end of the 1970s (Chart 4.7). Since then, average consumption has gradually fallen. There has been a degree of convergence in drinking habits across the OECD, with wine consumption increasing in many traditional beer-drinking countries and *vice versa*. The traditional wine-producing countries of Italy and France have seen their overall alcohol consumption drop substantially since 1970 (Chart 4.6). Norway, Finland and Sweden have all seen consumption remain relatively low over the period. On the other hand, alcohol consumption in Ireland rose by 60% between 1970 and 2000.

Variations in alcohol consumption across countries and over time reflect not only traditional drinking habits but also the policy responses to control the use of alcohol. Curbs on advertising, sales restrictions and taxation have all proven to be effective measures to reduce alcohol consumption (Bennett, 2003). Strict controls on sales and high taxation are mirrored by overall lower consumption in most Nordic countries, whilst falls in consumption in France, Italy and Spain have been correlated with the introduction of tighter control measures, particularly with regard to advertising.

Chart 4.8 shows the relationship between alcohol consumption and deaths from liver cirrhosis, using a 10-year time lag. In general, countries with high levels of alcohol consumption tend to experience higher death rates from liver cirrhosis than countries with lower levels of consumption. On average across OECD countries, death rates from liver cirrhosis over the past 20 years have also come down, following quite closely the overall reduction in alcohol consumption.

Definition and deviations

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 (*e.g.* Luxembourg), national sales do not reflect accurately actual consumption by residents, as purchases by non-residents may create a significant gap between national sales and consumption.

© OECD 2003

Chart 4.5. **Alcohol consumption in litres per capita, population 15 years and over, 2000**

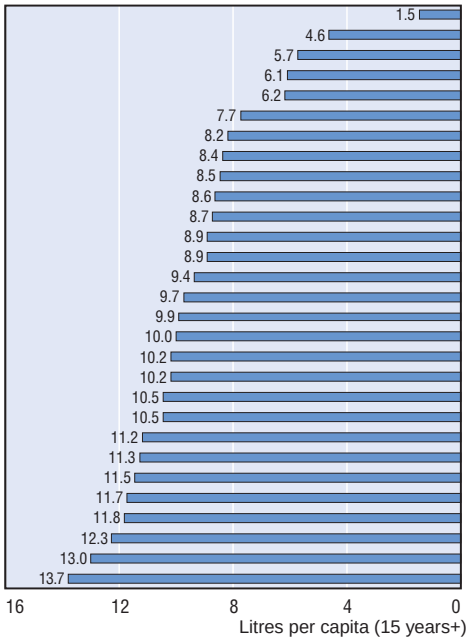
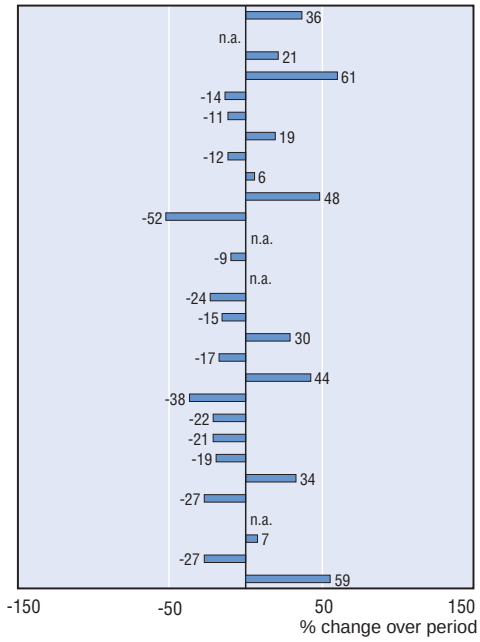


Chart 4.6. **Change in alcohol consumption per capita, 15 years and over, 1970 to 2000**



1. 1999.

Chart 4.7. **Trends in alcohol consumption, 1970 to 2000**

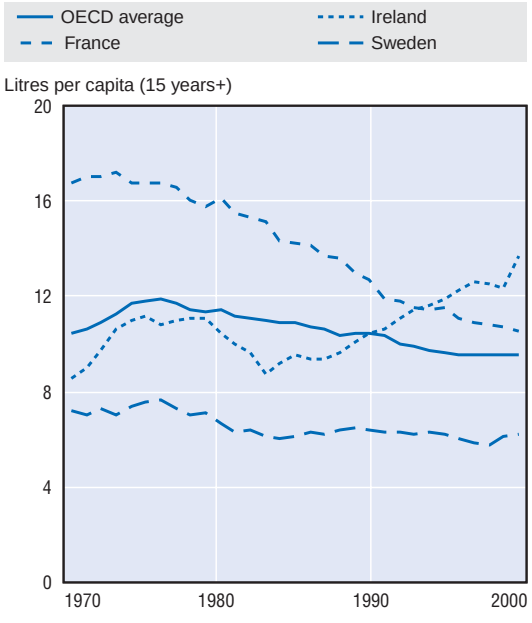
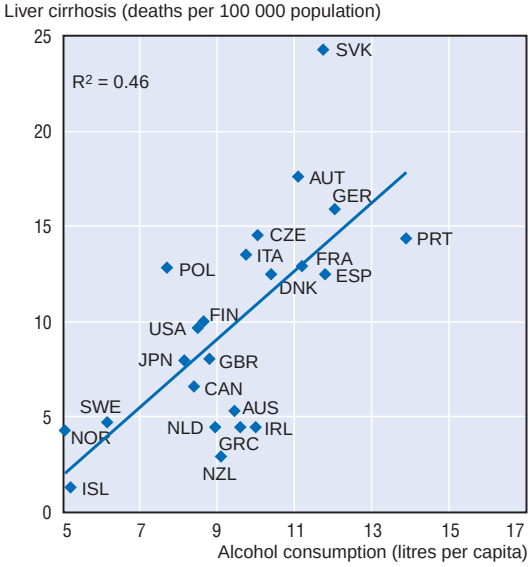


Chart 4.8. **Liver cirrhosis deaths in 2000 and alcohol consumption, 1990**



See footnotes to Table 4.2.
Source: OECD Health Data 2003.

© OECD 2003

Body weight (obesity)

Obesity rates have increased over the past two decades in all OECD countries for which trend data is available (Chart 4.11). Obesity is a known risk factor for several diseases such as diabetes, hypertension, cardiovascular diseases, respiratory problems (asthma) and musculoskeletal diseases (arthritis). At an individual level, several factors can lead to obesity, including excessive calorie consumption, lack of physical activity, genetic predisposition and disorders of the endocrine system. At a population-wide level, assuming genetic stability in populations, the rise in obesity can be attributed mainly to behavioral and environmental factors leading to over-consumption of calories and lack of physical activity.

Although problems of obesity have increased in all OECD countries, there continue to be marked differences in the prevalence of obesity among adults across countries (Charts 4.9 and 4.10, and Table 4.3). The prevalence of obesity varies from a low of 3% in Korea and Japan in 2001, to a high of 31% in the United States in 1999 (Chart 4.9). It should be noted however that this high estimate for the United States is based on health examinations whereby people's height and weight are measured (this is also the case for Australia and the United Kingdom), while data from other countries are based on self-reported information. Obesity rates arising from health examinations are generally higher and more reliable than those coming from self-reports in health interviews, since they preclude any misreporting. For the United States, the adult obesity rate based on face-to-face interviews was 22% in 1999 (compared with 31% in that same year based on examinations), while the interview-based obesity rate in Australia was 18% in 2001 (compared with 21% in 1999 based on examinations).

Based on consistent measures of obesity over time (health examinations in the case of these three countries), the rate of obesity has more than doubled over the past twenty years in Australia and the United States, while it has tripled in the United Kingdom. As a result, more than 20% of the adult population in Australia and the United Kingdom are now defined as obese, the same rate as in the United States in the early 1990s (Chart 4.11). The obesity rate in Nordic countries and Continental European countries have also increased substantially over the past decade, but they remain much lower than in English-speaking countries (even when differences in measurement methods are taken into account).

In slightly more than half of OECD countries, obesity is more common among women than men (Chart 4.10). Evidence from national studies indicates that obesity problems tend to be more common among individuals in lower socio-economic groups compared to people with higher levels of education or income. In most countries, the prevalence of overweight and obesity tends to increase until age 60 to 65, after which it starts to come down.

The economic and non-economic consequences of obesity are large. In the United States, a recent study looked at the relative consequences of obesity on various medical problems (such as diabetes and asthma) and related costs, in comparison with other risk factors such as smoking and alcohol consumption (Sturm, 2002). The study found that obesity has the same association with chronic health conditions as does 20 years of ageing, greatly exceeding the association of smoking or excessive drinking for those conditions studied. It was also estimated that obesity is associated with a higher average health cost increase per year, compared with the cost related to smoking. The time lag between the onset of obesity and increases in chronic disease occurrence suggest that the large increase in obesity that has occurred in the United States and several other countries since 1980 will have substantial implications for future incidence of health problems and related spending.

The prevention and treatment of obesity involves encouraging people to alter their eating habits and to be more physically active. Although this seems straightforward, the trend rise in obesity rates across virtually all OECD countries suggests that the behavioral and environmental barriers to achieving these changes will be difficult to overcome.

Definition and deviations

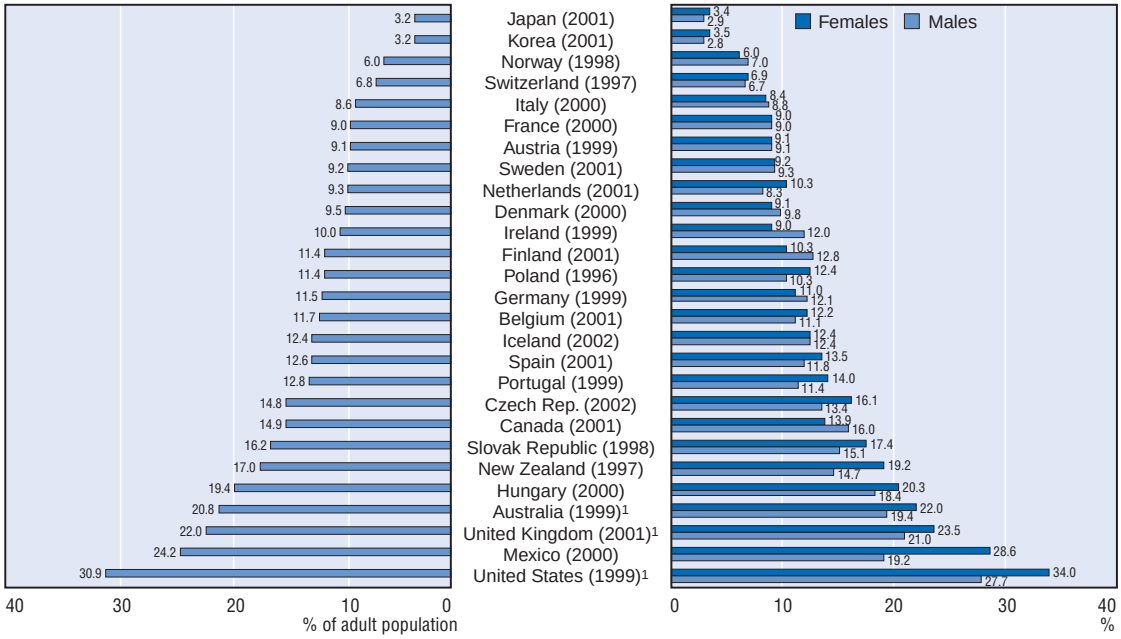
The Body Mass Index (BMI) is a single number that evaluates an individual's weight status in relation to height (weight/height^2, with weight in kilograms and height in metres). Based on the WHO classification (WHO, 1997), individuals with a BMI over 30 are defined as obese.

For most countries, data on obesity are self-reported through population-based health interview surveys. The exceptions are Australia, the United Kingdom and the United States, where the data come from health examinations whereby actual measures are taken of people's height and weight. These differences in data collection methodologies across countries limit data comparability. Estimates arising from health examinations are generally higher and more reliable than those coming from health interviews (because they preclude any misreporting), but health examination surveys are only conducted regularly in a few countries.

© OECD 2003

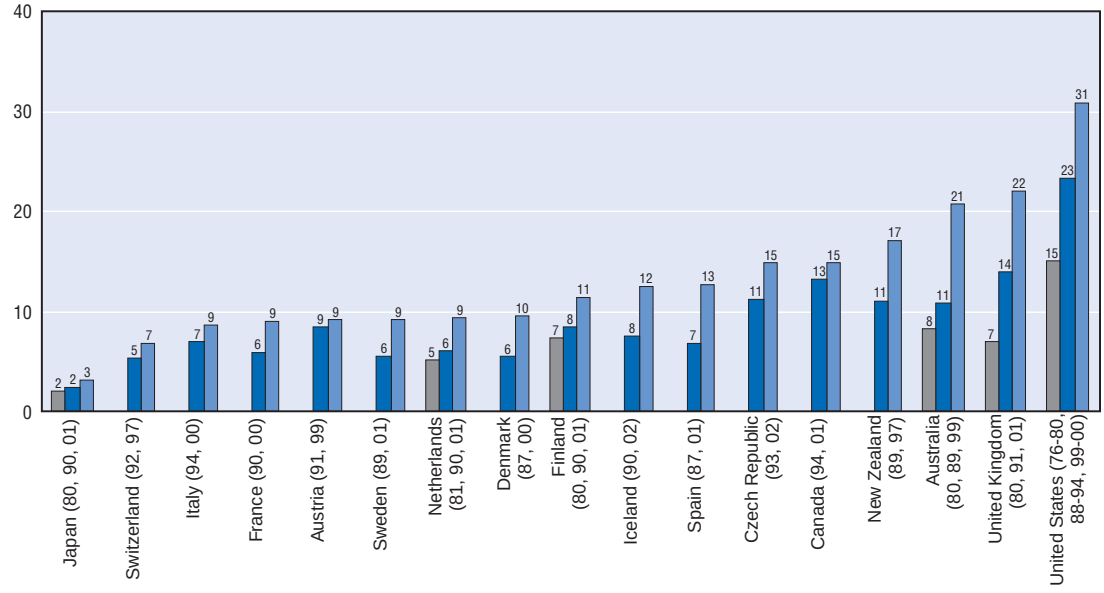
Chart 4.9. **Percentage of adult population aged 15 years and over with Body Mass Index over 30 (obese population)**
Latest year available

Chart 4.10. **Percentage of females and males aged 15 years and over with a Body Mass Index over 30 (obese population)**
Latest year available



1. For Australia, the United Kingdom and the United States, figures are based on health examination surveys, rather than health interview surveys.

Chart 4.11. **Increasing obesity rates among the adult population in OECD countries**



See footnotes to Table 4.3.
Source: OECD Health Data 2003.

© OECD 2003

5. DEMOGRAPHIC AND ECONOMIC CONTEXT

© OECD 2003

Total population

The total population of the 30 OECD countries has increased in the past forty years from just over 750 million people in 1960 to more than 1.1 billion in 2001. The United States remains by far the largest country in the OECD, in terms of population, with close to 285 million people, followed by Japan, Mexico and Germany. At the other end of the scale, Iceland and Luxembourg are the smallest countries in terms of population, each with less than half a million people (Chart 5.1 and Table 5.1).

The increase in OECD population was most pronounced between 1960 and 1970, with the total population rising by 1.3% on average per year, due to high fertility rates and falling mortality rates. Population growth has slowed significantly in the past two decades in many OECD countries, as fertility rates declined (see indicator "Fertility rates"). In the latter half of the 1990s, population growth on average across OECD countries was around 0.7% per year (Chart 5.4), almost half the rate observed in the 1960s.

There have been large variations across countries in population growth over the past decades (Charts 5.2). Mexico and Turkey experienced the highest population growth among OECD countries since 1960, with the population in these two countries more than doubling over this period. The strong population growth in these two countries has been driven by very high fertility rates combined with rapidly declining mortality rates. As fertility rates in Mexico and Turkey gradually came down closer to the OECD average over time, population growth also steadily decreased. Population growth in Australia, Canada, New Zealand and the United States has also been relatively strong over the past four decades, in part through natural increase but also through net migration to these countries.

By contrast, in some Central and Eastern European countries, rapidly falling fertility rates together with high mortality rates have resulted in low population growth over the past few decades. In Hungary, the population in 2000 was more or less the same as it was forty years ago (Chart 5.3).

Definition and deviations

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

Population figures for Germany represent West Germany prior to 1991.

© OECD 2003

Chart 5.1. **Total population in millions, 2001**

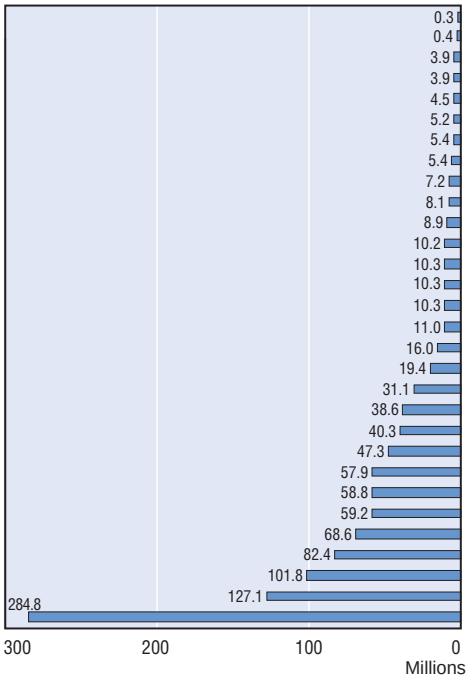


Chart 5.2. **Population change, 1960 to 2001**

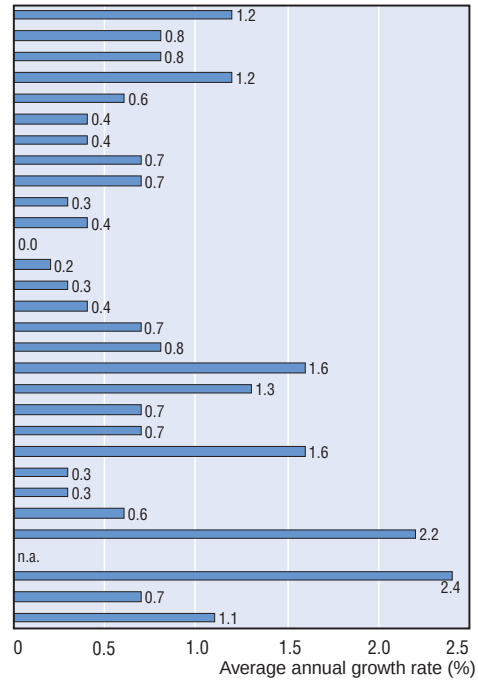


Chart 5.3. **Trends in population growth, 1960 to 2001 (1960 = 100)**

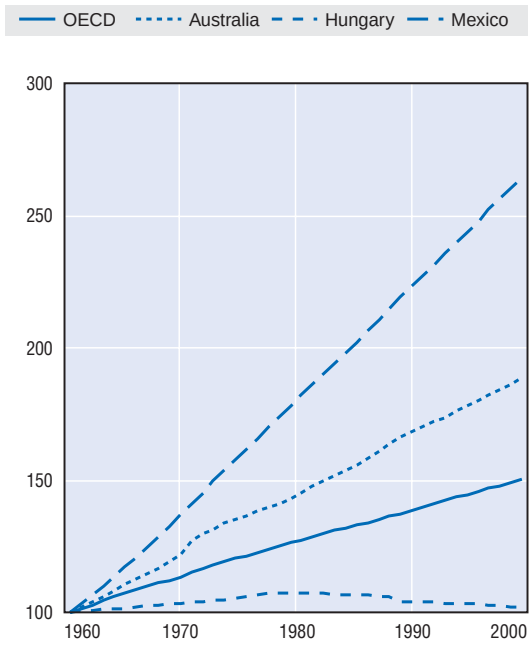
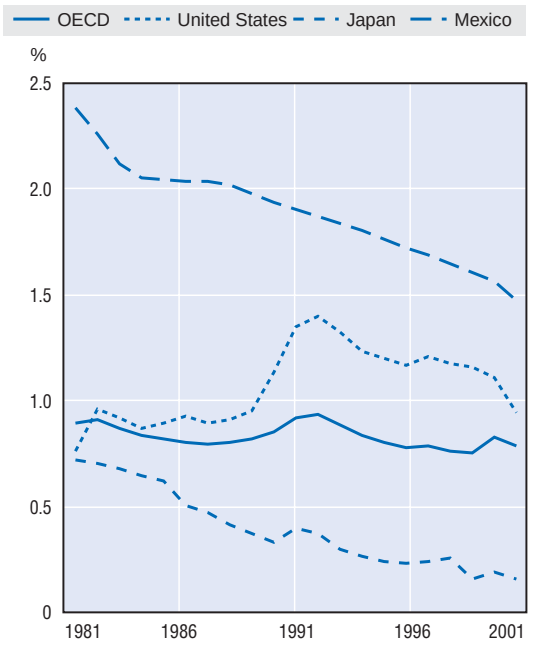


Chart 5.4. **Annual rate of population growth, 1981 to 2001**



Source: OECD Health Data 2003.

© OECD 2003

Share of the population aged 65 and over

The remarkable gains in life expectancy together with declines in fertility are translating into ageing populations throughout most OECD countries. The trend towards an older population has important implications on current and future demand for health and long-term care services.

In 1960, the population aged 65 and over accounted for 8.7% of the population on average across OECD countries. Forty years later, this percentage had increased to 13.7%. Similarly, the percentage of the population over 80 years of age has more than doubled between 1960 and 2000, from 1.3% to 3.1% (Charts 5.5 and 5.8; Table 5.2).

Japan has witnessed the greatest rise in the share of its older population over the past four decades. In 1960, people aged 65 and over accounted for only 5.7% of the Japanese population, at the time one of the lowest proportions amongst OECD countries. By 2000, the proportion of the Japanese population over 65 had increased three-fold, to 17.4%, amongst the highest of all OECD countries (only Italy had a greater share of the population aged over 65 in 2000). The rapid rise in the proportion of elderly people in Japan is due to rapid increases in life expectancy and a dramatic fall in fertility. By the end of the 1990s, for the first time in its history, Japan had a greater proportion of its population over 65 than aged under 15. But Japan is not unique in this regard. A number of European countries (Italy, Germany, Greece and Spain) also have now a higher number of elderly people than children under 15 years.

At the other end of the scale, Mexico has the lowest proportion of people over 65 years of age, with 4.6% in 2000. The percentage of people over 65 years in Mexico has been relatively stable over the past four decades (Chart 5.7), mainly as a result of high birth rates prior to the 1990s. Turkey and Korea are the only other OECD countries with a share of the elderly population of less than 10%.

An increasing proportion of people over 65 might be expected to exert upward pressures on health care costs. There is widespread uncertainty however about the precise effect of population ageing upon future costs. In general, older persons tend to consume more health care services than do younger age groups. But there is evidence that a high proportion of this age-related health expenditure is concentrated in the final year of life, rather than spread over all years of life after age 65 (Felder *et al.*, 2000; and Serup-Hansen *et al.*, 2002). To the extent that life expectancy among the elderly population continues to improve over time, this might help therefore to postpone pressures on health care expenditures arising from population ageing.

Definition and deviations

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

© OECD 2003

Chart 5.5. **Share of the population aged 65 and over, 2000**

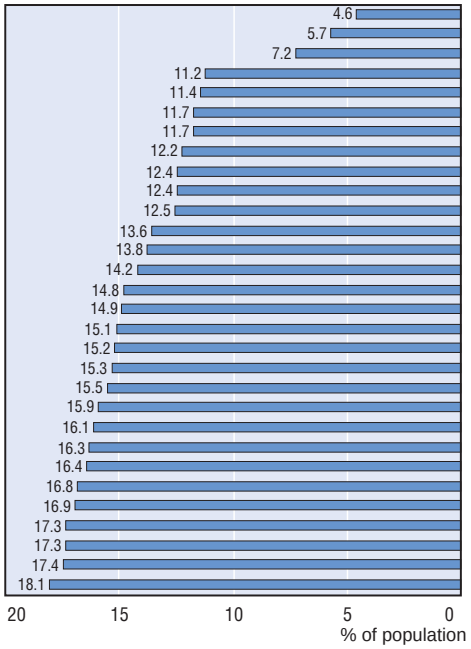


Chart 5.6. **Change in share of the population aged 65 and over, 1960 to 2000**

Chart 5.7. **Trends in the share of the population aged 65 and over, 1960 to 2000**

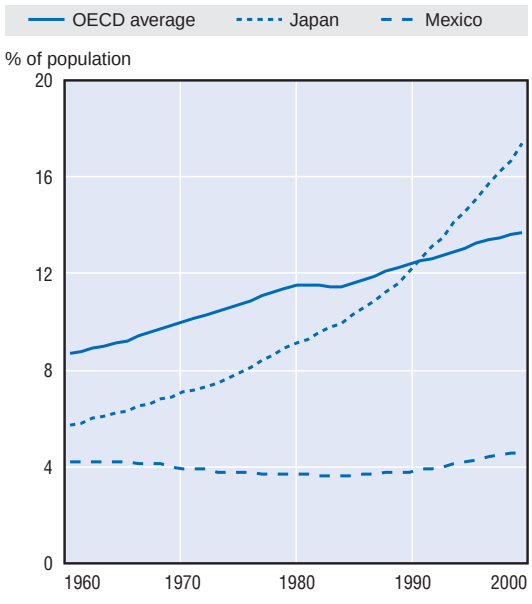
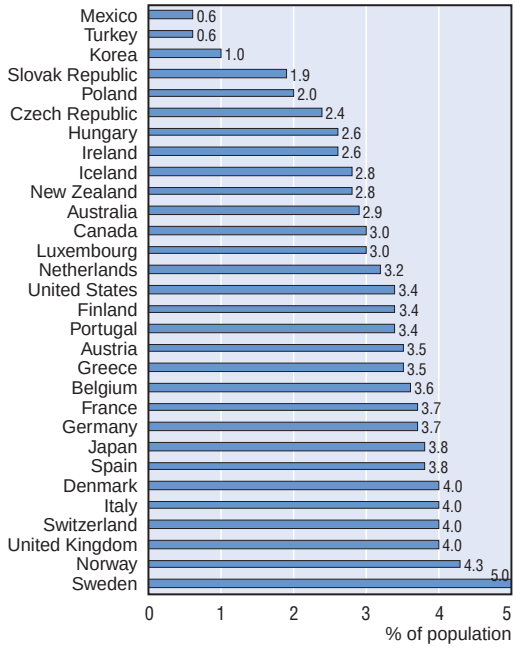


Chart 5.8. **Share of the population aged 80 and over, 2000**



Source: OECD Health Data 2003.

© OECD 2003

Fertility rates

The natural change of a nation's population is dependent on two factors – fertility and mortality. Common throughout the OECD has been a general decrease in fertility rates, with falls below the "replacement levels" in some countries raising concerns over both an ageing and a shrinking population.

Across OECD countries, the fertility rate for women aged 15-49 has been on a steady decline since the post-war baby boom of the 1950s and early 1960s, in part due to the diffusion of modern contraceptive methods. From an average of 3.2 children per woman of childbearing age in 1960, the rate has halved to 1.6 children in 2000 (Table 5.4). Only Turkey, Mexico, Iceland and the United States continue to show fertility rates at, or above, the "replacement level" of 2.1 children (Chart 5.9), the level needed to maintain population levels without immigration. While fertility rates in Turkey and Mexico continue to be the highest among OECD countries, they have declined rapidly from their rates of a few decades ago. In Korea and Spain also, fertility rates have come also down dramatically over the past thirty years (Charts 5.10 and 5.11).

In 2000, fertility rates among OECD countries were the lowest in Southern Europe (Spain, Italy, Greece), in Central and Eastern European countries (the Czech Republic, the Slovak Republic, Hungary and Poland) as well as in Austria and Germany, with rates of 1.4 children per woman of childbearing age or less. In the Czech Republic, Hungary, Poland and the Slovak Republic, fertility rates fell by 30 to 40% between 1990 and 2000, coinciding with the economic, social and political changes in these countries (UN/ECE, 2000).

Beyond the availability of modern contraceptive methods, one of the many factors influencing fertility rates is the economic situation and outlook that households are facing at any given time, with rates tending to fall in times of economic hardship or uncertainty. Another factor driving fertility rates down has been the movement towards late motherhood. The decisions to have a child might also be influenced to a certain extent by family-friendly policies, such as the level of child allowance, the provision of sufficient public childcare and the availability of part-time jobs (OECD, 2003d; Del Boca, 2002). A reversal in the downward trend in fertility rates has been observed in some OECD countries. An increase in fertility rates occurred in Denmark, Norway and the United States in the 1980s and more recently in France in the latter half of the 1990s (Chart 5.12).

Definition and deviations

The fertility rate is the average number of children a woman can be expected to bear over the course of her childbearing years if current age-specific fertility rates between the ages of 15 and 49 remained constant. The current fertility rate is usually taken as an indication of the number of children women are having at the present.

© OECD 2003

Chart 5.9. **Fertility rates, children per woman aged 15-49, 2000**

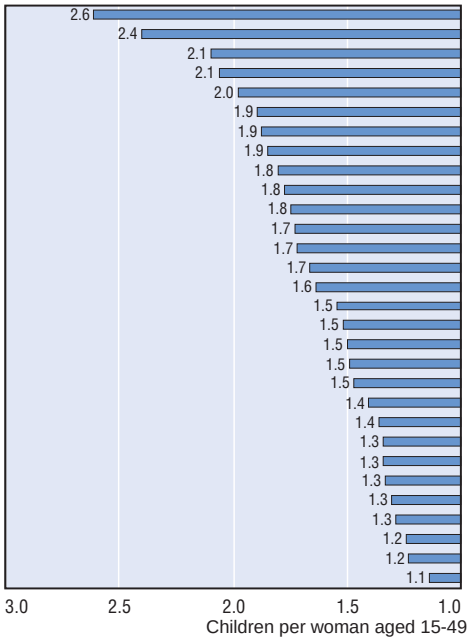


Chart 5.10. **Average annual change in fertility rate, 1970 to 2000**

1. 1998.

Chart 5.11. **Decline in fertility rates, 1970 to 2000**

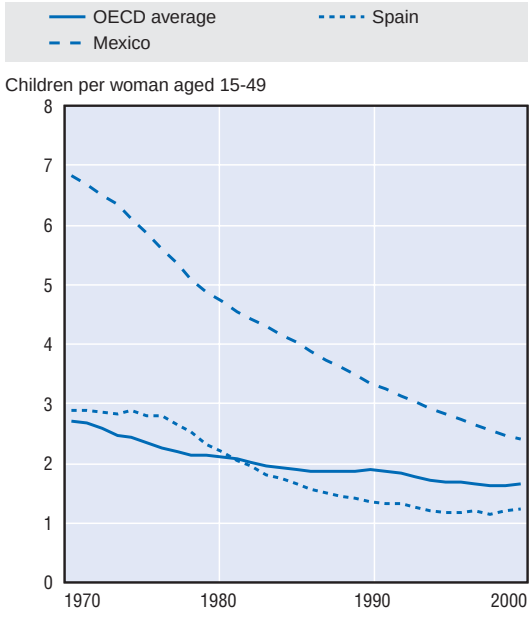
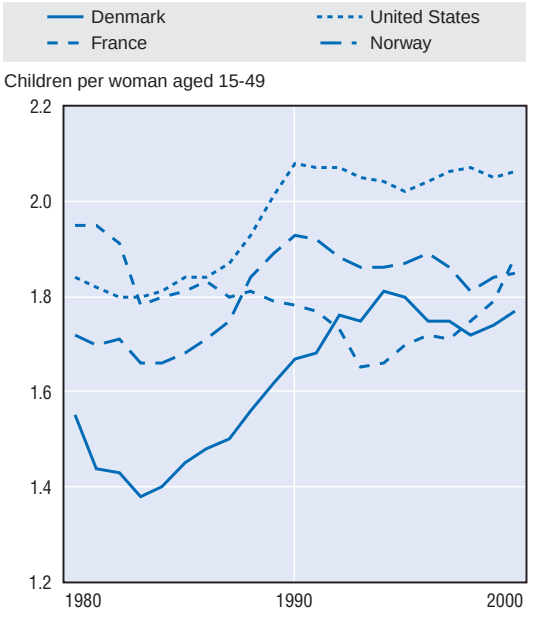


Chart 5.12. **Reversing the decline in fertility rates, 1980 to 2000**



See footnotes to Table 5.4.
Source: OECD Health Data 2003.

© OECD 2003

Gross domestic product (GDP)

GDP per capita is one of the main indicators of economic development and of the resources available to a country and its inhabitants. Since it is an average, it does not however measure the distribution of income across the population.

There is considerable variation in GDP per capita among OECD countries. In Turkey, Mexico and Poland, GDP per capita was under 10 000 USD PPP (adjusted for purchasing power parities) in 2001. It was somewhat higher, between 12 000-15 000 USD PPP, in the Czech Republic, Hungary and the Slovak Republic. Most other European countries, and Australia, Canada, Japan and New Zealand, had GDP per capita ranging between 20 000-30 000 USD PPP. The wealthiest countries in the OECD are Luxembourg, Norway and the United States, with GDP per capita over 35 000 USD PPP in 2001 (Chart 5.13 and Table 5.5).

Over the past decade, real GDP per capita increased in all OECD countries, although growth rates varied substantially. Ireland registered the highest growth rate in GDP per capita since 1990, with an average of more than 6% per year in real terms. GDP per capita in Korea also grew rapidly during that period, by more than 5% per year on average. On the other hand, GDP per capita in the Czech Republic and Switzerland grew by less than 1% on average per year between 1990 and 2001 (Chart 5.14).

Higher GDP per capita tends to be associated with higher life expectancy, although this association becomes less pronounced as countries reach a certain income level (Chart 5.15).

Looking beyond average GDP per capita, the distribution of the national income might also affect the health status of a country's population. Some analysts have reported evidence of a correlation between life expectancy *across* countries with income inequalities *within* countries, with life expectancy being higher in those countries with less income inequalities (Wilkinson, 1996, 2000). An OECD study of income distribution among 19 countries found that, in the mid-1990s, income inequality was the lowest in the Nordic countries, while it was the highest in Mexico and Turkey, the two countries with the lowest income per capita (Forster, 2000). In terms of trends over time, this study found that the distribution of income widened in several countries between the mid-1980s and the mid-1990s, but it decreased marginally in Denmark, Ireland and Sweden (Chart 5.16).

Definition and deviations

There are three different approaches to measuring GDP: 1) to sum up all the value added by resident producers; 2) to take the sum of income on labour and capital; or 3) to add up all domestic expenditure plus exports, less imports of goods and services. The data presented here are based on the third approach (expenditure-based) (OECD, 2000b).

Comparisons of GDP across countries are best based on purchasing power parities (PPP), not simply on market exchange rates. Purchasing power parities reflect the amount of a national currency that will buy the same basket of goods and services in a given country as the US dollar in the United States. Because the cost of living is often lower in poorer countries, calculating income per capita using PPPs generally reduces the difference between the richest and the poorest countries in the OECD. Real GDP is defined as nominal GDP deflated by GDP prices (1995 levels).

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% 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.

© OECD 2003

Chart 5.13. **GDP per capita, 2001**
USD PPP

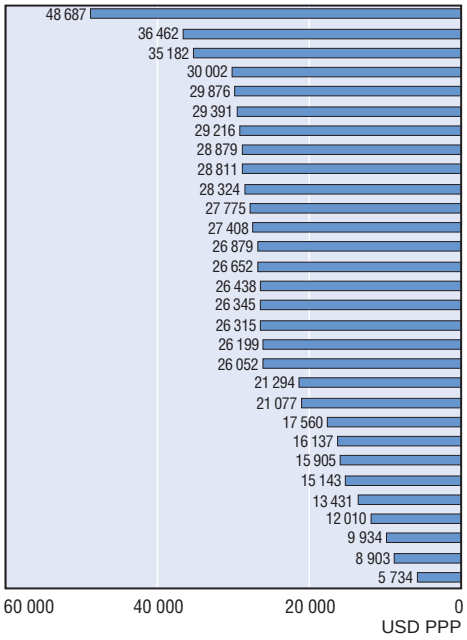


Chart 5.14. **Real GDP per capita, 1989 to 2001**

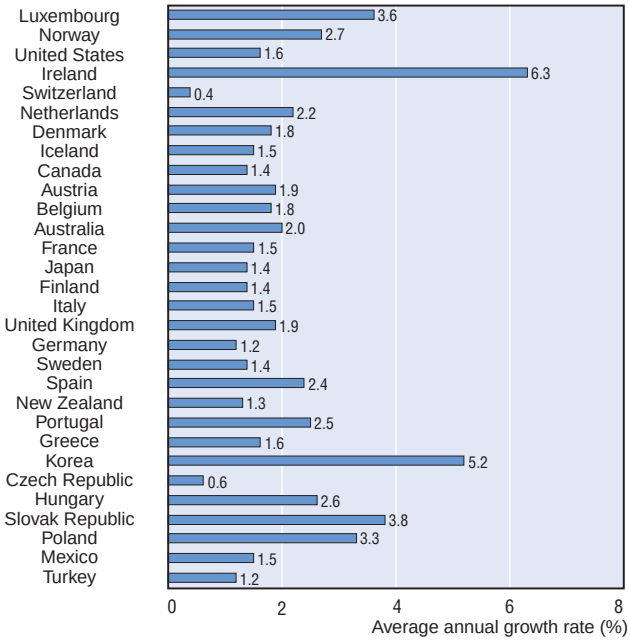
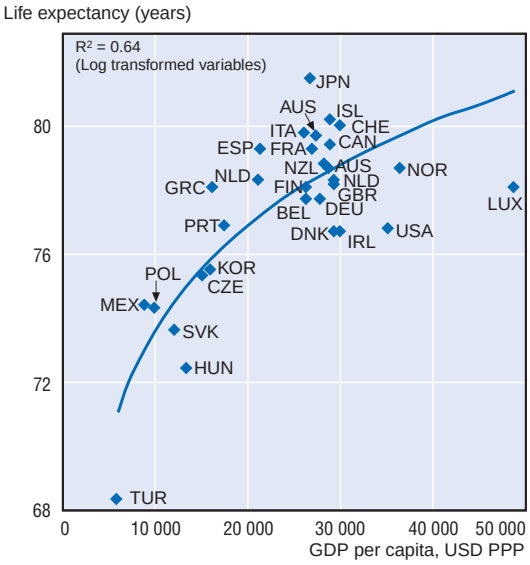
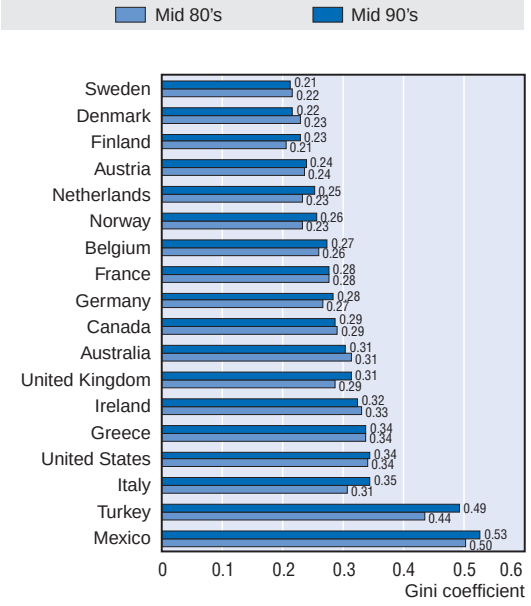


Chart 5.15. **GDP per capita and life expectancy at birth, 2000**



See footnotes to Table 5.5.
Source: *OECD Health Data 2003.*

Chart 5.16. **Trends in income inequality, mid-1980s to mid-1990s**



Source: Forster (2000).

© OECD 2003

Annex 1

ANNEX TABLES

© OECD 2003

Table 1.1. **Life expectancy at birth, total population, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	70.9	70.8	74.6	77.0	79.3
Austria	68.7	70.0	72.6	75.7	78.3
Belgium	70.6	71.0	73.4	76.1	77.7
Canada	71.4 (1961)	72.9 (1971)	75.3	77.6	79.4
Czech Republic	70.7	69.6	70.3	71.5	75.1
Denmark	72.4	73.3	74.3	74.9	76.9
Finland	69.0	70.8	73.4	74.9	77.6
France	70.3	72.2	74.3	76.9	79.0
Germany	69.6	70.4	72.9	75.2	77.7 (1999)
Greece	69.9	72.0	74.5	77.1	78.1 (1999)
Hungary	68.0	69.2	69.1	69.4	71.5
Iceland	72.9	74.3	76.7	78.0	79.7
Ireland	70.0	71.2	72.9	74.9	76.7
Italy	69.8 (1961)	72.0 (1971)	74.0	76.9	79.4
Japan	67.8	72.0	76.1	78.9	81.2
Korea	52.4	62.6 (1971)	65.4 (1979)	71.0 (1989)	75.5 (1999)
Luxembourg	69.4	70.3	72.5	75.4	78.1
Mexico	57.5	60.9	67.2	71.2	74.1
Netherlands	73.5	73.7	75.9	77.4	78.0
New Zealand	71.3	71.5	73.2	75.4	78.3
Norway	73.6	74.2	75.8	76.6	78.7
Poland	67.8	70.0	70.2	71.5	73.8
Portugal	64.0	67.5	71.5	73.9	76.2
Slovak Republic	70.6	69.8	70.6	71.0	73.3
Spain	69.8	72.0	75.6	76.8	79.1
Sweden	73.1	74.7	75.8	77.6	79.7
Switzerland	71.6	73.8	76.2	77.4	79.8
Turkey	48.3	54.2	58.1	66.5	68.1
United Kingdom	70.8	71.9	73.2	75.7	77.8
United States	69.9	70.9	73.7	75.3	76.8
Average (30)	**68.5**	**70.3**	**72.6**	**74.9**	**77.2**
Median	**70.0**	**71.1**	**73.4**	**75.6**	**77.9**

Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.
Life expectancy at birth for the total population is estimated by the OECD Secretariat for all countries, using the unweighted average of life expectancy of men and women.

Source: OECD Health Data 2003. (For the 22 European countries, the Eurostat NewCronos database is the main data source for 1985 onwards.)

© OECD 2003

Table 1.2. **Life expectancy at birth, females, 1960 to 2000**

	1960		1970		1980		1990		2000	
Australia	73.9		74.2		78.1		80.1		82.0	
Austria	71.9		73.4		76.1		78.9		81.2	
Belgium	73.5		74.2		76.8		79.4		80.8	
Canada	74.3	(1961)	76.4	(1971)	78.9		80.8		82.0	
Czech Republic	73.4		73.0		73.9		75.4		78.4	
Denmark	74.4		75.9		77.3		77.7		79.3	
Finland	72.5		75.0		77.6		78.9		81.0	
France	73.6		75.9		78.4		80.9		82.7	
Germany	72.4		73.6		76.1		78.4		80.7	(1999)
Greece	72.4		73.8		76.8		79.5		80.6	(1999)
Hungary	70.1		72.1		72.7		73.7		75.7	
Iceland	75.0		77.3		79.7		80.5		81.4	
Ireland	71.9		73.5		75.6		77.6		79.2	
Italy	72.3	(1961)	74.9	(1971)	77.4		80.1		82.4	
Japan	70.2		74.7		78.8		81.9		84.6	
Korea	53.7		66.1	(1971)	69.5	(1979)	75.1	(1989)	79.2	(1999)
Luxembourg	72.2		73.4		75.9		78.5		81.3	
Mexico	59.2		63.2		70.2		74.1		76.5	
Netherlands	75.4		76.5		79.2		80.9		80.5	
New Zealand	73.9		74.6		76.3		78.3		80.8	
Norway	75.8		77.3		79.2		79.8		81.4	
Poland	70.6		73.3		74.4		76.3		77.9	
Portugal	66.8		70.8		75.2		77.4		79.7	
Slovak Republic	72.7		72.9		74.3		75.4		77.4	
Spain	72.2		74.8		78.6		80.3		82.7	
Sweden	74.9		77.1		78.8		80.4		82.0	
Switzerland	74.5		76.9		79.6		80.7		82.6	
Turkey	50.3		56.3		60.3		68.7		70.4	
United Kingdom	73.7		75.0		76.2		78.5		80.2	
United States	73.1		74.7		77.4		78.8		79.5	
Average (30)	**71.0**		**73.4**		**76.0**		**78.2**		**80.1**	
Median	**72.6**		**74.4**		**76.8**		**78.9**		**80.8**	

Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

Source: OECD Health Data 2003. (For the 22 European countries, the Eurostat NewCronos database is the main data source for 1985 onwards.)

© OECD 2003

Table 1.3. **Life expectancy at birth, males, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	67.9	67.4	71.0	73.9	76.6
Austria	65.4	66.5	69.0	72.4	75.4
Belgium	67.7	67.8	70.0	72.7	74.6
Canada	68.4 (1961)	69.3 (1971)	71.7	74.4	76.7
Czech Republic	67.9	66.1	66.8	67.6	71.7
Denmark	70.4	70.7	71.2	72.0	74.5
Finland	65.5	66.5	69.2	70.9	74.2
France	67.0	68.4	70.2	72.8	75.2
Germany	66.9	67.2	69.6	72.0	74.7 (1999)
Greece	67.3	70.1	72.2	74.6	75.5 (1999)
Hungary	65.9	66.3	65.5	65.1	67.2
Iceland	70.7	71.2	73.7	75.4	78.0
Ireland	68.1	68.8	70.1	72.1	74.2
Italy	67.2 (1961)	69.0 (1971)	70.6	73.6	76.3
Japan	65.3	69.3	73.4	75.9	77.7
Korea	51.1	59.0 (1971)	61.3 (1979)	66.8 (1989)	71.7 (1999)
Luxembourg	66.5	67.1	69.1	72.3	74.9
Mexico	55.8	58.5	64.1	68.3	71.6
Netherlands	71.5	70.8	72.5	73.8	75.5
New Zealand	68.7	68.3	70.0	72.4	75.7
Norway	71.3	71.0	72.3	73.4	76.0
Poland	64.9	66.6	66.0	66.7	69.7
Portugal	61.2	64.2	67.7	70.4	72.7
Slovak Republic	68.4	66.7	66.8	66.6	69.2
Spain	67.4	69.2	72.5	73.3	75.5
Sweden	71.2	72.2	72.8	74.8	77.4
Switzerland	68.7	70.7	72.8	74.0	76.9
Turkey	46.3	52.0	55.8	64.2	65.8
United Kingdom	67.9	68.7	70.2	72.9	75.4
United States	66.6	67.1	70.0	71.8	74.1
Average (30)	**66.0**	**67.2**	**69.3**	**71.6**	**74.2**
Median	**67.4**	**68.1**	**70.1**	**72.4**	**75.1**

Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

Source: OECD Health Data 2003. (For the 22 European countries, the Eurostat NewCronos database is the main data source for 1985 onwards.)

© OECD 2003

Table 1.4. **Life expectancy at age 65, females, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	15.6	15.6	17.9	19.0	20.4
Austria	14.7	14.9	16.3	18.0	19.6
Belgium	14.8	15.3	16.9	18.5	19.5
Canada	16.1 (1961)	17.5 (1971)	18.9	19.9	20.5
Czech Republic	14.5	14.2	14.3	15.2	17.1
Denmark	15.3	16.7	17.6	17.8	18.3
Finland	13.7	14.4 (1971)	16.5	17.7	19.3
France	15.6	16.8	18.2	19.8	20.9 (1999)
Germany	14.6	15.0	16.7	17.6	19.2 (1999)
Greece	14.6	15.2	16.8	18.0	18.7 (1999)
Hungary	13.8	14.3	14.6	15.3	16.3
Iceland	. .	. .	19.1	19.5	19.6
Ireland	14.4	15.0	15.7	16.9	17.7
Italy	15.3 (1961)	16.2 (1971)	17.1	18.8	. .
Japan	14.1	15.3	17.7	20.0	22.4
Korea	. .	14.6 (1971)	15.1 (1979)	16.2 (1989)	18.0 (1999)
Luxembourg	14.5	14.9	16.0	18.2	19.8
Mexico	14.6	15.6	17.0	18.0	18.3
Netherlands	15.3	16.1	18.0	18.9	19.2
New Zealand	15.6	16.0	17.0	18.3	19.8
Norway	16.0	16.7	18.0	18.5	19.7
Poland	14.9	15.3	15.5	16.9	17.3
Portugal	15.3	15.0	16.5	17.0	18.3
Slovak Republic	14.6	14.5	15.4	15.7	16.5
Spain	15.3	16.0	17.9	19.0	20.1 (1999)
Sweden	. .	16.8	17.9	19.0	20.0
Switzerland	. .	. .	18.3 (1982)	19.4	20.7
Turkey	12.1	12.6	12.8	13.9	14.2
United Kingdom	15.1	16.0	16.6	17.9	18.9
United States	15.8 (1961)	17.0	18.3	18.9	19.2
Average (27)[a]	**n.a.**	**15.5**	**16.7**	**17.8**	**18.9**
Median	**14.9**	**15.3**	**17.0**	**18.1**	**19.2**

Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

a) The average excludes: Iceland, Italy and Switzerland.

Source: OECD Health Data 2003. (For the 22 European countries, the Eurostat NewCronos database is the main data source for 1985 onwards.)

© OECD 2003

Table 1.5. **Life expectancy at age 65, males, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	12.5	11.9	13.7	15.2	16.9
Austria	12.0	11.7	12.9	14.4	16.2
Belgium	12.4	12.1	13.0	14.3	15.5
Canada	13.6 (1961)	13.8 (1971)	14.5	15.7	16.9
Czech Republic	12.5	11.1	11.2	11.6	13.7
Denmark	13.7	13.7	13.6	14.0	15.2
Finland	11.5	11.4 (1971)	12.5	13.7	15.5
France	12.5	13.0	13.6	15.5	16.5 (1999)
Germany	12.4	12.0	13.0	14.0	15.5 (1999)
Greece	13.4	13.9	14.6	15.7	16.3 (1999)
Hungary	12.3	12.0	11.6	12.0	12.6
Iceland	. .	. .	15.8	16.2	18.1
Ireland	12.6	12.4	12.6	13.3	14.6
Italy	13.4 (1961)	13.3 (1971)	13.3	15.1	. .
Japan	11.6	12.5	14.6	16.2	17.5
Korea	. .	10.2 (1971)	10.4 (1979)	12.2 (1989)	14.1 (1999)
Luxembourg	12.5	12.1	12.3	14.2	15.6
Mexico	14.2	14.8	15.4	16.2	16.8
Netherlands	13.9	13.3	13.7	14.4	15.3
New Zealand	13.0	12.4	13.2	14.7	16.4
Norway	14.5	13.8	14.3	14.6	16.0
Poland	12.7	12.5	12.0	12.7	13.6
Portugal	13.0	12.2	12.9	13.9	14.7
Slovak Republic	13.2	12.3	12.3	12.2	12.9
Spain	13.1	13.3	14.8	15.4	16.1 (1999)
Sweden	. .	14.2	14.3	15.3	16.7
Switzerland	. .	. .	14.6 (1982)	15.3	16.9
Turkey	11.2	11.5	11.7	12.4	12.6
United Kingdom	11.9	12.0	12.6	14.0	15.6
United States	12.8	13.1	14.1	15.1	16.3
Average (27)[a]	**n.a.**	**12.6**	**13.2**	**14.2**	**15.4**
Median	**12.7**	**12.4**	**13.3**	**14.4**	**15.6**

Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

a) The average excludes: Iceland, Italy and Switzerland.

Source: *OECD Health Data 2003.* (For the 22 European countries, the Eurostat NewCronos database is the main data source for 1985 onwards.)

© OECD 2003

Table 1.6. **Infant mortality rate, deaths per 1 000 live births, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	20.2	17.9	10.7	8.2	5.2
Austria	37.5	25.9	14.3	7.8	4.8
Belgium	31.2	21.1	12.1	8.0	4.8
Canada	27.3	18.8	10.4	6.8	5.3
Czech Republic	20.0	20.2	16.9	10.8	4.1
Denmark	21.5	14.2	8.4	7.5	5.3
Finland	21.0	13.2	7.6	5.6	3.8
France	27.5	18.2	10.0	7.3	4.6
Germany	35.0	22.5	12.4	7.0	4.4
Greece	40.1	29.6	17.9	9.7	6.1
Hungary	47.6	35.9	23.2	14.8	9.2
Iceland	13.0	13.2	7.7	5.9	3.0
Ireland	29.3	19.5	11.1	8.2	6.2
Italy	43.9	29.6	14.6	8.2	4.5
Japan	30.7	13.1	7.5	4.6	3.2
Korea	. .	45.0	17.0 (1981)	12.0 (1989)	6.2 (1999)
Luxembourg	31.5	24.9	11.5	7.3	5.1
Mexico	. .	79.3	50.9	36.1	23.3
Netherlands	17.9	12.7	8.6	7.1	5.1
New Zealand	22.6	16.7	13.0	8.4	5.8 (1999)
Norway	18.9	12.7	8.1	7.0	3.8
Poland	56.1	36.4	25.4	19.4	8.1
Portugal	77.5	55.5	24.3	11.0	5.5
Slovak Republic	28.6	25.7	20.9	12.0	8.6
Spain	43.7	28.1	12.3	7.6	3.9
Sweden	16.6	11.0	6.9	6.0	3.4
Switzerland	21.1	15.1	9.1	6.8	4.9
Turkey	189.5	145.0	117.5	57.6	39.7
United Kingdom	22.5	18.5	12.1	7.9	5.6
United States	26.0	20.0	12.6	9.2	6.9
Average (28)[a]	**36.4**	**26.3**	**16.7**	**10.3**	**6.5**
Median	**28.1**	**20.1**	**12.2**	**8.0**	**5.2**

Note: Some of the international variation in infant mortality rates is due to variations among countries 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 which do not register them as live births.

a) The average excludes: Korea and Mexico.

Source: OECD Health Data 2003. (For the 22 European countries the main data source is the Eurostat NewCronos Database.)

© OECD 2003

Table 1.7. **Potential years of life lost before age 70, all causes, females, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	6 723	6 311	4 242	3 294	2 660 (1999)
Austria	8 753	6 803	4 951	3 456	2 640
Belgium	7 421	6 176	4 806	3 573	. .
Canada	6 792	5 646	4 385	3 317	2 768 (1998)
Czech Republic	. .	. .	. .	4 273	3 019
Denmark	6 159	5 169	4 523	3 989	3 185 (1998)
Finland	6 824	5 177	3 363	3 233	2 551
France	6 756	5 358	4 205	3 091	2 588 (1999)
Germany	8 241	6 673	4 702	3 420	2 672 (1999)
Greece	8 697	6 189	4 411	3 217	2 620 (1999)
Hungary	10 241	8 019	6 913	6 269	4 862
Iceland	5 062	4 029	2 948	2 938	. .
Ireland	7 772	6 321	4 551	3 732	3 000 (1999)
Italy	9 724	6 867	4 328	3 021	2 337 (1999)
Japan	10 109	5 555	3 387	2 492	2 149 (1999)
Korea	. .	. .	. .	3 980	2 941
Luxembourg	9 490	7 389	5 269	3 814	2 746
Mexico		17 634	9 607 (1981)	7 237	. .
Netherlands	5 238	4 680	3 579	3 163	2 888 (1999)
New Zealand	6 949	6 275	5 519	4 067	3 194 (1998)
Norway	5 220	4 110	3 289	2 980	2 570 (1999)
Poland	10 855	7 682	5 995	5 232	3 600
Portugal	14 743	11 811	5 905	4 436	3 141
Slovak Republic	. .	. .	. .	4 346 (1992)	3 589
Spain	8 248	6 350 (1969)	3 937	3 031	2 389 (1999)
Sweden	5 364	4 345	3 429	2 855	2 207 (1999)
Switzerland	5 727	4 910	3 704	3 016	2 407 (1999)
Turkey	. .	. .	. .	. .	. .
United Kingdom	6 263	5 756	4 665	3 559	2 947 (1999)
United States	7 410	6 679	5 124	4 183	3 836 (1999)
Average (23)[a]	**7 926**	**6 264**	**4 538**	**3 603**	**2 868**
Median	**7 410**	**6 232**	**4 467**	**3 456**	**2 757**

Note: All mortality rates are standardised to the OECD standard population (1980).

a) Excluding Belgium, Czech Republic, Iceland, Korea, Mexico, Slovak Republic and Turkey.

Source: OECD Health Data 2003. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.8. **Potential years of life lost before age 70, all causes, males, 1960 to 2000**

	1960	1970	1980	1990	2000	
Australia	10 740	10 869	7 939	6 016	4 866	(1999)
Austria	14 308	12 301	9 771	6 836	5 140	
Belgium	12 265	10 566	8 592	6 504	. .	
Canada	11 066	9 830	8 130	6 122	4 698	(1998)
Czech Republic	. .	. .	. .	9 521	6 581	
Denmark	8 880	8 207	7 380	6 537	5 113	(1998)
Finland	13 031	11 697	8 465	7 594	5 603	
France	11 268	9 929	8 716	7 012	5 610	(1999)
Germany	12 814	11 385	8 600	6 660	5 119	(1999)
Greece	10 993	9 257	7 240	5 729	5 397	(1999)
Hungary	14 323	12 881	12 772	13 301	10 685	
Iceland	8 464	9 318	7 133	5 594	. .	
Ireland	10 307	9 209	7 630	6 154	5 430	(1999)
Italy	13 695	10 816	7 946	6 029	4 501	(1999)
Japan	13 924	9 012	5 917	4 605	4 093	(1999)
Korea	. .	. .	. .	8 706	6 390	
Luxembourg	16 386	12 534	7 830	7 009	5 210	
Mexico	. .	22 909	16 342 (1981)	12 059	. .	
Netherlands	7 998	7 938	6 298	5 231	4 311	(1999)
New Zealand	10 438	10 395	8 496	7 077	5 495	(1998)
Norway	8 643	8 086	6 799	5 770	4 620	(1999)
Poland	16 107	13 026	12 715	11 973	8 565	
Portugal	19 914	17 404	11 450	9 143	7 072	
Slovak Republic	. .	. .	. .	10 502 (1992)	8 741	
Spain	11 681	10 044 (1969)	7 270	6 699	5 314	(1999)
Sweden	7 983	7 178	6 258	4 913	3 748	(1999)
Switzerland	9 847	8 966	7 074	5 991	4 365	(1999)
Turkey	. .	. .	. .	. .	. .	
United Kingdom	9 912	9 208	7 500	5 931	4 815	(1999)
United States	12 388	11 937	9 513	8 062	6 648	(1999)
Average (23)[a]	**12 028**	**10 526**	**8 335**	**6 974**	**5 496**	
Median	**11 268**	**10 220**	**7 943**	**6 660**	**5 262**	

Note: All mortality rates are standardised to the OECD standard population (1980).

a) Excluding Belgium, Czech Republic, Iceland, Korea, Mexico, Slovak Republic and Turkey.

Source: OECD Health Data 2003. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.9. **All cancers, age standardised mortality rate, per 100 000 females and males, 1980 to 2000**

	1980		1990		2000	
	Female	Male	Female	Male	Female	Male
Australia	135.4	238.1	138.9	234.8	127.2 (1999)	211.3 (1999)
Austria	162.9	274.0	151.3	256.0	132.6	215.3
Belgium	158.5	310.0	144.9	294.4	. .	. .
Canada	146.5	238.5	152.6	247.0	147.2 (1998)	223.0 (1998)
Czech Republic	. .	. .	178.4	338.7	166.9	308.8
Denmark	187.2	267.0	187.7	268.1	185.7 (1998)	251.5 (1998)
Finland	132.8	264.2	129.5	228.2	118.3	191.6
France	128.4	281.1	120.9	280.2	117.9 (1999)	259.4 (1999)
Germany	162.2	266.9	150.8	256.7	139.0 (1999)	232.7 (1999)
Greece	109.8	195.5	106.6	206.6	108.4 (1999)	209.6 (1999)
Hungary	176.9	299.1	182.7	346.5	171.4	340.4
Iceland	140.3	191.8	162.9	216.8	. .	. .
Ireland	168.8	237.7	170.6	257.8	161.4 (1999)	241.2 (1999)
Italy	135.2	256.0	136.7	272.9	120.9 (1999)	240.6 (1999)
Japan	117.3	211.3	107.5	218.2	105.1 (1999)	224.0 (1999)
Korea	. .	. .	88.7	212.9	103.4	265.5
Luxembourg	182.0	289.2	157.8	284.6	132.0	250.8
Mexico	99.5 (1981)	99.5 (1981)	106.8	123.0	. .	. .
Netherlands	149.9	296.9	151.6	285.9	151.1 (1999)	260.8 (1999)
New Zealand	165.8	247.9	173.3	247.3	164.3 (1998)	225.2 (1998)
Norway	137.4	207.5	140.9	215.1	136.5 (1999)	215.9 (1999)
Poland	139.8	244.7	144.0	277.2	148.0	284.2
Portugal	119.3	199.5	119.4	208.4	112.9	228.5
Slovak Republic	. .	. .	135.5 (1992)	281.9 (1992)	147.6	307.9
Spain	112.6	211.2	111.1	240.8	104.9 (1999)	243.8 (1999)
Sweden	150.1	212.7	135.8	192.0	129.3 (1999)	184.2 (1999)
Switzerland	142.0	250.7	137.9	252.6	113.5 (1999)	205.1 (1999)
Turkey	. .	. .	. .	. .	. .	. .
United Kingdom	168.7	273.0	173.9	266.4	155.9 (1999)	227.8 (1999)
United States	144.4	234.2	152.6	240.6	146.4 (1999)	214.6 (1999)
Average (23)[a]	**146.8**	**247.7**	**145.0**	**251.5**	**136.1**	**234.0**
Median	**143.2**	**246.3**	**144.0**	**252.6**	**134.6**	**230.6**

Note: All mortality rates are standardised to the OECD standard population (1980).
a) Excluding Belgium, Czech Republic, Iceland, Korea, Mexico, Slovak Republic and Turkey.
Source: OECD Health Data. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.10. **All cancers, age standardised incidence rate, per 100 000 females and males, 1980 to 2000**

	1980		1990		2000	
	Female	Male	Female	Male	Female	Male
Australia	217.8 (1982)	288.7 (1982)	243.0	319.0	263.0 (1999)	335.7 (1999)
Austria	. .	. .	220.7	292.5	203.4 (1999)	272.8 (1999)
Belgium	. .	. .	174.1 (1992)	220.6 (1992)	. .	. .
Canada	. .	. .	. .	. .	302.4 (1999)	374.1 (1999)
Czech Republic	207.1	298.9	242.2	354.4	291.8	402.2
Denmark	274.8	312.6	314.8	334.2	342.6 (1999)	350.3 (1999)
Finland	188.6	270.1	211.5	254.1	228.9	264.9
France	. .	. .	. .	. .	220.3	342.6
Germany	. .	. .	207.2	272.9	214.8 (1998)	269.8 (1998)
Greece	. .	. .	. .	. .	. .	. .
Hungary	. .	. .	. .	. .	357.3	497.7
Iceland	233.5	252.6	262.9	292.7	314.0	298.9
Ireland					306.9 (1999)	377.2 (1999)
Italy	283.0	349.0	326.0	432.0	350.0	489.0
Japan	146.1	216.9	157.9	259.6	. .	. .
Korea	. .	. .	. .	. .	161.3 (1999)	296.8 (1999)
Luxembourg	297.9 (1982)	335.3 (1982)	338.7	395.6	380.1	440.1
Mexico	. .	. .	. .	. .	119.5	71.0
Netherlands	314.4	326.3	357.1	405.7	400.7 (1998)	439.8 (1998)
New Zealand	242.4	277.8	270.6	286.2	286.3 (1999)	354.1 (1999)
Norway	216.0	244.5	233.5	279.6	267.1	317.0
Poland	. .	. .	. .	. .	. .	
Portugal	. .	. .	. .	. .	. .	
Slovak Republic	244.8	319.2	301.1	381.7	365.4 (1999)	421.9 (1999)
Spain						
Sweden	231.6	249.5	257.6	258.3	259.5	283.9
Switzerland		. .		. .	. .	. .
Turkey		. .		. .	. .	. .
United Kingdom	200.3	248.8	229.8	263.0	244.1 (1999)	265.5 (1999)
United States	255.2	317.0	288.7	372.3	288.2	368.1
Average (14)[a]	**243.4**	**292.2**	**277.0**	**330.6**	**305.8**	**359.4**
Median	**233.5**	**288.7**	**250.3**	**292.6**	**287.3**	**346.5**

Note: All incidence rates are standardised to the WHO World standard population (1960).

a) Including Australia, Czech Republic, Denmark, Finland, Iceland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Slovak Republic, Sweden, United Kingdom and United States.

Source: OECD Health Data 2003.

© OECD 2003

Table 1.11. **Selected cancers, age standardised mortality rate, per 100 000 females, 1990 and 2000**

	Lung		Colon		Breast		Cervix	
	1990	2000	1990	2000	1990	2000	1990	2000
Australia	17.3	18.8 (1999)	20.2	16.9 (1999)	26.3	21.9 (1999)	3.7	2.0 (1999)
Austria	12.1	15.5	21.5	16.8	29.4	25.2	3.6	2.3
Belgium	11.0	. .	18.4	. .	33.3	. .	2.7	. .
Canada	28.2	34.5 (1998)	17.4	15.0 (1998)	31.1	25.6 (1998)	2.9	2.1 (1998)
Czech Republic	12.5	16.9	26.5	24.0	28.2	25.6	6.3	5.2
Denmark	31.6	36.9 (1998)	25.3	23.0 (1998)	34.9	34.2 (1998)	6.4	4.7 (1998)
Finland	9.7	11.1	12.9	12.5	22.0	20.8	2.0	2.0
France	6.9	9.9 (1999)	15.4	14.4 (1999)	25.4	25.7 (1999)	2.1	1.9 (1999)
Germany	10.7	14.0 (1999)	22.7	19.6 (1999)	28.3	25.9 (1999)	4.4	3.2 (1999)
Greece	10.2	9.7 (1999)	8.5	11.8 (1999)	19.1	19.4 (1999)	1.7	1.7 (1999)
Hungary	20.8	26.9	27.4	25.8	29.2	28.3	8.7	6.4
Iceland	29.3	. .	19.5	. .	35.5	. .	2.3	. .
Ireland	26.0	25.0 (1999)	20.0	18.0 (1999)	32.9	31.5 (1999)	3.7	3.9 (1999)
Italy	10.3	11.2 (1999)	15.0	13.8 (1999)	26.5	22.9 (1999)	1.2	0.9 (1999)
Japan	11.8	12.7 (1999)	13.9	14.2 (1999)	7.4	9.5 (1999)	2.4	2.4 (1999)
Korea	8.7	15.3	5.0	10.0	3.2	4.9	2.0	3.4
Luxembourg	11.3	14.5	17.6	15.1	36.0	27.2	4.7	1.7
Mexico	8.6	. .	4.6	. .	10.3	. .	20.0	. .
Netherlands	13.3	20.9 (1999)	19.7	18.0 (1999)	34.7	33.3 (1999)	3.1	2.4 (1999)
New Zealand	24.4	25.3 (1998)	27.2	24.1 (1998)	35.4	28.8 (1998)	5.8	3.6 (1998)
Norway	14.0	18.4 (1999)	21.4	20.6 (1999)	24.9	21.5 (1999)	4.5	3.8 (1999)
Poland	13.2	16.5	14.7	16.5	20.3	19.4	9.3	8.2
Portugal	6.2	7.0	15.6	15.6	22.2	20.6	2.9	3.3
Slovak Republic	10.2 (1992)	11.0	19.7 (1992)	21.0	20.5 (1992)	24.3	6.0 (1992)	6.8
Spain	4.9	5.9 (1999)	13.5	14.5 (1999)	21.8	19.3 (1999)	2.2	1.9 (1999)
Sweden	12.9	17.1 (1999)	16.8	14.1 (1999)	22.9	20.3 (1999)	3.1	2.5 (1999)
Switzerland	10.3	13.8 (1999)	16.2	11.5 (1999)	32.7	22.5 (1999)	3.0	1.6 (1999)
Turkey	. .	. .	. .	. .	. .	. .	. .	. .
United Kingdom	29.0	29.1 (1999)	20.2	15.7 (1999)	36.4	28.9 (1999)	5.2	3.0 (1999)
United States	34.1	36.8 (1999)	16.8	14.7 (1999)	29.1	23.3 (1999)	3.2	2.5 (1999)
Average (26)[a]	**15.4**	**18.3**	**18.1**	**16.8**	**26.2**	**23.5**	**4.0**	**3.2**
Median	**12.1**	**16.0**	**17.6**	**15.7**	**28.2**	**23.8**	**3.2**	**2.5**

Note: All mortality rates are standardised to the OECD standard population (1980).
a) The average excludes: Belgium, Iceland, Mexico and Turkey.
Source: OECD Health Data. [The raw mortality data is extracted from the WHO Mortality Database (March 2003)].

© OECD 2003

Table 1.12. **Selected cancers, age standardised incidence rate, per 100 000 females, 1990 and 2000**

	Lung		Colon		Breast		Cervix	
	1990	2000	1990	2000	1990	2000	1990	2000
Australia	15.8	16.3 (1999)	32.1	33.4 (1999)	67.3	80.6 (1999)	10.2	6.3 (1999)
Austria	11.1	13.1 (1999)	27.7	23.8 (1999)	56.3	62.6 (1999)	12.9	7.8 (1999)
Belgium	7.4 (1992)	. .	18.7 (1992)	. .	63.7 (1992)	. .	. .	. .
Canada	. .	35.9 (1999)	. .	31.5 (1999)	. .	98.3 (1999)	. .	7.6 (1999)
Czech Republic	9.4	14.3	25.6	29.4	43.3	55.1	15.9	14.6
Denmark	25.8	32.1 (1999)	20.8	21.1 (1999)	72.4	86.0 (1999)		11.5 (1999)
Finland	8.2	8.5	18.6	18.2	65.1	83.4	3.4	4.7
France	. .	7.4	. .	26.8	. .	83.2	. .	10.1
Germany	8.3	10.7 (1998)	29.5	29.3 (1998)	61.3	63.0 (1998)	11.7	12.7 (1998)
Greece	. .	. .	. .	. .	. .	. .	. .	. .
Hungary	. .	33.5	. .	36.1	. .	77.3	. .	19.2
Iceland	26.4	31.3	26.2	27.9	76.8	102.6	9.8	6.8
Ireland		19.6 (1999)		25.3 (1999)		73.4 (1999)	. .	6.9 (1999)
Italy	8.1	8.8	26.9	35.0	71.9	51.6	. .	. .
Japan	9.6	. .	14.9	. .	26.5	. .	8.3	. .
Korea	. .	12.8 (1999)	. .	16.2 (1999)		22.2 (1999)		19.5 (1999)
Luxembourg	8.7	13.0	47.4	55.9	98.4	139.1	15.8	13.9
Mexico		. .		. .	. .	. .	. .	. .
Netherlands	17.8	27.5 (1998)	49.9	53.7 (1998)	113.6	129.9 (1998)	10.0	9.2 (1998)
New Zealand	20.3	20.3 (1999)	38.7	40.0 (1999)	79.7	87.6 (1999)	12.7	9.2 (1999)
Norway	13.3	20.6	28.3	33.8	53.1	72.2	13.9	9.2
Poland	. .	. .	. .	. .	34.0	. .	. .	. .
Portugal	. .	. .	. .	. .	56.7 (1992)	. .	. .	. .
Slovak Republic	. .	. .	. .	. .		. .	. .	. .
Spain	. .	. .	. .	. .		. .	. .	. .
Sweden	11.0	14.9	24.8	24.0	78.1	83.7	8.1	7.0
Switzerland	. .	. .	. .	. .	. .	. .	. .	. .
Turkey	. .	. .	. .	. .	. .	. .	. .	. .
United Kingdom	23.6	22.6 (1999)	24.0	24.5 (1999)	72.1	85.0 (1999)	12.4	7.5 (1999)
United States	33.5	33.1	31.2	28.6	93.6	97.7	8.4	6.0
Average (13)[a]	**16.0**	**18.9**	**31.1**	**32.5**	**73.7**	**87.9**	**11.2**	**8.8**
Median	**11.1**	**16.3**	**26.9**	**28.6**	**67.3**	**83.2**	**11.0**	**9.2**

Note: All incidence rates are standardised to the WHO World standard population (1960).

a) The average includes: Australia, Austria, Czech Republic, Finland, Germany, Iceland, Luxembourg, Netherlands, New Zealand, Norway, Sweden, United Kingdom and United States.

Source: OECD Health Data 2003.

© OECD 2003

Table 1.13. **Selected cancers, age standardised mortality rate, per 100 000 males, 1990 and 2000**

	Lung		Colon		Prostate	
	1990	2000	1990	2000	1990	2000
Australia	59.9	49.6 (1999)	29.8	26.4 (1999)	30.9	27.0 (1999)
Austria	64.0	51.3	34.3	28.3	29.9	28.1
Belgium	104.5	. .	29.6	. .	31.3	. .
Canada	81.2	69.3 (1998)	25.7	23.2 (1998)	28.9	25.8 (1998)
Czech Republic	103.5	84.4	51.1	50.0	25.5	28.7
Denmark	75.3	63.7 (1998)	35.1	33.5 (1998)	31.9	32.5 (1998)
Finland	71.0	50.8	18.5	17.2	31.4	29.1
France	63.2	63.2 (1999)	26.0	25.8 (1999)	29.6	27.1 (1999)
Germany	68.0	59.4 (1999)	31.6	29.1 (1999)	27.5	25.4 (1999)
Greece	69.2	68.7 (1999)	10.7	15.3 (1999)	14.2	17.1 (1999)
Hungary	104.0	105.1	43.6	45.7	27.3	24.3
Iceland	44.3	. .	15.4	. .	35.8	. .
Ireland	68.9	55.1 (1999)	31.8	33.3 (1999)	32.1	30.5 (1999)
Italy	79.3	70.6 (1999)	23.5	23.5 (1999)	20.5	18.7 (1999)
Japan	46.4	48.9 (1999)	22.2	24.7 (1999)	6.5	9.3 (1999)
Korea	35.8	66.8	7.4	17.1	1.7	5.8
Luxembourg	88.2	70.0	32.1	28.2	28.4	29.1
Mexico	23.8	. .	4.9	. .	18.4	. .
Netherlands	100.9	81.6 (1999)	25.6	27.4 (1999)	31.9	30.9 (1999)
New Zealand	62.8	49.7 (1998)	36.2	32.8 (1998)	32.3	30.9 (1998)
Norway	42.4	46.1 (1999)	28.9	27.7 (1999)	37.4	39.8 (1999)
Poland	93.4	92.7	21.7	26.9	15.7	21.2
Portugal	36.0	41.1	24.6	28.7	24.2	34.1
Slovak Republic	81.9 (1992)	83.2	34.9 (1992)	46.4	17.8 (1992)	26.6
Spain	63.8	66.8 (1999)	21.7	26.5 (1999)	22.9	23.2 (1999)
Sweden	34.0	31.7 (1999)	22.1	20.5 (1999)	35.8	38.0 (1999)
Switzerland	63.1	47.3 (1999)	28.4	21.0 (1999)	40.7	32.3 (1999)
Turkey	. .	. .	. .	. .	. .	. .
United Kingdom	84.7	61.3 (1999)	30.3	24.7 (1999)	28.3	26.7 (1999)
United States	81.9	68.6 (1999)	25.4	21.0 (1999)	29.5	22.9 (1999)
Average (26)[a]	**70.1**	**63.3**	**27.8**	**27.9**	**26.3**	**26.4**
Median	**68.9**	**63.5**	**26.0**	**26.7**	**28.9**	**27.1**

Note: All mortality rates are standardised to the OECD standard population (1980).
a) The average excludes: Belgium, Iceland, Mexico and Turkey.
Source: OECD Health Data. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.14. **Selected cancers, age standardised incidence rate, per 100 000 males, 1990 and 2000**

	Lung		Colon		Prostate	
	1990	2000	1990	2000	1990	2000
Australia	48.0	38.2 (1999)	45.7	46.0 (1999)	52.6	73.8 (1999)
Austria	52.6	42.0 (1999)	43.2	37.7 (1999)	40.0	61.5 (1999)
Belgium	55.1 (1992)	. .	26.7 (1992)	. .	30.4 (1992)	. .
Canada	. .	55.1 (1999)	. .	46.3 (1999)	. .	107.2 (1999)
Czech Republic	78.9	64.0	46.0	58.3	22.8	35.5
Denmark	50.8	45.9 (1999)	22.9	23.9 (1999)	31.7	35.9 (1999)
Finland	51.2	31.8	23.9	23.5	39.0	79.3
France	. .	53.5	. .	39.8	. .	56.5
Germany	49.8	42.7 (1998)	40.1	41.3 (1998)	39.3	45.0 (1998)
Greece	. .	. .	. .	. .	. .	. .
Hungary	. .	101.9	. .	61.6	. .	32.6
Iceland	39.2	34.3	24.9	32.0	54.7	84.3
Ireland		39.4 (1999)		41.9 (1999)	. .	54.3 (1999)
Italy	62.9	48.4	36.7	48.3	22.8	28.6
Japan	36.3	. .	23.6	. .	8.4	. .
Korea	. .	55.4 (1999)	. .	25.8 (1999)	. .	7.9 (1999)
Luxembourg	72.7	55.1	49.4	60.6	61.6	130.0
Mexico	. .	. .	. .	. .	. .	. .
Netherlands	98.8	84.8 (1998)	48.8	57.4 (1998)	56.6	84.9 (1998)
New Zealand	47.3	36.0 (1999)	51.0	51.8 (1999)	35.0	98.2 (1999)
Norway	35.0	35.0	39.0	42.5	48.4	81.5
Poland	. .	. .	. .	. .	. .	. .
Portugal	. .	. .	. .	. .	. .	. .
Slovak Republic	83.2	71.0 (1999)	41.8	31.7 (1999)	28.0	31.9 (1999)
Spain	. .	. .	. .	. .	. .	. .
Sweden	25.7	21.4	29.4	30.3	52.6	85.9
Switzerland	. .	. .	. .	. .	. .	. .
Turkey	14.2	22.2 (1998)	. .	. .	. .	. .
United Kingdom	62.0	44.6 (1999)	34.3	36.8 (1999)	29.0	46.1 (1999)
United States	63.5	50.5	44.8	39.0	95.2	117.4
Average (16)[a]	**57.6**	**46.6**	**38.9**	**41.3**	**44.3**	**70.0**
Median	**51.2**	**44.6**	**39.6**	**40.6**	**39.2**	**59.0**

Note: All incidence rates are standardised to the WHO World standard population (1960).

a) The average includes: Australia, Austria, Czech Republic, Denmark, Finland, Germany, Iceland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Slovak Republic, Sweden, United Kingdom and United States.

Source: OECD Health Data 2003.

© OECD 2003

Table 1.15. **Ischaemic heart disease, age standardised mortality rate, per 100 000 females and males, 1970 to 2000**

	1970		1980		1990		2000	
	Female	Male	Female	Male	Female	Male	Female	Male
Australia	239.1	481.4	163.0	340.1	130.1	241.1	83.3 (1999)	158.3 (1999)
Austria	153.8	264.5	100.5	219.3	106.0	212.6	90.3	174.5
Belgium	104.5	226.8	80.4	186.7	54.3	124.5	. .	. .
Canada	218.0	412.2	159.1	322.0	107.8	213.9	81.0	163.6
Czech Republic	. .	. .	. .	. .	212.9	418.1	132.3	245.1
Denmark	199.6	371.3	179.6	366.1	140.7	282.0	83.1 (1998)	171.7 (1998)
Finland	187.8	450.9	168.9	411.4	154.9	344.3	114.5	244.0
France	46.2	101.9	47.3	108.0	38.4	87.6	29.2 (1999)	72.7 (1999)
Germany	106.7	230.9	107.6	249.7	104.1	218.0	94.6 (1999)	182.0 (1999)
Greece	45.2	91.7	44.1	114.5	59.7	129.1	51.0 (1999)	115.0 (1999)
Hungary	193.5	300.0	156.1	298.0	164.3	312.8	133.4	258.8
Iceland	190.1	339.2	136.7	325.1	114.2	226.7	. .	. .
Ireland	187.5	356.0	177.2	367.3	151.8	324.5	119.7 (1999)	239.5 (1999)
Italy	108.4	180.4	86.9	169.6	61.1	129.4	51.3 (1999)	106.8 (1999)
Japan	46.1	78.3	40.0	68.1	27.7	48.7	26.0 (1999)	50.9 (1999)
Korea	. .	. .	. .	. .	13.3	23.4	24.0	43.1
Luxembourg	161.9	284.2	96.5	190.9	66.3	154.8	49.0	120.5
Mexico	44.7	63.7	52.7 (1981)	83.6 (1981)	74.6	113.9	. .	. .
Netherlands	132.0	279.7	106.1	246.2	80.3	187.6	57.3 (1999)	130.5 (1999)
New Zealand	202.2	430.7	193.3	386.3	139.9	276.6	97.7 (1998)	201.4 (1998)
Norway	150.7	324.6	125.2	293.4	112.5	267.5	79.8 (1999)	174.9 (1999)
Poland	50.3	113.9	57.5	160.7	62.0	178.7	92.4	189.3
Portugal	135.4	200.9	64.2	124.3	57.9	109.7	46.5	89.9
Slovak Republic	. .	. .	. .	. .	189.3 (1992)	337.4 (1992)	225.9	352.3
Spain	40.3 (1969)	7 8.8 (1969)	49.0	108.7	46.5	101.5	42.7 (1999)	97.3 (1999)
Sweden	209.2	364.4	187.7	388.5	115.8	261.1	83.0 (1999)	182.4 (1999)
Switzerland	69.8	156.5	71.5	175.7	68.3	157.1	63.9 (1999)	127.7 (1999)
Turkey	. .	. .	. .	. .	. .	. .	. .	. .
United Kingdom	170.5	373.0	162.0	366.6	141.5	295.0	98.5 (1999)	206.9 (1999)
United States	266.3	480.8	168.5	330.2	121.8	228.3	110.0 (1999)	194.3 (1999)
Average (23)[a]	**144.4**	**278.6**	**117.9**	**252.4**	**98.2**	**207.0**	**77.3**	**158.8**
Median	**152.3**	**282.0**	**106.9**	**248.0**	**106.0**	**213.9**	**83.1**	**173.1**

Note: All mortality rates are standardised to the OECD standard population (1980).
a) The average excludes: Belgium, Czech Republic, Iceland, Korea, Mexico, Slovak Republic and Turkey.
Source: OECD Health Data. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.16. **AIDS, incidence and mortality rates, per 100 000 population, 1985 to 2000**

	Incidence				Mortality (age standardised)			
	1985	1990	1995	2000	1985	1990	1995	2000
Australia	0.8	3.9	4.5	1.3	0.3	1.9	2.5	0.6 (1999)
Austria	0.3	2.1	2.6	1.0	0.2 (1986)	0.8	1.8	0.5
Belgium	0.7	2.1	2.5	1.3	0.0	0.8	2.0	. .
Canada	1.5	5.1	5.5	1.4	1.2 (1986)	3.2	5.0	1.3
Czech Republic	0.0 (1986)	0.1	0.1	0.1	0.0 (1986)	0.0	0.0	0.0
Denmark	0.8	3.8	4.1	1.1	. .	. .	4.3	0.6 (1998)
Finland	0.1	0.3	0.8	0.3	0.0 (1987)	0.0	0.0	0.2
France	1.0	7.4	8.9	2.7	1.6 (1987)	4.6	7.4	1.5 (1999)
Germany	0.4	2.3	2.3	0.9	0.2	1.5	2.1	0.6 (1999)
Greece	0.2	1.4	2.1	1.2	0.0 (1987)	0.0	0.6	0.3 (1999)
Hungary	0.0 (1986)	0.2	0.3	0.3	0.0 (1987)	0.1	0.1	0.1
Iceland	0.4	1.2	1.5	0.4	0.0 (1986)	2.0	1.0	. .
Ireland	0.1	1.7	1.5	0.4	0.0 (1987)	0.0	1.4	0.4 (1999)
Italy	0.3	5.2	9.9	3.4	0.1	3.2	7.8	1.5 (1999)
Japan	0.0	0.0	0.1	0.3	. .	0.0	0.0	0.0 (1999)
Korea	0.0 (1987)	0.0	0.0	0.1	. .		0.0	0.1
Luxembourg	0.8	2.4	3.7	2.3	. .	0.0	0.0	0.6
Mexico	0.5	3.3 (1989)	4.6	4.6	. .	. .	. .	. .
Netherlands	0.5	2.8	3.5	0.7	0.2	1.6	2.4	0.7 (1999)
New Zealand	0.9 (1987)	2.1	1.7	0.7	0.4 (1986)	1.5	1.5	0.3 (1998)
Norway	0.3	1.4	1.5	0.9	0.2 (1986)	0.8	1.2	0.2 (1999)
Poland	0.0 (1987)	0.1	0.3	0.3	. .	. .	. .	0.3
Portugal	0.3	2.6	7.9	9.3		1.5	9.3	8.5
Slovak Republic	0.0	0.0	0.0	0.1	. .	0.0 (1992)	0.0	0.0
Spain	0.4	9.7	17.8	6.6	0.1	5.0	13.9	4.0 (1999)
Sweden	0.3	1.5	2.2	0.6	0.2 (1987)	0.7	1.4	0.3 (1999)
Switzerland	1.3	9.7	8.5	2.7	. .	. .	7.6	1.7 (1999)
Turkey	0.0	0.0	0.0	0.1	. .	. .	. .	. .
United Kingdom	0.4	2.2	3.0	1.4	. .	0.0	1.0	0.3 (1999)
United States[a]	3.4	16.7	27.0	14.3	0.0 (1984)	9.1	14.3	4.7 (1999)
Average (22)[b]	**0.5**	**3.0**	**4.3**	**2.0**	**0.3**	**1.6**	**2.9**	**0.8**
Median	**0.4**	**2.1**	**2.4**	**1.0**	**0.1**	**0.8**	**1.5**	**0.5**

Note: Mortality rates are standardised to the OECD standard population (1980).

a) The United States AIDS surveillance case definition differs from the definition used in Europe in that it includes CD4+ T-lymphocyte count criteria. This broader definition results in higher reported incidence rates compared with other countries.

b) Average mortality rates exclude: Belgium, Denmark, Iceland, Mexico, Poland, Portugal, Switzerland and Turkey.

Source: OECD Health Data. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.17. **Suicides, age standardised suicide rate, per 100 000 females, males and total population, 1980 to 2000**

	1980			1990			2000		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Australia	5.6	16.9	11.1	5.0	20.3	12.5	4.9 (1999)	20.4 (1999)	12.5 (1999)
Austria	12.5	36.9	23.7	10.7	32.2	20.5	8.2	26.2	16.5
Belgium	14.0	27.3	20.2	9.9	24.5	16.6	. .	. .	. .
Canada	6.8	21.3	13.9	4.9	19.6	12.0	4.7 (1998)	18.3 (1998)	11.4 (1998)
Czech Republic	. .	. .	. .	9.0	28.6	17.8	5.4	23.4	13.8
Denmark	20.2	38.8	29.2	13.3	28.3	20.5	6.5 (1998)	18.2 (1998)	12.1 (1998)
Finland	9.7	39.9	24.1	11.1	46.1	27.8	9.8	31.4	20.4
France	9.8	27.3	17.9	9.4	27.4	17.7	7.8 (1999)	23.2 (1999)	15.0 (1999)
Germany	11.6	26.7	18.5	8.0	22.3	14.5	5.5 (1999)	17.6 (1999)	11.2 (1999)
Greece	1.7	4.6	3.1	1.3	5.0	3.1	1.3 (1999)	4.9 (1999)	3.1 (1999)
Hungary	22.8	63.1	41.4	17.5	56.7	35.4	11.0	44.4	26.5
Iceland	9.6	12.9	11.4	4.4	27.3	15.9	. .	. .	. .
Ireland	4.8	9.3	7.1	5.0	15.3	10.1	4.3 (1999)	18.0 (1999)	11.1 (1999)
Italy	4.1	9.9	6.7	3.4	10.3	6.5	2.7 (1999)	9.3 (1999)	5.7 (1999)
Japan	13.0	23.4	17.9	10.4	19.0	14.5	10.8 (1999)	29.9 (1999)	20.0 (1999)
Korea	. .	. .	. .	4.7	11.7	7.9	8.3	21.1	14.1
Luxembourg	6.0	18.7	11.6	8.7	24.1	16.0	6.1	20.7	12.8
Mexico	0.9 (1981)	3.8 (1981)	2.3 (1981)	0.8	5.5	3.0	. .	. .	. .
Netherlands	7.1	13.0	9.9	6.3	11.5	8.7	5.5 (1999)	11.7 (1999)	8.5 (1999)
New Zealand	7.4	15.5	11.3	5.3	22.0	13.4	6.8 (1998)	23.9 (1998)	15.2 (1998)
Norway	6.3	17.7	11.9	7.2	21.7	14.4	6.5 (1999)	19.0 (1999)	12.7 (1999)
Poland	4.0 (1979)	22.0 (1979)	12.6 (1979)	4.3	22.2	12.9	4.3	24.2	13.8
Portugal	3.9	12.7	7.6	3.9	13.1	8.1	1.6	7.5	4.2
Slovak Republic	. .	. .	. .	4.9 (1992)	25.5 (1992)	14.6 (1992)	4.3	21.5	12.4
Spain	2.0	7.2	4.4	3.4	10.8	6.8	3.1 (1999)	10.7 (1999)	6.7 (1999)
Sweden	10.1	25.6	17.7	9.0	21.3	15.0	7.0 (1999)	17.3 (1999)	12.0 (1999)
Switzerland	13.7	35.1	23.8	10.8	28.5	19.1	8.1 (1999)	23.6 (1999)	15.4 (1999)
Turkey	. .	. .	. .	. .	. .	. .	. .	. .	. .
United Kingdom	5.9	10.6	8.1	3.3	11.7	7.4	2.9 (1999)	10.9 (1999)	6.9 (1999)
United States	5.3	18.7	11.6	4.6	20.2	11.9	3.8 (1999)	17.0 (1999)	10.1 (1999)
Average (23)[a]	**8.4**	**22.4**	**15.0**	**7.3**	**22.2**	**14.3**	**5.8**	**19.5**	**12.3**
Median	**7.0**	**18.7**	**11.8**	**5.3**	**21.7**	**14.4**	**5.5**	**19.7**	**12.5**

Note: All mortality rates are standardised to the OECD standard population (1980).
a) The average excludes: Belgium, Czech Republic, Iceland, Korea, Mexico, Slovak Republic and Turkey.
Source: OECD Health Data. [The raw mortality data is extracted from the WHO Mortality Database (March 2003).]

© OECD 2003

Table 1.18. **Percentage of population who report their health as "good" or better, latest year available**

		Population 15 and over			Population 65 and over		
		Female	Male	Total	Female	Male	Total
Australia	2001	83.2	81.7	81.9	66.5	66.1	66.3
Austria	1999	71.8	75.3	73.5	45.6	51.0	47.6
Belgium	2001	74.9	79.6	77.2	50.2	56.3	52.7
Canada	2001	87.3	88.8	88.0	70.6	69.7	70.2
Czech Republic	2002	58.5	66.4	62.2	20.9	37.6	27.4
Denmark	2000	76.4	79.5	77.9	56.1	63.2	59.7
Finland[a]	2001	68.0	65.9	67.1	39.6	41.1	40.4
France		. .	. .	. .	. .	. .	. .
Germany	1998	64.0	68.9	66.1	45.1	49.7	47.4
Greece		. .	. .	. .	. .	. .	. .
Hungary	2000	38.9	48.1	43.2	. .	. .	. .
Iceland	2002	83.7	85.7	84.6	53.9	76.5	65.0
Ireland	1998	86.3	84.9	85.7			61.6
Italy	2001	55.5	65.6	60.6	20.5	29.7	24.3
Japan	2001	38.4	43.1	40.6	22.6	27.4	24.6
Korea	2001	41.1	50.8	45.9	23.7	34.0	27.7
Luxembourg		. .	. .	. .	. .	. .	. .
Mexico	2001	63.0	68.6	65.2	38.0	41.4	39.5
Netherlands	2001	74.9	80.9	77.9	54.1	60.7	56.9
New Zealand	1997	88.2	87.3	87.8	76.4	74.7	75.6
Norway	1998	78.2	81.1	79.6	59.4	66.3	62.3
Poland	2001	42.6	51.7	46.8	8.1	13.4	10.1
Portugal	1999	27.1	38.5	31.3	6.9	15.7	10.4
Slovak Republic	2000	31.6	39.3	35.6	. .	. .	. .
Spain	2001	64.3	75.6	69.8	36.3	47.4	41.0
Sweden	2001	71.3	75.8	73.5	49.3	52.3	50.7
Switzerland	1997	80.4	86.2	83.2	65.6	76.1	69.8
Turkey		. .	. .	. .	. .	. .	. .
United Kingdom	2001	74.0	74.6	74.3	53.4	55.7	54.4
United States	2001	88.2	89.7	88.9	73.8	72.8	73.4

Note: Caution is required in making cross-country comparisons of self-reported general health, for at least two reasons. First, there remain some variations in the question and answer categories used to measure self-rated general health across surveys/countries. A second comparability problem arises from the fact that people's overall assessment of their own health is subjective and can be affected by a number of factors beyond their real health status, such as cultural background and national traits.

a) In Finland, estimates for the population 15 and over relate only to the population aged 15-64 (they exclude the population aged over 65).

Source: OECD Health Data 2003.

© OECD 2003

Table 1.19. **Low birth weight, percentage of total live births, 1980 to 2000**

	1980		1985		1990	1995		2000	
Australia	5.6	(1983)	5.8		6.1	5.9		6.3	
Austria	5.7		5.8		5.6	5.7		6.3	
Belgium	5.6	(1982)	6.1	(1986)	6.1	6.5		. .	
Canada	6.0		5.7		5.4	5.9		5.8	
Czech Republic	5.9		5.6		5.5	5.5		5.8	
Denmark	5.8		5.7		5.2	5.5		5.9	
Finland	3.9		4.1		3.6	4.0		4.3	
France	5.2	(1981)	5.3	(1986)	5.3	5.8		6.4	
Germany	5.5		5.7		5.7	6.1		6.5	(1999)
Greece	5.9		6.0		6.0	6.8		8.1	
Hungary	10.4		9.9		9.3	8.2		8.4	
Iceland	3.4		3.9		3.2	4.7		4.1	
Ireland	. .		4.1		4.2	4.7		4.8	
Italy	5.6		5.6		5.6	6.0		. .	
Japan	5.2		5.5		6.3	7.5		8.6	
Korea	. .		. .		. .	3.0		3.8	
Luxembourg	6.3		6.0		5.4	5.7		6.8	(1998)
Mexico	. .		. .		. .	6.8	(1994)	6.1	
Netherlands	4.0	(1979)	. .		4.8	4.8	(1996)	4.7	(1999)
New Zealand	5.8		6.0		6.2	6.0		6.4	
Norway	3.8		4.4		4.6	4.6		5.0	
Poland	7.6		7.8		8.1	6.7		5.7	
Portugal	4.6		5.3		5.6	6.0		7.1	
Slovak Republic	5.9		5.8		5.8	6.5		6.7	
Spain	. .		3.6		4.5	5.5		6.5	
Sweden	4.2		4.8		4.5	4.4		4.2	
Switzerland	5.1		5.2		5.1	5.5		5.9	
Turkey	. .		. .		. .	. .		7.9	(1998)
United Kingdom	6.7		6.8		6.8	7.3		7.6	
United States	6.8		6.8		7.1	7.3		7.6	
Average (23)[a]	**5.6**		**5.8**		**5.7**	**5.9**		**6.3**	
Median	**5.6**		**5.7**		**5.6**	**5.9**		**6.3**	

Note: Low birth weight is measured by the number of live births weighing less than 2 500 grams as a percentage of total live births.
a) The average excludes: Belgium, Ireland, Italy, Korea, Mexico, Spain and Turkey.
Source: OECD Health Data 2003.

© OECD 2003

Table 2.1. **Practising physicians, density per 1 000 population, 1960 to 2000**

	1960	1970	1980	1990	2000
Australia	1.1 (1961)	1.2 (1971)	1.8 (1981)	2.2	2.4
Austria	1.6 (1961)	1.6	2.2	3.0	3.8
Belgium[a]	1.3	1.6 (1969)	2.3	3.3	3.9
Canada	1.1 (1961)	1.4	1.8	2.1	2.1
Czech Republic[b]	. .	1.8	2.3	2.7	3.4
Denmark[a]	1.2	1.4	2.2	3.1	3.4
Finland[c]	0.6	0.9	1.7	2.4	3.1
France[a]	1.0	1.3	2.0	3.1	3.3
Germany	. .	. .	. .	2.8 (1991)	3.3
Greece	1.3	1.6	2.4	3.4	4.5
Hungary	1.5	2.0	2.3	2.9	3.1 (1999)
Iceland[a]	1.2	1.4	2.1	2.8	3.4
Ireland[c]	. .	. .	. .	2.0 (1992)	2.2
Italy	. .	. .	. .	. .	4.1
Japan	1.0	1.1	1.3	1.7	1.9
Korea	. .	. .	0.5 (1981)	0.8	1.3
Luxembourg[a]	1.0	1.1	1.7	2.0	2.5
Mexico[b]	. .	. .	. .	0.8	1.1
Netherlands[c]	1.1	1.2	1.9	2.5	3.2
New Zealand	1.1 (1961)	1.1 (1971)	1.6	1.9	2.2
Norway[b]	1.2	1.4	2.0	2.6 (1991)	2.9
Poland	1.0	1.4	1.8	2.1	2.2
Portugal	0.8	0.9	2.0	2.8	3.2
Slovak Republic	. .	. .	. .	. .	3.7
Spain	. .	. .	. .	. .	3.3
Sweden	1.0	1.3	2.2	2.9	3.0
Switzerland	1.4	1.5	2.5	3.0	3.5
Turkey	0.3	0.4	0.6	0.9	1.3
United Kingdom	0.8	0.9	1.3	1.5	2.0
United States[a]	1.4	1.6	2.0	2.4	2.7 (1999)
Average (22)[d]	**1.1**	**1.3**	**1.9**	**2.5**	**2.9**
Median	**1.1**	**1.4**	**2.0**	**2.5**	**3.1**

a) Includes physicians working in industry, administration and research.
b) The Czech Republic, Mexico and Norway report full time equivalents (FTE) rather than headcounts.
c) Finland, Ireland and Netherlands provide the number of physicians entitled to practise rather than actively practising physicians.
d) The average excludes: Czech Republic, Germany, Ireland, Italy, Korea, Mexico, Slovak Republic and Spain.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.2. **Practising nurses, density per 1 000 population, 1970 to 2000**

	1970		1980	1990	2000	
Australia	6.7		10.3	11.6	10.7	
Austria[a]	3.4		5.4	7.2	9.2	
Belgium	. .		8.5	. .	. .	
Canada[b]	6.9		9.6	11.1	9.9	
Czech Republic	. .		6.8	8.4	8.9	
Denmark	. .		6.9	8.6	9.5	
Finland[c]	6.0		8.3	10.2	14.7	
France[d]	3.1	(1971)	4.7	5.6	6.7	
Germany[e]	. .		. .	. .	9.6	
Greece	1.4		1.9	3.4	3.9	(1999)
Hungary	2.7		3.7	4.5	4.8	
Iceland	4.9		9.6	13.3	14.0	
Ireland	. .		. .	11.3	14.0	
Italy[a]	. .		. .	. .	5.2	(1999)
Japan	2.6		4.2	6.0	7.8	(1998)
Korea	. .		. .	. .	3.0	
Luxembourg	. .		. .	. .	10.1	
Mexico[e]	. .		. .	1.5	2.2	
Netherlands	. .		. .		13.4	
New Zealand	. .		6.1	9.3	9.6	
Norway[e]	. .		. .	. .	10.3	
Poland	3.0		4.4	5.5	4.9	
Portugal	1.8	(1971)	2.3	2.8	3.7	
Slovak Republic	. .		. .	. .	7.5	
Spain[f]	. .		. .	. .	6.6	
Sweden	4.3		7.0	9.2	8.8	
Switzerland	. .		. .	. .	10.7	
Turkey	. .		1.0	1.3	1.7	
United Kingdom	. .		. .	7.8	8.8	
United States	3.7		5.6	7.2	8.1	(1999)
Average (17)[g]	**n.a.**		**5.8**	**7.4**	**8.1**	
Median	**3.4**		**5.9**	**7.5**	**8.8**	

a) Austria and Italy report only nurses employed in hospitals; they do not include nurses working in other health facilities.
b) Canada includes practising registered nurses, plus licensed practical nurses (not all practising), but does not include psychiatric nurses.
c) Finland reports all nurses entitled to practise.
d) In France, nursing assistants are not included.
e) In Germany, Mexico and Norway, data refer to full time equivalent nurses (not headcounts).
f) Spain includes only publicly employed nurses (nurses employed in the National Health Service).
g) The average excludes: Belgium, Germany, Ireland, Italy, Korea, Luxembourg, Mexico, Netherlands, Norway, Slovak Republic, Spain, Switzerland and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.3. **Acute care beds, density per 1 000 population, 1980 to 2000**

	1980	1985	1990	1995	2000
Australia	6.4	5.3	4.8 (1989)	4.2	3.8
Austria	. .	7.4	7.0	6.6	6.2
Belgium	5.5	5.9	4.9	4.7	. .
Canada[a]	4.6	4.4	4.0	3.9	3.2
Czech Republic	8.6	8.6	8.5	7.2	6.6
Denmark	5.3	4.7	4.1	3.6	3.3 (1999)
Finland[b]	4.9	4.8	4.3	4.0	2.4
France	6.2	5.7	5.2	4.6	4.2
Germany	7.7	7.6	7.5	6.9	6.4
Greece	4.7	4.2	4.0	4.0	4.0 (1999)
Hungary	6.6	6.8	7.1	7.0	6.3
Iceland	. .	. .	4.3	3.7	. .
Ireland	4.3	4.2	3.3	3.2	3.0
Italy	7.9	7.0	6.2	5.5	4.3
Japan	. .	. .	. .	. .	. .
Korea	. .	. .	2.7	3.8	5.2
Luxembourg	7.4	7.5	7.0	7.4	6.7
Mexico			1.0 (1991)	1.1	1.0
Netherlands	5.2	4.7	4.3	3.8	3.5
New Zealand	. .	8.7 (1986)	8.0	. .	. .
Norway	5.2	4.7	3.8	3.3	3.1
Poland	5.6	5.7	6.3	5.8	5.1
Portugal	4.2	3.5	3.4	3.3	3.3 (1998)
Slovak Republic	. .	. .	. .	6.5 (1996)	5.9
Spain	. .	3.5	3.3	3.0	3.2 (1998)
Sweden	5.1	4.6	4.1	3.0	2.4
Switzerland	7.2	6.8	6.5	5.5	4.1
Turkey	1.5	1.6	2.0	2.1	2.2
United Kingdom	. .	. .	. .	4.1	3.9
United States	4.4	4.2	3.7	3.3	2.9
Average (20)[c]	**5.7**	**5.3**	**5.0**	**4.6**	**4.0**
Median	**5.3**	**5.1**	**4.3**	**4.0**	**3.9**

a) Break in time series in Canada in 1995. Before 1995, the Canadian figures represent beds in short-term units of all hospitals. Starting in 1995, they represent beds in short-stay hospitals; many of the short-stay hospitals also have long-term care beds.

b) Break in time series in Finland after 1995.

c) The average excludes: Austria, Belgium, Iceland, Japan, Korea, Mexico, New Zealand, Slovak Republic, Spain and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.4. **Long-term care beds, density per 1 000 population aged 65 and over, 1980 to 2000**

	1980	1985	1990	1995	2000
Australia	46.1	45.5	38.4	34.7	30.6
Austria	. .	15.4	13.8	12.7	11.6
Belgium	. .	. .	. .	. .	. .
Canada	. .	. .	. .	. .	. .
Czech Republic	. .	. .	. .	. .	. .
Denmark	66.6	64.5	56.0	45.8	37.5
Finland	100.1 (1981)	93.4 (1986)	77.4	62.2	52.0
France	. .	. .	. .	. .	. .
Germany	. .	. .	22.5 (1991)	23.9	. .
Greece	11.4	11.0	10.7	8.7	. .
Hungary	. .	. .	. .	. .	. .
Iceland	. .	. .	67.0	71.5	66.8
Ireland	80.7	75.6	63.1	60.5	54.2
Italy	. .	. .	. .	. .	. .
Japan[a]	. .		2.0	5.6	10.6
Korea	. .	. .	. .	. .	. .
Luxembourg	. .	13.3 (1986)	15.2	24.3	38.9
Mexico	. .	. .		. .	. .
Netherlands	28.6	28.2	26.9	27.1	26.9
New Zealand	. .	. .	. .	. .	. .
Norway	. .	. .	66.2 (1991)	63.1	63.0
Poland	57.7	60.4	55.5	49.3	45.1
Portugal	. .	. .	. .	. .	. .
Slovak Republic	. .	. .	. .	8.7 (1996)	9.3
Spain	. .	. .	. .	. .	. .
Sweden	33.1	35.8	30.2	. .	. .
Switzerland	. .	. .	80.9 (1991)	84.3 (1997)	76.3
Turkey	. .	. .	. .	3.2 (1996)	3.8
United Kingdom	. .	. .	22.2	26.7	24.7
United States	. .	. .	. .	. .	. .

Note: Some of the international variation in long-term care beds is due to the difficulty of distinguishing clearly long-term health care from long-term social services in different institutions for elderly dependent persons (or even in different units within an institution).

a) Data for Japan excludes beds in long term care units in hospitals.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.5. **Medical technology: CT scanners and MRI units, density per million population, 1990 and 2000**

	CT scanners				MRI units			
	1990		2000		1990		2000	
Australia	13.8		. .		0.6		4.7	
Austria	11.6		25.8		1.2	(1989)	10.8	
Belgium	16.1		. .		2.0		3.2	(1997)
Canada	7.1		9.5	(2001)	0.7		2.5	
Czech Republic	2.1	(1991)	9.6		0.2	(1991)	1.7	
Denmark	4.3		11.4		2.5		6.6	
Finland	9.8		13.5		1.8		9.9	
France	6.7		9.6		0.8		2.6	
Germany	10.1		17.1	(1997)	1.9		6.2	(1997)
Greece	6.5		13.8	(1997)	0.4		2.0	(1998)
Hungary	1.9		5.3		0.1		1.5	
Iceland	11.8		21.3		3.9		10.7	
Ireland	4.3		. .		. .		. .	
Italy	6.0		20.6		1.3		7.5	
Japan	55.2		84.4	(1999)	6.1		23.2	(1999)
Korea	12.2	(1993)	28.4		1.4	(1992)	5.4	
Luxembourg	15.7		25.1		2.6		4.6	
Mexico	. .		2.0		. .		0.3	
Netherlands	7.3		. .		0.9		. .	
New Zealand	3.6		8.8		. .		2.6	(1998)
Norway	11.6		. .		0.7		. .	
Poland	0.2		0.4	(1997)	0.1	(1991)	0.4	(1997)
Portugal	4.5		12.1	(1997)	0.8		2.8	(1997)
Slovak Republic	0.8		8.3		. .		1.1	
Spain	4.4	(1988)	12.1		0.7	(1988)	4.9	
Sweden	10.5		14.2	(1999)	1.5		7.9	(1999)
Switzerland	12.5		18.5		3.9		12.9	
Turkey	1.6		7.2	(1999)	. .		. .	
United Kingdom	4.3		6.2	(1999)	1.0		4.6	(1999)
United States[a]	14.6		13.1		3.7		8.1	
Average (21)[b]	**10.1**		**17.7**		**1.7**		**6.5**	
Median	**7.1**		**12.1**		**1.2**		**4.7**	

a) US data is an under estimation as it refers to the number of general hospitals reporting to have at least one CT or MRI scanner, rather than the total number of scanners in all health care facilities.
b) The average excludes: Australia, Belgium, Ireland, Mexico, Netherlands, New Zealand, Norway, Slovak Republic and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.6. **Consultations with doctors, per capita, 1970 to 2000**

	1970		1980	1990		2000	
Australia[a]	3.1		4.0	6.1		6.4	
Austria	5.2		5.4	5.9		6.7	
Belgium	6.0		7.1	7.7		7.9	
Canada	4.3	(1972)	5.6	6.7		6.3	
Czech Republic	9.9		12.4	11.8		12.6	
Denmark[b]	. .		5.0	5.7		6.1	
Finland	2.4		3.2	3.9		4.3	
France	. .		4.2	5.9		6.9	
Germany	. .		. .	5.3	(1991)	. .	
Greece	2.2		2.6	2.5		2.5	(1998)
Hungary	. .		. .	. .		12.2	
Iceland	. .		. .	5.1		5.5	
Ireland	. .		5.8	6.6	(1988)	. .	
Italy	6.3		8.0	6.8	(1991)	6.1	
Japan	. .		. .	13.8		14.4	
Korea	. .		. .	. .		8.8	(1999)
Luxembourg	. .		. .	. .		6.1	
Mexico	. .		1.3	1.7		2.5	
Netherlands[c]	4.2	(1968)	4.9	5.5		5.9	
New Zealand	. .		3.7	. .		4.4	(2001)
Norway	. .		. .	3.8	(1991)	. .	
Poland	4.9		6.5	5.8		5.4	
Portugal[d]	1.5		3.7	3.0		3.4	(1998)
Slovak Republic	. .		. .	. .		. .	
Spain	. .		. .	. .		8.7	(2001)
Sweden	1.9	(1971)	2.6	2.8	(1988)	2.8	
Switzerland	. .		. .	. .		. .	
Turkey[d]	1.2	(1972)	1.2	1.5	(1987)	2.5	
United Kingdom[e]	5.0	(1972)	5.2	6.1		4.9	
United States[f]	. .		. .	. .		8.9	
Average (14)[g]	**4.2**		**5.2**	**5.4**		**5.6**	
Median	**4.2**		**5.0**	**5.7**		**6.1**	

a) Australian data up to 1975 represent visits to general practitioners only, while data from 1975 onward reflect visits to generalists and specialists.
b) Denmark includes consultations by telephone, but excludes consultations with specialists.
c) The Netherlands do not include contacts for maternal and childcare, nor discharge planning visits in hospitals and nursing homes.
d) Portugal and Turkey exclude visits to private practitioners.
e) The UK does not include consultations with specialists in the independent sector or consultations with specialists outside hospital outpatient departments.
f) The US estimates include all telephone calls for medical advice, prescriptions and test results; they are therefore not limited to physician visits.
g) The average includes: Australia, Austria, Belgium, Canada, Czech Republic, Finland, Greece, Italy, Netherlands, Poland, Portugal, Sweden, Turkey and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.7. **Immunisation, percentage of children immunised against DTP and measles, 1980 to 2000**

	DTP			Measles		
	1980	1990	2000	1980	1990	2000
Australia[a]	. .	71.0 (1989)	89.8	. .	83.9 (1989)	91.0
Austria	90.0 (1981)	90.0	84.0 (2001)	. .	60.0	78.5 (2001)
Belgium	95.0 (1981)	94.0 (1989)	97.1 (1999)	. .	. .	82.4 (1999)
Canada	. .	. .	84.2 (1998)	. .	. .	96.2 (1998)
Czech Republic	97.0	99.2	98.4	98.0	98.0	97.1
Denmark	99.0	99.0	97.0		82.0	100.0
Finland	92.0 (1981)	94.0	95.0	70.0 (1981)	87.0	96.0
France	79.0 (1981)	95.0	98.0	. .	71.0	84.0
Germany	. .	. .	96.8	. .	70.0 (1991)	89.7
Greece	. .	85.0 (1991)	88.0 (1999)	. .	76.0	88.0 (1999)
Hungary	99.0	99.9	99.8	99.0	99.0	99.8
Iceland	99.0	99.0	98.0	. .	95.0	91.0
Ireland	. .	65.0	86.0 (1999)	. .	78.0 (1989)	77.0 (1999)
Italy	. .	83.0	87.3	. .	43.0	74.1
Japan	65.0	90.0	85.0	54.2	65.5	97.6
Korea	. .	90.7 (1988)	98.7 (1999)	. .	85.1 (1988)	90.2 (1999)
Luxembourg	. .	90.0		. .	80.0	. .
Mexico	. .	52.9	97.4	. .	75.3	95.9
Netherlands	94.5	97.1	97.0	92.0	94.0	96.0
New Zealand	. .	80.6 (1992)	88.7	. .	82.0 (1992)	85.0
Norway	. .	86.0	95.0	. .	93.0	92.0
Poland	95.0 (1981)	99.3	98.0	65.0 (1981)	95.0	98.2
Portugal	73.0	88.7	96.0 (2001)	54.0	85.0	87.0
Slovak Republic	98.9	99.0	98.3	98.5	98.5	99.2
Spain	. .	93.0	94.6	. .	97.0	95.2
Sweden	99.0 (1981)	99.0	99.1	. .	95.0	95.5
Switzerland	. .	95.0 (1991)	94.0 (1998)	. .	90.0	81.0 (1998)
Turkey	42.0	74.0	80.0	. .	68.0	86.0
United Kingdom	57.0	81.0	91.8	53.0	87.0	88.0
United States	. .	72.1 (1993)	81.7	. .	82.0 (1991)	90.5
Average[b]	**85.9**	**93.6**	**94.5**	**76.0**	**89.9**	**95.4**
Median	**94.8**	**90.4**	**95.0**	**70.0**	**84.5**	**91.0**

a) Data for Australia for 1989 are self-reported from the National Health Survey covering 1-4 years olds.
b) The average for DTP coverage includes the 16 countries for which data is available for all time periods. The average for measles coverage includes the nine countries for which data is available for all time periods.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.8. **Hospital discharge rates for all causes, per 100 000 population, 1990 to 2000**

	1990		1995		2000	
Australia	. .		16 482		15 771	
Austria[a]	22 671		23 955		28 442	
Belgium	. .		15 884		15 431	
Canada	. .		11 028		9 391	
Czech Republic	17 367	(1992)	20 739		21 203	
Denmark	. .		18 093		18 813	
Finland	21 743		24 567		25 659	
France	. .		23 370	(1993)	24 962	
Germany	. .		18 159		19 730	(1999)
Greece	12 599		14 321		15 412	(1998)
Hungary[a]	. .		. .		24 071	
Iceland	. .		. .		15 261	(1998)
Ireland	. .		11 460		12 731	
Italy	. .		15 209	(1996)	15 477	
Japan	9 915		10 710	(1996)	10 051	(1999)
Korea	6 536		7 710	(1994)	9 596	(1999)
Luxembourg[a]	. .		. .		22 851	
Mexico[b]	3 699	(1991)	3 913		4 038	
Netherlands	10 212		10 230		9 266	
New Zealand[a]	14 716		17 362		19 975	
Norway	. .		14 544		15 408	
Poland	12 597		13 887		13 138	(1999)
Portugal	6 813		8 601		7 362	
Slovak Republic	15 336		19 188		19 694	
Spain	9 502		10 697		11 277	
Sweden	17 884		17 458		16 458	
Switzerland	. .		. .		. .	
Turkey	5 669		6 104		7 463	
United Kingdom	. .		. .		. .	
United States[a]	12 333		11 538		11 239	
Average (16)[c]	**12 475**		**13 811**		**14 392**	
Median	**12 465**		**14 544**		**15 422**	

a) Austria, Hungary, Luxembourg, New Zealand and the United States include same-day separations whereas other countries exclude them.
b) Data for Mexico are restricted to public hospitals only.
c) The average excludes: Australia, Belgium, Canada, Denmark, France, Germany, Hungary, Iceland, Ireland, Italy, Luxembourg, Norway, Switzerland and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.9. **Hospital discharge rates for selected causes, per 100 000 population, 1990 to 2000**

	Circulatory				Respiratory				Digestive			
	1990		2000		1990		2000		1990		2000	
Australia	. .		1 753		. .		1 455		. .		1 506	
Austria[a]	3 198		4 022		1 685		2 025		2 150		2 272	
Belgium	. .		2 335		. .		1 399		. .		1 754	
Canada	1 569		1 453		1 294		833		1 485		1 045	
Czech Republic	2 474	(1992)	3 379		1 515	(1992)	1 489		1 794	(1992)	2 157	
Denmark	. .		2 542		. .		1 556		. .		1 582	
Finland	3 293		3 783		2 094		2 388		1 553		1 842	
France	. .		2 252		. .		1 374		. .		2 946	
Germany	. .		3 367	(1999)	. .		1 265	(1999)	. .		1 911	(1999)
Greece	1 593		2 214	(1998)	1 052		1 305	(1998)	1 444		1 702	(1998)
Hungary[a]	. .		4 202		. .		2 000		. .		1 802	
Iceland	. .		1 900	(1998)	. .		1 288	(1998)	. .		1 238	(1998)
Ireland	. .		1 426		. .		1 438		. .		1 332	
Italy	. .		2 544		. .		1 203		. .		1 724	
Japan	1 202		1 357	(1999)	726		866	(1999)	1 198		1 032	(1999)
Korea	330		705	(1999)	525		588	(1999)	872		982	(1999)
Luxembourg[a]	. .		2 627		. .		2 042		. .		2 101	
Mexico[b]	132	(1991)	196		209	(1991)	257		295	(1991)	403	
Netherlands	1 420		1 409		686		636		854		825	
New Zealand[a]	1 383		1 879		1 182		1 476		1 071		1 603	
Norway	1 924		2 250		924		1 308		962		1 108	
Poland	1 816		2 051	(1999)	1 169		1 099	(1999)	1 286		1 191	(1999)
Portugal	. .		1 070		. .		714		. .		969	
Slovak Republic	1 960		2 809		1 595		1 528		1 850		2 111	
Spain	783		1 382		701		1 084		971		1 292	
Sweden	2 796		2 823		1 274		1 093		1 359		1 293	
Switzerland	. .		. .		. .		. .		. .		. .	
Turkey	572		946		558		836		603		695	
United Kingdom	. .		. .		. .		. .		. .		. .	
United States[a]	2 067		2 231		1 188		12 21		1 298		1 114	
Average (17)[c]	**1 677**		**2 052**		**1 081**		**1 178**		**1 238**		**1 333**	
Median	**1 593**		**2 223**		**1 169**		**1 297**		**1 286**		**1 419**	

a) Austria, Hungary, Luxembourg, New Zealand and the United States include same-day separations whereas other countries exclude them.
b) Data for Mexico are restricted to public hospitals only.
c) The average excludes: Australia, Belgium, Denmark, France, Germany, Hungary, Iceland, Ireland, Italy, Luxembourg, Norway, Switzerland and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.10. **Average length of stay for acute care, all conditions, days, 1985 to 2000**

	1985	1990	1995	2000
Australia	7.4	7.2 (1989)	6.5	6.1
Austria[a]	10.8	9.3	7.9	6.3
Belgium	. .	. .	9.4	8.0 (1999)
Canada[b]	10.7	8.6	7.2	7.2
Czech Republic	13.1	12.0	10.2	8.7
Denmark	7.8	6.4	4.1	3.8
Finland	8.0	7.0	5.5	4.4
France	8.3	7.0	5.9	5.5 (1999)
Germany	13.5	14.1	11.4	9.6
Greece	8.9	7.5	6.4	6.3 (1998)
Hungary[a]	10.6	9.9	8.6	7.9
Iceland	. .	7.0	5.9	5.7 (1998)
Ireland	7.4	6.7	6.6	6.4
Italy	. .	9.5 (1991)	8.4	7.0
Japan	. .	. .	. .	. .
Korea	11.0	12.0	11.0	11.0
Luxembourg[a]	11.9	11.0	9.8	9.3
Mexico[c]	4.0 (1986)	4.2	3.7	3.6
Netherlands	12.5	11.2	9.9	9.0
New Zealand[a]	. .	. .	5.5 (1997)	4.9 (1998)
Norway	9.6	7.8	6.5	6.0
Poland	. .	. .	. .	. .
Portugal	11.1	8.4	7.9	7.3 (1998)
Slovak Republic	. .	. .	10.6 (1996)	8.6
Spain	10.1	9.6	8.8	7.5 (1998)
Sweden	7.5	6.5	5.2	5.0
Switzerland	14.7	13.4	12.0	9.3
Turkey	6.2	6.0	5.7	5.4
United Kingdom[c, d]	8.0	5.7	7.0	6.9
United States[a]	7.1	7.3	6.5	5.8
Average (23)[e]	**9.6**	**8.6**	**7.6**	**6.9**
Median	**9.6**	**7.8**	**7.1**	**6.7**

a) Austria, Hungary, Luxembourg, New Zealand and the United States include same-day separations whereas other countries exclude them.
b) Break in time series in Canada in 1995. Before 1995, the Canadian figures represent ALOS in short-term units of all hospitals. Starting in 1995, they represent ALOS in short-stay hospitals; many of the short-stay hospitals also have long-term care beds.
c) Data for the United Kingdom and Mexico are restricted to public hospitals only.
d) Break in the UK series; prior to 1995 psychiatric care is excluded.
e) The average excludes: Belgium, Iceland, Italy, Japan, New Zealand, Poland and Slovak Republic.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.11. **Average length of stay, specific conditions, days, 1990 to 2000**

	AMI		Cerebrovascular		Pneumonia/Influenza		Normal delivery	
	1990	2000	1990	2000	1990	2000	1990	2000
Australia	. .	6.8	. .	12.3	. .	7.0	. .	2.9
Austria	18.9	15.0	21.9	15.5	14.7	16.3	7.2	5.7
Belgium	. .	9.7	. .	15.8	. .	12.6	. .	5.3
Canada	. .	8.4	. .	14.8	. .	7.8	. .	2.0
Czech Republic	16.8 (1992)	8.9	18.0 (1992)	14.3	14.3 (1992)	10.8	7.4 (1992)	5.8
Denmark	8.0	6.7	. .	15.6	9.3	7.1	3.8	3.2
Finland	22.3	14.4	51.2	35.1	58.6	29.6	5.4	3.7
France	. .	7.5	. .	11.6	. .	9.8	. .	4.9
Germany	. .	12.6 (1999)	. .	15.1 (1999)	. .	12.9 (1999)	. .	4.8 (1999)
Greece	11.0	7.0 (1998)	14.0	13.0 (1998)	8.0	7.0 (1998)	5.0	4.0 (1998)
Hungary	15.4 (1992)	11.6	. .	11.9	18.2 (1992)	10.4	7.3 (1992)	6.6
Iceland	12.5	9.2 (1998)	. .	11.8 (1998)	11.5	8.2 (1998)	5.3	3.6 (1998)
Ireland	10.7	10.5	. .	18.5	16.2	10.4	5.8	3.9 (1999)
Italy	15.6	9.4	16.5 (1991)	10.2	15.9	10.5	5.8	3.9
Japan	. .	. .	. .		. .	. .	. .	. .
Korea	. .	. .	. .	22.9 (1999)	. .	7.7 (1999)	. .	2.2 (1999)
Luxembourg	. .	9.7	. .	16.5	. .	11.8	. .	5.3
Mexico[a]	9.0 (1992)	7.1	. .	7.4	6.9 (1991)	5.9	1.0 (1991)	1.3
Netherlands	12.7		25.5 (1988)	21.1	15.4 (1988)	13.3	3.7	2.7
New Zealand	8.7	6.5	48.8	38.2	15.8	9.8	4.2	2.0
Norway	8.6	7.4	21.4	10.0	12.4	8.1	5.3	4.0
Poland	19.1	13.7 (1999)	19.3	15.5 (1999)	18.1	13.1 (1999)	. .	5.5 (1999)
Portugal	11.9	9.5 (1999)	. .	10.0 (1999)	10.9 (1991)	10.1 (1999)	3.5	2.9 (1999)
Slovak Republic	18.5	11.5	18.3	12.1	17.8	10.8	8.3	6.8
Spain	12.9	11.0	19.7	13.6	12.7	10.5	4.1	3.0
Sweden	9.2 (1992)	6.6	25.6 (1992)	12.9	38.7 (1991)	6.8	4.4	2.8
Switzerland	15.1	. .	. .	. .	15.5 (1991)	. .	7.6	. .
Turkey	. .	. .	8.7	6.3	5.6	6.0	1.9	1.7
United Kingdom[a]	9.7	. .	. .	. .	30.3	. .	. .	. .
United States	8.4	5.7	9.5	5.4	8.2	5.8	2.0	2.0
Average[b]	**13.2**	**9.5**	**22.7**	**15.9**	**16.5**	**10.5**	**4.8**	**3.7**
Median	**12.5**	**9.3**	**19.5**	**13.6**	**15.1**	**10.1**	**5.2**	**3.7**

a) Data for the United Kingdom and Mexico are restricted to public hospitals only.
b) The average includes those countries for which data is available for both 1990 and 2000.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.12. **Surgical procedures, ambulatory and inpatient, per 1 000 population, 1995 and 2000**

	1995				2000			
	Total	Inpatient	Day cases	% of total	Total	Inpatient	Day cases	% of total
Australia	. .	. .	. .	. .	88.5	50.0	38.4	43%
Austria	. .	118.6 (1997)	. .	. .	. .	130.1	. .	. .
Belgium	. .	. .	. .	. .	. .	. .	. .	. .
Canada	. .	40.5	. .	. .	. .	33.9	. .	. .
Czech Republic	. .	53.6	. .	. .	. .	60.2	. .	. .
Denmark	. .	75.8 (1996)	. .	. .	. .	75.7	. .	. .
Finland	78.5	62.1	16.3	21%	90.1	58.9	31.2	35%
France	. .	. .	. .	. .	. .	. .	. .	. .
Germany	. .	63.8 (1994)	. .	. .	. .	77.6 (1999)	. .	. .
Greece	. .	35.5 (1996)	. .	. .	. .	41.1 (1998)	. .	. .
Hungary	. .	. .	. .	. .	162.7	160.4	2.3	1%
Iceland	. .	. .	. .	. .	79.7 (1998)	69.5 (1998)	10.2 (1998)	13%
Ireland[a]	107.1	65.5	41.6	39%	169.9	100.5	69.4	41%
Italy	112.3 (1996)	97.5 (1996)	14.8 (1996)	13%	144.7	110.4	34.3	24%
Japan	. .	. .	. .	. .	. .	. .	. .	. .
Korea	. .	. .	. .	. .	. .	. .	. .	. .
Luxembourg	208.8 (1996)	118.1 (1996)	90.7 (1996)	43%	215.1	129.2	85.9	40%
Mexico	. .	. .	. .	. .	25.1	18.6	6.4	25%
Netherlands	71.8	44.0	27.8	39%	70.3	37.7	32.6	46%
New Zealand	43.5 (1997)	28.6 (1997)	14.8 (1997)	34%	49.1	30.7	18.4	37%
Norway	. .	. .	. .	. .	. .	. .	. .	. .
Poland	. .	. .	. .	. .	. .	. .	. .	. .
Portugal	. .	. .	. .	. .	. .	. .	. .	. .
Slovak Republic	. .	. .	. .	. .	. .	. .	. .	. .
Spain	59.5	54.2	5.3	9%	63.6 (1998)	52.9 (1998)	10.6 (1998)	17%
Sweden	. .	55.3	. .	. .	. .	52.6	. .	. .
Switzerland	. .	. .	. .	. .	. .	. .	. .	. .
Turkey	. .	19.4	. .	. .	. .	24.3	. .	. .
United Kingdom[b]	122.6	. .	. .	. .	130.2	66.3	63.9	49%
United States[a]	. .	84.6	. .	. .	. .	82.4	. .	. .

a) Ireland and the United States report up to four procedures per discharged patient while other countries only report the main surgical procedure. Data from Ireland and the United States also include both surgical and non-surgical procedures (for example, diagnostic procedures such as endoscopies). They therefore over-estimate the volume of surgical procedures compared with data from other countries.

b) Data for the United Kingdom refer to England NHS only. Source: Hospital Episode Statistics (HES), Department of Health.

Source: OECD Health Data 2003.

© OECD 2003

Table 2.13. **Cardiovascular surgeries, per 100 000 population, 1990 to 2000**

	Coronary artery bypass grafts (CABG)			Coronary angioplasties		
	1990	1995	2000	1990	1995	2000
Australia	61.1	94.9	89.4	28.7	62.8	114.2
Austria	. .	. .	56.7	. .	. .	174.8
Belgium	. .	. .	. .	. .	97.8	262.1
Canada	44.3	55.3	68.6	. .	60.7	97.3
Czech Republic	6.2 (1991)	23.0	53.0	5.8 (1992)	. .	. .
Denmark	20.1	41.5	66.2	17.5 (1992)	29.8	96.2
Finland	38.4	84.9	80.3	13.1	35.3	55.9
France	. .	36.0 (1993)	40.1	. .	34.8 (1993)	144.5
Germany	41.3	71.5	90.2 (1998)	51.3	108.5 (1994)	. .
Greece	18.8	60.6		6.6	27.4	. .
Hungary	. .	12.9 (1993)	91.4	1.6 (1992)	6.4 (1993)	46.5
Iceland	54.2	72.9	40.4 (1999)	51.4	127.1	166.9 (1999)
Ireland	. .	25.8	40.0 (2001)	. .	18.0	101.0
Italy	. .	33.5 (1996)	48.0	. .	29.0 (1996)	86.9
Japan	. .	. .	. .	. .	. .	. .
Korea	. .	. .	. .	. .	. .	. .
Luxembourg	. .	. .	40.7	. .	. .	125.2
Mexico	. .	0.4	1.3	. .	0.3	0.9
Netherlands	61.5	. .	92.9	42.2 (1992)	. .	74.0
New Zealand	. .	68.3 (1996)	103.3	. .	54.2 (1996)	73.9
Norway	. .	72.7 (1996)	76.1	. .	49.4 (1993)	117.2
Poland	. .	8.0 (1993)	. .	4.4 (1992)	4.8 (1993)	. .
Portugal	. .	19.3	22.9	. .	14.4	45.5
Slovak Republic	. .	. .	. .	. .	. .	. .
Spain	11.2	18.0	17.0	12.7 (1991)	31.5	50.9
Sweden	50.6	71.7	72.8	12.8	54.7	94.1
Switzerland	. .	62.2 (1993)	. .	45.7 (1992)	65.1 (1993)	. .
Turkey	. .	. .	. .	. .	. .	. .
United Kingdom	20.2 (1991)	38.5	40.8	7.8 (1991)	22.3	38.8
United States	157.1	215.2	204.8 (1999)	114.3	163.1	363.3
Average (9)[a]	**52.7**	**n.a.**	**78.3**	**33.4**	**n.a.**	**117.1**
Median	**41.3**	**48.4**	**61.5**	**13.1**	**35.1**	**96.2**

Note: The data relate to the number of inpatient procedures only. They do not include coronary angioplasties performed on an ambulatory basis (a growing share of overall activity rates in many countries).

a) The average includes: Australia, Denmark, Finland, Iceland, Netherlands, Spain, Sweden, United Kingdom and United States.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.1. **Total and public health expenditure, per capita, USD PPP, 2001**

	Total health expenditure per capita			Public expenditure on health per capita		
	USD PPP	as % of OECD average		USD PPP	as % of OECD average	
	2001	1990	2001	2001	1990	2001
Australia	2 350 (2000)	113	111	1 618 (2000)	103	107
Austria	2 191	105	104	1 489	105	98
Belgium	2 490	. .	. .	1 784	. .	. .
Canada	2 792	145	132	1 978	148	131
Czech Republic	1 106	50	52	1 010	67	67
Denmark	2 503	126	118	2 063	143	136
Finland	1 841	113	87	1 392	124	92
France	2 561	131	121	1 947	137	129
Germany[a]	2 808	162	133	2 104	171	139
Greece	1 511	60	71	846	44	56
Hungary	911	46	43	684	56	45
Iceland	2 643	120	125	2 192	141	145
Ireland	1 935	62	91	1 470	61	97
Italy	2 212	115	104	1 666	124	110
Japan	1 984 (2000)	94	94	1 554 (2000)	99	103
Korea	893 (2000)	31	42	396 (2000)	15	26
Luxembourg	2 719 (2000)	130	128	2 386 (2000)	166	158
Mexico	586	23	28	269	13	18
Netherlands	2 626	116	124	1 663	106	110
New Zealand	1 733	81	82	1 330	92	88
Norway	3 012	118	142	2 576	134	170
Poland	629	23	30	452	28	30
Portugal	1 613	53	76	1 113	47	74
Slovak Republic	682	. .	. .	609	. .	. .
Spain	1 600	71	76	1 143	76	76
Sweden	2 270	130	107	1 935	159	128
Switzerland	3 248	159	153	1 758 (2000)	114	116
Turkey	. .	. .	. .	. .	. .	. .
United Kingdom	1 992	85	94	1 637	97	108
United States	4 887	238	231	2 168	129	143
Average (27)[b]	**2 117**			**1 513**		

Note: For an explanation of PPP (purchasing power parity) and further information about the definition of health expenditure and comparisons across countries, see Annex 2.

a) For Germany 1990 refers to 1992 (after reunification).

b) The average excludes: Belgium, Slovak Republic and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.2. **Total health expenditure as a percentage of Gross Domestic Product, 1970 to 2001**

	1970	1980	1990	2000	2001
Australia	5.6 (1971)	7.0	7.8	8.9	. .
Austria	5.3	7.6	7.1	7.7	7.7
Belgium	4.0	6.4	7.4	8.6	9.0
Canada	7.0	7.1	9.0	9.2	9.7
Czech Republic	. .	. .	5.0	7.1	7.3
Denmark	8.0 (1971)	9.1	8.5	8.3	8.6
Finland	5.6	6.4	7.8	6.7	7.0
France	. .	. .	8.6	9.3	9.5
Germany[a]	6.2	8.7	9.9 (1992)	10.6	10.7
Greece	6.1	6.6	7.4	9.4	9.4
Hungary	. .	. .	7.1 (1991)	6.7	6.8
Iceland	4.7	6.2	8.0	9.3	9.2
Ireland	5.1	8.4	6.1	6.4	6.5
Italy	. .	. .	8.0	8.2	8.4
Japan	4.5	6.4	5.9	7.6	. .
Korea	. .	. .	4.8	5.9	. .
Luxembourg	3.6	5.9	6.1	5.6	. .
Mexico	. .	. .	4.5	5.6	6.6
Netherlands	6.9 (1972)	7.5	8.0	8.6	8.9
New Zealand	5.1	5.9	6.9	8.0	8.2
Norway	4.4	6.9	7.7	7.7	8.3
Poland	. .	. .	5.3	6.0	6.3
Portugal	2.6	5.6	6.2	9.0	9.2
Slovak Republic	. .	. .	. .	5.7	5.7
Spain	3.6	5.4	6.7	7.5	7.5
Sweden	6.7	8.8	8.2	8.4	8.7
Switzerland	5.6	7.6	8.5	10.7	10.9
Turkey	2.4	3.3	3.6	4.8 (1998)	. .
United Kingdom	4.5	5.6	6.0	7.3	7.6
United States	6.9	8.7	11.9	13.1	13.9
Average (28)[b]	**n.a.**	**n.a.**	**7.3**	**8.1**	**8.4**
Average (18)[c]	**5.3**	**7.0**	**7.6**	**8.4**	**8.6**

a) For all years preceding 1990, data for Germany refer to West Germany. 1990 data refer to 1992.
b) The average excludes: Slovak Republic and Turkey. The 2001 average includes 2000 figures for Australia, Japan, Korea and Luxembourg.
c) The average excludes: Belgium, Czech Republic, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland and Turkey.
Source: OECD Health Data 2003.

© OECD 2003

Table 3.3. **Public expenditure on health as a percentage of Gross Domestic Product, 1970 to 2001**

	1970	1980	1990	2000	2001
Australia	3.5 (1971)	4.4	5.2	6.1	. .
Austria	3.3	5.2	5.2	5.4	5.3
Belgium	. .	. .	. .	6.2	6.4
Canada	4.9	5.4	6.7	6.5	6.9
Czech Republic	. .	. .	4.9	6.5	6.7
Denmark	6.7 (1971)	8.0	7.0	6.9	7.1
Finland	4.1	5.0	6.3	5.0	5.3
France	. .	. .	6.6	7.1	7.2
Germany[a]	4.5	6.8	7.7 (1992)	7.9	8.0
Greece	2.6	3.7	4.0	5.3	5.2
Hungary	. .	. .	6.4 (1991)	5.1	5.1
Iceland	3.1	5.5	6.9	7.8	7.6
Ireland	4.2	6.8	4.4	4.7	4.9
Italy	. .	. .	6.4	6.0	6.3
Japan	3.1	4.6	4.6	6.0	. .
Korea	. .	. .	1.7	2.6	. .
Luxembourg	3.2	5.5	5.7	4.9	. .
Mexico	. .	. .	2.0	2.7	3.0
Netherlands	4.2 (1972)	5.2	5.4	5.5	5.7
New Zealand	4.1	5.2	5.7	6.2	6.3
Norway	4.0	5.9	6.4	6.5	7.1
Poland	. .	. .	4.8	4.2	4.6
Portugal	1.6	3.6	4.1	6.2	6.3
Slovak Republic	. .	. .	. .	5.1	5.1
Spain	2.3	4.3	5.3	5.3	5.4
Sweden	5.8	8.2	7.4	7.1	7.4
Switzerland	. .	. .	4.5	5.9	. .
Turkey	0.9	0.9	2.2	3.5 (1998)	. .
United Kingdom	3.9	5.0	5.0	5.9	6.2
United States	2.5	3.6	4.7	5.8	6.2
Average (27)[b]	**n.a.**	**n.a.**	**5.4**	**5.7**	**5.9**
Average (18)[c]	**3.7**	**5.4**	**5.7**	**6.1**	**6.2**

a) For all years preceding 1990, data for Germany refer to West Germany. 1990 data refer to 1992.
b) The average excludes: Belgium, Slovak Republic and Turkey. The 2001 average includes 2000 figures for Australia, Japan, Korea and Luxembourg.
c) The average excludes: Belgium, Czech Republic, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland and Turkey.
Source: OECD Health Data 2003.

© OECD 2003

Table 3.4. **Total health expenditure per capita, average annual growth rates in real terms, 1970 to 2001**

	1970-1979	1979-1989	1989-1999	1999-2001	1989-1992	1992-1997	1997-2001
Australia	5.6 (69-79)	2.4	3.8	2.5[a]	3.2	3.9	4.0[a]
Austria	7.8	1.5	2.8	1.3	3.8	1.4	3.0
Belgium	9.0	3.1	3.3	4.5	4.3	2.7	3.9
Canada	3.2	3.9	1.9	5.0	3.6	–0.3	5.1
Czech Republic	. .	. .	3.8 (90-99)	5.2	. .	8.0	2.6
Denmark	2.9 (71-79)	1.2	1.6	2.1	0.0	1.7	3.0
Finland	4.7	4.4	0.7	3.1	3.9	–1.4	2.2
France	. .	. .	2.2 (90-99)	3.7	. .	1.5	3.1
Germany	6.4	2.0	2.1 (92-99)	2.0	. .	2.2	1.8
Greece	4.5 (70-80)	1.4 (80-89)	4.3	0.7	3.1	5.0	2.5
Hungary	. .	. .	1.5 (91-99)	4.5	. .	0.1	4.1
Iceland	9.1	5.0	2.3	0.9	–2.4	1.8	5.9
Ireland	8.0	0.9	6.2	8.1	7.8	4.8	7.6
Italy	. .	. .	1.5	5.8	4.2	–0.4	4.0
Japan	6.9	3.3	3.5	5.0[a]	3.4	3.4	4.2[a]
Korea	. .	. .	6.7	14.7[a]	6.5	7.1	9.0[a]
Luxembourg	7.6	4.4	3.9	–1.5[a]	5.4	1.9	4.1[a]
Mexico	. .	. .	3.6 (90-99)	10.8	. .	0.4	7.4
Netherlands	. .	2.2	3.2	2.9	3.8	1.5	4.9
New Zealand	3.3	1.5	3.1	4.2	2.8	2.6	4.6
Norway	8.3	4.5	4.2	–0.3	4.6	3.2	2.9
Poland	. .	. .	5.3 (90-99)	3.6		3.9	4.4
Portugal	10.5	5.7	6.2	4.8	7.2	6.2	4.7
Slovak Republic	. .	. .	. .	1.5	. .	. .	1.8
Spain	7.3	4.1	4.2	2.7	7.0	2.6	3.4
Sweden	4.3	1.6	1.5	4.2	–0.7	1.3	4.8
Switzerland	4.1	2.9	2.4	2.2	3.4	1.6	2.6
Turkey	. .	2.1	7.1 (89-98)	. .	7.4	5.2	. .
United Kingdom	4.1	3.5	3.8	4.9	4.7	2.8	4.9
United States	4.5	5.3	3.3	4.4	5.1	2.3	3.7
Average (28)[b]	**n.a.**	**n.a.**	**3.3**	**4.0[a]**	**n.a.**	**2.6**	**4.2**
Average (18)[c]	**6.1**	**3.1**	**3.3**	**3.0**	**3.7**	**2.5**	**4.0**

a) For those countries not reporting 2001 figures the growth rates cover the period up to 2000.
b) The average excludes: Slovak Republic and Turkey.
c) The average excludes: Belgium, Czech Republic, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland and Turkey.
Source: OECD Health Data 2003.

© OECD 2003

Table 3.5. **Public expenditure on health per capita, average annual growth rates in real terms, 1970 to 2001**

	1970-1979	1979-1989	1989-1999	1999-2001	1989-1992	1992-1997	1997-2001
Australia	6.4 (69-79)	3.3	4.1	1.6[a]	2.5	4.1	4.9[a]
Austria	8.8	2.3	2.2	0.3	3.7	0.4	2.3
Belgium	. .	. .	. .	4.1	. .	. .	3.9
Canada	4.1	3.8	1.3	5.3	3.3	–1.4	5.4
Czech Republic	. .	. .	3.1 (90-99)	5.2	. .	7.1	2.5
Denmark	3.5 (71-79)	0.8	1.4	2.2	–0.4	1.5	3.1
Finland	5.4	4.6	0.1	3.3	3.8	–2.3	2.0
France	. .	. .	2.1 (90-99)	3.7	. .	1.4	3.0
Germany	7.3	1.7	1.6 (92-99)	2.0	. .	1.7	1.7
Greece	7.4 (70-80)	1.5 (80-89)	3.8	3.1	2.3	4.4	4.0
Hungary	. .	. .	–0.2 (91-99)	2.4	. .	–1.5	2.1
Iceland	12.8	4.6	2.0	0.3	–3.1	1.4	5.9
Ireland	8.2	–0.6	6.3	10.4	7.7	5.7	8.1
Italy	. .	. .	0.8	8.3	4.2	–1.7	5.1
Japan	7.6	3.6	3.7	5.3[a]	4.1	3.3	4.5[a]
Korea	. .	. .	10.0	18.0[a]	8.2	11.4	11.9[a]
Luxembourg	8.1	4.4	3.4	–1.7[a]	5.3	1.8	2.3[a]
Mexico	. .	. .	5.2 (90-99)	6.8	. .	0.1	8.7
Netherlands	. .	1.9	2.6	3.0	6.6	0.1	3.1
New Zealand	3.8	1.6	2.0	3.7	0.0	2.1	4.4
Norway	8.8	3.2	4.3	–0.1	4.9	3.0	3.2
Poland	. .	. .	2.4 (90-99)	4.1	. .	2.7	4.3
Portugal	12.5	3.0	8.8	5.8	11.4	7.9	6.3
Slovak Republic	. .	. .	. .	1.3	. .	. .	1.1
Spain	9.6	3.9	3.4	2.2	6.6	1.3	3.0
Sweden	5.0	1.4	1.1	3.9	–1.6	1.0	4.6
Switzerland	. .	. .	3.1	3.0[a]	4.6	2.1	3.1[a]
Turkey	. .	11.9	9.7 (89-98)	. .	12.7	6.6	. .
United Kingdom	4.4	2.7	3.4	6.1	5.3	1.7	5.6
United States	5.9	4.9	4.4	4.6	7.7	3.6	3.1
Average (27)[b]	**n.a.**	**n.a.**	**3.2**	**4.2[a]**	**n.a.**	**2.3**	**4.4**
Average (18)[c]	**7.2**	**2.8**	**3.2**	**3.2**	**3.7**	**2.3**	**4.1**

a) For those countries not reporting 2001 figures the growth rates cover the period up to and including 2000.
b) The average excludes: Belgium, Slovak Republic and Turkey.
c) The average excludes: Belgium, Czech Republic, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland and Turkey.
Source: OECD Health Data 2003.

© OECD 2003

Table 3.6. **Growth of total health expenditure compared to GDP growth, 1989 to 2001**

	1989-1999 real annual growth rate		1999-2001 real annual growth rate		2001 real per capita expenditure; 1989 = 100
	GDP	Total health expenditure	GDP	Total health expenditure	
Australia (1999-2000)	2.1	3.8	1.5	2.5	149
Austria	2.0	2.8	1.9	1.3	135
Belgium	1.8	3.3	1.9	4.5	151
Canada	1.3	1.9	2.0	5.0	134
Czech Republic (1990-99)	–0.1	3.8	3.8	5.2	156
Denmark	1.8	1.6	1.8	2.1	123
Finland	1.1	0.7	2.8	3.1	114
France (1990-99)	1.3	2.2	2.3	3.7	131
Germany (1992-99)	1.0	2.1	1.6	2.0	133
Greece	1.5	4.3	2.1	0.7	155
Hungary (1991-99)	2.1	1.5	4.8	4.5	123
Iceland	1.2	2.3	2.9	0.9	128
Ireland	6.3	6.2	6.4	8.1	212
Italy	1.3	1.5	2.3	5.8	130
Japan (1999-2000)	1.3	3.5	1.4	5.0	148
Korea (1999-2000)	5.1	6.7	5.3	14.7	220
Luxembourg (1999-2000)	3.6	3.9	3.8	–1.5	145
Mexico (1990-99)	1.3	3.6	1.6	10.8	169
Netherlands	2.3	3.2	1.5	2.9	146
New Zealand	1.1	3.1	2.3	4.2	145
Norway	3.0	4.2	1.3	–0.3	150
Poland (1990-99)	3.4	5.3	2.5	3.6	171
Portugal	2.6	6.2	2.0	4.8	200
Slovak Republic	. .	. .	2.8	1.5	. .
Spain	2.4	4.2	2.6	2.7	159
Sweden	1.2	1.5	2.5	4.2	126
Switzerland	0.2	2.4	1.4	2.2	133
Turkey (1989-98)	2.8	7.1	–2.4	. .	. .
United Kingdom	1.8	3.8	2.2	4.9	160
United States	1.8	3.3	1.0	4.4	150
Average (28)[a]	**2.0**	**3.3**	**2.5**	**4.0**	

a) The average excludes: Slovak Republic and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.7. **Growth of public expenditure on health compared to GDP growth, 1989 to 2001**

	1989-1999 real annual growth rate		1999- 2001 real annual growth rate		2001 real per capita public expenditure; 1989 = 100
	GDP	Public health expenditure	GDP	Public health expenditure	
Australia (1999-2000)	2.1	4.1	1.5	1.6	152
Austria	2.0	2.2	1.9	0.3	125
Belgium	1.8	. .	1.9	4.1	. .
Canada	1.3	1.3	2.0	5.3	127
Czech Republic (1990-99)	–0.1	3.1	3.8	5.2	146
Denmark	1.8	1.4	1.8	2.2	120
Finland	1.1	0.1	2.8	3.3	108
France (1990-99)	1.3	2.1	2.3	3.7	130
Germany (1992-99)	1.0	1.6	1.6	2.0	132
Greece	1.5	3.8	2.1	3.1	155
Hungary (1991-99)	2.1	–0.2	4.8	2.4	104
Iceland	1.2	2.0	2.9	0.3	123
Ireland	6.3	6.3	6.4	10.4	226
Italy	1.3	0.8	2.3	8.3	127
Japan (1999-2000)	1.3	3.7	1.4	5.3	151
Korea (1999-2000)	5.1	10.0	5.3	18.0	305
Luxembourg (1999-2000)	3.6	3.4	3.8	–1.7	137
Mexico (1990-99)	1.3	5.2	1.6	6.8	180
Netherlands	2.3	2.6	1.5	3.0	137
New Zealand	1.1	2.0	2.3	3.7	129
Norway	3.0	4.3	1.3	–0.1	152
Poland (1990-99)	3.4	2.4	2.5	4.1	134
Portugal	2.6	8.8	2.0	5.8	260
Slovak Republic	. .	. .	2.8	1.3	. .
Spain	2.4	3.4	2.6	2.2	145
Sweden	1.2	1.1	2.5	3.9	120
Switzerland (1999-2000)	0.2	3.1	1.4	3.0	139
Turkey (1989-98)	2.8	9.7	–2.4	. .	. .
United Kingdom	1.8	3.4	2.2	6.1	158
United States	1.8	4.4	1.0	4.6	169
Average (27)[a]	**2.0**	**3.2**	**2.5**	**4.2**	

a) The average excludes: Belgium, Slovak Republic and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.8. **Public funding as a percentage of health expenditure, 1970 to 2001**

	1970	1980	1990	2000	2001
Australia	62.7 (1971)	63.0	67.1	68.9	. .
Austria	63.0	68.8	73.5	69.7	. .
Belgium	. .	. .	. .	72.1	71.7
Canada	69.9	75.6	74.5	70.9	70.8
Czech Republic	96.6	96.8	97.4	91.4	91.4
Denmark	83.7	87.8	82.7	82.5	82.4
Finland	73.8	79.0	80.9	75.1	75.6
France	. .	. .	76.6	75.8	76.0
Germany	72.8	78.7	76.2	75.0	74.9
Greece	42.6	55.6	53.7	56.1	56.0
Hungary	. .	. .	89.1 (1991)	75.5	75.1
Iceland	66.2	88.2	86.6	83.7	82.9
Ireland	81.7	81.6	71.9	73.3	76.0
Italy	. .	. .	79.3	73.4	75.3
Japan	69.8	71.3	77.6	78.3	. .
Korea	. .	. .	36.6	44.4	. .
Luxembourg	88.9	92.8	93.1	87.8	. .
Mexico	. .		43.0	47.9	45.9
Netherlands	60.2 (1972)	69.4	67.1	63.4	63.3
New Zealand	80.3	88.0	82.4	78.0	76.7
Norway	91.6	85.1	82.8	85.0	85.5
Poland	. .	. .	91.7	70.0	71.9
Portugal	59.0	64.3	65.5	68.5	69.0
Slovak Republic	. .	. .	. .	89.4	89.3
Spain	65.4	79.9	78.7	71.7	71.4
Sweden	86.0	92.5	89.9	85.0	85.2
Switzerland	. .	. .	52.4	55.6	. .
Turkey	37.3	27.3	61.0	71.9 (1998)	. .
United Kingdom	87.0	89.4	83.6	80.9	82.2
United States	36.4	41.5	39.6	44.2	44.4
Average (27)[a]	**n.a**	**n.a.**	**73.8**	**71.6**	**71.7**[c]
Average (21)[b]	**70.2**	**75.1**	**75.5**	**74.3**	**74.5**[c]

a) The average excludes: Belgium, Slovak Republic and Turkey.
b) The average excludes: Belgium, France, Hungary, Italy, Korea, Mexico, Poland, Slovak Republic and Switzerland.
c) The average includes 2000 figures for countries that have not reported 2001 figures.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.9. **Health expenditure by source of funding, 1990 and 2000 (total expenditure = 100)**

	1990						2000					
		of which:			*of which:*			*of which:*			*of which:*	
	Total public	*General govt.*	*Social security schemes*	Total private	*Private insurance*	*Out-of-pocket*	Total public	*General govt.*	*Social security schemes*	Total private	*Private insurance*	*Out-of-pocket*
Australia	67	*67*	*0*	33	*11*	*17*	69	*69*	*0*	31	*7*	*18*
Austria	74	. .	. .	27	*9*	. .	70	*29*	*40*	31	*7*	*19*
Belgium	. .	. .	. .	. .	. .	. .	71	. .	. .	28	. .	. .
Canada	75	*74*	*1*	26	*8*	*14*	71	*70*	*1*	29	*11*	*16*
Czech Republic	97	*97*	*0*	3	*0*	*3*	91	*10*	*82*	9	*0*	*9*
Denmark	83	*83*	*0*	17	*1*	*16*	83	*83*	*0*	18	*2*	*16*
Finland	81	*70*	*11*	19	*2*	*16*	75	*60*	*15*	25	*3*	*20*
France	77	*2*	*74*	23	*11*	*11*	76	*3*	*73*	24	*13*	*10*
Germany	76	*11*	*65*	24	*7*	*11*	75	*6*	*69*	25	*13*	*11*
Greece	54	. .	. .	46	. .	. .	56	. .	. .	44	. .	. .
Hungary (1991)	89	*16*	*73*	11	*0*	*11*	76	*12*	*63*	25	*0*	*21*
Iceland	87	*53*	*34*	13	*0*	*13*	84	*59*	*25*	16	*0*	*16*
Ireland	72	*71*	*1*	28	*9*	*16*	73	*72*	*1*	27	*8*	*13*
Italy	79	*79*	*0*	21	*1*	*15*	73	*73*	*0*	27	*1*	*23*
Japan	78	. .	. .	22	. .	. .	78	*13*	*65*	22	*0*	*17*
Korea	37	*10*	*27*	63	*5*	*53*	44	*10*	*34*	56	*9*	*41*
Luxembourg	93	*21*	. .	7	. .	*5*	88	*15*	*73*	11	*2*	*8*
Mexico	43	*8*	*35*	57	*0*	*57*	48	*16*	*32*	52	*1*	*52*
Netherlands	67	*5*	*62*	33	. .	. .	63	*4*	*59*	37	*15*	*9*
New Zealand	82	*82*	*0*	18	*3*	*14*	78	*78*	*0*	22	*6*	*15*
Norway	83	*83*	*0*	17	*0*	*15*	85	*85*	*0*	15	*0*	*15*
Poland	92	. .	. .	8	. .	. .	71	. .	. .	30	. .	. .
Portugal	66	. .	. .	35	*1*	. .	69	. .	. .	32	. .	. .
Slovak Republic	. .	. .	. .	. .	. .	. .	89	. .	. .	11	*0*	*11*
Spain (1991)	79	*56*	*22*	21	*4*	. .	72	*65*	*7*	28	*4*	*24*
Sweden	90	. .	. .	10	. .	. .	85	. .	. .	15	. .	. .
Switzerland	52	*19*	*33*	48	*11*	*36*	56	*15*	*40*	44	*10*	*33*
Turkey (1998)	61	. .	. .	39	. .	. .	72	. .	. .	28	. .	. .
United Kingdom	84	*84*	*0*	16	*3*	*11*	81	*81*	*0*	19	. .	. .
United States	40	*25*	*15*	60	*34*	*20*	44	*29*	*15*	56	*35*	*15*
Average (27)[a]	**74**	**n.a.**	**n.a.**	**26**	**n.a.**	**n.a.**	**72**	**n.a.**	**n.a.**	**28**	**n.a.**	**n.a.**
Average (14)[b]	**68**	**42**	**25**	**32**	**7**	**23**	**67**	**42**	**25**	**33**	**8**	**22**

Note: Total Private may not necessary equal the sum of Private Insurance and Out-of-pocket. The difference will consist of all other private sources (companies, non-governmental organisations, etc).

a) Excluding Belgium, Slovak Republic and Turkey.

b) Including Australia, Canada, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Korea, Mexico, Spain, Switzerland and United States.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.10. **Out-of-pocket health spending as a percentage of private health expenditure, total health expenditure and final consumption of households, 1990 and 2000**

	1990 out-of-pocket expenditure				2000 out-of-pocket expenditure			
	per capita USD PPP	% of private health expenditure	% of total health expenditure	% of final household consumption	per capita USD PPP	% of private health expenditure	% of total health expenditure	% of final household consumption
Australia	216	50.5	16.6	2.2	434	59.3	18.5	2.7
Austria	. .	. .	. .	. .	415	61.3	18.6	2.7
Belgium	. .	. .	. .	. .	. .	. .	. .	. .
Canada	242	56.7	14.4	2.4	408	54.3	15.8	2.7
Czech Republic	15	100.0	2.6	0.3	85	100.0	8.6	1.2
Denmark	232	92.6	16.0	2.8	381	90.9	15.9	2.8
Finland	201	81.4	15.5	2.5	346	81.9	20.4	2.9
France	172	48.7	11.4	1.8	249	43.1	10.4	1.8
Germany	178	46.8	11.1	1.8	293	42.2	10.5	2.0
Greece	. .	. .	. .	. .	. .	. .	. .	. .
Hungary (1991)	58	100.0	10.9	1.5	174	87.0	21.3	2.8
Iceland	184	100.0	13.4	1.8	425	100.0	16.3	2.6
Ireland	119	58.7	16.5	1.8	242	50.5	13.5	1.9
Italy	202	73.8	15.3	2.1	466	84.9	22.6	3.1
Japan	. .	. .	. .	. .	334	77.6	16.8	2.3
Korea	188	83.6	53.0	4.9	369	74.2	41.3	4.3
Luxembourg	83	79.5	5.5	0.7	209	73.0	7.7	1.1
Mexico	148	100.0	57.0	3.7	253	98.9	51.5	4.3
Netherlands	. .	. .	. .	. .	210	24.5	9.0	1.6
New Zealand	135	82.2	14.5	1.7	247	69.9	15.4	2.1
Norway	198	84.6	14.6	2.4	405	96.7	14.5	2.7
Poland	. .	. .	. .	. .	. .	. .	. .	. .
Portugal	. .	. .	. .	. .	. .	. .	. .	. .
Slovak Republic	. .	. .	. .	. .	68	100.0	10.6	1.1
Spain (1991)	172	83.2	18.7	2.2	352	83.1	23.5	3.0
Sweden	. .	. .	. .	. .	. .	. .	. .	. .
Switzerland	655	74.9	35.7	5.5	1 039	74.1	32.9	6.1
Turkey	61	95.1	31.4	1.7	. .	. .	. .	. .
United Kingdom	104	64.5	10.6	1.1	. .	. .	. .	. .
United States	550	33.3	20.1	3.6	690	27.2	15.2	2.9
Average (19)[a]	**208**	**75.3**	**19.1**	**2.4**	**372**	**73.2**	**19.8**	**2.8**

a) The average excludes: Austria, Belgium, Greece, Japan, Netherlands, Poland, Portugal, Slovak Republic, Sweden, Turkey and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.11. **Real per capita expenditure on pharmaceuticals, average annual growth, 1970 to 2001**

	1970-1979	1979-1989	1989-1999	1999- 2001	Per capita USD PPP	Real per capita health expenditure growth
					2001	1989-1999
Australia	–2.9	3.7	7.0	3.9 (99-2000)	292 (2000)	3.8
Austria	. .	. .	. .	3.4	324	2.8
Belgium	3.2	2.4	3.5 (89-97)	. .	. .	3.3
Canada	0.3	6.6	5.1	7.9	451	1.9
Czech Republic	. .	. .	4.7 (90-99)	3.5	242	3.8 (90-99)
Denmark	. .	2.4 (80-89)	4.1	3.6	223	1.6
Finland	3.5	2.4	5.5	5.3	289	0.7
France	. .	. .	3.8 (90-99)	7.7	537	2.2 (90-99)
Germany	4.2	2.7	0.9 (92-99)	5.0	402	2.1 (92-99)
Greece	1.7	–2.1	4.5	1.3	211	4.3
Hungary	. .	. .	–0.3 (91-97)	5.5[a]	280	1.5 (91-99)
Iceland	6.3	5.9	2.1		370 (1999)	2.3
Ireland	1.1	0.9	4.5	6.9	200	6.2
Italy	. .	. .	1.9	5.9	493	1.5
Japan	. .	3.3 (80-89)	0.3	1.9 (99-2000)	315 (2000)	3.5
Korea	. .	. .	. .	. .	142 (2000)	6.7
Luxembourg	4.4	4.8	1.3	–1.4 (99-2000)	329 (2000)	3.9
Mexico	. .	. .	. .	. .	152	3.6 (90-99)
Netherlands	. .	3.4	4.0	3.6	266	3.2
New Zealand	2.6 (71-80)	4.8 (80-89)	2.6 (89-97)	. .	. .	3.1
Norway	3.6	7.1	. .	. .	. .	4.2
Poland	. .	. .	. .	. .	. .	5.3 (90-99)
Portugal	17.7	5.9	5.9 (89-98)	. .	. .	6.2
Slovak Republic	. .	. .	. .	1.5	232	. .
Spain	. .	2.4 (80-89)	. .	3.3[a]	. .	4.2
Sweden	4.8	3.0	7.4	2.8	306	1.5
Switzerland	. .	. .	2.9	4.5 (99-2000)	338 (2000)	2.4
Turkey	. .	11.3 (81-90)	. .	. .	. .	7.1 (89-98)
United Kingdom	2.5	4.2	5.3 (89-97)	. .	. .	3.8
United States	1.1	5.2	5.5	9.4	605	3.3
Average (17)[b]	**n.a.**	**n.a.**	**3.7**	**4.5**	**340**	**2.8**

a) Medical goods used as a proxy for pharmaceutical expenditure.
b) Excluding Austria, Belgium, Iceland, Korea, Mexico, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Turkey and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 3.12. **Public funding as a percentage of pharmaceutical and total expenditure, 1990 and 2001**

	1990	2001	1990	2001
	Public share of pharmaceutical expenditure		Public share of total expenditure	
Australia	44.8	57.0 (2000)	67.1	68.9 (2000)
Austria	. .	. .	73.5	69.7 (2000)
Belgium	46.8	. .	. .	71.7
Canada	32.9	36.1	74.5	70.8
Czech Republic	89.0	76.7	97.4	91.4
Denmark	34.2	50.5	82.7	82.4
Finland	47.4	51.8	80.9	75.6
France	61.9	65.9	76.6	76.0
Germany	73.1	70.6	76.2	74.9
Greece	56.7	. .	53.7	56.0
Hungary	79.3 (1991)	61.8	89.1	75.1
Iceland	70.6	63.7 (1999)	86.6	82.9
Ireland	65.0	. .	71.9	76.0
Italy	62.8	54.2	79.3	75.3
Japan	61.1	63.3 (2000)	77.6	78.3 (2000)
Korea	. .	17.4 (2000)	36.6	44.4 (2000)
Luxembourg	84.6	81.4 (2000)	93.1	87.8 (2000)
Mexico	. .	20.6	43.0	45.9
Netherlands	66.6	60.6	67.1	63.3
New Zealand	74.6	. .	82.4	76.7
Norway	78.5	. .	82.8	85.5
Poland	. .	. .	91.7	71.9
Portugal	62.3	. .	65.5	69.0
Slovak Republic	. .	82.7	. .	89.3
Spain	71.7	. .	78.7	71.4
Sweden	71.7	69.1	89.9	85.2
Switzerland	. .	60.8 (2000)	52.4	55.6 (2000)
Turkey	. .	. .	61.0	71.9 (1998)
United Kingdom	66.6	. .	83.6	82.2
United States	11.5	18.7	39.6	44.4
Average (15)[a]	**59.4**	**58.8**	**78.5**	**75.5**
Average (27)[b]	**n.a.**	**n.a.**	**73.8**	**71.7**

a) Excluding Austria, Belgium, Greece, Ireland, Korea, Mexico, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Switzerland, Turkey and United Kingdom.
b) Excluding Belgium, Slovak Republic and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Table 4.1. **Tobacco consumption, self reported daily smokers, female, male and total population, aged 15 years and over, 1980 to 2000**

	1980 (or closest year)			1990 (or closest year)			2000 (or closest year)		
	Females	Males	Total	Females	Males	Total	Females	Males	Total
Australia	31.1	41.1	36.0	27.0	30.2	28.6	18.2	21.4	19.8
Austria	17.1	41.1	28.1	20.3	35.5	27.5	. .	. .	. .
Belgium	28.4	52.6	40.5	26.0	38.0	32.0	26.0	36.0	31.0
Canada	30.1	38.6	34.4	26.7	29.8	28.2	18.4	21.2	19.8
Czech Republic	. .	. .	. .	. .	. .	. .	17.3	30.1	23.5
Denmark	44.0	57.0	50.5	42.0	47.0	44.5	29.0	32.0	30.5
Finland	16.6	35.2	26.1	20.0	32.4	25.9	20.3	27.3	23.4
France	16.0	44.0	30.0	21.0	39.0	30.0	21.0	33.0	27.0
Germany	21.2	48.4	34.8	22.2	38.0	31.2	18.9	30.9	24.7
Greece	. .	. .	. .	26.0	51.0	38.5	29.0	46.8	35.0
Hungary	. .	. .	. .	. .	. .		22.9	38.2	30.1
Iceland	. .	. .	. .	29.9	30.8	30.3	22.5	23.3	22.9
Ireland	34.1	39.0	36.6	29.0	31.0	30.0	27.0	28.0	27.0
Italy	16.7	54.3	35.5	17.8	37.8	27.8	17.4	31.9	24.4
Japan	14.4	70.2	42.3	14.3	60.5	37.4	13.7	53.5	32.9
Korea				6.4	65.7	34.6	5.4	61.8	30.4
Luxembourg				26.0	40.0	33.0	27.0	39.0	32.0
Mexico				14.4	38.3	25.8	16.3	42.9	27.7
Netherlands	34.0	52.0	43.0	32.0	43.0	37.0	29.0	35.0	32.0
New Zealand	28.9	34.0	32.0	27.3	27.8	27.5	25.0	25.0	25.0
Norway	30.0	42.0	36.0	33.0	36.0	35.0	32.0	31.0	32.0
Poland	. .	. .	. .	28.0	55.0	41.5	19.5	37.0	27.6
Portugal	. .	. .	. .	. .	. .	. .	9.5	32.8	20.5
Slovak Republic	. .	. .	. .	. .	. .	. .	. .	. .	. .
Spain	. .	. .	. .	21.4	51.5	35.9	24.6	39.2	31.7
Sweden	28.7	36.3	32.4	25.9	25.8	25.8	21.0	16.8	18.9
Switzerland	28.0	45.0	38.0	29.0	39.0	34.0	. .	. .	. .
Turkey	. .	. .	. .	24.3	62.8	43.6	. .	. .	. .
United Kingdom	37.0	42.0	39.0	29.0	31.0	30.0	25.0	29.0	27.0
United States	29.3	37.6	33.5	22.8	28.4	25.6	17.2	21.0	19.0
Average (16)[a]	**27.5**	**45.3**	**36.4**	**26.0**	**36.0**	**31.0**	**22.4**	**29.6**	**25.9**
Median	**28.8**	**42.0**	**35.8**	**26.0**	**38.0**	**30.8**	**21.0**	**32.0**	**27.0**

a) The average excludes: Austria, Czech Republic, Greece, Hungary, Iceland, Korea, Luxembourg, Mexico, Poland, Portugal, Slovak Republic, Spain, Switzerland and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Table 4.2. **Alcohol consumption, litres per population aged 15+, 1960 to 2000**

	1960		1970		1980		1990	2000	
Australia	9.4		11.6		12.9		10.5	9.9	(1999)
Austria	10.9		13.9		13.8		12.6	11.3	
Belgium	8.9		12.3		14.0		12.1	10.2	
Canada	7.2		8.7		11.1		9.2	7.7	
Czech Republic	. .		. .		11.8		11.3	11.8	
Denmark	5.5		8.6		11.7		11.7	11.5	
Finland	2.7		5.8		7.9		9.5	8.6	
France	. .		16.8		16.1		12.7	10.5	
Germany	7.5		13.4		14.2	(1982)	13.8	10.5	
Greece	. .		. .		13.2		10.7	9.4	
Hungary	8.2		11.5		14.9		13.9	12.3	
Iceland	2.5	(1961)	3.8		4.3		5.2	6.1	
Ireland	4.9		8.6		10.5		10.4	13.7	
Italy	16.6		18.2		13.2		10.9	8.7	
Japan	. .		6.9		8.1		8.9	8.2	
Korea	. .		. .		. .		9.1	8.9	
Luxembourg[a]	13.1		15.6		16.8	(1979)	14.7	14.9	
Mexico	. .		. .		3.5		4.9	4.6	
Netherlands	3.7		7.7		11.3		9.9	10.0	
New Zealand	5.3		9.8		11.8		10.1	8.9	
Norway	3.4		4.7		5.3		5.0	5.7	
Poland	6.3	(1961)	8.0	(1971)	8.7	(1981)	8.3	8.5	
Portugal	17.2	(1961)	17.9	(1969)	14.9		16.1	13.0	
Slovak Republic	6.9		12.8		14.5		13.4	9.7	
Spain	14.6	(1962)	16.1		18.5		13.5	11.7	
Sweden	4.8		7.2		6.7		6.4	6.2	
Switzerland	12.1		14.2		13.5		12.9	11.2	
Turkey	0.9		1.1		1.8		1.4	1.5	
United Kingdom	. .		7.1		9.4		9.7	10.2	
United States	7.8		9.5		10.5		9.3	8.4	(1999)
Average (23)[b]	**7.8**		**10.5**		**11.4**		**10.5**	**9.6**	
Median	**7.2**		**9.7**		**11.8**		**10.5**	**9.8**	

a) In Luxembourg, national sales do not reflect accurately actual consumption as consumption by tourists and cross border traffic of alcoholic beverages may lead to a significant gap between sales and consumption by residents.

b) The average excludes: Czech Republic, France, Greece, Japan, Korea, Mexico and United Kingdom.

Source: OECD Health Data 2003.

© OECD 2003

Table 4.3. **Percentage of population aged 15+ with a BMI > 30, latest year available**

		Females	Males	Total
Australia[a]	1999	22.0	19.4	20.8
Austria	1999	9.1	9.1	9.1
Belgium	2001	12.2	11.1	11.7
Canada[b]	2001	13.9	16.0	14.9
Czech Republic	2002	16.1	13.4	14.8
Denmark	2000	9.1	9.8	9.5
Finland	2001	10.3	12.8	11.4
France	2000	9.0	9.0	9.0
Germany	1999	11.0	12.1	11.5
Greece	n.a.	. .	. .	. .
Hungary	2000	20.3	18.4	19.4
Iceland	2002	12.4	12.4	12.4
Ireland	1999	9.0	12.0	10.0
Italy	2000	8.4	8.8	8.6
Japan	2001	3.4	2.9	3.2
Korea	2001	3.5	2.8	3.2
Luxembourg	n.a.	. .	. .	. .
Mexico	2000	28.6	19.2	24.2
Netherlands	2001	10.3	8.3	9.3
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	1999	14.0	11.4	12.8
Slovak Republic	1998	17.4	15.1	16.2
Spain	2001	13.5	11.8	12.6
Sweden	2001	9.2	9.3	9.2
Switzerland	1997	6.9	6.7	6.8
Turkey	n.a.	. .	. .	. .
United Kingdom[a]	2001	23.5	21.0	22.0
United States[a]	1999	34.0	27.7	30.9

Note: Obesity rates are defined as the percentage of the population with a Body Mass Index (BMI) over 30. The 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).

a) For Australia, the United Kingdom and the United States, figures are based on health examinations, rather than self-reported information. Obesity estimates arising from health examinations by professionals are generally higher and more reliable than those coming from self-reports in health interview surveys, because they preclude any misreporting of people's height and weight. However, health examinations are only conducted regularly in a few countries.

b) For Canada, data refer to the population aged 20 to 64.

Source: OECD Health Data 2003.

© OECD 2003

Table 5.1. **Total population, mid-year, thousands, 1960 to 2001**

	1960	1970	1980	1990	2000	2001
Australia	10 275	12 507	14 695	17 065	19 153	19 413
Austria	7 048	7 467	7 549	7 729	8 112	8 130
Belgium	9 154	9 656	9 859	9 967	10 251	10 287
Canada	18 180	21 682	24 516	27 701	30 770	31 111
Czech Republic	9 602	9 858	10 304	10 363	10 272	10 268
Denmark	4 580	4 929	5 123	5 141	5 340	5 359
Finland	4 430	4 606	4 780	4 986	5 176	5 188
France	45 684	50 772	53 880	56 709	58 894	59 191
Germany[a]	55 433	60 651	61 566	63 254	82 212	82 350
Greece	8 334	8 793	9 643	10 161	10 543	10 964
Hungary	9 984	10 338	10 711	10 374	10 211	10 188
Iceland	176	204	228	255	281	285
Ireland	2 829	2 957	3 413	3 514	3 801	3 854
Italy	50 200	53 822	56 434	56 719	57 762	57 894
Japan	94 302	104 665	117 060	123 611	126 926	127 130
Korea	25 012	32 241	38 124	42 869	47 008	47 343
Luxembourg	314	339	364	382	438	442
Mexico	3 8579	52 775	68 686	84 446	100 350	101 826
Netherlands	11 487	13 039	14 150	14 952	15 926	16 046
New Zealand	2 377	2 820	3 144	3 363	3 859	3 881
Norway	3 581	3 876	4 086	4 242	4 491	4 514
Poland	29 406	32 642	35 578	38 111	38 649	38 638
Portugal	8 858	8 680	9 766	9 899	10 231	10 299
Slovak Republic	3 994	4 538	4 980	5 280	5 401	5 391
Spain	30 455	33 753	37 439	38 850	39 927	40 266
Sweden	7 485	8 043	8 311	8 559	8 872	8 896
Switzerland	5 328	6 181	6 319	6 712	7 184	7 233
Turkey	27 755	35 605	44 439	56 203	67 461	68 610
United Kingdom	52 449	55 711	56 313	57 238	58 643	58 837
United States	180 671	205 052	227 727	249 623	282 125	28 4797
Total	**757 962**	**858 202**	**949 187**	**1 028 278**	**1 130 269**	**1 138 631**

a) Population figures for Germany refer to the Federal Republic of Germany only prior to 1991.

Source: OECD Health Data 2003.

© OECD 2003

Table 5.2. **Share of the population aged 65 and over, 1960 to 2001**

	1960	1970	1980	1990	2000	2001
Australia	8.5	8.3	9.6	11.1	12.4	12.5
Austria	12.2	14.1	15.4	14.9	15.5	15.5
Belgium	12.0	13.4	14.3	14.9	16.8	16.9
Canada	7.5	7.9	9.4	11.3	12.5	12.6
Czech Republic	8.7	12.1	13.5	12.5	13.8	13.8
Denmark	10.6	12.3	14.4	15.6	14.8	14.8
Finland	7.3	9.1	12.0	13.4	14.9	15.1
France	11.6	12.9	13.9	14.0	16.1	16.2
Germany	. .	. .	. .	15.0 (1992)	16.4	16.9
Greece	8.1	11.1	13.1	13.8	17.3	. .
Hungary	9.0	11.5	13.4	13.4	15.1	15.2
Iceland	8.0	8.8	10.1	10.6	11.7	11.6
Ireland	11.1	11.1	10.7	11.4	11.2	11.2
Italy	9.3	10.9	13.1	14.9	18.1	18.4
Japan	5.7	7.1	9.1	12.1	17.4	17.8
Korea	2.9	3.1	3.8	5.1	7.2	7.6
Luxembourg	10.8	12.7	13.7	13.4	14.2	14.0
Mexico	4.2	3.9	3.7	3.8	4.6	. .
Netherlands	9.0	10.2	11.5	12.8	13.6	13.6
New Zealand	8.6	8.5	10.0	11.1	11.7	11.9
Norway	11.0	12.9	14.8	16.3	15.2	15.0
Poland	6.0	8.4	10.1	10.1	12.2	12.4
Portugal	7.9	9.4	11.3	13.4	16.3	16.4
Slovak Republic	6.9	9.1	10.5	10.3	11.4	11.4
Spain	8.2	9.6	11.0	13.6	16.9	17.0
Sweden	11.7	13.7	16.3	17.8	17.3	17.2
Switzerland	10.2	11.4	13.8	14.6	15.3	15.4
Turkey	3.5	4.4	4.7	4.3	5.7	. .
United Kingdom	11.7	12.8	14.9	15.7	15.9	15.9
United States	9.2	9.8	11.3	12.5	12.4	12.4
Average (29)[a]	**8.7**	**10.0**	**11.5**	**12.4**	**13.7**	**n.a.**
Median	**8.7**	**10.2**	**11.5**	**13.4**	**14.9**	**15.0**

a) Excluding Germany (due to unification in 1990).

Source: OECD Health Data 2003.

© OECD 2003

Table 5.3. **Share of the population aged 80 and over, 1960 to 2001**

	1960	1970	1980	1990	2000	2001
Australia	1.2	1.4	1.7	2.2	2.9	3.1
Austria	1.8	2.1	2.7	3.6	3.5	3.7
Belgium	1.8	2.1	2.6	3.5	3.6	3.7
Canada	1.2	1.5	1.8	2.3	3.0	3.1
Czech Republic	1.2	1.5	1.9	2.5	2.4	2.5
Denmark	1.6	2.0	2.8	3.7	4.0	4.0
Finland	0.9	1.1	1.8	2.8	3.4	3.5
France	2.0	2.3	2.8	3.7	3.7	4.0
Germany	. .	. .	. .	3.8	3.7	3.8
Greece	1.3	2.0	2.3	3.0	3.5	. .
Hungary	1.1	1.5	2.0	2.5	2.6	2.8
Iceland	1.1	1.5	2.2	2.4	2.8	2.8
Ireland	1.9	2.0	1.8	2.2	2.6	2.6
Italy	1.4	1.8	2.1	3.2	4.0	4.2
Japan	0.7	0.9	1.4	2.4	3.8	4.0
Korea	0.2	0.3	0.5	0.7	1.0	1.1
Luxembourg	1.6	1.8	2.2	3.1	3.0	2.9
Mexico	0.5	0.6	0.7	0.7	0.6	. .
Netherlands	1.4	1.7	2.2	2.9	3.2	3.3
New Zealand	1.5	1.5	1.7	2.3	2.8	2.9
Norway	2.0	2.2	2.9	3.7	4.3	4.4
Poland	0.7	1.0	1.4	2.0	2.0	2.1
Portugal	1.1	1.4	1.6	2.5	3.4	3.4
Slovak Republic	1.0	1.1	1.5	2.0	1.9	1.9
Spain	1.1	1.5	1.8	2.9	3.8	3.9
Sweden	1.9	2.3	3.1	4.3	5.0	5.1
Switzerland	1.5	1.7	2.6	3.7	4.0	4.1
Turkey	0.3	0.3	0.7	0.8	0.6	. .
United Kingdom	1.9	2.2	2.7	3.6	4.0	4.2
United States	1.4	1.8	2.3	2.8	3.3	3.4
Average (29)[a]	**1.3**	**1.6**	**2.0**	**2.7**	**3.1**	**n.a.**
Median	**1.3**	**1.5**	**2.0**	**2.8**	**3.4**	**3.4**

a) Excluding Germany (due to unification in 1990).

Source: OECD Health Data 2003.

© OECD 2003

Table 5.4. **Fertility rate, children per woman aged 15-49, 1960 to 2001**

	1960	1970	1980	1990	2000	2001
Australia	3.5	2.9	1.9	1.9	1.8	. .
Austria	2.7	2.3	1.6	1.5	1.3	1.3
Belgium	2.6	2.3	1.7	1.6	1.7	1.7
Canada	3.9	2.3	1.7	1.7	1.5	. .
Czech Republic	2.1	1.9	2.1	1.9	1.1	1.1
Denmark	2.6	2.0	1.6	1.7	1.8	1.7
Finland	2.7	1.8	1.6	1.8	1.7	1.7
France	2.7	2.5	2.0	1.8	1.9	1.9
Germany	2.4	2.0	1.6	1.5	1.4	1.3
Greece	2.3	2.4	2.2	1.4	1.3	1.3
Hungary	2.0	2.0	1.9	1.9	1.3	1.3
Iceland	4.2	2.8	2.5	2.3	2.1	1.9
Ireland	3.8	3.9	3.3	2.1	1.9	2.0
Italy	2.4	2.4	1.6	1.3	1.2	1.2
Japan	2.0	2.1	1.8	1.5	1.4	. .
Korea	6.0	4.5	2.8	1.6	1.5	1.3
Luxembourg	2.3	2.0	1.5	1.6	1.8	1.7
Mexico	7.3	6.8	4.7	3.4	2.4	. .
Netherlands	3.1	2.6	1.6	1.6	1.7	1.7
New Zealand	4.2 (1958)	3.2	2.0	2.2	2.0	2.0
Norway	2.9	2.5	1.7	1.9	1.9	. .
Poland	3.0	2.2	2.3	2.0	1.3	1.3
Portugal	3.1	2.8	2.2	1.6	1.5	1.4
Slovak Republic	3.1	2.4	2.3	2.1	1.3	1.2
Spain	2.9	2.9	2.2	1.4	1.2	1.3
Sweden	2.2	1.9	1.7	2.1	1.5	1.6
Switzerland	2.4	2.1	1.6	1.6	1.5	1.4
Turkey	6.4	5.1	4.2	3.6	2.6 (1998)	. .
United Kingdom	2.7	2.4	1.9	1.8	1.6	1.6
United States	. .	2.5	1.8	2.1	2.1	. .
Average (30)[a]	**3.2**	**2.7**	**2.1**	**1.9**	**1.6**	**n.a.**
Median	**2.7**	**2.4**	**1.9**	**1.8**	**1.6**	**1.4**

a) 1960 average does not include the United States.

Source: OECD Health Data 2003.

© OECD 2003

Table 5.5. **GDP per capita, average annual real growth rates, 1970 to 2001 and current levels in 2001 in USD PPP**

	Annual average growth rate					GDP per capita USD PPP
	1970-1979	1979-1989	1989-1999	1999-2000	2000-2001	2001
Australia	1.3	1.9	2.1	0.5	2.5	27 408
Austria	3.6	2.0	2.0	3.3	0.4	28 324
Belgium	3.0	2.0	1.8	3.5	0.4	27 775
Canada	3.3	1.7	1.3	3.6	0.3	28 811
Czech Republic (1990-99)	. .	. .	–0.1	3.4	4.1	15 143
Denmark	1.8	1.4	1.8	2.5	1.1	29 216
Finland	3.1	3.2	1.1	5.3	0.4	26 438
France	2.9	1.8	1.4	3.3	1.3	26 879
Germany (1992-99)	2.8	1.7	1.0	2.7	0.4	26 199
Greece	4.1	0.2	1.5	4.1	0.1	16 137
Hungary (1991-99)	. .	. .	2.1	5.5	4.1	13 431
Iceland	5.4	2.0	1.2	4.0	1.7	28 879
Ireland	3.4	2.7	6.3	8.6	4.2	30 002
Italy	3.1	2.3	1.3	2.9	1.7	26 345
Japan	3.4	3.2	1.3	2.7	0.1	26 652
Korea	6.7	6.2	5.1	8.4	2.3	15 905
Luxembourg	2.0	4.1	3.6	7.7	0.1	48 687
Mexico	4.3	0.0	1.5	5.0	–1.7	8 903
Netherlands	2.3	1.4	2.3	2.6	0.5	29 391
New Zealand	0.7	1.3	1.1	2.0	2.7	21 077
Norway	4.1	2.3	3.0	1.7	0.9	36 462
Poland (1990-99)	. .	. .	3.4	4.1	1.0	9 934
Portugal	3.5	3.0	2.6	3.1	1.0	17 560
Slovak Republic (1993-99)	. .	. .	4.1	2.1	3.5	12 010
Spain	2.7	2.3	2.4	3.4	1.8	21 294
Sweden	1.6	2.0	1.2	4.2	0.8	26 052
Switzerland	0.7	1.6	0.2	2.6	0.2	29 876
Turkey	. .	1.7	1.9	4.7	–9.0	5 734
United Kingdom	2.3	2.2	1.8	2.8	1.6	26 315
United States	2.6	2.0	1.8	2.6	–0.7	35 182
Average (25)[a]	**3.0**	**2.2**	**2.0**	**3.7**	**1.0**	**24 067**
Median	**3.0**	**2.0**	**1.8**	**3.4**	**1.0**	**26 392**

a) The average excludes: Czech Republic, Hungary, Poland, Slovak Republic and Turkey.

Source: OECD Health Data 2003.

© OECD 2003

Annex 2

DEFINITION OF HEALTH EXPENDITURE AND METHODOLOGICAL NOTES ON DATA COMPARABILITY

Definition of health expenditure

Total expenditure on health measures the final consumption of health care goods and services plus capital investment in health care infrastructure. This includes spending by both public and private sources (including households) on medical services and goods, public health and prevention programmes and administration. Excluded are health-related expenditure such as training, research and environmental health. Total expenditure on health does *not* include compensation for loss in income due to health problems (sick pay and disability allowances). For a more detailed definition, please see *A System of Health Accounts* (OECD, 2000a).

The following table presents major expenditure categories used in *OECD Health Data 2003* and the tables presented in this publication.

ICHA Code	Description
HC.1; HC.2	Services of curative and rehabilitative care (inpatient, outpatient and home care)
HC.3	Services of long-term nursing care (inpatient and home care)
HC.4	Ancillary services to health care
HC.1-HC.4	*Medical services*
HC.5	Medical goods dispensed to outpatients
HC.1-HC.5	***Total expenditure on personal health***
HC.6	Services of prevention and public health
HC.7	Health administration and health insurance
HC.6+HC.7	*Total expenditure on collective health*
HC.1-HC.7	***Total current expenditure***
HC.R.1	Investment (gross capital formation) in health
HC.1-HC.7 + HC.R.1	***TOTAL EXPENDITURE ON HEALTH***

Comparison of health expenditure across countries

OECD countries are at varying stages of reporting total expenditure on health according to the boundary of health care proposed in the OECD manual *A System of Health Accounts* (SHA). This means that data reported in *OECD Health Data 2003* are at varying levels of comparability. The comparability of the functional breakdown of health expenditure data in *OECD Health Data* has gradually improved over the past few years. However, it is still limited (even among those countries where total expenditure is fairly comparable), due to the fact that data reporting is connected to administrative records of financing systems. For example, inpatient expenditure does not contain independent billing (office-based) of physicians' fees for inpatient care in Australia, Canada and the United States, while inpatient expenditure includes outpatient care provided in hospitals in Germany and the Netherlands. Different practices in including long-term care in health or social expenditure also affect data comparability.

Regarding the functional breakdown of health expenditure presented in this publication, outpatient expenditure is used in a broad sense to include also ancillary services and home care, in order to improve data comparability. *OECD Health Data 2003* presents a more detailed breakdown (as shown in the table above).

For further information, please see the "Note on General Comparability of Health Expenditure and Finance Data" in *OECD Health Data 2003* (also available at *www.oecd.org/health/healthdata*).

Adjustment for differences in national currency

Health expenditure based on national currency units can be used for comparing some indicators, such as the ratio of health expenditure to GDP and health spending growth rates over time.

© OECD 2003

However, to make useful comparisons of health expenditure across countries at a given point in time, it is necessary to convert data from national currency units to a common currency, such as the US dollar (USD). It is also useful to take into account differences in the purchasing power of national currencies in each country. To calculate the conversion rate of national currencies into US dollar purchasing power parity (PPP), the same, fixed basket of goods and services across different countries is priced in the national currency, and then converted to US dollars. For example, if an identical basket of goods and services cost 140 Canadian dollars (CAD) in Canada and 100 USD in the United States, then the PPP conversion rate would be 1.4 CAD to one USD. The economy-wide (GDP) PPPs are used as the most available and reliable conversion rates. These are based on a broad basket of goods and services, chosen to be representative of all economic activity. 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.

Health expenditure converted to USD PPP are not adjusted for price inflation; hence they are not suitable for comparison of real growth rates over time.

Correcting data for price inflation

To make useful comparison of real growth rates over time, it is necessary to deflate (remove inflation from) nominal health expenditure through the use of a suitable price index, and also to divide by population, to derive real spending per capita. Due to limited availability of reliable health price indices, an economy-wide (GDP) price index is used in this publication (1995 GDP price levels). It should be kept in mind that the health sector usually has a higher inflation than the economy as a whole in most countries.

Interpretation of OECD averages

Data availability influences the number of countries than can be included in calculating OECD averages. For example, Table 3.2 presents two versions of the OECD average for the 1990s. Comparable data for the last three decades were available only in 18 OECD countries, while for the latest years data are available in 28 countries. These latter averages are more appropriate to characterise the current situation across the OECD. However, averages across 28 countries in 2000-2001 are comparable only with averages of the 1990s (and not comparable with averages for the 1980s and 1970s).

© OECD 2003

Annex 3

LIST OF VARIABLES IN *OECD HEALTH DATA 2003*

Part 1. Health status

- Mortality
  - *Life expectancy*
  - *Causes of mortality*
  - *Maternal and infant mortality*
  - *Potential years of life lost*
- Morbidity
  - *Perceived health status*
  - *Healthy life expectancy/Disability-free life expectancy*
  - *Infant health*
  - *Congenital anomalies*
  - *Dental health*
  - *Communicable diseases (HIV/AIDS)*
  - *Cancer*
  - *Injuries*
  - *Absence from work due to illness*

Part 2. Health care resources

- Health employment
- In-patient beds
- Employment-to-beds ratio
- Medical technology
- Education in health and welfare

Part 3. Health care utilisation

- Prevention (Immunisation)
- Consultations
- In-patient utilisation
- Average length of stay
  - *Average length of stay: in-patient and acute care*
  - *Average length of stay by Diagnostic categories*
- Discharges
  - *Discharge rates by Diagnostic categories*
- Surgical procedures
  - *Total surgical procedures*
  - *Surgical procedures by ICD-CM*
  - *Transplants and dialyses*

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 by functions*
  - *Expenditure on in-patient care*
  - *Expenditure on out-patient care*
  - *Expenditure on home care*
  - *Expenditure on ancillary services*
- Medical goods dispensed to out-patients
  - *Total expenditure on medical goods*
  - *Pharmaceuticals and other medical non-durables*
  - *Therapeutic appliances and other medical durables*
- Current health expenditure by provider
- Price index

Part 5. Financing and remuneration

- Health expenditure by sources of funds

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

More information on *OECD Health Data 2003* available at *www.oecd.org/health/healthdata*

© OECD 2003

BIBLIOGRAPHY

AIHW (2001), *Health Expenditure Bulletin,* No. 17, Australia's health services expenditure to 1999-00, Australian Institute of Health and Welfare, September 2001.

AIKEN, L.H., S.P. CLARKE and D.M. SLOANE (2002a), "Hospital Staffing, Organization, and Quality of Care: cross-national findings", *International Journal for Quality in Health Care*, Vol. 14, No. 1, pp. 5-13.

AIKEN, L.H., S.P. CLARKE, D.M. SLOANE, J. SOCHALSKI and J.H. SILBER (2002b), "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction", *Journal of the American Medical Association*, Vol. 288, No. 16, pp. 1987-1993.

ANELL, A. and P. SVARVAR, (1999), "Health Care Reforms and Cost Containment in Sweden", in E. Mossialos and J. LeGrand (eds.), *Health Care and Cost Containment in the European Union*, Ashgate.

BENNETT, J. (2003), "Investment in Population Health in Five OECD Countries", *OECD Health Working Papers*, No. 2, OECD, Paris.

BUNKER, J. (1995), "Medicine Matters after All", *Journal of the Royal College of Physicians of London*, Vol. 29, No. 2, pp. 105-112.

BUNKER, J. *et al.* (1994),"Improving Health: Measuring Effects of Medical Care", *Millbank Quarterly*, Vol. 72, No. 2, pp. 225-258.

CANADIAN INSTITUTE FOR HEALTH INFORMATION (2001), *Canada's Health Care Providers*, Ottawa, (*www.cihi.ca*).

CENTERS FOR DISEASE CONTROL (2001), *1999 Hospital Discharge Survey*, No. 319, US National Center for Health Statistics.

CENTERS FOR DISEASE CONTROL (2002), *National Vital Statistics Report*, Vol. 50, No. 5, US National Center for Health Statistics, pp. 77-78.

COWAN, C.A. *et al.* (2001), "National Health Expenditures, 1999", *Health Care Financing Review*, Summer, Vol. 22, No. 4, pp. 77-110.

CUTLER, D and E. MEARA, (2001), "Changes in the Age Distribution of Mortality over the 20th Century", *Working Paper,* No. 8556, National Bureau of Economic Research, October 2001.

DE LATHOUWER, C. and J-P. POULLIER, (2000), "How Much Ambulatory Surgery in the World in 1996-97 and Trends?", *Ambulatory Surgery*, Vol. 8, pp. 191-210.

DEL BOCA, D. (2002), "Low Fertility and Labour Force Participation of Italian Women: Evidence and Interpretations", *Labour Market and Social Policy Occasional Papers*, No. 61, OECD, Paris.

DICKSON, M., J. HURST, AND S. JACOBZONE, (2003), "Survey of Pharmacoeconomic Assessment Activity in Eleven Countries", *OECD Health Working Papers,* No. 4, OECD, Paris.

DOCTEUR, E., H. SUPPANZ, AND I. WOO, (2003), "The US Health System: An Assessment and Prospective Directions for Reform", *Economics Department Working Papers, No.* 350, OECD, Paris.

DOCTEUR, E., and H. OXLEY (2003), "Health Care Systems: Lessons from the Reform Experience", *Economics Department Working Papers and OECD Health Working Papers,* OECD, Paris.

EZZATI, M., A.D. LOPEZ, A. RODGERS, S. VANDERHOORN, and C.J.L. MURRAY (2002), "Selected Major Risk Factors and Global and Regional Burden of Disease", *The Lancet*, Vol. 360, pp. 1347-1360.

FELDER, S., M. MEIER, and H. SCHMITT (2000), "Health Care Expenditure in the Last Months of Life", *Journal of Health Economics*, Vol. 19, pp. 679-695.

FORSTER, M. (2000), "Trends and Driving Factors in Income Distribution and Poverty in the OECD Area", *OECD Labour Market and Social Policy Occasional Papers*, No. 42, OECD, Paris.

GRUBAUGH, S.G. and R.E. SANTERRE (1994), "Comparing the Performance of Health Care Systems: An alternative approach", *Southern Economic Journal*, Vol. 60, pp. 1030-1042.

HÄKKINEN, U. (1999), "Cost Containment in Finnish Health Care", in E. Mossialos and J. LeGrand (eds.), *Health Care and Cost Containment in the European Union,* Ashgate.

HENRIKSSON, M.M. *et al.* (1993), "Mental Disorders and comorbidity in suicide", *American Journal of Psychiatry*, Vol. 150, pp. 935-940.

HISASHIGE, A. (1992), "The Introduction and Evaluation of MRI in Japan", *International Society for Technology Assessment in Health Care*, Vol. 3, No. 126.

HUBER, M. (1999), "Health Expenditure Trends in OECD Countries, 1970-1997", *Health Care Financing Review*, Vol. 21, No. 2, pp. 99-117.

INSTITUTE OF CANCER RESEARCH (2003), Prostate cancer, Fact sheet, website accessed on 26/05/2003 (*www.icr.ac.uk/everyman/about/prostate.html*).

JEE-HUGHES, M. and S. JACOBZONE (forthcoming), "Ageing-related Diseases Project: Comparing the Treatment, Costs and Outcomes for Breast Cancer in OECD Countries", *OECD Health Working Papers*, forthcoming, OECD, Paris.

JEONG, H-S. and J. HURST (2001), "An Assessment of the Performance of the Japanese Health Care System", *OECD Labour Market and Social Policy Occasional Papers,* No. 56, Paris.

KATZ, S.J., L.F. MCMAHON, and W.G. MANNING (1996), "Comparing the Use of Diagnostic Tests in Canadian and US Hospitals", *Medical Care*, Vol. 34, No. 2, pp. 117-125.

KRONEMAN, M.W. *et al.* (2001), "International Variations in Availability and Diffusion of Alternatives to Inpatient Care in Europe: The case of day surgery", *Ambulatory Surgery*, Vol. 9, pp. 147-154.

MARIS, R. (2002), "Suicide", *The Lancet*, Vol. 360, No. 9329, 27 July 2002, pp. 319-326.

MAX PLANCK INSTITUTE FOR DEMOGRAPHIC RESEARCH (1999), "Male-female Differences in Mortality in the Developed World", *MPIDR Working Paper* 1999-2000, by Arjan Gjonça, Cecilia Tomassini and James W. Vaupel, Germany.

MIILUNPALO, S. *et al.* (1997), "Self-rated Health Status as a Health Measure: The predictive value of self-reported health status on the use of physician services and on mortality in the working-age population", *Journal of Clinical Epidemiology*, Vol. 50, No. 5, May 1997, pp. 517-528.

MOÏSE, P. (2003), "The Heart of the Health Care System: Summary of the Ischaemic Heart Disease Part of the OECD Ageing-Related Diseases Study", *A Disease-based Comparison of Health Systems: What is Best and at What Cost?*, OECD, Paris.

MOISE, P., S. JACOBZONE *et al.* (2003), "OECD Study of Cross-national Differences in the Treatment, Costs and Outcomes for Ischaemic Heart Disease", *OECD Health Working Papers,* No. 3, OECD, Paris.

MONTSERRAT, A. and N. HAMZAOUI (2002), "Trends on Incidence and Mortality of AIDS in the European Union (1985-2001)", *Statistics in focus – Population and Social Conditions*, Eurostat, Theme 3, 18/2002.

MOON, L., P. MOISE and S. JACOBZONE (2003), "OECD Study of Cross-national Differences in the Treatment, Costs and Outcomes of Stroke", *OECD Health Working Papers,* No. 5, OECD, Paris.

NATIONAL CENTER FOR HEALTH STATISTICS (2002), *Health, United States 2002 With Chartbook on Trends in the Health of Americans*, Hyattsville, Maryland.

NAYLOR, D. *et al.* (2002), "Measuring Health System Performance: Problems and Opportunities in the Era of Assessment and Accountability", *Measuring Up: Improving Health System Performance in OECD Countries*, OECD, Paris, pp. 13-34.

OECD (2000a), *A System of Health Accounts*, Version 1.0, OECD, Paris.

OECD (2000b), *National Accounts*, OECD, Paris.

OECD (2003a), *A Disease-based Comparison of Health Systems: What is Best and at What Cost?*, Paris.

OECD (2003b), *Society at a Glance – OECD Social Indicators*, Paris.

OECD (2003c), *OECD Reviews of Health Care Systems – Korea*, Paris.

OECD (2003d), *Babies and Bosses – Reconciling Work and Family Life: Austria, Ireland and Japan*, Vol. 2, Paris.

OFFICE OF NATIONAL STATISTICS – ONS (2001), "Cancer Trends in England and Wales 1950-1999", in M. Quinn, P. Babb, A. Brock, L. Kirby and J. Jones (eds.), *Studies on Medical and Population Subjects*, No. 66, London.

OHMI, H., K. HIROOKA, A. HATA and Y. MOCHIZUKI (2001), "Recent Trend of Increase in Proportion of Low Birth Weight Infants in Japan", *International Journal of Epidemiology*, Vol. 30, pp. 1269-1271.

OR, Z. (2000), "Determinants of Health Outcomes in Industrialised Countries: a pooled, cross-country, time-series analysis", *OECD Economic Studies*, Vol. 30, pp. 53-78.

OROSZ, E. and A. BURNS, (2000), "The Health Care System in Hungary", *OECD Economics Department Working Papers,* No. 241, OECD, Paris.

PEREZ-CUEVAS, R., H. REYES, U. PEGO, P. TOME, K. CEJA, S. FLORES and G. GUTIERREZ, (1999), "Immunisation Promotion Activities: are they effective in encouraging mothers to immunize their children?", *Social Science and Medicine*, Vol. 49, pp. 921-932.

 © OECD 2003

ROBERTS, K.A., M. DIXON-WOODS, R. FITZPATRICK, K.R. ABRAMS, and D.R. JONES (2002), "Factors Affecting Uptake of Childhood Immunisation: a Bayesian synthesis of qualitative and quantitative evidence", *The Lancet*, Vol. 360, pp. 1596-1599.

SACHS, B.P. *et al.* (1995), "The Impact of Extreme Prematurity and Congenital Anomalies on the Interpretation of International Comparisons of Infant Mortality", *Obstetrics and Gynaecology*, Vol. 85, pp. 941-946.

SANT, M. *et al.* (1998), "Survival of Women with Breast Cancer in Europe: variation with age, year of diagnosis and country", *International Journal of Cancer*, Vol. 77, pp. 679-683.

SERUP-HANSEN, N., J. WICKSTRØM and I.S. KRISTIANSEN, (2002), "Future Health Care Costs – do health care costs during the last year of life matter?", *Health Policy*, Vol. 62, pp. 161-172.

SLADE, E.P. and G.F. ANDERSON (2001), "The Relationship between Per Capita Income and Diffusion of Medical Technologies", *Health Policy,* Vol. 58, pp. 1-14.

STAKES and EUROPEAN COMMISSION (2000), *Minimum Data Set of European Mental Health Indicators.*

STATISTICS CANADA (2001), "Five-year Relative Survival from Prostate, Breast, Colorectal and Lung Cancer", by L. Ellison, L. Gibbons and the Canadian Survival Analysis Group, *Health Reports*, Vol. 13, No. 1, Catalogue 82-003, December 2001.

STATISTICS CANADA (2002), "Suicide Deaths and Suicide Attempts", by Stephanie Langlois and Peter Morrison, *Health Reports*, Vol. 13, No. 2, Catalogue 82-003, January 2002, pp. 9-22.

STREEFLAND, P.H. (2001), "Public Doubts about Vaccination Safety and Resistance against Vaccination", *Health Policy*, Vol. 55, pp. 159-172.

STURM, R. (2002), "The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs", *Health Affairs*, Vol. 21, No. 2, March/April 2002, pp. 245-253.

THOMSON, L.A., D.C. GOODMAN and G.A. LITTLE (2002), "Is More Neonatal Intensive Care always Better? Insights from a cross-national comparison of reproductive care", *Pediatrics*, Vol. 109, pp. 1036-1043.

TUNSTALL-PEDOE *et al.* (2000), "Estimation of Contribution of Changes in Coronary Care to Improving Survival, Event Rates, and Coronary Heart Disease Mortality across the WHO MONICA Project Populations", *The Lancet*, Vol. 355, pp. 688-700.

TYRRELL, L. and D. DAUPHINEE (1999), *Task Force on Physician Supply in Canada*, prepared for the Canadian Medical Forum Task Force, November 1999, Ottawa.

UN/ECE (2000), "Fertility Decline in the Transition Economies, 1982-1997: political, economic and social factors", *Economic Survey of Europe*, No. 1, UN/ECE, Geneva, pp. 181-194.

UNAIDS (2002), "Aids Epidemic Update", December 2002.

VAN DOORSLAER, E., X. KOOLMAN and F. PUFFER (2002), "Equity in the Use of Physician Visits in OECD Countries: Has equal treatment for equal need been achieved?", *Measuring Up: Improving Health System Performance in OECD Countries*, OECD, Paris.

WHO (1997), *Obesity: Preventing and Managing the Global Epidemic*, Geneva.

WHO (2002a), *World Report on Violence and Health*, Geneva.

WHO (2002b), *The Tobacco Atlas*, Judith Mackay, Geneva.

WILKINSON, R.G. (2000), "Putting the Picture Together: prosperity, redistribution, health and welfare", in M. Marmot and R. Wilkinson (eds.), *Social Determinants of Health*, Oxford University Press.

WILKINSON, R.G. (1996), *Unhealthy Societies: the afflictions of inequality*, Routledge, London.

WORLD BANK (1999), *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, Prabhat Jha, editor.

YUTAKA, I. (2002), "Health Care Reform in Japan", *OECD Economics Department Working Papers,* No. 321, OECD, Paris.

© OECD 2003

ORDER FORM
OECD HEALTH DATA 2003

YES! Please send me the OECD Health Data 2003 CD-ROM
(81 2003 103C5) ISBN 92-64-10126-8 Single-user version
(81 2003 103C1) ISBN 92-64-10127-6 Network version

1. Enter your delivery details

Title (Prof./Dr/Mr/Ms)..... First name ..... Surname.....
Organisation.....
Address ..... Post/ZIP Code .....
Country ..... Tel.: ..... Fax ..... E-mail.....

2. Choose the correct price option

Single-user version

For profit organisations.....	€ 325	US$325	£ 218	Y 41 500
For non-profit organisations	€ 225	US$225	£ 150	Y 28 750

Network version

For profit organisations.....	€ 1 050	US$1 050	£ 705	Y 134 100
For non-profit organisations	€ 895	US$895	£ 600	Y 114 300

3. Enter method of payment

- ❑ Cheque/Eurocheque enclosed (please make payable to OECD)
- ❑ Please invoice me. Purchase order No.
- ❑ Please charge my credit card: AMEX/VISA/MASTERCARD

  Card number ..... Expiry date .....
  Today's date ..... Signature.....
- ❑ Please send me details on your related publications

4. Post, fax or e-mail your order to:

OECD Turpin Distribution Services Limited
P.O. Box 22, Letchworth SG6 1YT, UK
Tel: +44 (0)1462-672555 – Fax: +44 (0)1462-480947
E-mail: *books@turpinltd.com*

Browse OECD titles online at *www.oecd.org/bookshop*

For more information, contact *sales@oecd.org*

To find out more about health research at OECD, visit *www.oecd.org/health/healthdata*

Organisation for Economic Co-operation and Development
2, rue André-Pascal, 75775 Paris Cedex 16, France
www.oecd.org

OECD PUBLICATIONS, 2, rue André-Pascal, 75775 PARIS CEDEX 16
PRINTED IN FRANCE
(81 2003 13 1 P 1) ISBN 92-64-10404-6 – No. 53159 2003