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# OECD Countries Struggle with Rising Demand for Health Spending

Spending on health care is outpacing economic growth in most OECD countries, forcing governments to find new funds or to pass a larger share of the costs onto individuals. In 2000 and 2001, health spending increased by 4% per year in real terms on average across OECD countries, while real GDP growth averaged just 2.3% per year. This gap led to a further rise in health spending as a share of GDP, reaching 8.4% on average in 2001, up from 7.3% in 1990 and just over 5% in 1970.

Particularly in the United States, Canada and Finland, the share of GDP devoted to health rose dramatically in 2000 and 2001 after having stabilised during the 1990s. This was due partly to an economic slowdown in these countries and partly to a marked increase in health spending following a period of restraint. In the United States, which spends far more than any other country on health, the proportion of GDP spent on health reached 13.9% in 2001, up from 11.9% in 1990 and 6.9% in 1970. Following the United States in 2001 were Switzerland and Germany, which allocated, respectively, 10.9% and 10.7% of their GDP on health. Canada and France followed, with 9.7% and 9.5%, respectively.

As the bulk of healthcare expenditure in most countries (except Korea, Mexico and the United States) is publicly financed, the higher spending is putting pressure on public budgets. Even in the United States, where the private sector plays a particularly large role in financing, public spending on health represents 6% of GDP, comparable to the OECD average.

Public spending on health accounted for 72% of total health spending on average across OECD countries in 2001, virtually unchanged from its share in 1990. The remaining 28% of spending was paid by private sources, mainly private insurance and individuals. 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, while 15% only was paid directly by consumers. By contrast, in Switzerland, only 10% of total health spending was funded by private insurance, with 33% paid directly by consumers. Apart from Switzerland, the share of out-of-pocket payments was also relatively high in Korea and Mexico.

## Health technologies and new drugs are major cost drivers

Development and diffusion of medical technologies and new drugs are among the main drivers of rising health expenditures. During the past 20 years, there has been a surge in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) in most OECD countries. The number of MRIs has increased particularly rapidly over the past ten years, especially in Switzerland, Austria, Iceland and Finland.

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Reflecting the introduction of new and more expensive drugs, pharmaceutical expenditure has also risen rapidly in many countries since 1990. It has doubled, in real terms, in Sweden and Australia between 1990 and 2001, while it increased by more than 70% in Canada, Finland, Ireland and the United States.

There has also been rapid growth in the use of many surgical procedures, such as cataract surgeries, hip and knee replacements, and cardiac procedures. The number of coronary artery bypass graft (CABG) and coronary angioplasty rose over the 1990s, particularly in those countries that started with relatively low utilisation levels (e.g., Australia, Denmark, Hungary and Sweden for coronary angioplasty). In 2000, the rates of CABG and coronary angioplasty in the United States remained by far the highest. These differences in the use of expensive medical procedures explain part of the differences in overall healthcare spending between the United States and other countries.

Despite the rapid rise in many surgical procedures in OECD countries, supply does not always seem to have kept up with demand. Significant waiting times for elective surgery persist in a number of countries, such as the United Kingdom, the Nordic countries and Spain[1].

**Efforts to shore up hospital spending**

Cost-containment measures in the hospital sector, combined with greater recourse to ambulatory or same-day surgical procedures, have led to a decline in the number of hospital beds in nearly all OECD countries. Acute-care beds per 1 000 population have dropped from 5.7 in 1980 to 4.0 in 2000 on average. In 2000, there were notable variations in the number of acute-care beds, varying from a high of more than 6 beds per 1 000 population in some European countries (Luxembourg, the Czech Republic, Germany, Hungary and Austria), to less than 3 beds per 1 000 in Mexico, the United States, Sweden and Finland.

In tandem with the decline in the number of hospital beds, there was a sharp reduction in the average length of stays (ALOS) in hospitals. 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 during that period in the Nordic countries (Denmark, Finland and Sweden) and other European countries such as France and Austria. A reduction in ALOS is often treated as an indicator of efficiency; all other things being equal, a shorter stay will reduce the cost per episode. However, if the stay is too short, there may be adverse effect on health outcomes or on the comfort and recovery of the patient which in turn could lead to higher readmission rates.

**Health risks**

Premature mortality (measured in terms of potential years of life lost) halved on average across OECD countries in the past 30 years, due generally to a steep reduction in deaths related to heart diseases. In 2000, premature mortality in the United States remained much higher than the OECD average: 21% higher for men and 34% for women. Premature death from homicides in the United States, for both men and women, is especially high - four times the OECD average.

Tobacco consumption, closely correlated with death from lung cancer, has fallen across many OECD countries over the past two decades. However, obesity rates have been rising in all OECD countries. They have more than doubled over the past twenty years in countries like Australia and the United States and tripled in the United Kingdom. More than 20% of the adult population in Australia and the United Kingdom are obese. In the early 1990s, 23% of adults in the United States were obese. Ten years later, that number was up to 31%. Obesity rates are much lower in Continental Europe, but they are on the rise. The time lag between the onset of obesity and related health problems (such as diabetes, hypertension, cardiovascular diseases and asthma) suggests higher health care costs are in store for the future.

These are some of the trends and developments explored in ***Health at a Glance – OECD Indicators 2003***, a publication displaying variations and trends over time in key health indicators across OECD countries. ***Health at a Glance – OECD Indicators 2003*** presents comparative data on four key dimensions: health status (life expectancy, premature mortality and self-reported health), health care resources and their utilisation (practising physicians and nurses, medical technologies, hospital beds, average length of stays), health

expenditure (per capita and as a proportion of GDP, including a breakdown between public and private sources), and non-medical determinants of health (tobacco and alcohol consumption, and obesity).

More indicators are contained in the CD-Rom ***OECD Health Data 2003***. The latest and final update of ***OECD Health Data 2003*** has been released on 3 October 2003, with a special focus on expenditure data and health care system diagrams depicting how health care is funded in different OECD countries. Visit www.oecd.org/health/healthdata for detailed information.

Journalists may obtain a copy of the publication or the CD-Rom from the Media Relations Division (requests by fax: 33 1 45 24 80 03, or news.contact@oecd.org). For further information about the publication, please contact Gaetan Lafortune, OECD Health Policy Unit (tel. 33 1 45 24 92 67 or gaetan.lafortune@oecd.org) or David Morgan (tel. 33 1 45 24 76 09 or david.morgan@oecd.org). To obtain more information about the OECD *Waiting Times* study, journalists are invited to contact Jeremy Hurst, OECD Health Policy Unit (tel. 33 1 45 24 92 55 or Jeremy.hurst@oecd.org).

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[1] A new OECD study examines the causes of variations in waiting times for elective surgery and identifies policies to tackle the problem. This separate OECD report is available at:
http://www.oecd.org/findDocument/0,2350,en_2649_33929_1_119684_1_1_37407,00.html).