

### Definition and measurement

Life expectancy is the most general and best known measure of the health status of the population. Changes in life expectancy are related to a range of interdependent variables such as living standards, lifestyles, and access to quality health services. As underlying socio-economic factors do not change overnight, changes in life expectancy are best assessed over long periods of time.

The indicators presented here, life expectancy at birth and in old age, are defined as the average number of years that a person could expect to live if he or she experienced the age-specific mortality rates prevalent in a given country in a particular year. They do not include the effect of any future decline in age-specific mortality rates. Each country calculates its life expectancy according to methodologies that can vary somewhat. These methodological differences can affect the comparability of reported estimates, as different methods can change a country's measure of life expectancy by a fraction of a year.

Gains in life-expectancy at birth realised in all OECD countries over the last four decades have been remarkable. These gains mirror the sharp reductions in mortality rates at all ages and higher survival rates in old age. On average, life expectancy at birth across OECD countries has increased from 66 to 74.7 years for men and from 71 to 80.6 years for women from 1960 to 2002 (Chart HE1.1), i.e. an increase per decade of around 2.1 years for men and 2.3 years for women. In 2002, life expectancy at birth was highest in Iceland (at 78.5 years) for men, and in Japan (85.2 years) for women.

Gains in life-expectancy at birth have been especially large in countries where this was lowest in 1960 (e.g. Korea, Mexico and Turkey), leading to convergence towards the OECD average. Much lower gains in life-expectancy at births have been realised in recent years by some Eastern European countries. In Hungary, for example, life-expectancy at births of men has remained broadly stable, at relatively low levels, over the second half of the 1990s – a result that has been attributed to unhealthy lifestyles, poor diets, and excessive alcohol and tobacco consumption (OECD, 1999) – followed by strong increases since 2000. While life-expectancy at birth has also increased outside the OECD area, there have also been major set-backs. In Russia, life-expectancy at birth of men fell by over seven years from the late 1980s to 1994, and despite a recovery since remain significantly lower than levels recorded before

the transition to a market system. In some of the African countries most affected by HIV (e.g. Zimbabwe and Zambia) life-expectancy at birth has declined by 20 years or more since 1990.

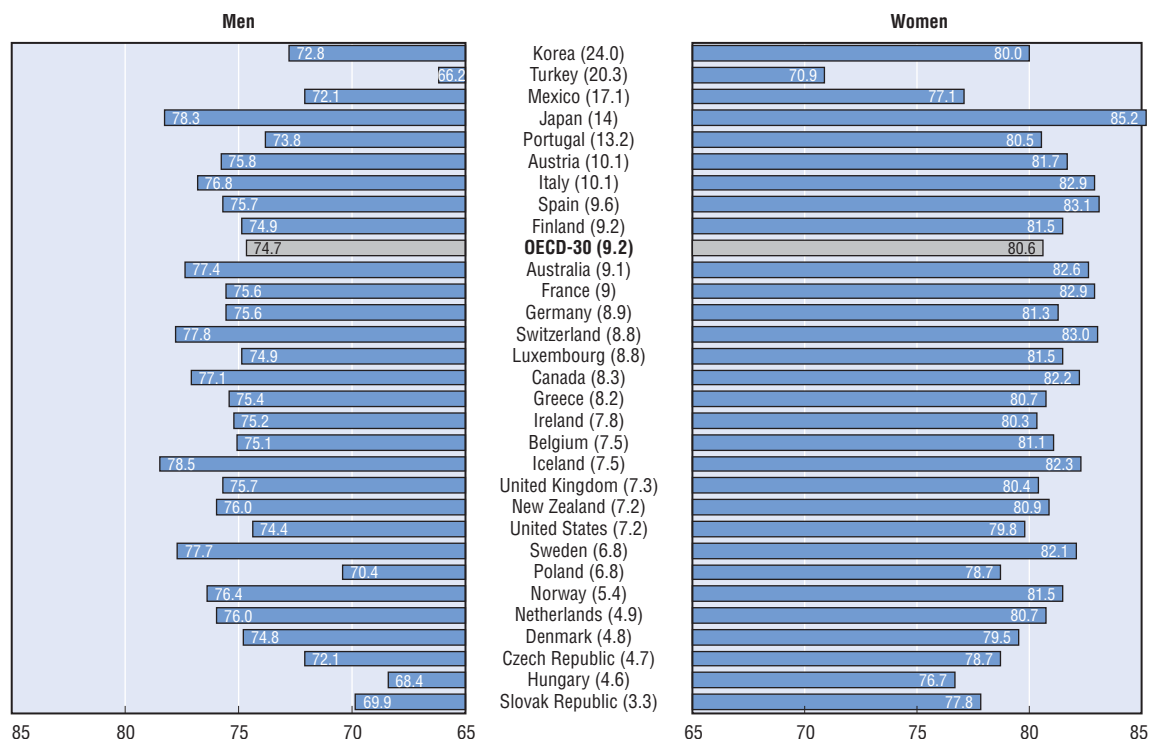
In OECD countries, life expectancies in old age have increased faster since 1970 than over the 1960s (Chart HE1.2). By 2002, women at age 65 could on average expect to live another 19 years, as compared to 16 years for men; at age 80, women could on average expect to live another 9 years, compared to 7 years for men. Improved access to quality health services and medical progress, especially for cardiovascular diseases, have contributed to much of this increase (AIHW, 1998). Gains in life-expectancy in old age since 1960 have generally been greater for women (4 additional years at age 65) than for men (3 at age 65), and the wider longevity gap has increased the share of older women that survive their spouses. Gender gaps in old-age are however stable on average since the mid-80s, and narrowing in several OECD countries (Australia, Canada, Denmark, Netherlands, United Kingdom and United States). This trend is projected to continue in future decades.

**Status indicators:** Healthy life expectancy (HE2), Infant mortality (HE3).

**Response indicators:** Total health care expenditure (HE4).

## HE1.1. Women still live longer than men, with remarkable gains in life expectancy at birth for both sexes in the last decades

Life expectancy at birth, in years, men and women, in 2002<sup>1</sup>

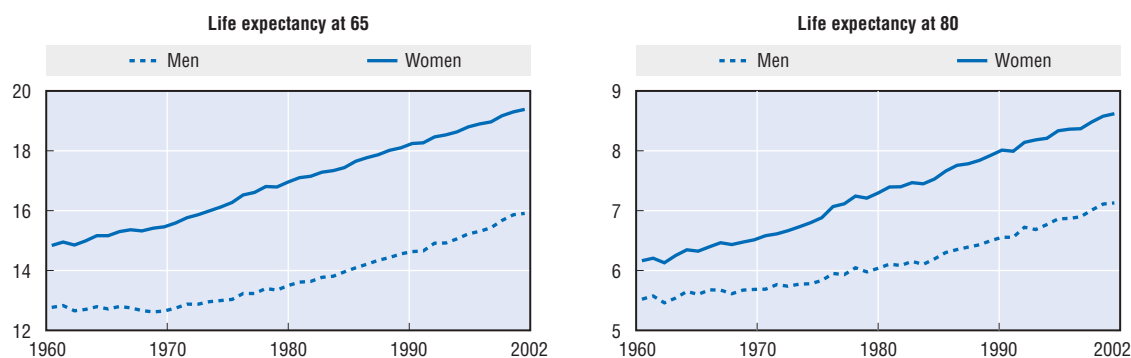


Note: Countries are ranked by decreasing order of 1960-2002<sup>2</sup> gains for total population (values in brackets).

1. 2001 for Canada, Germany, Korea, Luxembourg, United Kingdom and United States.
2. 1960-2001 for Germany, Korea, Luxembourg, United Kingdom and United States; 1961-2001 for Canada; 1961-2002 for Italy.

## HE1.2. Elderly live longer, especially since the 1970s

Life expectancies at 65 and 80, in years, average of 21 OECD countries,<sup>3</sup> men and women, 1960-2002



3. Excludes Denmark, Iceland, Ireland, Korea, Portugal, Slovak Republic, Switzerland and United Kingdom.

Source: OECD (2004), OECD Health Data 2004, first edition, OECD, Paris (see also [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata)).

StatLink: <http://Dx.doi.org/10.1787/720553055715>

**Further reading:** ■ AIHW (1998), Australia's Health 1998, Australian Institute of Health and Welfare, Canberra. ■ OECD (1999), OECD Economic Surveys: Hungary, OECD, Paris. ■ OECD (2004), Towards High-Performing Health Systems, Paris.

### Definition and measurement

The increase in life expectancy begs the question as to whether the extra years of life are spent in good health, or are leading to prolonged period of illness and dependency. In order to get a measure of life expectancy in good health, the World Health Organisation (WHO) calculates estimates of Healthy Life Expectancy (HALE). HALE aims to summarise the number of years to be lived in what might be termed the equivalent of “full health”. To calculate HALE, the World Health Organisation weights the years of ill-health according to severity and subtracts them from overall life expectancy to give the equivalent years of healthy life.

There remain however a number of issues regarding the reliability and comparability of HALE estimates. One of the main issues relates to the measurement of health status in a comparable manner across countries. HALE estimates are expected to be refined in the years ahead and to benefit from effort underway to improve the comparability of survey-based measures of health status and the results of new epidemiological studies.

Estimates of healthy life expectancy from WHO suggest that new-borns in 2002 can expect to live 70 years or more in good health in around two thirds of all OECD countries (Table HE2.1). Given the very strong correlation between healthy life expectancy and life expectancy at birth (a correlation coefficient of 0.95), it is not surprising that those countries which rank high in terms of life expectancy also rank high in terms of HALE. For the population as a whole, Japan registers the highest HALE at birth, followed by Sweden, Switzerland, Iceland and Italy. This ranking needs to be treated with caution, however, given uncertainties regarding the precision of current HALE estimates. The same factors that contribute to rising life expectancy also contribute to gains in HALE. These include rising standards of living, better lifestyles and working conditions, public health interventions and access to quality healthcare services.

Estimates of HALE show that while women live longer than men, they also tend to be ill for longer periods. In most OECD countries, women are likely to experience almost 2 more years of ill health than men during the course of their lives (Chart HE2.2). As a percentage of total lifetime, the burden of ill

health for women is estimated at 10%, as compared with almost 9% for men on average across OECD countries.

There are few trend data on HALE which would provide direct evidence of whether the observed gains in life expectancy at birth for women and men over time represent additional years lived in good or ill health. However, survey-based data on disability rates among the elderly population from several countries indicate a decline in the prevalence of disability among people aged 65 and over, although the evidence is not conclusive in some countries (e.g. Australia and the United States). To the extent that people at older ages remain healthy and are able to continue to live independently, this will reduce pressures on the provision of health and long-term care, although these might simply involve a postponement of care needs.

**Status indicators:** Life expectancy (HE1).

**Response indicators:** Total health care expenditure (HE4).

## HE2. HEALTH-ADJUSTED LIFE EXPECTANCY

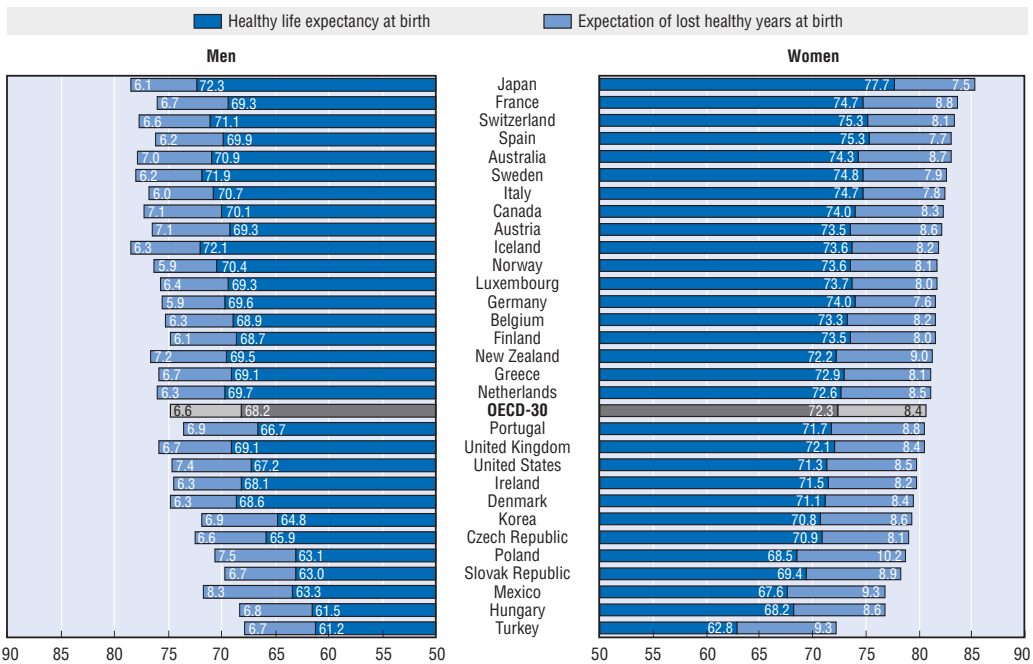
### HE2.1. Healthy life expectancy reaches 70 years in two-thirds of OECD countries

Healthy life expectancy, estimates for 2002

	Healthy life expectancy at birth (years)			Expectation of lost healthy years at birth (years)		Percentage of total life expectancy lost	
	Total population	Men	Women	Men	Women	Men	Women
Australia	72.6	70.9	74.3	7.0	8.7	9.0	10.4
Austria	71.4	69.3	73.5	7.1	8.6	9.3	10.5
Belgium	71.1	68.9	73.3	6.3	8.2	8.3	10.1
Canada	72.0	70.1	74.0	7.1	8.3	9.2	10.0
Czech Republic	68.4	65.9	70.9	6.6	8.1	9.1	10.3
Denmark	69.8	68.6	71.1	6.3	8.4	8.4	10.5
Finland	71.1	68.7	73.5	6.1	8.0	8.1	9.9
France	72.0	69.3	74.7	6.7	8.8	8.8	10.6
Germany	71.8	69.6	74.0	5.9	7.6	7.8	9.3
Greece	71.0	69.1	72.9	6.7	8.1	8.9	10.0
Hungary	64.9	61.5	68.2	6.8	8.6	10.0	11.2
Iceland	72.8	72.1	73.6	6.3	8.2	8.1	10.0
Ireland	69.8	68.1	71.5	6.3	8.2	8.5	10.3
Italy	72.7	70.7	74.7	6.0	7.8	7.8	9.5
Japan	75.0	72.3	77.7	6.1	7.5	7.8	8.8
Korea	67.8	64.8	70.8	6.9	8.6	9.7	10.8
Luxembourg	71.5	69.3	73.7	6.4	8.0	8.4	9.8
Mexico	65.4	63.3	67.6	8.3	9.3	11.6	12.1
Netherlands	71.2	69.7	72.6	6.3	8.5	8.3	10.4
New Zealand	70.8	69.5	72.2	7.2	9.0	9.3	11.1
Norway	72.0	70.4	73.6	5.9	8.1	7.8	9.9
Poland	65.8	63.1	68.5	7.5	10.2	10.6	13.0
Portugal	69.2	66.7	71.7	6.9	8.8	9.4	10.9
Slovak Republic	66.2	63.0	69.4	6.7	8.9	9.6	11.4
Spain	72.6	69.9	75.3	6.2	7.7	8.2	9.3
Sweden	73.3	71.9	74.8	6.2	7.9	7.9	9.5
Switzerland	73.2	71.1	75.3	6.6	8.1	8.5	9.7
Turkey	62.0	61.2	62.8	6.7	9.3	9.8	12.9
United Kingdom	70.6	69.1	72.1	6.7	8.4	8.8	10.4
United States	69.3	67.2	71.3	7.4	8.5	9.9	10.7
<b>OECD-30</b>	<b>70.3</b>	<b>68.2</b>	<b>72.3</b>	<b>6.6</b>	<b>8.4</b>	<b>8.9</b>	<b>10.4</b>

### HE2.2. Women are likely to live almost two more years than men in ill health

Healthy life expectancy, by gender, estimates for 2002



Note: Countries are ranked in decreasing order of the sum of healthy life expectancy and expectation of lost healthy years at birth of women.  
Source: WHO (2004), *World Health Report 2004*, World Health Organisation, Geneva (see also [www.who.int/whr](http://www.who.int/whr)).

StatLink: <http://Dx.doi.org/10.1787/525456321557>

**Further reading:** ■ OECD (2003), *Health at a Glance – OECD Indicators*, OECD, Paris.

### Definition and measurement

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

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 increase mortality rates compared with other countries that do not register them as live births.

Infant mortality has dropped significantly in all OECD countries over the last decades, declining on average from 28 deaths per 1 000 live births in 1970 to less than 7 in 2002 (Chart HE3.1). Progress has been especially large in some of the countries with highest infant mortality rates in 1970. In Portugal, for example, infant mortality fell from 56 deaths per 1 000 live births in 1970 (close to double the OECD average at that time) to 5.5 by 2000 (below the OECD average). Cross-country differences in levels of infant mortality remain large (Chart HE3.2). Even excluding Turkey and Mexico, whose infant mortality rates are significantly higher than the OECD average, rates in the next three countries with highest rates are close to three times higher those of the three best-performing countries.

Over the second half of the 1990s, some of the countries with infant mortality rates below the OECD average (e.g. Finland, Iceland, Ireland, Luxembourg, the Netherlands and the United Kingdom) reported an increase in infant mortality in at least one year. This suggests that it may prove difficult to obtain further reductions once infant mortality rates are around four to five deaths per 1 000 live births.

Infant mortality is related to a number of social and economic factors. Countries with higher income levels tend to have lower infant mortality rates than poorer countries, although there are exceptions (e.g. the United States). At comparable income levels, countries with a more equal distribution of income also tend to report lower infant mortality rates than

countries with larger inequalities (Hales *et al.*, 1999). But it is unclear whether higher infant mortality is related to higher relative poverty *per se* or to the more limited accesses to health services among households at the bottom end of the income distribution. Cross-country variations in infant mortality are also associated with the availability of specific health care resources, such as the number of doctors and hospital beds.

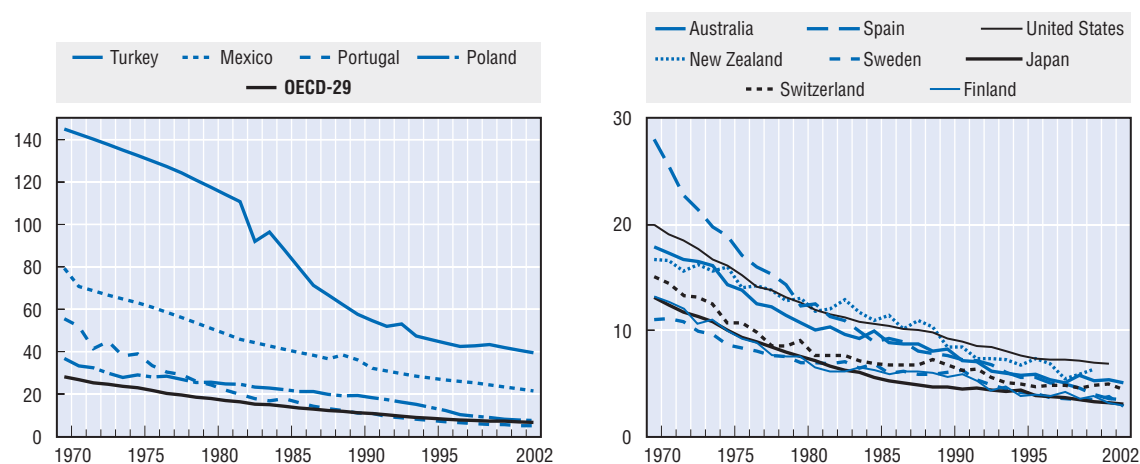
Neonatal deaths (those deaths occurring in the first four weeks) can account for up to two-thirds of all infant mortality. Most neonatal deaths in developed countries are a result of congenital anomalies or premature birth. Because of higher ages of first motherhood and the rise in multiple pregnancies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

**Status indicators:** Relative poverty (EQ1), Income inequality (EQ2), Life expectancy (HE1).

**Response indicators:** Total health care expenditure (HE4).

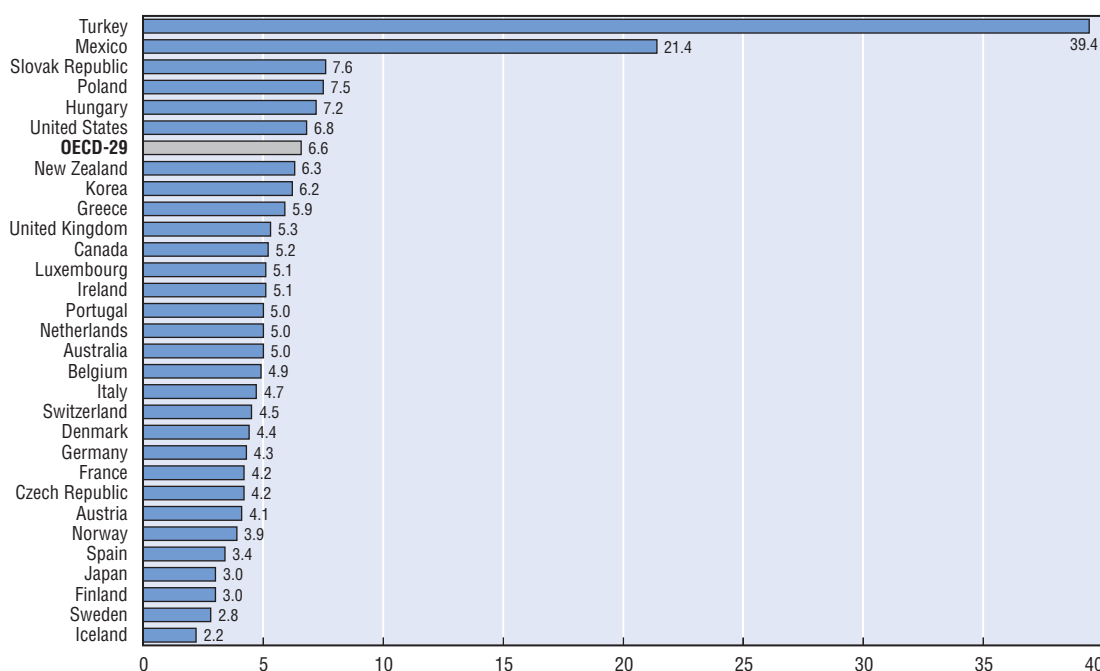
### HE3.1. Strong decline in infant mortality rates

Deaths of children under one year of age per 1 000 live births, 1970 to 2002



### HE3.2. Still high infant mortality rates in Turkey and Mexico, 5 per 1 000 otherwise on average

Deaths of children under one year of age per 1 000 live births, 2002<sup>1</sup>



Note: Some of the international variations in infant mortality rates are 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, at least, very premature babies (with relatively low odds of survival) are registered as live births, which increases mortality rates relative to countries that do not register them as live births.

1. 2001 in Canada, Norway, United States; 2000 in New Zealand; 1999 in Korea.

Source: OECD (2004), OECD Health Data 2004, first edition, OECD, Paris (see also [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata)).

StatLink: <http://Dx.doi.org/10.1787/626836671375>

**Further reading:** ■ Hales, S., P. Howden-Chapman, C. Salmond, A. Woodward and J. Mackenbach (1999), "National Infant Mortality Rates in Relation to Gross National Product and Distribution of Income", *The Lancet*, December 11. ■ Mayer, S.E. and A. Sarin (2004), "Some Mechanisms Linking Economic Inequality and Infant Mortality", *Social Science and Medicine*, No. 2005, pp. 439-455. ■ Retzlaff-Roberts, D., C.F. Chang and R.M. Rubin (2004), "Technical Efficiency in the Use of Health Care Resources: a comparison of OECD countries", *Health Policy*, No. 69, pp. 55-72.

### Definition and measurement

Total expenditure on health is the amount spent on health care goods and services plus capital investment in health care infrastructure, by both public and private sources. Health expenditures include all outlays that have as a goal to promote health and prevent disease; cure illness and reduce premature mortality; care for persons affected by chronic illness who require nursing care; and provide and administer health programmes, health insurance and other funding arrangements.

Comprehensive health expenditure estimates for 2002, based on national health accounts that are in compliance with the recently developed System of Health Accounts (SHA), exist for 15 countries: Australia, Canada, Denmark, France, Germany, Hungary, Japan, Korea, Mexico, Netherlands, Spain, Switzerland, Turkey, the United Kingdom and the United States. Caution is needed when comparing these recent estimates with those for 1990. For other countries, spending estimates are based on health spending as reported in national accounts or locally developed health accounting systems. Cross-country comparisons of per capita expenditure require a conversion of national currencies into a common currency (USD at purchasing power parity conversion rates).

OECD countries spend on average around 8½ per cent of their GDP on health (Chart HE4.1). The share of health spending in GDP is highest in the United States, at close to 15% in 2002, and lowest in the Slovak Republic and Korea, at less than 6%. These differences in health care expenditure, however, are only weakly associated with differences in health outcomes (as measured by healthy life expectancy) achieved for a given level of health spending (Chart HE4.2). This suggests that other factors – including both features of the health delivery system and life-style and social factors – are at work.

Cross-country differences in terms of the structure of spending are also large (Chart HE4.1). In all countries health spending is financed by both public and private sources. The public sector is usually the main source of funding, accounting for 70% to 80% of total spending in most OECD countries. In contrast, in the United States and Mexico, more than half of health spending is paid by private sources.

Over the past decade, the annual increase in per capita health spending in OECD countries has outpaced per capita GDP growth by almost 70% (Chart HE4.3). Country variations in the growth of health spending per capita range from more than 7% in Turkey, Korea and Ireland, to less than 2% in Finland and Italy.

Growth in health spending is explained by several factors. First, health costs tend to rise faster than economy-wide inflation: the labour-intensive nature of health care means that its productivity

growth is lower than the economy-wide average, while wages in the health sector tend to rise in line with the economy-wide trends. Second, advances in the capability of medicine to treat and prevent health conditions are another major factor driving health cost growth, and this trend is likely to continue in the foreseeable future. Third, population ageing also plays a significant role in driving health spending, although there are uncertainties as to the extent to which this reflects higher health costs during the terminal years of a person's life (and the concentration of these years at higher ages) rather than the effect of ageing *per se*.

The interactions between health systems and the economy are important when considering the financial sustainability of such trends in expenditures. Just as economic factors influence population health, health also has an impact on the economy. In fact, the performance of health systems and economies are deeply intertwined. Decisions about health systems affect economic conditions and have economic implications for stakeholders – and *vice versa*. This relationship needs to be taken into account in both health and economic policy-making.

**Status indicators:** Life expectancy (HE1); Healthy life expectancy (HE2).

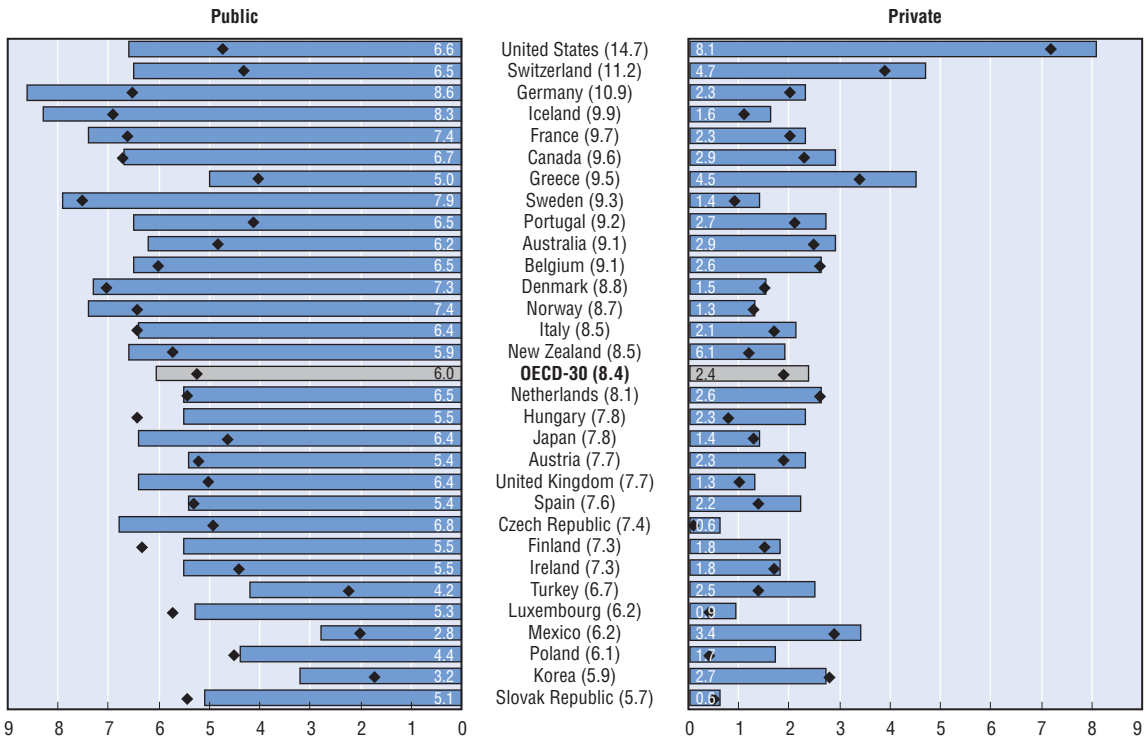
**Response indicators:** Public social spending (EQ5).



# HE4. TOTAL HEALTH CARE EXPENDITURE

## HE4.1. More spending on public and private health since 1990

Public and private spending of health, in percentage of GDP, 2002<sup>1</sup> (blue bar) and 1990<sup>2</sup> (diamond marker)

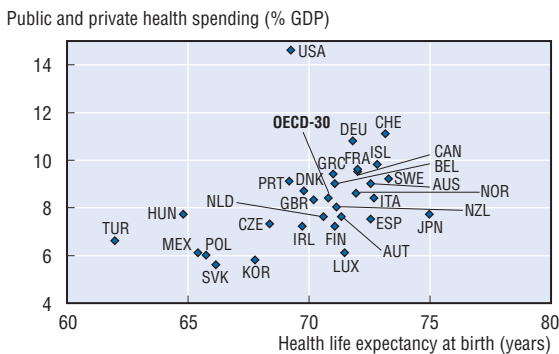


Note: Countries are ranked by decreasing order of total health spending in 2002 (values in brackets in central column).

- 2001 in Australia, Korea, Japan, New Zealand and in the United States; 2000 in Turkey; 1997 in the Netherlands.
- 1991 in Hungary; 1995 in Belgium; 1997 in Slovak Republic.

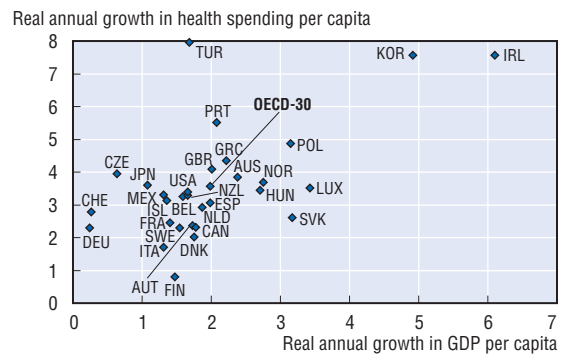
## HE4.2. Variation across OECD countries between health spending and health outcome

Health care spending in percentage of GDP and healthy life expectancy at birth, 2002



## HE4.3. Increase in health care expenditure and GDP per capita in the 1990s

Annual real growth per capita for GDP and total health expenditure, 1990-2002, <sup>1</sup> percentages



- 1990-2001 for Australia, Japan, Korea; 1990-2000 for Turkey; 1991-2002 for Hungary, 1997-2002 for Slovak Republic.

Source: OECD (2004), OECD Health Data 2004, first edition, OECD, Paris (see also [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata)).

StatLink: <http://Dx.doi.org/10.1787/501111843525>

**Further reading:** ■ OECD (2004), *Towards High-Performing Health Systems*, OECD, Paris.



### Definition and measurement

While older persons with various limitations in their capacity to live autonomously are provided long-term care in a variety of settings, often outside the health care system, indicators on long-term care are included among health indicators as they generally involve provision of medical services. Long-term care is either provided informally by other family members, or through formal care services provided to people living in institutions or at home. Institutionalisation of older people covers a range of settings, varying with the extent of medical services that are available: nursing homes, assisted living facilities, centres for day- and respite-care. Sometimes, care is also provided through long-term stays in acute hospital beds. Frail elderly people living at home may receive formal care services, either in the form of services provided or as cash-transfers to pay for these services.

The institutionalisation rate of older people is the share of the population aged 65 and over receiving long-term care in institutions. These exclude certain types of service flats in Nordic countries. Public programmes support home care in various ways: by providing personal services at home and in the community; in the form of day- and respite-care and of other services to support informal carers (e.g. counselling, income payments, or social benefits such as pension rights accrued for the time spent on caring for an older person). Measurement problems exist regarding the distinction between homes and institutions and because of the variety of different sources for national data (local and central governments, health and social care agencies). The growing number of programmes supporting care at home in the form of personal budgets, consumer-directed employment of care assistants and payments for informal care raise issues of where to draw the boundary between care allowances and income protection. Data on the proportion of older people living alone in different years, as presented in this section, are based on special tabulations from household income and expenditure surveys.

Institutionalisation rates for older people vary significantly across countries (Chart HE5.1). The share of the elderly population receiving care in institutions around the year 2000 is relatively high in the northern and continental European countries – at between 5 and 7% – while in southern European countries it is below 4%. Cross-country differences in institutionalisation rates among the elderly are not explained by differences in the prevalence of disability in old age.

In all countries for which data are available, institutionalisation rates for older people declined since the mid-1980s. This trend towards de-institutionalisation reflects a range of interdependent factors which include: increased reluctance among the elderly to enter institutions, particularly where they feel stigmatised for receiving care services within a social assistance framework; the high costs of institutional care; and a shift in policies towards promoting autonomy and independent living.

As a result, alternative forms of long-term care arrangements have been created. While a full continuum of care services adapted to the circumstances of each individual is often unavailable in many countries, the share of the elderly living in more medically oriented care institutions has certainly fallen, while other forms of assisted living arrangements have developed. Often, new institutions provide older people with alternative housing arrangements, as for example in the Nordic

countries, and provide formal care services to frail elderly living at home. On average, across the 15 OECD countries shown in Chart HE5.1, around 9% of older people receive formal care services or public support in the form of cash benefits for care at home, with this share ranging from less than 3% in the United States to 20% in the United Kingdom.

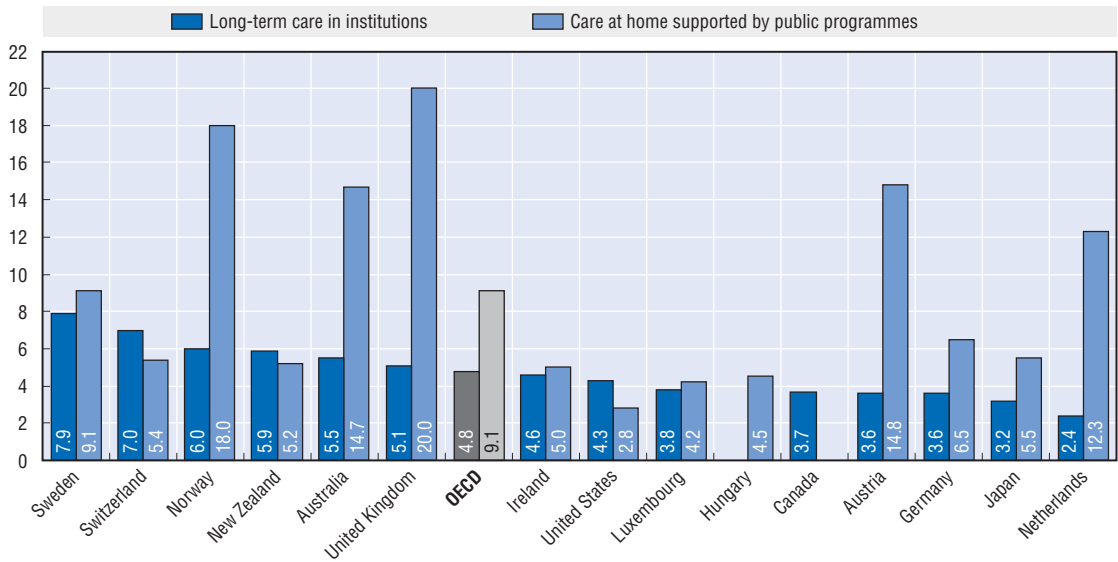
Demand for formal long-term care services is shaped by living arrangements of the elderly. In most OECD countries, large proportions of older people live on their own (Chart HE5.2). Because of differences in life expectancy between men and women, most of them are women. This proportion also appears to have increased in most OECD countries, with the exception of the United States. Conversely, the proportion of elderly living within the extended family environment is diminishing, although it remains high in Japan, Korea and southern Europe. Even in countries where cohabitation does not prevail, however, members of the (extended) family provide the bulk of care as informal caregivers to the frail elderly living alone.

**Status indicators:** Life expectancy (HE1), Health-adjusted life expectancy (HE2).

**Response Indicators:** Public social spending (EQ5), Total health care expenditure (HE4).

**HE5.1. Higher variation across countries in the proportion of the elderly receiving formal care at home than in those receiving care in institutions**

Persons aged 65 and over receiving long-term care in institutions or public support at home as a percentage of the population aged 65 and over, around 2000

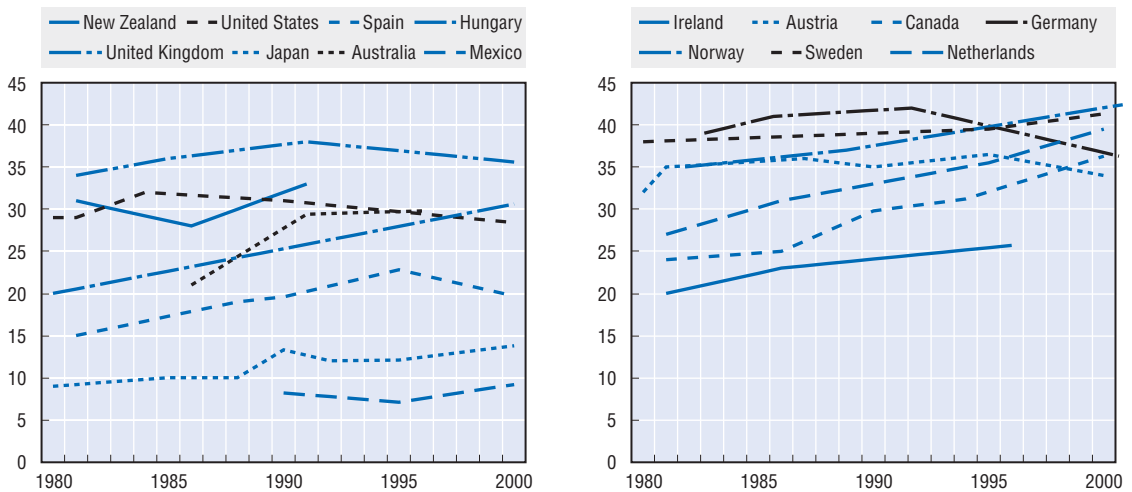


Note: Countries are ranked in decreasing order of the proportion of persons aged 65 and over receiving care in institutions. Data refer to year 2000 for all countries except: 2003 for Germany; 2002 for the United Kingdom; 2001 for Luxembourg; 1999 for the United States (institutional care only); and 1998 for Canada.

Source: OECD (2005), *Long-term Care for Older People*, forthcoming, OECD, Paris.

**HE5.2. The share of older people living alone is increasing in many countries**

Proportion of individuals aged 65 and over living alone, percentages



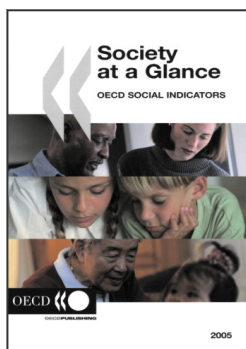
Source: OECD (2005), *Long-term Care for Older People*, forthcoming, OECD, Paris.

StatLink: <http://Dx.doi.org/10.1787/213755005800>

**Further reading:** ■ OECD (2004), *Towards High-Performing Health Systems*, OECD, Paris; OECD (2005), *Long-term Care for Older People*, forthcoming, OECD, Paris

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