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# Better healthcare

## Measuring healthcare quality

### DELSA Newsletter Issue 4

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The Directorate for Employment, Labour and Social Affairs (DELSA) at the OECD works on labour markets, social policy, international migration and health. The fourth issue of the Directorate's newsletter focuses on healthcare, describing our progress in developing indicators of healthcare quality and some results from the latest health database.

Patients and governments are concerned about the quality of healthcare in all OECD countries. Surveys suggest that more than half of doctors in some countries feel that their ability to provide quality care has worsened over time. Patients and the public also indicate overwhelmingly that health systems need fundamental change.

Demand for healthcare is growing rapidly, fuelled by growing patient expectations, population ageing and new technologies. But this is increasingly pushing against resource constraints. Improving the performance of healthcare systems is important both to optimise health spending and correct any deficiencies in quality of care.

After five years of painstaking work, including numerous meetings involving dozens of experts, DELSA has issued an initial set of indicators of the quality of healthcare systems, which provides the lead story for this newsletter (pages 2-3). This will feed into a programme on how to improve the performance of health systems (page 8).

The aim is also to add the indicators of healthcare quality to the 1 200 already in the OECD health database, some of which go back to 1960. Key findings from OECD Health Data 2006 are set out in two articles (pages 4-5), one on healthcare spending and the other on obesity.

Too often there is a gulf between academics and policymakers in all areas of our work. DELSA has

long tried to bridge that gap, by bringing academic rigour to bear on important policy questions. A key way in which we try to achieve that objective is by dissemination of our work through two Working Paper series: on Health and on Social, Employment and Migration topics. A second route is through publications in academic journals, where the intellectual underpinnings of the Directorate's research can be shared with academics and subjected to the scrutiny and discipline of the peer-review process. Some recent articles are briefly summarised on pages 6 and 7.

The next issue of the newsletter will focus on our work on international migration.

**John P. Martin, Director**  
**Martine Durand, Deputy Director**  
**Employment, Labour and Social Affairs**  
**OECD**

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#### Getting hold of the DELSA newsletter

Past issues of the newsletter, on ageing [1], older workers [2] and boosting jobs and incomes [3] are available on the internet at:

<http://www.oecd.org/els/newsletter>

To receive future issues, either electronically or in hard copy, please e-mail us at [els.newsletter@oecd.org](mailto:els.newsletter@oecd.org)

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## Healthcare quality indicators

The HCQI project aims to find scientifically sound, clinically important, policy-relevant comparable measures that can be used to raise questions on healthcare quality and can be reliably reported by different countries.

The quality of healthcare is vitally important: patients may die as a result of poor quality care. Many countries already compare healthcare outcomes for different providers, although most national quality indicator systems are in their infancy. There are potentially important lessons to be learned from international comparisons of quality of healthcare.

Differences in health have a number of causes, only some of which are in the control of the health system. Some healthcare quality indicators, such as cancer survival rates, try to measure health outcomes – changes in health status attributable to healthcare – but it is not always easy to control for differences in patient risk. Other healthcare quality indicators, such as immunisation rates, measure medical-care processes that are known to be effective.

The first phase of the HCQI project, summarised in the initial-indicators report, concentrated on 17 important and readily available measures of healthcare effectiveness. Work in 2006 involved a second round of data collection on a wider set of indicators. An update report, to be released in April 2007, contains 19 indicators and enables comparisons between 32 countries.

### Initial results

The initial indicator set showed huge differences between countries. For example, the proportion of women with breast cancer who die within five years of diagnosis varies between 11 and 23% (compared with survival rates for the whole population). Death rates from cervical cancer, measured in the same way, vary between 22 and 38% and for colorectal cancer, between 35 and 53%. These major differences in health outcomes must be monitored to identify trends and changes over time. Explanations for such trends will be explored in future stages of the project.

The initial indicators also show major differences between countries in healthcare inputs as well as outcomes. According to surveys, screening programmes for breast cancer reach between 28

and 71% of women, while the proportion screened for cervical cancer varies between 24 and 79%.

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## Healthcare quality indicators

Breast cancer survival

Mammography screening

Cervical cancer survival

Cervical cancer screening

Colorectal cancer survival

Incidence of vaccine-preventable diseases (3)

Coverage of basic, childhood vaccinations (3)

Asthma mortality

Acute-myocardial-infarction 30-day case fatalities

Stroke 30-day case fatalities

Waiting time for femur fracture surgery

Influenza vaccination for adults over 65

Prevalence of smoking

Retinal exams in diabetics

Asthma admissions

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## Co-ordination

The project, which began in 2001, built on two existing international collaborations. The first, covering five countries, was organised by the Commonwealth Fund. The second, consisting of six countries, was established by the Nordic Council of Ministers. The HCQI project now involves 32 countries.

The work is co-ordinated with other international organisations, such as the European Commission (particularly Eurostat), the World Health Organization (WHO) and ongoing international data collection efforts, such as Eurocare (which collects statistics related to cancer). Since 2006, the European Commission has also been one of the financial supporters of the project.

The aim is eventually to add the quality indicators to OECD Health Data (see pages 4-5), which will ensure that they are regularly updated.

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## What next?

Patient safety and mental healthcare were selected as new areas in which suitable quality indicators will be identified.

In June 2006, a seminar on patient safety data systems, sponsored jointly by the OECD and the Irish Department of Health and Children, was held in Dublin. Country experts shared their experiences with data systems to monitor patient safety. The findings of the conference were published in March 2007 (see follow-up). Work is focussing now on calculating indicators based on national data systems for hospital administration.

Investigating mental health requires a different approach. There is a wide range of care settings and patterns of diagnoses in OECD countries. Definitions and boundaries of mental healthcare systems differ and there is very little comparable data in this area. On June 18-19, the Danish Ministry of Health and the OECD will co-host a conference in Copenhagen to exchange experiences in organising mental health information systems. The first data collection for an initial set of indicators is planned for the first half of 2008.

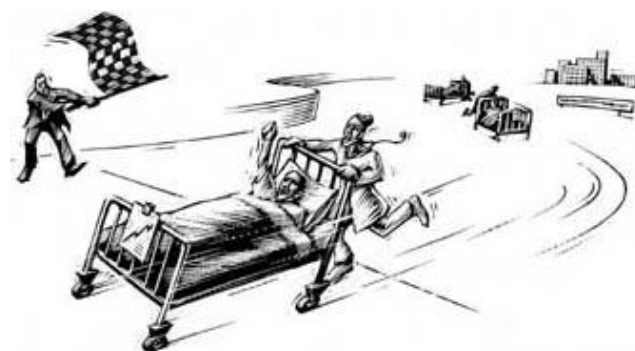
Two new areas are also being addressed by the project. The first relates to the responsiveness of healthcare services and the experiences that patients have when seeking and receiving care. The second covers health promotion, primary care and prevention. The challenge here is to find data on ambulatory and primary care that can be used to calculate the relevant quality indicators. The work in this area is starting in spring 2007.

Future indicators to be considered in the second phase of work will consider a broader set of clinical conditions and other dimensions of healthcare quality, such as cardiac and diabetes care.

In addition to the initial indicators report, a companion paper (see follow-up below) provides a conceptual framework for the project. A further paper on the concepts appeared in the *International Journal for Quality in Health Care* (see page 6).

The healthcare quality indicators project has already made great strides and has carefully plotted the way forward. In this sense, 2007 is a

challenging year for the project. The low-hanging fruit has been picked but the basket is not yet representative of the many healthcare quality issues with which policymakers struggle. The aim is to expand the technical work further and eventually cover a much wider spectrum of services – preventive, acute, chronic and palliative care – as well as underlying diseases and handicaps.



**And they're off!** David Rooney's take on measuring healthcare quality for the OECD *Observer* magazine at the start of the HCQI project in 2001.

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## Follow-up

Health care quality indicators project: initial indicators report, Soeren Mattke *et al.*, Health Working Paper no. 22, OECD, June 2006.

Health care quality indicators project: conceptual framework paper, Edward Kelley and Jeremy Hurst, Health Working Paper no. 23, OECD, June 2006.

Patient safety data systems in the OECD: a report of a joint Irish Department of Health – OECD conference, Edward Kelley, Lihan Wei and Sandra Garcia Armesto, March 2007.

2006 data collection: update report on indicators. Edward Kelley, Sandra Garcia Armesto, Maria Luisa, Gil Lapetra and Lihan Wei, Health Working Paper, OECD, forthcoming in April 2007.

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## Health spending grows faster than economies

Health spending continues to rise in OECD countries, necessitating some hard policy choices. Maintaining existing healthcare systems will require a mix of higher taxes, lower spending on other programmes and making people pay more out of their own pockets.

OECD Health Data 2006 shows that health spending has grown faster than gross domestic product (GDP) in every OECD country bar Finland. Average expenditure rose from 7% of GDP in 1990 to reach 8.9% of GDP in 2004.

The vast bulk of healthcare in OECD countries – nearly 75% – is paid from the public purse. The public share has fallen in countries where it was high in the past – in Poland, Hungary and the Czech Republic – and increased where it had been low. In Korea, for example, the public share of health spending rose from 38% in 1990 to just over 50% in 2004. In the United States, it increased from 40% to 45%. Although the private sector continues to dominate healthcare financing, public spending per head is still greater than that in most other OECD countries because overall health spending is so much higher.

Private payments for health include those financed by private insurance and those paid directly out of the pocket of private households. Direct, out-of-pocket spending is an important source of financing in some OECD countries, particularly those where private health insurance is low. In 2004, the share of direct, out-of-pocket spending was highest in Mexico (51%), followed by Greece (45%), and Korea (37%).

Private health insurance accounts for only around 6% of total health spending on average. But it is

important for most of the non-elderly population in the United States: 37% of total health spending in 2004. Private insurance, offering extra services, accounts for 10-15% of overall spending in Canada and France.

Private money plays a greater role in pharmaceuticals than hospital care, because drugs are often less well-covered under publicly financed insurance schemes (although this varies). In 2004, public coverage of drug costs was lowest in Mexico (12%), the United States (24%), Poland (37%) and Canada (38%). In contrast, more than two-thirds of drug spending came from public sources in countries such as Austria, France, Germany, Spain and Sweden.

### Follow-up

OECD Health Data 2006 is available online or on CD-ROM. The database is multilingual (English, French, German, Italian, Spanish and Russian, and available in Japanese on the online version).

Internet:

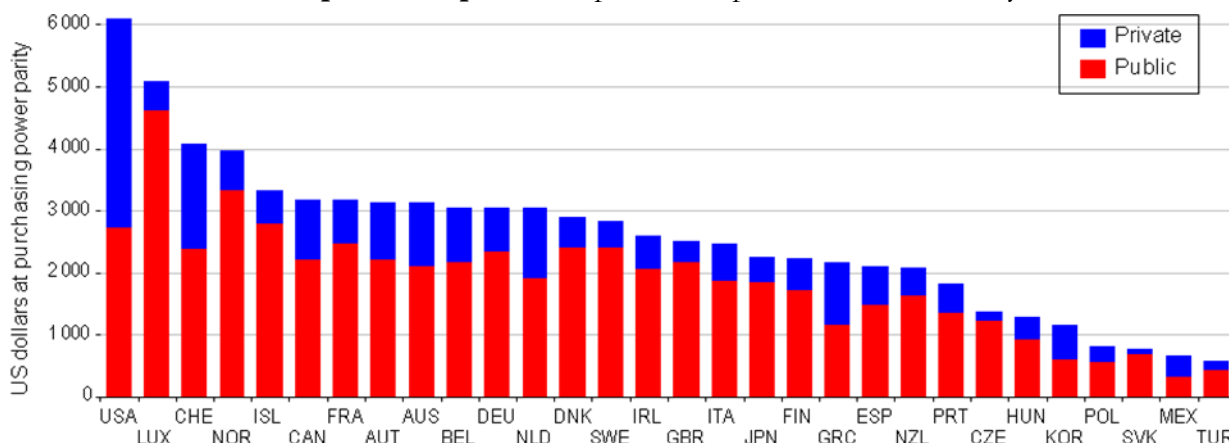
[www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata)

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Health expenditure per head: public and private, 2004 or latest year



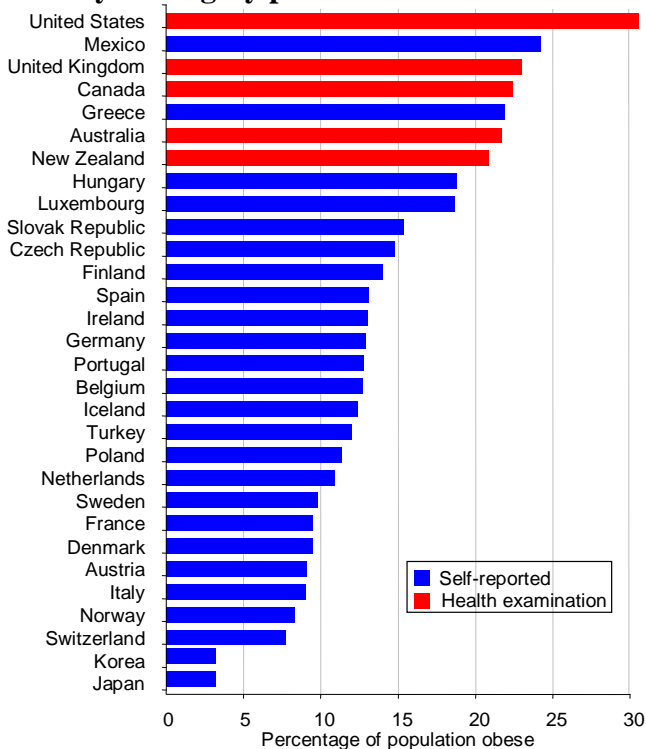
## Big is bad

Food in OECD countries is more plentiful, cheaper, varied and, despite periodic scares, safer than ever before. But diets are getting worse and people exercise less. The most obvious sign of this is the spread of obesity, which people have begun to call an epidemic.

Being fat will not necessarily kill you, but the menu of illnesses associated with obesity is an unsavoury one: hypertension, diabetes, stroke, diseases of the heart and gall-bladder, osteoarthritis, problems breathing and at least four kinds of cancer. The total cost of obesity-related disease to the United States is approximately \$100 billion according to the healthcare quality indicators project (pages 2-3). An estimated 300 million people around the world are clinically obese, as measured by the body mass index (BMI, see below).

While the prevalence of obesity in OECD countries varies enormously, the increase is universal. Fewer than 3% of adults are obese in the OECD Asian countries. But obesity rates exceed 20% in most of the English-speaking countries in the OECD – Canada, United Kingdom, United States and Australasia – and in Greece and Mexico.

### Obesity: a weighty problem



In countries where OECD Health Data includes a long time series – 20 years or more – obesity rates have doubled and, in some cases trebled. Although the United States has had the highest obesity rate for a long time, other countries are catching up.

Mireille Guiliano, the face of champagne house Veuve Clicquot in the United States, argues that “French women don’t get fat”. The book of this title reached number 2 on the bestseller lists of both the New York Times and the Sunday Times (of London). The chart appears to confirm that she is substantially correct (particularly when addressing a British or American audience).

However, there is one important caveat in interpreting the data on obesity rates. In the countries highlighted in red, height and weight are measured during health examinations. In the countries coloured blue, BMI are calculated from individuals reporting their height and weight. In countries where both sources of data are available, direct measurement results in obesity rates around 50% higher than self-reporting. No country can afford to be complacent about this threat to health.

A new project on the *Economics of Prevention* started in January 2007. The main focus will be on chronic diseases which arise from unhealthy diets and lack of physical activity, including those that result from obesity.

### Measuring obesity

Body mass index (BMI) is calculated from an individual’s weight and height. BMI is easy to calculate in metric: weight in kilograms divided by height in metres squared. In Imperial measurements, calculating BMI is slightly trickier: weight in pounds divided by height in inches squared multiplied by 703.

A BMI of 30 or over is considered obese, while between 25 and 30 is classified as overweight and 20-25 is the ideal.

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## Ivory towers

DELSA's work is disseminated in a range of formats, from short policy briefs to papers in technical and academic journals. Here is a selection of recent journal articles that may be of interest. The topics covered span the range of the Directorate's programme.

### Special supplement on the OECD Health Care Quality Indicators project

*International Journal for Quality in Health Care*  
vol. 18, supplement 1

This special issue reviews the work of the OECD's healthcare quality indicators project in eight papers. The first paper looks at the background to the project, concluding that 'international consensus can be achieved in how to measure the quality of care in priority areas, suggesting substantial demand for and interest in comparative information at the health system level.'



The results of the second paper, setting out the conceptual framework, are discussed on pages 2-3 of this newsletter.

Five subsequent papers discuss different areas of the project, such as patient safety, prevention and health promotion and care in the areas of mental health, diabetes and heart disease. The final paper sets out future developments.

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#### Follow-up

<http://intqhc.oxfordjournals.org/>

### Welfare reform in European countries: A microsimulation analysis

*Herwig Immervoll, Henrik Kleven, Claus Kreiner and Emmanuel Saez*

*Economic Journal*, Issue 516, January 2007

This article compares the effects of increasing traditional welfare to introducing in-work benefits in the 15 (pre-enlargement) countries of the European Union. 'In-work benefits' like the UK's Working Families Tax Credit, which target the working poor, are much more effective than traditional anti-poverty measures. They maintain,

and even strengthen, people's incentives to work, and make transferring money from rich to poor much cheaper.

The authors conclude that in-work benefits are a valuable policy option for helping low-income families, especially in those continental European countries where taxes are high and up to a third of the population rely on government transfers for most of their incomes.



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#### Follow-up

<http://www.res.org.uk/economic/ejbrowse.asp>

### Pension challenges and pension reforms in OECD countries

*Peter Whiteford and Edward Whitehouse*

*Oxford Review of Economic Policy*,  
vol. 22, no. 1, Spring 2006

The pension systems of OECD member countries are very diverse. For example, current old-age public spending on pensions varies from less than 1% to more than 10% of gross domestic product (GDP). Also, public spending on pensions per person aged 65 or over varies from less than 15% to more than 40% of economy-wide GDP per head.

Recent pension reforms have common themes, including tighter eligibility conditions, less generous indexation of pensions in payment, links between benefits and changes in life expectancy. Finally, some countries have introduced defined-contribution pensions: privately managed schemes where the pension benefit depends on contributions and investment returns.



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The paper draws on work involving many DELSA staff, including *Pensions at a Glance: Public Policies across OECD Countries* and the Older Workers study (see Issues 1 and 2 of the DELSA newsletter, respectively).

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**Follow-up**

[www.oxrep.oxfordjournals.org](http://www.oxrep.oxfordjournals.org)

**New indicators of 30 OECD countries' pension systems**

**Edward Whitehouse**

*Journal of Pensions Economics and Finance*,  
vol. 5, no. 3, November 2006

The paper presents a range of indicators of pension systems, building on the OECD pension models and the *Pensions at a Glance* report. Some of the indicators, such as replacement rates, are familiar. Others, such as the structure of the pension package and measures of progressivity of pension benefit formulae, are novel.



The paper emphasises the diversity of OECD member countries' retirement-income systems.

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**Follow-up**

[www.pensions-journal.com](http://www.pensions-journal.com)

**Policies, institutions and fertility rates: a panel data analysis for OECD countries**

**Anna Cristina D'Addio and Marco Mira d'Ercole**

*OECD Economic Studies*, no. 41, June 2006

With fertility rates now well below replacement levels throughout the developed world, several OECD governments are directing their attention to policies that may lessen the obstacles to childbearing that confront families. This paper provides an overview of recent trends in fertility rates and what is known about their determinants, including the effect of various public policies.

Dynamic panel models of total fertility rates are then estimated using two different specifications. The results confirm that various policies – transfers to families with children and parental leave – and institutional factors – such as the characteristics of the labour market – significantly affect childbearing. A better policy mix could increase fertility rates from the very low levels they have reached in several countries.



**Follow-up**

[www.oecd.org/eco](http://www.oecd.org/eco)

**Beyond the headlines: new evidence on the brain drain**

**Jean-Christophe Dumont and Georges Lemaître**

*Revue économique*, vol. 5, no. 6, 2005

The “brain-drain” debate is an old one, but, until now, was carried out with little in the way of solid data. This paper uses the OECD’s new database on the foreign-born population in member countries, their country of birth and educational attainment to provide new evidence on this phenomenon.

The highly qualified are more likely to move from less developed economies to live and work in OECD countries if they are born in smaller, more insular nations that have few other people with high educational attainment. This means that limited opportunities – both in education and the labour market – are significant drivers of international migration for the highly qualified.



**Follow-up**

[www.sciences-po.fr/edition/revues/revuec.html](http://www.sciences-po.fr/edition/revues/revuec.html)

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## Check-up for health systems

Improving the performance of healthcare systems is a major and growing concern for OECD governments and citizens. Reforms of healthcare provision are needed. But policymakers often find it difficult to overcome the obstacles to change, argues **Francesca Colombo**.

How do countries' health systems perform relative to others? And what lessons can be learned from these differences? To answer these questions, the OECD conducts assessments of health-system performance with a focus on economic issues. The *Reviews of Health Systems* are initiated at the request of the country to be examined. To date, reviews of Korea (2003), Mexico (2005), Finland (2005) and a joint OECD-WHO review of the Swiss health system (2006) have been completed.

The reviews look at a range of issues that are common to all countries to evaluate performance. These include pressures to improve value for money from health spending, increased demands for better quality of care and population ageing. However, key policy challenges differ, reflecting the history, economic development, and institutional structures of each country. The reviews place their emphasis on issues of key domestic policy interest.

Take, for example, Mexico and Korea. Health spending in both countries is relatively low: 5.6% of GDP (Korea) and 6.5% of GDP (Mexico), against an OECD average of 9% in 2004 (see page 4). Yet the two countries face different issues. Korea successfully achieved universal healthcare coverage in 1989, through the gradual inclusion of additional population groups to their social health-insurance system. The key policy challenge here is how to maintain fiscal sustainability of the national health insurance system, especially after some major insurance and pharmaceutical reforms in 2002.

The Mexican system, in contrast, is highly fragmented and unequal. Social security institutions cover half of the population and the remaining half receives lower-quality care at state health facilities. The key policy challenge here is to improve access for the poorest. An innovative 2004 reform introduced incentives to encourage the uninsured population to take up voluntary coverage at the state level.

Despite different set-ups of their health systems, Finland and Switzerland have much in common. Both countries have decentralised health systems, populations that are largely satisfied with the type and quality of the care services, and the health outcomes are good. But Finland controls municipal spending on health services well while the Swiss health system is very expensive. Improving cost effectiveness is thus a key priority in Switzerland. Part of the challenge here arises from the decentralized organisation of health supply, which has resulted in redundant capacity.

Another challenge for Switzerland is how to encourage value-based competition across multiple competing private health insurance funds. Value for money from drug spending could be improved through a greater use of generics in Switzerland and more appropriate prescriptions in Finland.

*OECD Reviews of Health Systems* have a significant impact on policy. They have supported the reform process in different countries by showing ways of achieving designated policy goals, thereby promoting value for money.

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### Follow-up

<http://www.oecd.org/health/reviews>

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This newsletter is issued by the Directorate for Employment, Labour and Social Affairs (DELSA) of the Organisation for Economic Co-operation and Development (OECD).

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