

## Introduction

**H** *Health at a Glance 2009* allows readers to compare health systems and their performance across a number of key dimensions, using a core set of indicators of health and health systems selected for their policy relevance and on the basis of the availability and comparability of the data.

The OECD has long been an international leader in the development of tools and collection of data for assessing the performance of health systems. OECD work to improve the comparability of health statistics goes back to the 1980s when efforts began to improve the comparability of health expenditure data, at a time when concerns emerged on rapidly rising health spending and the growing pressures on both public and private financing (OECD, 1985). The release of the manual, *A System of Health Accounts*, in 2000 provided a renewed impetus and key tool for the OECD to strengthen this effort to improve the comparability of health expenditure data across a larger group of countries, working in close collaboration with WHO and Eurostat.

While comparable data on health spending are necessary to assess the amount of financial resources that countries allocate to health, they are obviously not sufficient to assess the performance of health systems. The OECD effort to improve the comparability of health statistics was broadened to cover the supply and activities of health workers and physical resources in health care systems. Following the meeting of OECD Health Ministers in 2004, the OECD further extended its effort to assemble comparable data for assessing health system performance through developing and collecting a set of indicators to measure the quality of care and the outcomes of health interventions. In addition, initial work has been undertaken on a set of indicators related to access to care, another key objective of health systems across OECD countries. The OECD continues to work with experts in its member states and with other international organisations to fill gaps in the assessment and comparison of health system performance.

### Policy, economic and social context

Beginning in the second half of 2008, OECD countries entered into a deep economic recession. The June 2009 OECD projections indicate that GDP may decline by about 4% in the OECD area in 2009, and unemployment rate is projected to reach about 10% of the labour force by the end of 2010 (OECD, 2009b).

Government budgets provide a very important cushion for economic activity in the downturn, mainly through automatic stabilisers and discretionary spending or tax reductions. However, the result has been a marked increase in government deficits. When the economic recovery is sufficiently firm, substantial reductions in budget deficits will be required in many countries. The extent of government spending reductions and/or tax increases will depend on the strength of the recovery and the size of the deficit and cumulative debt.

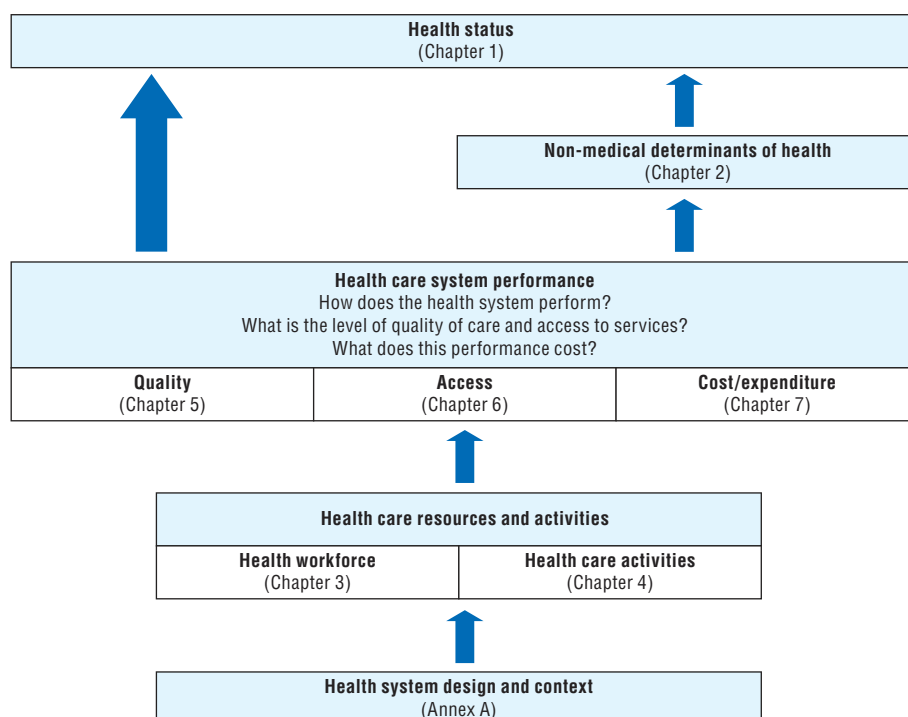
Given that health spending accounts for a high and growing share of public budgets, it will be hard to protect it from any general effort to control public spending during or after the recession. The extent to which public spending on health may be affected will depend on the relative priority allocated to health compared to other priorities. It will also depend on the extent to which public spending on health brings demonstrated benefits in terms of better health outcomes for the population. In a context of scarce public resources, there will be growing pressures on Health Ministries and health care providers to demonstrate efficiency (cost-effectiveness) in how resources are allocated and spent. Chapter 5 presents some of the progress achieved thus far in measuring quality of care and health outcomes across countries, while noting that the set of measures is still partial and further effort is needed to improve data comparability.

## Structure of the publication

The framework underlying this publication allows for examining the performance of health care systems in the context of a broader view of public health (Figure 0.1). This framework is based on one that has been endorsed for the OECD Health Care Quality Indicators project (Kelley and Hurst, 2006; Arah et al., 2006).

The framework highlights that the goal of health (care) systems is to improve the health status of the population. Many factors influence the health status of the population, including those falling outside health care systems, such as the social, economic and physical environment in which people live, and individual lifestyle and behavioural

Figure 0.1. **Conceptual framework for health system performance assessment**



Source: Adaptation of the OECD (2006), "Conceptual Framework for the OECD Health Care Quality Indicators Project", OECD Health Working Paper, No. 23, OECD Publishing, Paris.

factors. The performance of health care systems also contributes to the health status of the population. This performance includes several dimensions, most notably the degree of access to care and the quality of care provided. Performance measurement also needs to take into account the financial resources required to achieve these access and quality goals. The performance of health systems depends on the people providing the services, and the training, technology and equipment that are at their disposal. Finally, a number of factors are related to health care system performance, such as the demographic, economic and social context, and the design of health systems.

*Health at a Glance 2009* provides comparisons across OECD countries on each component of this framework. It is organised as follows:

- Chapter 1 on *Health Status* highlights large variations across countries in life expectancy, mortality and other measures of population health status.
- Chapter 2 on *Non-medical Determinants of Health* focuses on selected determinants related to modifiable lifestyles and behaviours. The chapter has been extended this year to cover risk or protective factors among children, such as nutrition habits, physical activity, smoking and alcohol drinking. These complement the set of adult risk factor indicators.
- Chapter 3 looks at the *Health Workforce*, the key actors in any health system. This new chapter provides information on the supply and remuneration of doctors and nurses, and recent trends on the international migration of doctors in OECD countries.
- Chapter 4 reviews a key set of *Health Care Activities*, both within and outside hospitals. It examines cross-country variations in the supply and use of medical technologies, such as medical resonance imaging (MRI) units and computed tomography (CT) scanners. It also looks at variations in the use of high-volume and high-cost procedures, such as coronary artery bypass graft and coronary angioplasty, caesarean sections, and cataract surgeries.
- Chapter 5 on *Quality of Care* provides comparisons on selected indicators of quality with respect to care for chronic conditions, mental disorders, cancers and communicable diseases. The measures include indicators of *process* of care that is recommended for certain population or patient groups to maximise desired outcomes, and key *outcomes* measures such as survival rates following heart attack, stroke and cancer.
- Chapter 6 is a new chapter on *Access to Care*, and aims to fill the gap in measuring this important dimension of health system performance. It begins with a limited number of indicators related to financial and geographic access. The intent is to expand this chapter in future editions, once further progress has been achieved in indicator development and data collection.
- Chapter 7 on *Health Expenditure and Financing* compares how much OECD countries spend on health, both overall and for different types of health services and goods. It also looks at how these health services and goods are paid for in different countries (*i.e.* the mix between public funding, private health insurance where it exists, and out-of-pocket payments by patients).
- Annex A provides some additional information on the demographic and economic context within which health systems operate, as well as some key characteristics of health system financing and delivery. This can assist readers in interpreting the indicators presented in the main body of the publication.

An increasing number of OECD countries are regularly publishing reports on different aspects of health and the performance of their health care systems. Examples of such

national reports include *A Set of Performance Indicators across the Health and Aged Care System* in Australia (AIHW, 2008e), the *Dutch Health Care Performance Report* in the Netherlands (RIVM, 2008), *Quality and Efficiency in Swedish Health Care* in Sweden (Swedish Association of Local Authorities and Regions and National Board of Health and Welfare, 2008), and the *National Healthcare Quality Report* together with the *National Healthcare Disparities Report* in the United States (AHRQ, 2008a and 2008b). These national reports often focus on variations across different regions within the country. The Dutch performance report provides a good example of how such national reports may also be enriched by including international comparisons, to provide a broader perspective on the relative strengths and weaknesses of the national health system and identify potential areas for improvement.

### Presentation of indicators

Each of the topics covered in the different chapters of this publication is presented over two pages. The first provides a brief commentary highlighting the key findings conveyed by the data, defines indicators and discloses any significant national variations from that definition which might affect data comparability. On the facing page is a set of figures. These figures typically show current levels of the indicator and, where possible, trends over time. In some cases, an additional figure relating the indicator to another variable is included. Where an OECD average is included in a figure, it is the unweighted average of the countries presented, unless otherwise specified in the accompanying notes.

### 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 figures. Readers should exercise particular caution when considering time trends for Germany. Data for Germany up to 1990 generally refer to West Germany and data for subsequent years 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 2009*. This information is available free-of-charge at [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata). *OECD Health Data 2009* can also be ordered online at SourceOECD ([www.sourceOECD.org](http://www.sourceOECD.org)) or through the OECD’s online bookshop ([www.oecd.org/bookshop](http://www.oecd.org/bookshop)). Regarding Chapter 5 on *Quality of Care*, more information on definitions, sources and methods underlying the data is available at [www.oecd.org/health/hcqi](http://www.oecd.org/health/hcqi).

### Population figures

The population figures presented in Annex A and used to calculate rates per capita throughout this publication come mainly from the OECD Labour Force Statistics Database (as at April 2009), and refer to mid-year estimates. Population estimates are subject to revision, so they may differ from the latest population figures released by national statistical offices of OECD member countries.

Note that some countries such as France, the United Kingdom and the United States have overseas colonies, protectorates and territories. These populations are generally excluded. The calculation of GDP per capita and other economic measures may, however, be based on a different population in these countries, depending on the data coverage.

## Country codes (ISO codes)

Australia	AUS	Korea	KOR
Austria	AUT	Luxembourg	LUX
Belgium	BEL	Mexico	MEX
Canada	CAN	Netherlands	NLD
Czech Republic	CZE	New Zealand	NZL
Denmark	DNK	Norway	NOR
Finland	FIN	Poland	POL
France	FRA	Portugal	PRT
Germany	DEU	Slovak Republic	SVK
Greece	GRC	Spain	ESP
Hungary	HUN	Sweden	SWE
Iceland	ISL	Switzerland	CHE
Ireland	IRL	Turkey	TUR
Italy	ITA	United Kingdom	GBR
Japan	JPN	United States	USA

## List of acronyms

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ALOS</b>	Average length of stay
<b>AMI</b>	Acute myocardial infraction
<b>ATC</b>	Anatomic-therapeutic classification
<b>BMI</b>	Body Mass Index
<b>CAD</b>	Coronary artery disease
<b>CAT (or CT)</b>	Computed axial tomography
<b>CHF</b>	Congestive heart failure
<b>COPD</b>	Chronic obstructive pulmonary disease
<b>DDD</b>	Defined daily dose
<b>DMFT</b>	Decayed, missing or filled permanent teeth
<b>EHR</b>	Electronic health record
<b>ESRF</b>	End-stage renal failure
<b>EU-SILC</b>	European Union Statistics on Income and Living Conditions survey
<b>GDP</b>	Gross domestic product
<b>GP</b>	General practitioner
<b>HBSC</b>	Health Behavior in School-aged Children survey
<b>HCQI</b>	Health Care Quality Indicators (OECD Project)
<b>HIV</b>	Human immunodeficiency virus
<b>ICHA</b>	International Classification for Health Accounts
<b>IHD</b>	Ischemic heart disease
<b>ISIC</b>	International Standard Industrial Classification
<b>MRI</b>	Medical resonance imaging
<b>PPP</b>	Purchasing power parities
<b>PSI</b>	Patient safety indicators
<b>PYLL</b>	Potential years of life lost
<b>SHA</b>	System of Health Accounts
<b>SIDS</b>	Sudden infant death syndrome
<b>UPI</b>	Unique patient identifiers