



MR PEARSON GOES TO WASHINGTON

Mark Pearson, Head of the OECD Health Division, recently gave evidence to the US Senate Special Committee on Aging in Washington, DC. Find out why.

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OECD TO ORGANISE HEALTH MINISTERIAL MEETING IN 2010

Six years after the first ever meeting of OECD health ministers, they will meet to discuss 'Health system priorities in the aftermath of the crisis' in 2010.

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THE WORLD MEDICAL TOURISM AND GLOBAL HEALTH CONGRESS

David Morgan from OECD's Health Division moderated a Ministers' Roundtable at the World Medical Tourism and Global Health Congress in Los Angeles.

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UPCOMING EVENTS

14–15 December 2009

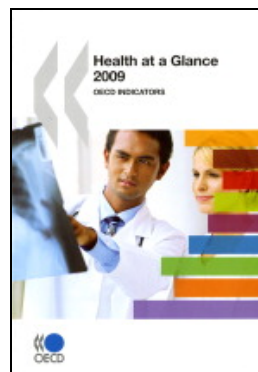
6th session of the OECD Health Committee
OECD Conference Centre, Paris.

7–8 October 2010

Meeting of Health Ministers
OECD Conference Centre, Paris.

JUST OUT

OECD HEALTH AT A GLANCE 2009



The fifth edition of OECD's flagship publication on health is now available. It presents striking evidence of large variations in the costs, activities and results of health systems across countries.

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MR PEARSON GOES TO WASHINGTON

It is well known that the United States spends twice as many dollars per capita (around USD 7 300 in 2007) on health than the average OECD country (just under USD 3 000), but does not have particularly good health outcomes. What is less well understood is *why* the United States spends so much, and so this was the issue that Mark Pearson, Head of the OECD Health Division, addressed when he gave evidence to the US Senate Special Committee on Aging in September.

Drawing on the extensive data that the OECD has collected over many years, Mark was able to show that the US has high spending in almost every area of health, but particularly so in the case of out-patient care – a part of the US system which is financed mainly on a fee-for-service basis. The richer a country is, the greater its health spending; even so, the United States spends around USD 2 500 more per person per year than might be expected, given its income level.

The main cause of high spending is the particularly high prices for health goods and services relative to prices in the rest of the economy in the United States – pharmaceutical prices are 30-50% higher than in the average OECD country; the average cost of a range of in-patient treatments is double that in a range of other countries; and physicians are paid USD 25–40 000 more per year than in Canada, Germany, and the United Kingdom. In addition, there are high rates of some interventions such as caesarean sections, knee replacements and tonsillectomies, which depend largely on physician opinions, and heavy use of high-cost diagnostic testing – about twice as much as the average of those OECD countries where comparable data are available.

When questioning the witnesses called by the Committee, the Chair, Senator Herb Kohl (Democrat, Wisconsin), was particularly interested in whether the public/private mix of spending explained high health spending in the US. Senator Bob Corker (Republican, Tennessee), the ranking minority member of the Committee, was not convinced that international comparisons of health spending were useful. Senator Al Franken (Democrat, Minnesota) pointed out that personal bankruptcies due to health care costs were almost unheard of in the rest of the developed world, so ensuring wide insurance coverage should be a central goal of US health reform. Senator George LeMieux (Republican, Florida) was interested in how fraud in the system could be contained.

Mark concluded his testimony by pointing out that all other OECD countries have more mechanisms built into their health systems to restrict expenditures than is the case in the United States, even though most if not all people in these other countries are covered by health insurance. This is done either by regulating quantities or prices of health care, or both. Observers of the ongoing

discussions of health reform on Capitol Hill know that such policies are controversial in the United States.

Website: www.oecd.org/health

Contact: Mark Pearson

OECD TO ORGANISE HEALTH MINISTERIAL MEETING IN 2010

OECD Ministers will meet to discuss 'Health system priorities in the aftermath of the crisis' in October 2010. The OECD Council agreed that, six years after the first ever meeting of OECD ministers, it was high time for them to get together once again. This time, they will be discussing how health policy makers will need to make tough choices in order to improve health system performance in the future.

Public expenditure has already been cut sharply in some countries, and health spending has not been immune. In most countries, the health system has been one part of the economy which has not been particularly affected by the crisis and the subsequent recession. However, public sector deficits are unsustainably high in many countries. Health ministers will face the painful experience of having to find budget cuts. The challenge will be to do so by eliminating expenditure which is least efficient, while ensuring that high performing parts of the health system continue to receive adequate funding.



Left: Dr Julio FRENK MORA, Chair of the last OECD Health Ministers' Meeting

Even if there is no fiscal pressure to cut spending, health ministers will still want to discuss how to get the most out of their health spending. A chance to compare views on hot health topics such as pay-for-performance, the use of health technology assessments and health information technologies will, no doubt, be welcomed by Ministers, who will need to make a convincing case to finance ministries that health spending can deliver good value for money.

Preventing the onset of disease by helping people live healthier lives will receive particular attention. Past fiscal crises have sometimes led to reductions in spending on prevention. After all, it can take years or even decades before the benefits of prevention policies are felt. But OECD work shows that prevention can be highly cost-effective in improving health. Ministers need to find a way to

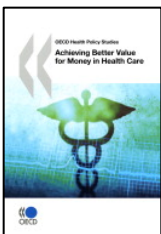
ensure that the importance of prevention policies is not forgotten in the aftermath of the crisis.

The OECD Council has also agreed to the holding of a Forum on 'Quality of Care' before the Ministerial meeting. This will give political profile to a vital programme of work that has generated internationally comparable data, allowing countries to benchmark quality of care against other countries. But further progress in developing better data will require some difficult decisions to ensure that the performance of health systems can be monitored effectively.

Website: www.oecd.org/health

Contact: Mark Pearson

OECD HEALTH POLICY STUDIES ACHIEVING BETTER VALUE FOR MONEY IN HEALTH CARE




Rising public health care spending remains a problem in virtually all OECD and EU member countries. A key policy question, therefore, is "How can health systems improve efficiency of resource use and thereby help ensure the financial viability of health care systems?"

This report largely represents the proceedings of OECD/EU conference in Brussels on 17th September 2008. It examines selected policies that may help countries better achieve the goal of improved health system efficiency, and thus better value-for-money as one means of offsetting part of the fiscal stress.

Drawing on multinational data sets and case studies, it examines a range of policy instruments. These include: the role of competition in health markets, the scope for improving care coordination, better pharmaceutical pricing policies, greater quality control supported by stronger information and communication technology in health care, and increased cost sharing.

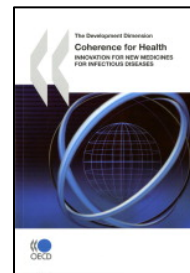
Recent publications:

 *OECD (2009), OECD Health Policy Studies: Achieving Better Value for Money in Health Care*

Website: www.oecd.org/health

Contact: Mark Pearson

POLICY COHERENCE FOR HEALTH AND DEVELOPMENT



Are OECD countries' health policies coherent with their development commitments? Although aid remains an important driver for development, mutually supportive policies across a wide range of economic, social and environmental issues are essential to combat the spread

of diseases, maintaining a healthy workforce and ultimately reduce poverty.


Infectious diseases are one of the primary causes of mortality in the world and in developing countries they are a major barrier to economic development, social progress and human health. However, the health innovation system is failing to deliver new medicines, vaccines and diagnostics for neglected infectious diseases. These diseases include tuberculosis and malaria, but also various tropical diseases. Recent OECD research suggests ways of co-operation and coherent policies required to improve the incentives and efficiency of the innovation system to scale-up research and discovery.

A recent seminar, held in conjunction with the launch of two publications on policy coherence for health and development, provided an opportunity for an informal discussion between health and development experts, as well as OECD ambassadors and staff.

Mr. Stephen Lewis, Co-director of AIDS-free World, called upon the OECD to be tough and uncompromising when it comes to policy coherence for development. He asked that increased attention be paid to (i) the implications on human health of climate change; (ii) the transfer of technology; and (iii) gender equality.

He saw as the single most important achievement in the struggle for gender equality the recent adoption by the United Nations General Assembly to create a new UN agency for women. OECD Deputy Secretary-General, Mr. Aart de Geus, agreed with Mr. Lewis on the importance of gender equality and its impact on improving health conditions. He stated that there is new attention to gender equality at the OECD.

Recent publications:

 *OECD (2009), Coherence for Health: Innovation for New Medicines for Infectious Diseases*

 *Health: Improving Policy Coherence for Development, OECD Policy Brief, October 2009*

Website:

www.oecd.org/development/policycoherence

Contact: Raili Lahnalampi

CAPTURING PATIENTS' PERSPECTIVE ON HEALTH CARE QUALITY

The Health Care Quality Indicator (HCQI) project has made important progress in the priority areas of patient experiences of health care, patient safety and primary care indicator development in recent months.

Building on the foundational work of the last two years, efforts have focussed on the development of a draft "patient experience" questionnaire, in collaboration with the Dutch Centre for Consumer Experiences in Health Care, the Commonwealth Fund, the World Health Organisation and country experts. The objective has been to develop a robust set of standardised questions that can be readily integrated into the national survey programmes of countries.

Early in the development phase it was decided the questionnaire would be restricted to about 20 questions relating to ambulatory care and focussing on issues of access, communications and patient autonomy.

In September, national experts considered the draft questionnaire with a view to undertaking pilot data collection and cognitive testing in their countries during 2010. Broad support for the questionnaire was received and a number of countries are now planning to participate in the data collection activities for next year.

The preliminary outcomes of this work will be presented at a Forum on Quality of Care preceding the OECD Health Ministerial meeting in October 2010, along with an agreed set of high-level principles for establishing national systems of patient experience measurement.

In relation to patient safety and health promotion, prevention and primary care, meetings of country experts were convened in October to consider further development of indicators in these priority areas. Plans for further refinement of the existing indicators on primary care and exploration of indicators relating to perinatal and paediatric care are now proceeding.

As for patient safety, an OECD *Health Working Paper* on the existing set of indicators was released in conjunction with the 2009 edition of *OECD Health at a Glance* in December and a number of potentially fruitful approaches to improving the cross-country comparability of the indicators are being further explored.

Recent publication:

📖 Drösler, S.E. et al. (2009), "Health Care Quality Indicators Project, Patient Safety Indicators Report 2009", *OECD Health Working Paper No. 47*

Website: www.oecd.org/health/hcqi

Contacts: Niek Klazinga, Rie Fujisawa

TRACKING THE GROWTH IN MEDICAL TOURISM: OECD HELPS MINISTERS SHAPE THE DEBATE

Globalisation, the increasing importance of the health sector and the removal of regulatory obstacles to economic activities have all fuelled the growth of international trade in health goods and services.

Better communications and transportation have facilitated the movement of people, both as patients and independent service suppliers. The demand for statistics on the trade in health goods and services to help monitor such trends is increasing.

These were some of the issues discussed at the 2nd Annual World Medical Tourism and Global Health Congress (www.MedicalTourismCongress.com), organised by the Medical Tourism Association, and held in Los Angeles on 26-28 October 2009. The conference featured approximately 1,500 attendees from both the public and private sectors, as well as health insurance companies, employers and insurance agents.

David Morgan from the OECD Health Division took part in a Ministers' Roundtable, and moderated a keynote session where Ministers of Health and Tourism addressed the opportunities and challenges of the industry in their respective countries. The discussions touched on the responsibility of government ministries in developing coherent policies for medical tourism with regard to access, delivery and financing. The role of international agencies in establishing clear definitions and reporting requirements, as well as in helping to determine best practices and standards, was also high on the agenda.



Top row, 3rd right: David Morgan at the World Medical Tourism and Global Health Congress Ministers Roundtable

"Bringing together so many attendees from all sides of the industry – both public and private – and from around the world under one roof is vital in reaching a better understanding of what appears to be a fast-growing area in healthcare provision" said David Morgan, who heads up a two year project to improve the measurement of trade

in health services and goods under the System of Health Accounts.

The Medical Tourism Association is a non-profit trade association for the medical tourism industry with over 300 members, made up of insurance companies, governmental organizations, NGO's, hospitals, facilitators and industry professionals.

Contact: David Morgan

VALUATION OF ENVIRONMENT-RELATED HEALTH IMPACTS

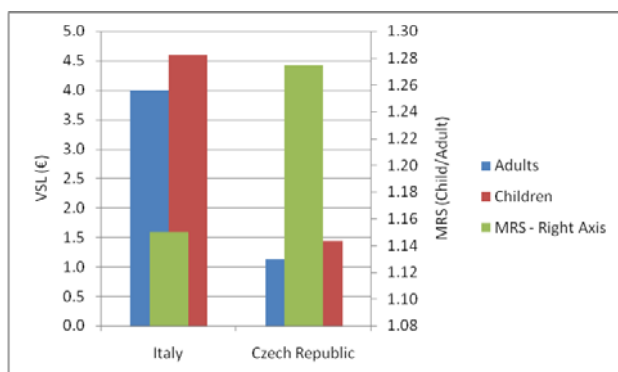


The primary objective of the three-year VERHI project has been the estimation of a value of a statistical life (VSL) for children—and adults—for use in an environmental context.

Why do policymakers care about how members of society value mortality risk reductions for children? There is some evidence that children are particularly vulnerable to some environmental hazards. Also, the health of children can be seen as a 'public good', with the good health of children having positive spillovers both for their parents and for society-at-large. Lastly, while the interests of children are often defended by parents and other caregivers, policymakers in OECD governments have always had a special role in protecting the interests of children.

In the past, most assessments of the economic efficiency of environmental policies have relied upon VSL estimates which are derived from adult populations (e.g. through wage-risk studies). If members of society have different preferences for risk reductions for children relative to adults, then the use of such values will result in a misallocation of resources and policy efforts, perhaps with inadequate attention paid to the specific vulnerabilities of children.

VSL and Marginal Rate of Substitution (MRS) in Italy and the Czech Republic




Based upon some innovative survey instruments in three OECD countries, we find mixed evidence for a 'child premium'. In the case of a conjoint choice experiment implemented in Italy, the VSL for an adult (€4.0 million) is not statistically different from that of a child (€4.6 million). In the Czech Republic the values are statistically different at the 10% level, with values of CZK 24.5 million for a child and CZK 19.2 million for an adult. The implementation of a different survey instrument using the so-called 'chaining approach' – found more robust evidence of a 'child premium' in the United Kingdom.

Such studies are costly, and not all cost-benefit analyses involve original research. Are there general rules, which can be applied to determine cases in which children-specific values would be most helpful? In cases where the policy intervention particularly affects children due to nature/scope of policy (e.g. pesticides in school grounds) or because children are particularly vulnerable to a given hazard (e.g. lead in drinking water), then child-specific values are likely to be particularly helpful in ensuring that resources and policy efforts are allocated efficiently.

In addition, if private risk-reduction opportunities available for children are limited or ineffective, valuing the benefits of public interventions is likely to be particularly useful.

Forthcoming publication:

 *OECD (2010), Valuation of Environment-Related Health Impacts for Children*

Website:

www.oecd.org/env/social/envhealth/verhi

Contact: Nick Johnstone

RELEASE OF HEALTH AT A GLANCE 2009




Health at a Glance 2009 - OECD Indicators was released in early December. The fifth edition of this OECD flagship publication presents the latest comparable data on different aspects of the performance of health systems in OECD countries. It presents striking evidence of large variations in the costs, activities and results of health systems across countries.

Key indicators provide information on health status, the determinants of health, health care activities and health expenditure and financing. In addition, the 2009 edition contains new chapters on the health workforce and on access to care. The chapter on quality of care has been extended to include a set of indicators on the quality of care for chronic conditions, while the overall comparability of the data has been improved.

Each indicator is presented in a user-friendly format, consisting of charts illustrating variations across countries and over time, a brief descriptive analyses highlighting the major findings conveyed by the data, and a methodological box on the definition of the indicator and any limitations in data comparability. An annex provides additional information on the demographic and economic context within which health systems operate, as well as a concise description of key characteristics in health system financing and delivery of services in OECD countries.

Besides the English and French versions, the 2009 edition of *Health at a Glance* will be translated into German, Japanese and Korean.

Recent publication:

 *OECD (2009), Health at a Glance 2009 – OECD Indicators, OECD, Paris*

Website: www.oecd.org/health/healthataglance

Contacts: Gaetan Lafortune, Michael de Looper

UPDATE: SURVEY OF HEALTH SYSTEMS INSTITUTIONAL CHARACTERISTICS

In October 2008, the Health Committee launched an online survey of countries to collect information on the main institutional characteristics of their health systems.

This survey had two goals: to inform policy analyses conducted by the Health Committee, and to feed an Economic Policy Committee project on health systems efficiency. This project aims to explore the links between institutional characteristics of health systems and their efficiency.

Twenty-nine countries responded to the survey. During the first half of 2009, the Secretariat validated responses and completed missing information.

A set of about 20 indicators were developed in cooperation with the Economics Department, covering three areas of interest: arrangements for health coverage, organisation and incentives in health care delivery, and governance of health systems. For example, indicators were constructed to assess the level of coverage by basic health insurance; the degree of patient choice across providers, and volumes incentives embedded in providers' payments. The indicators were "normalised", i.e. scored from 0 to 6.

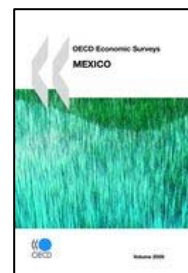
The set was presented to the Health Committee in July 2008. Several delegates felt that more time and collective thought needed to be devoted to this important project, and asked for an expert meeting to reach consensus. The Health Division organised this expert meeting on September 14-15.

Experts and/or delegates from seventeen countries, and from the European Commission and WHO suggested a number of revisions to respond to two main concerns: that indicators should better reflect countries' reality (beyond "theoretical" institutional features), and to ensure consistency between countries' responses. The expert meeting resulted in a better understanding of the questionnaire and led several countries to revise their responses. All revisions were processed in September and October.

The Economic Department outlined its plans to explore the links between institutions and efficiency to the Working Party No. 1 (WP1) of the Economic Policy Committee on 23rd October, where it received strong support. This draft will be presented to the Health Committee in December. The final version of the paper will be presented to WP1 of the EPC and the Health Committee in 2010.

Contacts: Michael Borowitz, Valérie Paris

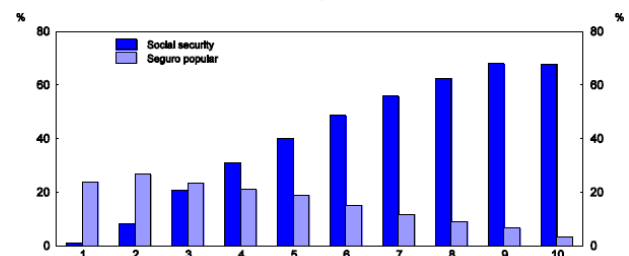
MEXICO: ENHANCING HEALTH SPENDING EFFICIENCY



Although public spending per capita on health in Mexico has more than doubled in real terms since the 1995 financial crisis, it remains low by international standards. At the same time, Mexico's health indicators lag behind those of most OECD countries. Although population health indicators have improved

over the past two decades, life expectancy at birth remains lower, child mortality higher and outcomes highly uneven across socioeconomic groups. While this partly reflects Mexico's lower per capita income, incomplete coverage and fragmentation in services provision contribute to poor outcomes.

Health insurance coverage in Mexico by income decile, 2006



Source: ENIGH Household Income Survey 2006.

Further spending pressures will arise from the plan to achieve universal health insurance by 2011. While additional spending may help, improving health outcomes will result primarily from increasing the efficiency of spending. Although current reforms go into the right direction, better

outcomes in some Latin American countries with similar per capita income and spending suggest that there is further scope for improving the efficiency of the health sector in Mexico.

Recent publications:

- 📖 *OECD Economic Survey of Mexico 2009*
- 📖 *Economic Survey of Mexico, 2009, OECD Policy Brief, July 2009*
- 📖 Schwellnus, C. (2009), "Achieving Higher Performance: Enhancing Spending Efficiency in Health and Education in Mexico", *Economics Department Working Paper No. 732*

Website: www.oecd.org/eco/surveys/mexico

Contacts: Nicola Brandt, Cyrille Schwellnus

HEALTHCARE @ THE DIGITAL CROSSROADS

Coming soon: A new OECD report *Achieving Efficiency Improvements in the Health Sector through ICTs* will provide advice on a range of options, conditions and practices that policy makers can adapt to their own national circumstances, in order to accelerate adoption and effective use of information and communication technologies.

Under what conditions will these technologies result in efficiency and quality-of-care improvements? The analysis draws upon a considerable body of recent literature, as well as lessons learned from case studies in six OECD countries (Australia, Canada, the Netherlands, Spain, Sweden, and the United States), all of which reported varying degrees of success deploying health ICT solutions. These ranged from foundational communication infrastructures to sophisticated electronic health record (EHR) systems.

Website: www.oecd.org/health/ict

Contact: Elettra Ronchi

LONG-TERM CARE WORK AND FINANCING

Can health and social systems afford the expected growth in long-term care (LTC) costs, and still provide adequate coverage against LTC risks? How can they cope with the growing demand for formal LTC jobs, while at the same time alleviate the burden of informal carers and reduce the economic losses associated with caring responsibilities?

The OECD seeks to:

- Review factors driving the demand for LTC and affecting the supply of carers, and provide an

overview of LTC systems in OECD countries;

- Investigate how informal caring affects carers' health and decisions to work;
- review/assess policies to improve carers' well-being and help them combine caring with paid work;
- Identify challenges facing LTC labour markets and review policies to improve recruitment, retention, and productivity of LTC workers;
- Analyse LTC coverage and financing systems and how they perform against policy objectives of access, cost, and transparency;
- Project future LTC cost in OECD countries; and
- Analyse interventions to improve the cost-efficiency of LTC systems.

The project uses a mix of quantitative and qualitative analysis. Responses to a fact-finding and policy questionnaire will be complemented by selected country missions (see the piece on Belgium below) and analysis of data from longitudinal household surveys on the impact of caring on the labour market and health outcomes of informal carers. This analysis will complement the overview of systems of support for informal carers.

Preliminary results show that the majority of carers are female and are married. Carers are less likely to work than non-carers and they work fewer hours. Being involved in informal care appears to have a detrimental effect on the health of carers, as it is observed that they have a higher prevalence of mental health problems.

One of the main tools to assess the sustainability of age-related spending in areas such as long term care is to elaborate projections as a share of GDP. Building on work undertaken by the European Commission as part of *The 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060)*, the methodology has been extended to 4 non-EU OECD countries. Preliminary results are consistent with previous work in the area and show that total expenditure on LTC, as a share of GDP, is generally projected to double between 2006 and 2050.

A draft of the report is planned for the end of 2010.

Websites: www.oecd.org/health/longtermcare
www.oecd.org/health/LTCsurvey

Contacts: Francesca Colombo, Ana Llana-Nozal
Jerome Mercier, Frits Tjadens

LONG-TERM CARE POLICIES IN BELGIUM

Members of the OECD Long-term care team went to Belgium during the last week of October to meet with policy makers, experts, and representatives of LTC providers and recipients.



The purpose of the mission was to understand opportunities and challenges in the Belgium LTC system, and learn more about new policy directions, innovative changes or proposals for change.

About 17% (OECD average 15%) of Belgium's population is aged over 65 and about 5% (OECD average 4%) over 80. In 2006, Belgium's expenditure on long-term nursing care was equivalent to about 1.6% of its GDP, of which about 70% is targeted to institutional care. Long term care responsibilities are shared among different levels of government, with community and regional responsibilities generally complementing those of the federal state.

Belgium's public health insurance provides comprehensive and universal coverage for all costs associated with the provision of help with daily activities, subject to a personal contribution. In 2006, close to half of all LTC recipients received care in an institution such as a rest home or nursing home. Generally, costs for board and lodging in nursing homes, as well as help with instrumental activities of daily living such as shopping and paperwork, are not covered. Different measures exist to mitigate out-of-pocket payments, and they appear to be effective.

Semi-residential care settings such as day-care centres and short-stay-care centers provide nursing care to individuals with moderate-to-severe restrictions who still live in their own homes. Home nursing care is available to all individuals with mild-to-severe limitations. Belgium places significant efforts on mechanisms to ensure care coordination across providers and between providers and users.

There are two major cash benefits targeted to individuals with restrictions in activities of daily living. At the federal level, the Allowance of the Elderly provides targeted monthly benefits to eligible low- and modest-income individuals 65 years or older. At the regional level, a compulsory dependence insurance scheme implemented by the Flemish government provides a flat rate monthly allowance of EUR 130 to all individuals assessed as having severely reduced or no ability to function independently. Seniors whose disposable income is not sufficient to meet their long-term care obligations are guaranteed a minimum level of income through 'la Garantie de revenus aux personnes âgées'.

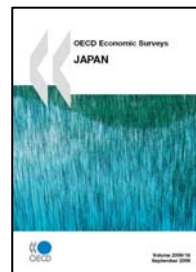
According to the 2009 Ageing Report published by the European Commission, about 55 per cent of

dependent older persons received formal care in an institution or at home, while 45 per cent relied on informal (or no) care. The Centre d'Etudes socio-économiques de la Santé (SESA) reported that about 10 per cent of Belgium's population aged 15 and over were informal carers in 2006. The majority are women aged between 45 and 60 years of age. For family caregivers, there are several possibilities to combine work and care. There are regulations mandating various forms of leave for carers.

Website: www.oecd.org/health/longtermcare

Contacts: Jerome Mercier, Francesca Colombo

HEALTH-CARE REFORM IN JAPAN: CONTROLLING COSTS, IMPROVING QUALITY

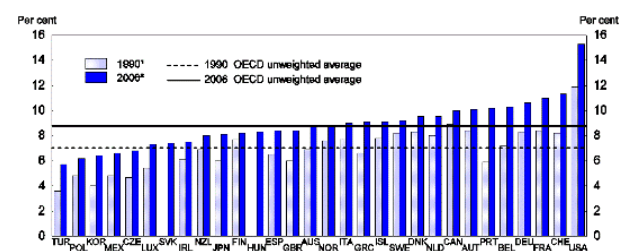


Japan's health-care system is outstanding in a number of respects, contributing to the excellent health status of the Japanese population, which is near the top of the OECD in a variety of indicators, while holding spending as a share of GDP below the OECD average.

It provides universal access in principle to all medical institutions in the country. Nevertheless, it faces a number of important challenges.

There is growing dissatisfaction with the quality of health care, which culminated in the 2008 government decision to upgrade social welfare programmes. The system faces imbalances by region and by type of care, and universal coverage requires improving compliance in paying premiums.

The level of health-care spending as a share of GDP in Japan is below the OECD average



Source: OECD Health Data 2008

One key area for reform is the length of hospital stays, which is four times the OECD average, reflecting in part the important role of hospitals in providing long-term care for the elderly. Hospital stays for acute care are about three times higher than the OECD average. In particular, it is essential to move away from a per diem payment scheme and toward a "diagnostic-related group" approach.



Concerns about quality have become more prominent as medical fees and prices have declined. One major issue is the “drug lag”; one-quarter of the world’s top-selling drugs in 2006 had not been introduced in Japan and half had become available on average six years after their global launch. The situation is similar for medical devices.

A second issue is the ban on “mixed billing”. Patients wishing to combine a new medicine or treatment that is not included in the prescribed treatment in the health insurance package with services that are included must pay not only the cost of the additional treatment but also the cost of services that would normally be covered by health insurance. In effect, this regulation discourages patients from choosing new drugs and treatments that are not listed in public health insurance.

Another concern is the share of the population that does not pay health insurance premiums. By 2008, about 21% of households that were covered by National Health Insurance (which includes primarily the self-employed, economically inactive and elderly) failed to pay the premium. Of this group, around 1.5% of total households have to pay health costs out-of-pocket. It is important to reduce this share by improving compliance, as well as to include more non-regular workers in employer-based insurance.

A significant portion of households limit their use of health care for financial reasons according to a 2007 poll. It is important to reduce the monthly ceiling on co-payments to ensure adequate health care, particularly for those with serious or chronic illnesses.

Recent publications:

-  *OECD Economic Survey of Japan 2009*
-  *Economic Survey of Japan, 2009, OECD Policy Brief, September 2009*

Website: www.oecd.org/eco/surveys/japan

Contact: Randall Jones




IMPROVING THE PERFORMANCE OF THE GREEK HEALTH CARE SYSTEM



Greek health outcomes compare favourably with the OECD average. However, the health care system is seen as not working well by the population. One source of dissatisfaction is the high proportion of private household spending on health, including informal payments, while public health spending relative to GDP is one of the lowest in the OECD. This situation leads to inequities in access to certain medical services.

Also, there is a weakening of efficiency of the system, which should be addressed sooner than later in view of a rising demand for medical services, which is going to intensify in the coming decades, and the need to keep government health care spending in check. This calls for reforms in four areas: (i) reviewing the excessively fragmented structure of the health care system and its governance; (ii) enhancing the quality of public primary health care services; (iii) modernising hospital administration; and (iv) further tightening control over pharmaceutical expenditure.

Recent publications:

-  *OECD Economic Survey of Greece 2009*
-  *Economic Survey of Greece, 2009, OECD Policy Brief, July 2009*
-  *Economou, C. & Giorno, C. (2009), “Improving the Performance of the Public Health Care System in Greece”, Economics Department Working Paper No. 722*

Website: www.oecd.org/eco/surveys/greece

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THE SYSTEM OF HEALTH ACCOUNTS

The 11th meeting of OECD Health Accounts Experts, held on 7-8 October 2009, discussed progress in uniform health accounts and in the revision of the System of Health Accounts (SHA) Manual.

Regarding the 2009 joint data collection by OECD, Eurostat and WHO on health expenditure, 29 countries provided data. A proposal was made to add a pilot module to the joint health accounts questionnaire in 2010 on expenditure by disease, age and gender. A number of countries indicated that they could provide such data, but others asked that this pilot collection be done separately from the joint questionnaire due to comparability issues.

The SHA Manual establishes a conceptual basis of statistical reporting rules that are compatible with other economic and social statistics. The manual is currently being revised, a process which is being jointly managed by the International Health Accounts Team (IHAT) of Eurostat, OECD and WHO. This revision is at the half-way point, and the aim is to complete the project by end 2010.

The meeting discussed IHAT drafts of priority units of the revision, covering purposes, principles, health system boundaries, key concepts and definitions as well as the basic classifications of consumption, provision and financing of health care; and capital expenditure. The drafts can be found at www.oecd.org/health/sha/revision.

A top priority is to make improvements on specific issues while at the same time giving strong weight

to continuity with SHA Version 1.0 and the joint health accounts questionnaire. Countries' comments will guide the Secretariat in its discussions with WHO and Eurostat.

The OECD proposed that the final manual might be split into: (i) the foundation units of the consumption approach; and (ii) the rest, including health costs, expenditure by disease, prices, capital, trade, and accounting guidelines. Together these will provide a tool set for countries in developing health accounts in the future. The meeting broadly supported this approach.

A final report on the project examining the measurement of private health expenditure was presented, and its recommendations were endorsed.

A trade-in-health project is also being conducted in 2009-10. In the first phase, country case studies are being undertaken and participation was invited.

Website: www.oecd.org/health/sha

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THE NHS IN THE UNITED KINGDOM: AN ECONOMIC HEALTH CHECK



The United Kingdom government's health reform programme since 2000 has covered many aspects of the organisation of health care and was accompanied by a sizeable increase in spending on healthcare. Many of these reforms have the potential to improve the efficiency and responsiveness of the health care system and ultimately health outcomes.

A chapter in the *Economic Survey of the United Kingdom 2009* provides an overview of the organisation and financing of the National Health Service, reviews its performance, assesses the reforms since the start of the decade and provides recommendations for further development.

Recent publications:

OECD Economic Survey of the United Kingdom 2009

Economic Survey of the United Kingdom, 2009, OECD Policy Brief, June 2009

Smith, P. & Goddard, M. (2009), "The English National Health Service: an Economic Health Check", Economics Department Working Paper No. 716

Website: www.oecd.org/eco/surveys/uk

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HEALTH-SPECIFIC PPP'S: PROGRESS REPORT ON THE PILOT STUDIES

Purchasing power parities (PPPs) are price deflators used for comparing price levels between countries. PPPs are primarily estimated from expenditure, which identifies the components of final demand. To calculate PPPs, information on the prices in different countries of a large set of goods and services are collected, including in the area of health.

For *hospital services*, the Eurostat-OECD PPP programme has so far consisted of comparisons of costs per unit of input, such as doctor's wages. Better than comparing costs per unit of input is the comparison of costs per unit of output and this is the object of the OECD PPPs pilot work.

The feasibility of an output-based approach using administrative data sets was evaluated through two retrospective descriptive studies. The first round was carried out in 2008 in six countries. Twelve countries took part in the second round: Australia, Canada, Finland, Germany, Israel, Italy, Korea, the Netherlands, Portugal, Slovenia, Sweden and the United Kingdom. This study was carried out from April to September 2009.

Forty representative hospital products were identified and measured using diagnosis, procedure, and DRG-type classifications, and their unit price/quasi price was estimated for 2007. PPPs and Comparative Price Levels were computed and compared.

The results of the pilot studies were discussed with experts at the 4th Health PPPs Task Force meeting on 6th October. The two studies confirmed that the proposed approach is feasible. The use of routinely collected information on inpatient activity and costs as a basis for estimating a unit quasi price/price by product for across-country comparisons had the advantages of larger sample size, greater data validity, limited cost of collection, and a larger number of observations. Nevertheless, the variation in the cost finding approaches among countries, the rules/drivers used to allocate costs to products/services, and the use of unit revenues as compared to quasi prices needs to be carefully evaluated.

The approach used and the results of the pilot studies will be presented and discussed at the next meeting of the Eurostat PPP working party in November for possible use in the 2011 Eurostat-OECD PPPs price survey.

After a review of results with pilot countries, the Secretariat plans to publish an OECD working paper early next year.

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