BETTER POLICIES FOR BETTER LIVES

OECD 50th Anniversary

Measuring Progress in Health in OECD Countries over the Past Fifty Years

Work on health at the OECD began in the early 1980s, as part of an examination of the strong growth in health expenditure in the prior decade. In the 1980s and the 1990s, this work focused largely on building a robust database that could be used for comparative analyses of health systems, beginning with comparable data on health spending. This developmental work led to the release of the first version of the OECD manual *A System of Health Accounts* in 2000. In the ten years since the launch of the *OECD Health Project* in 2001, OECD work has broadened to address some of the main challenges that policy makers face to improve the performance of their countries' health systems (see box on next page).

As work on both health data and health policy has expanded, so has co-operation with other international organisations, in particular the World Health Organization (WHO) and the European Commission. A first framework of co-operation was signed between the OECD Secretary-General and the WHO Director-General in 1999, and this agreement was further extended in 2005 to cover not only statistical work but also analytical work related to the financing and delivery of health care services. At the end of 2005, the OECD, WHO and Eurostat (the European statistical agency) launched a first joint data collection based on the work already undertaken for *A System of Health Accounts*, to improve the availability and comparability of data on health expenditure and financing. Building on this success, a new joint collection between the three organisations was launched in 2010 to gather comparable data on non-monetary health care statistics. This strong collaboration avoids duplication of work and ensures synergies between the three organisations.

The *OECD Health Data* database, the main source for this publication, has been built up over the past 30 years in close co-operation with officials from all OECD countries and other international organisations. It provides a unique source of information to compare the evolution of health and health systems across OECD countries, with some time series spanning the whole 50-year period since the Organisation's foundation.

Looking back at the evolution of health and health systems since the OECD was created in 1961, three major trends stand out:

1. The remarkable gains in life expectancy.
2. The changing nature of risk factors to health.
3. The steady growth in health spending, which has exceeded GDP growth by a substantial amount.

Key events related to OECD work on health

1961: Creation of the OECD as a successor to the Organisation for European Economic Co-operation.

1980: OECD Conference on Social Policies calls for more analysis on health expenditure growth, leading to the beginning of OECD work on health under the Working Party on Social Policy.

1985: First OECD report on health, *Measuring Health Care, 1960-1983: Expenditure, Costs and Performance* (including the first paper edition of the *OECD Health Database*).

1991: First electronic edition of *OECD Health Data*.

1999: First OECD/WHO *Framework for Co-operation*.

2000: Release of OECD manual *A System of Health Accounts* to improve the comparability of data on health expenditure and financing.

2001: Launch of the *OECD Health Project* to address key policy challenges in improving the performance of OECD health systems.

2001: Creation of *OECD Group on Health* to oversee the *OECD Health Project* (the name and mandate of this group was changed in 2006 to the *OECD Health Committee*).

2001: First edition of *Health at a Glance* to present key indicators from the database in a user-friendly format.

2003: Launch of *OECD Health Care Quality Indicators (HCQI) project* to develop a set of indicators measuring and comparing quality of care across countries.

2004: First *OECD Health Ministerial Meeting* in Paris to discuss the main findings from the *OECD Health Project*. Release of publication *Towards High-Performing Health Systems*, along with a series of policy studies.

2005: Renewal of the *OECD/WHO Framework for Co-operation*, extending the co-operation beyond statistical work to include analysis of health systems issues related to financing, human resources and efficiency.

2005: First annual OECD, WHO and Eurostat *Joint Health Accounts Questionnaire* to increase the availability and comparability of data on health expenditure based on *A System of Health Accounts*.

2010: New OECD, WHO (European region) and Eurostat *Joint Questionnaire on non-monetary health care statistics* to improve availability and comparability of data on health workforce and other resources.

2010: Release of editions of *Health at a Glance* covering European and Asia/Pacific regions.

2010: Release of first OECD report on prevention, *Obesity and the Economics of Prevention – Fit Not Fat*, identifying trends in obesity and cost-effective interventions to address the obesity epidemic.

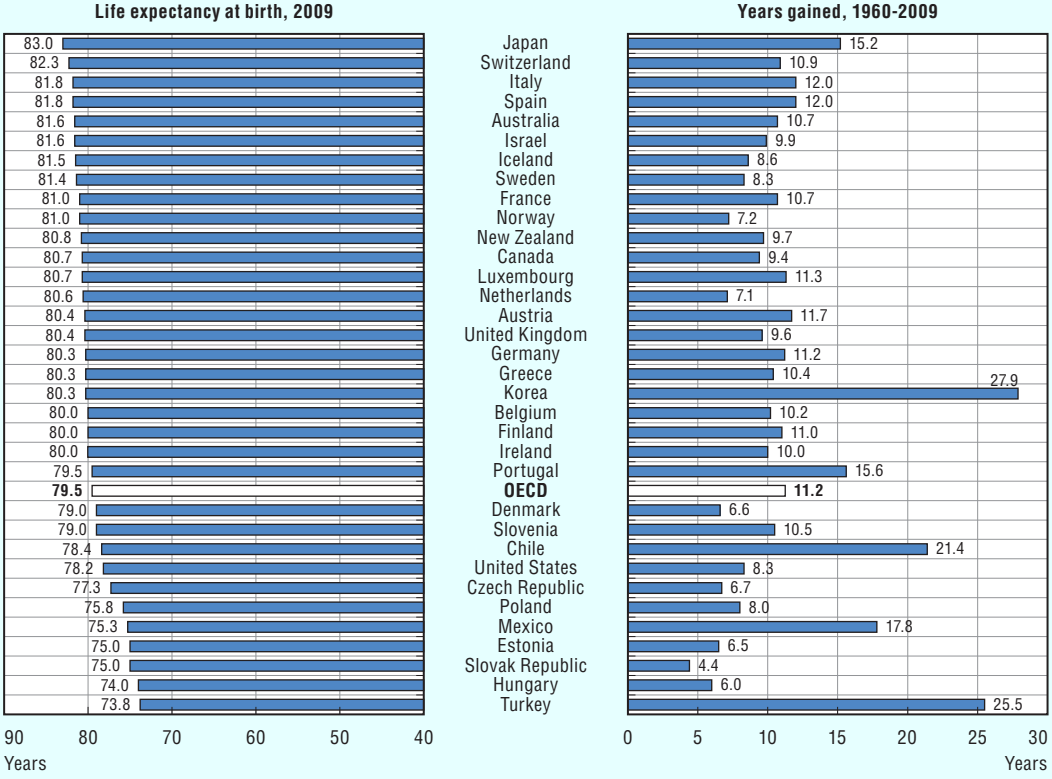
2010: Second *OECD Health Ministerial Meeting* in Paris to discuss health system priorities in the aftermath of the economic crisis. Release of first HCQI publication *Improving Value in Health Care: Measuring Quality*, and a series of policy studies in the publication *Value for Money in Health Spending*.

2011: Second edition of the manual *A System of Health Accounts* released jointly by OECD, WHO and Eurostat to promote greater comparability in health accounting systems in developed and developing countries.

Remarkable gains in life expectancy

The health of populations in OECD countries has improved greatly over the past 50 years, with women and men living longer than ever before. Since 1960, life expectancy has increased on average across OECD countries by more than 11 years, reaching nearly 80 years in 2009. The increase has been particularly noticeable in those OECD countries that started with relatively low levels in 1960, such as Korea where life expectancy has increased by a remarkable 28 years between 1960 and 2009. There have also been huge gains in life expectancy in Turkey and Mexico as well as in Chile, one of the countries that has recently joined the OECD. Japan has also achieved large gains and is now leading OECD countries, with a life expectancy of 83 years. But many other countries are close behind. In 2000, only 2 OECD countries had a total life expectancy of 80 years or more. By 2009, 22 countries had reached this milestone.

Life expectancy at birth, 2009 (or nearest year available), and years gained since 1960



Information on data for Israel: *http://dx.doi.org/10.1787/888932315602.*

Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932523177

These gains in life expectancy reflect large declines in mortality at all ages. Infant mortality rates have declined sharply in all countries. Deaths from cardiovascular diseases (comprising mostly heart attack and stroke) have also fallen dramatically. Although cardiovascular diseases remain the leading cause of death in OECD countries, mortality rates have been cut by more than half since 1960. Falls in important risk factors for heart and cerebrovascular diseases, including smoking, combined with improvements in medical treatment, have played a major role in reducing cardiovascular mortality rates.

The gender gap in life expectancy was 5.5 years on average across OECD countries in 2009, with average life expectancies reaching 82.2 years for women compared with 76.7 years for men. While the gender gap tended to widen in the 1960s and the 1970s, since the 1980s it has narrowed in most OECD countries because of higher gains in longevity for men. This can be attributed at least partly to the narrowing of differences in risk-increasing behaviours such as smoking, accompanied by sharp reductions in mortality rates from cardiovascular diseases among men.

There have also been large gains in life expectancy at age 65. Women in OECD countries can now expect to live an additional 20 years after 65 (up from 15 years in 1960), while men can expect to live another 17 years (up from 13 years in 1960). Whether longer life expectancy is accompanied by good health and functional status among ageing populations has important implications for health and long-term care systems.

The changing nature of risk factors to health in OECD countries

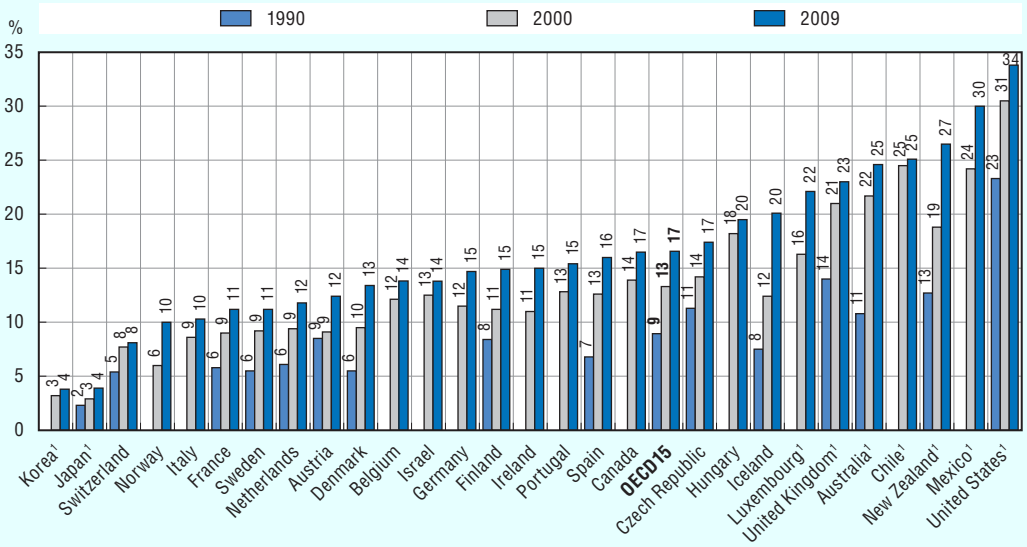
Although some of the gains in longevity can be explained by a reduction in important risk factors to health, much of the burden of diseases in OECD countries nowadays is linked to lifestyle factors, with tobacco smoking, alcohol consumption, obesity, unhealthy diet and lack of physical activity being largely responsible. People who live a physically active life, do not smoke, drink alcohol in moderate quantities, and eat plenty of fruit and vegetables have a risk of death in a given period that is less than one-fourth of those who have invariably unhealthy habits (Sassi, 2010).

Many OECD countries have achieved remarkable progress in reducing tobacco consumption over the past decades, although it still remains a leading cause of early death and hence an important public health issue. Much of this decline can be attributed to policies promoting public awareness campaigns, advertising bans and increased taxation. In many OECD countries, smoking rates among adults have been cut by more than half since the 1960s, from over 40% to less than 20% now. In both Canada and the United States, smoking rates fell from 42% in 1965 to 16% in 2009.

Progress has been mixed concerning alcohol consumption. In many OECD countries, consumption has fallen markedly since 1980, with curbs on advertising, sales restrictions and taxation proving to be effective measures. On the other hand, consumption has risen in some countries, notably in some Nordic countries, the United Kingdom and Ireland. The worrying trend in these and other countries is the consumption pattern among younger people, with the practice of heavy episodic drinking ("binge drinking") increasing in recent years. Heavy alcohol consumption has considerable impacts on health, as well as health care and social costs. Causes of death directly or indirectly attributable to alcohol consumption can include car accidents, violence and suicides, while diseases made more likely by alcohol include cardiovascular diseases, cancers of the mouth and oesophagus, and cirrhosis of the liver.

The alarming rise in obesity rates has risen at the top of the public health policy agenda in recent decades, not only in OECD countries, but increasingly in developing countries. Obesity is a key risk factor for numerous chronic conditions. Research shows that severely obese people die 8-10 years earlier than those of normal weight, a value similar to that for smokers. Obesity rates have doubled or even tripled in many countries since 1980, and in more than half of OECD countries, 50% or more of the population is now overweight, if not obese. The obesity rate among the adult population is the highest in the United States, having risen from 15% in 1980 to 34% in 2008. Japan and Korea have the lowest rates, although obesity is also rising in these two countries.

Increasing obesity rates among the adult population in OECD countries, 1990, 2000 and 2009 (or nearest years)



Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.
1. Data are based on measurements rather than self-reported height and weight.
Source: OECD Health Data 2011.

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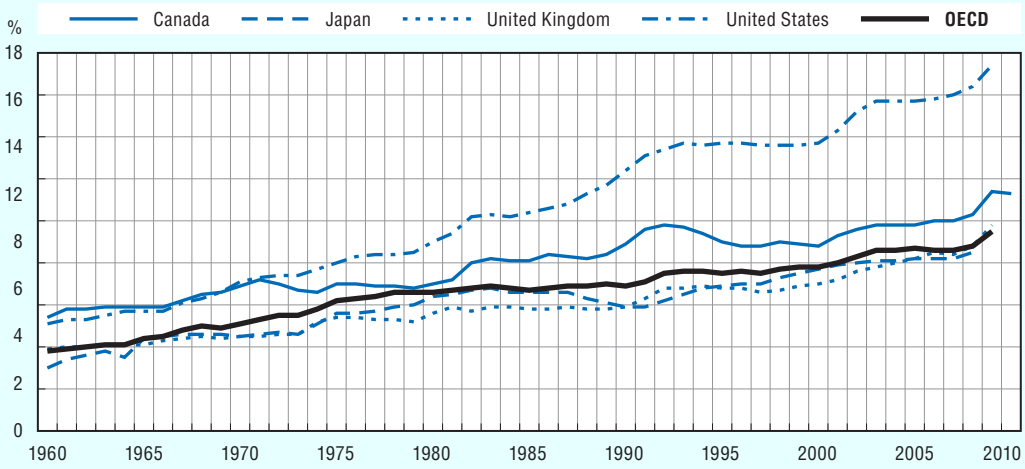
The obesity epidemic is the result of multiple and interacting dynamics, which have progressively led to lasting changes in people's lifestyles in relation to nutrition and physical activity. Many OECD governments are now intensifying their efforts to promote a culture of healthy eating and active living, with a large majority adopting initiatives aimed at school-age children. A recent OECD report found that interventions aimed at tackling obesity in at least three areas – health education and promotion, regulation and fiscal measures, and counselling in primary care – are all effective in improving health and longevity and have favourable cost-effectiveness ratios compared with scenarios in which chronic diseases are treated only as they emerge. When multiple interventions are combined in a strategy that targets different groups and determinants of obesity simultaneously, overall health gains can be significantly enhanced without any loss in cost-effectiveness (Sassi, 2010).

The steady growth in health spending

A third important trend observed over the past 50 years among health systems in OECD countries has been the steady rise in health spending, which has tended to grow faster than GDP. In 1960, health spending accounted for under 4% of GDP on average across OECD countries. By 2009, this had risen to 9.6%, and in a dozen countries health spending accounted for over 10% of GDP. The health spending share of GDP grew particularly rapidly in the United States, rising from about 5% in 1960 to over 17% in 2009, which is 5 percentage points more than in the next two highest countries, the Netherlands and France, which allocated 12% and 11.8% respectively.

Health spending per capita has also grown rapidly over the past few decades, at a rate of 6.1% per year in real terms on average across OECD countries during the 1970s, falling to 3.3% per year in the 1980s, then up to 3.7% in the 1990s, and 4.0% between 2000 and 2009. The rate of growth of health spending has consistently exceeded GDP growth in each and

Health expenditure as a share of GDP, 1960-2009, selected OECD countries



Source: OECD Health Data 2011.

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every decade. But it has varied across countries. In the United States, health expenditure has increased faster than in all other high-income OECD countries since 1970, increasing five-fold in real terms, even taking account population growth.

In many countries, the health spending share of GDP has tended to rise strongly during economic recessions, and then to stabilise or decline only slightly during periods of economic expansion. Looking back at the recession of the early 1990s, some countries such as Canada and Finland substantially reduced public expenditure on health in order to reduce their budgetary deficits, leading to a noticeable reduction in the health spending share of GDP for a few years. But these reductions in public spending on health often proved to be short-lived and after a short period of cost-containment, growing supply and demand of health services led to a revival of health expenditure growth which exceeded GDP growth.

The public sector is the main source of health financing in all OECD countries, except in Chile, Mexico and the United States. The public share of health spending was 72% of total health expenditure on average across OECD countries in 2009, a share that has been relatively stable over the past 20 years. However, there has been a convergence of the public share of health spending among OECD countries in recent decades. Many of those countries that had a relatively high public share in the early 1990s, such as Poland and Hungary, have decreased their share, while other countries which historically had a relatively low level (*e.g.* Portugal, Turkey) have increased their public share, reflecting health system reforms and the expansion of public health insurance coverage.

As shown in this edition of *Health at a Glance*, while there is some relationship between higher health spending per capita and higher life expectancy, the relationship tends to be less pronounced as countries spend more on health. This indicates that many other factors beyond health spending affect life expectancy. The weak correlation at high levels of health expenditure suggests that there is room to improve the efficiency of health systems to ensure that the additional money spent on health brings about measurable benefits in terms of health outcomes.

Looking ahead

Over the past three decades, the OECD has played an important role in developing and making available data and indicators to assess and compare the performance of health systems. While substantial progress has been achieved, much work is still needed to improve the comparability of data on health systems and to promote analysis to support health policy making.

In renewing its mandate in June 2011, the OECD Health Committee reaffirmed that the overarching objective of OECD work on health is to foster improvements in the performance of health systems in OECD countries and in non-OECD countries as appropriate. Following this mandate, the OECD will continue to share data, experiences and advice regarding current and emerging health issues and challenges. As the health sector represents an ever-growing share of OECD economies, measuring trends in health expenditure, how spending is allocated between prevention and care, and whether this brings about the expected benefits in terms of improved health outcomes, will become increasingly important.

In October 2011, the OECD, in collaboration with WHO and Eurostat, released the second edition of the manual *A System of Health Accounts*. This publication will help to further improve the comparability of data on health expenditure through agreed international standards. The OECD encourages co-operation among OECD countries and non-members in developing health accounts on a consistent basis. It will continue to work closely with WHO and Eurostat in administering an annual questionnaire to collect comparable data based on this accounting system.

The OECD also continues to develop and collect indicators measuring the quality of care and outcomes of health services, as part of the Health Care Quality Indicators project. The developmental work carried out under this project is crucial for filling key gaps in measuring the performance of health systems. At the same time, the OECD intends to expand its analytical work to explore the reasons for the observed variations in quality of care in OECD and partner countries, beginning with the areas of cancer and primary care.

In a context of population ageing, it will also become increasingly important to monitor the financing, delivery and quality of long-term care services across OECD countries. Building on recent work on long-term care (Colombo *et al.*, 2011), the OECD is not only pursuing the collection of more comparable data about long-term care systems, but also analysing policies related to access, quality and financial sustainability of long-term care systems, and sharing best practices.

Keeping with the spirit of openness that has characterised the OECD since its inception, the Organisation is expanding its co-operation with non-member countries on issues where collaboration may be mutually beneficial. The release of European and Asia/Pacific editions of *Health at a Glance* in 2010 provided an example of such growing co-operation. The OECD aims to promote the sharing of the health data systems and the policy expertise and experience that reside in its member countries in order to foster improvements in health system performance in non-member countries as well.

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