Introduction

Health at a Glance 2011 presents comparisons of key indicators of health and health systems across the 34 OECD countries, as well as for some major non-OECD economies. It includes, for the first time, a special chapter on long-term care. The indicators presented in this publication have been selected on the basis of their policy relevance and data availability and comparability. The data come mainly from official national statistics, unless otherwise indicated.

Policy and economic context

The recent economic recession has resulted in a marked increase in government deficits in many countries since 2008. Many countries will need to substantially reduce their budget deficits. The extent of government spending reductions and/or tax increases needed will depend on the strength of the economic recovery and the size of the deficit and cumulative debt.

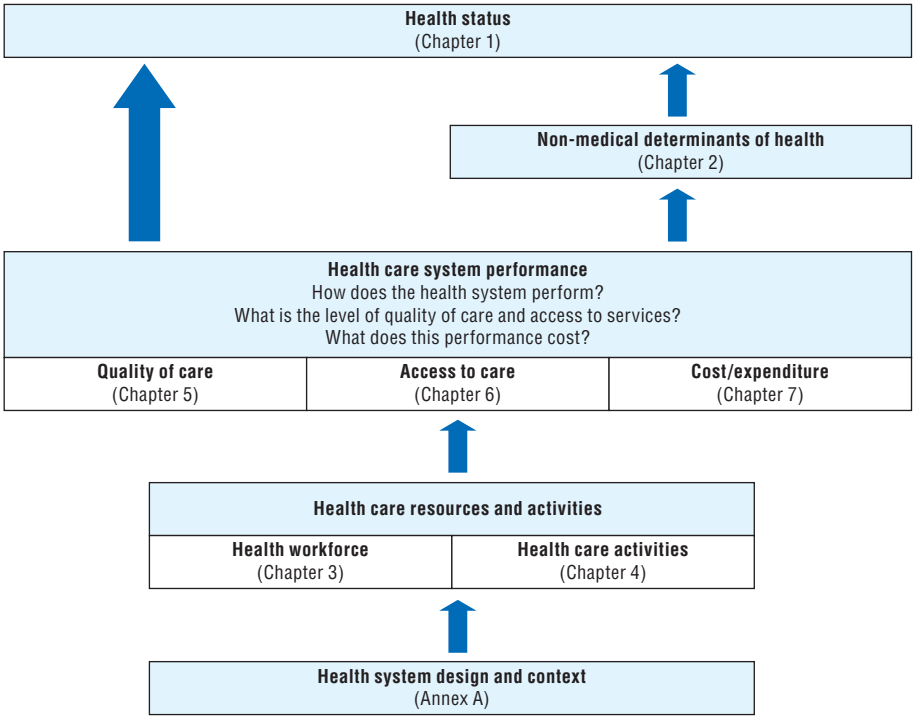
Given that health spending accounts for a high and growing share of public budgets, it will be hard to protect it from any overall effort to control public spending following the recession. The extent to which public spending on health may be affected will depend on the relative priority allocated to health. It will also depend on the extent to which public spending on health brings demonstrated benefits in terms of better health outcomes. 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, although further effort is needed to improve data availability and comparability.

Structure of the publication

The framework underlying this publication looks at the performance of health care systems in the context of a broader view of public health (Figure 0.1). It is based on one that was 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 a number that fall outside health care systems, such as the social, economic and physical environment in which people live, and individual lifestyle and behavioural 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.

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



Source: Adapted from Kelley and Hurst (2006).

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 that are related to health care system performance are presented, such as countries' demographic, economic and social context, and the design of their health systems.

Health at a Glance 2011 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, disease incidence and other measures of population health status. The length of life and whether it is lived free of illness and disability has intrinsic value, with good health consistently ranked as one of the most valued aspects in people's lives. Good health status also has instrumental value through enhancing opportunities to participate in education, training, and the labour market.

Chapter 2 on *Non-medical Determinants of Health* focuses on modifiable lifestyles and behaviours. Many factors affect population health status, including tobacco smoking, alcohol drinking, and overweight and obesity problems. Most of these factors can be modified by supporting health and other policies.

Chapter 3 looks at the *Health Workforce*, the key actors in any health system. It provides data on the supply and remuneration of doctors and nurses in OECD countries. Trends are also presented on the number of new graduates from medical and nursing education programmes – a key determinant of current and future supply.

Chapter 4 reviews a key set of *Health Care Activities*. The chapter begins by looking at consultations with doctors, one of the most common services received by patients. It then goes on to review cross-country variations in the supply and use of diagnostic technologies such as magnetic resonance imaging (MRI) and computed tomography (CT) scanners. The hospital sector continues to absorb the largest share of health spending in OECD countries, hence a focus on the availability of hospital beds, their rate of use, the number of hospital discharges and average length of stay. The chapter also looks at variations in the use of high-volume and high-cost procedures, such as coronary angioplasty, caesarean sections and cataract surgeries. It concludes with an examination of the volume of pharmaceutical consumption, particularly the use of drugs that treat diabetes and depression, drugs that lower cholesterol, and antibiotics.

Chapter 5 examines *Quality of Care* or the degree to which care is delivered in accordance with established standards and improves health outcomes. It summarises the data collection conducted through the *OECD Health Care Quality Indicators Project*, providing comparisons on selected indicators of care for chronic conditions, mental disorders, cancers and communicable diseases. The measures include indicators of *process* of care that are 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. For the first time, the chapter also includes a set of indicators on patient safety.

Chapter 6 on *Access to Care* aims to gauge whether OECD countries are meeting their stated health policy goal of ensuring adequate access to essential health care services on the basis of individual need. It begins with a review of self-reported unmet needs for medical and dental care, as a broad measure of perceived access problems. This subjective measure is complemented by more objective indicators of *financial* access such as the degree of public or private health insurance coverage and the burden of out-of-pocket payments. *Geographic* access to care follows, here measured by the "density" of doctors in different regions within each country. Another approach is to measure inequalities among different socio-economic groups in their use of health services, taking into account differences in need. Three indicators look at the use of doctors and dentists and at screening for cancer by income groups. The final indicator relates to *timely* access to care and considers variations in waiting times to see a doctor (whether a GP or a specialist), and to obtain an elective surgery.

Chapter 7 on *Health Expenditure and Financing* compares how much OECD countries spend on health, both on a per capita basis and in relation to GDP. As well as indicators of total spending, the chapter provides an analysis of the different types of health services and goods consumed across OECD countries, including a separate focus on pharmaceuticals. Along with the allocation of health care spending, the chapter 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). Lastly, with the growth in medical tourism and international trade in health services, current levels and trends are examined, in the light of efforts to improve data availability.

Chapter 8 is a special chapter on *Long-term Care*, building on a recent OECD project which focussed particularly on the long-term care workforce and the financing of services (Colombo *et al.*, 2011). Indicators on life expectancy and life expectancy in good health at 65, self-reported health and disability status and dementia prevalence provide a context for the proportion of the older population who may be in need of care. These are complemented by an indicator on older persons receiving long-term care services at home or in institutions. Care provision, both informal and formal, is discussed through two

indicators on family carers and paid long-term care workers. The final indicator of this chapter looks at long-term care expenditure as a share of GDP and the growth rate over the past decade.

Annex A provides additional information on the demographic and economic context within which health and long-term care systems operate, as well as some key characteristics of health system financing and delivery.

Presentation of indicators

Text and figures

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 the indicator and discloses any significant national variation from the definition which might affect data comparability. On the facing page is a set of figures. These typically show current levels of the indicator and, where possible, trends over time. In some cases, an additional figure relating the indicator to another is included. Where an OECD average is included in a figure, it is the unweighted average of the OECD countries presented, unless otherwise specified.

Data limitations

Limitations in data comparability are indicated both in the text (in the box related to "Definition and comparability") 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 the former 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 presented in the *OECD Health Database* on OECD.Stat (*http://stats.oecd.org/index.aspx*, then choose "Health"). More information on the *OECD Health Database* is available at *www.oecd.org/health/healthdata*.

Population figures

The population figures presented in the annex and used to calculate rates per capita throughout this publication come from the OECD Historical Population Data and Projections (as of June 2011), and refer to mid-year estimates. Population estimates are subject to revision, so they may differ from the latest population figures released by the 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 or 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.

OECD country ISO codes

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

Other major economy ISO codes

Brazil	BRA	Indonesia	IDN
China	CHN	Russian Federation	RUS
India	IND	South Africa	ZAF