International Health Comparisons

A compendium of published information on healthcare systems, the provision of healthcare and health achievement in 10 countries

NAO

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Part 1

Making comparisons

Introduction

1.1 Members of the Committee of Public Accounts have expressed interest in comparative material on healthcare in other countries. This compendium of information has been compiled from published sources by the National Audit Office and is provided for background information. A copy has been placed in the library of the House of Commons.

Scope and structure of the compendium

1.2 This compendium sets out comparative data on healthcare systems and health in 10 countries, selected as broadly comparable industrialised nations (specifically, the G7 countries[1]), or as those innovative countries frequently included in comparisons (Australia, New Zealand and Sweden).

1.3 The structure of the compendium is as follows:

- Part 1: Making comparisons;
- Part 2: Healthcare systems;
- Part 3: Providing healthcare; and
- Part 4: Health achievements.

1.4 In addition, two appendices set out more detail on healthcare delivery systems (Appendix 1) and death rates from the main cancers over time (Appendix 2).

Basis of the report

1.5 The report draws exclusively on published information, principally the most recent data for 2002 from the Organisation for Economic Co-operation and Development (OECD)[2]. Other sources of data include the World Health Organization[3], the two reports prepared for the Chancellor of the Exchequer by Derek Wanless in 2001 and 2002[4], together with the supporting report commissioned by HM Treasury from the European Observatory[5], work by The Commonwealth Fund[6], and the EUROCARE-2 and National Cancer Institute studies on cancer survival rates[7].

1.6 Analysis of the data has been confined to setting out the comparisons in tabular and graphical form to show relative positions at a certain date, and the direction of travel, together with brief textual explanations and highlighting of key differences. The compendium does not examine the causes of differences between countries or draw conclusions on policy issues such as which methods of financing healthcare are best. The Department of Health has seen the compendium, and has noted that the inconsistencies and incompatibilities between data sources in different countries mean that valid comparisons cannot be made on the basis of these figures alone.

Difficulties in interpreting the information

Lack of comparability and completeness of the data

1.7 The OECD data used extensively in this compendium are collected by countries primarily for their own purposes and methods, timing and definitions vary, see **Figure 1** for example. In addition, available information indicates that validation procedures vary between countries. In some countries, for example, data are based on surveys of self-reporting individuals. The report notes when a comparison is likely to be particularly prone to such problems, but inevitably a margin of uncertainty remains within the data as presented.

1 *Canada, France, Germany, Italy, Japan, the United Kingdom and the United States.*
2 *OECD Health Data 2002.*
3 *World Health Report 2000: Health systems: improving performance, World Health Organization, 2000.*
4 *Securing Our Future Health: Taking a Long-Term View, Interim report, November 2001, Final report, April 2002.*
5 *Health care systems in eight countries: trends and challenges, European Observatory on Health Care Systems, April 2002.*
6 *Multinational comparisons of health systems data, Anderson G.F. and Hussey P.S., The Commonwealth Fund, 2000.*
7 *Survival of cancer patients in Europe: the EUROCARE-2 Study, 1999, SEER Cancer Statistics Review 1973-1999, National Cancer Institute, 2002.*

1 Definitions of 'disability' used in calculating disability adjusted life expectancy

- Australia takes disability to be one or more of 17 defined conditions.
- Canada takes disability to be limitations in 19 specific activities lasting at least six months - the last survey was in 1991.
- France includes as disabled all those in retirement homes - the last survey was in 1991-92.
- Germany extrapolates to disability days the results of a survey asking about disability in the previous four weeks.
- Japan takes disability to be confinement to bed.
- New Zealand takes disability to be as self-reported in the Household Disability Survey.
- United Kingdom available data relate to Great Britain households only, although an adjustment for communal establishments was made from the 1991 census - disability is self-reported as a long-standing limitation on activities in any way.

Source: OECD Health Data 2002

1.8 A further difficulty is that published data are more complete on some issues of interest than others. This inevitably means that only a partial picture can be drawn for some topics.

The nature of healthcare systems impacts on measured indicators

1.9 Differences between countries measured by any particular indicator may reflect the way that healthcare systems are organised or demographic factors. They do not necessarily imply that healthcare received by patients is better or worse. For example, general practitioners in the United Kingdom act as gatekeepers for secondary (hospital) care. As a result there are fewer in-patient admissions per 1,000 of the population than in a country such as France, which has no such gatekeeper function. A country where older people make up a smaller proportion of the population than average might be expected to have lower expenditure per head on healthcare for example. The compendium flags up such problems where applicable.

There are uncertain relationships between cause and effect and the impact of policy changes may not yet be apparent

1.10 Complex relationships between cause and effect mean that it is not straightforward to identify which elements should be changed to achieve desired outcomes. The indicators may be misleading if used in an uncritical way to suggest that healthcare could be improved, for example, by a simple matching against the levels of indicators in other countries.

1.11 A further consideration in drawing conclusions is that the comparisons make no allowance for policy and resourcing changes already in train in this country or elsewhere, aimed at producing improvements, but which have not had time to work through. In particular, the Government has allocated an additional £2.4 billion in 2003-04 to improve the NHS in the United Kingdom, with spending growing by 7.4 per cent a year after inflation over the five years to 2007-08. Health spending in England will rise by 7.5 per cent a year. Taking into account these new resources, United Kingdom health spending is expected to rise to 9.4 per cent of Gross Domestic Product (GDP) in 2007-08. Current comparisons may not therefore be a reliable guide to the future or where intervention is needed to raise standards of healthcare.

Part 2 Healthcare systems

2.1 There is a lack of systematic published material on the details of how healthcare systems are organised across the world, though Appendix 1 gives details of healthcare systems in the 10 comparator countries. Better information is available on healthcare expenditure and how this expenditure is financed, which is set out in this Part.

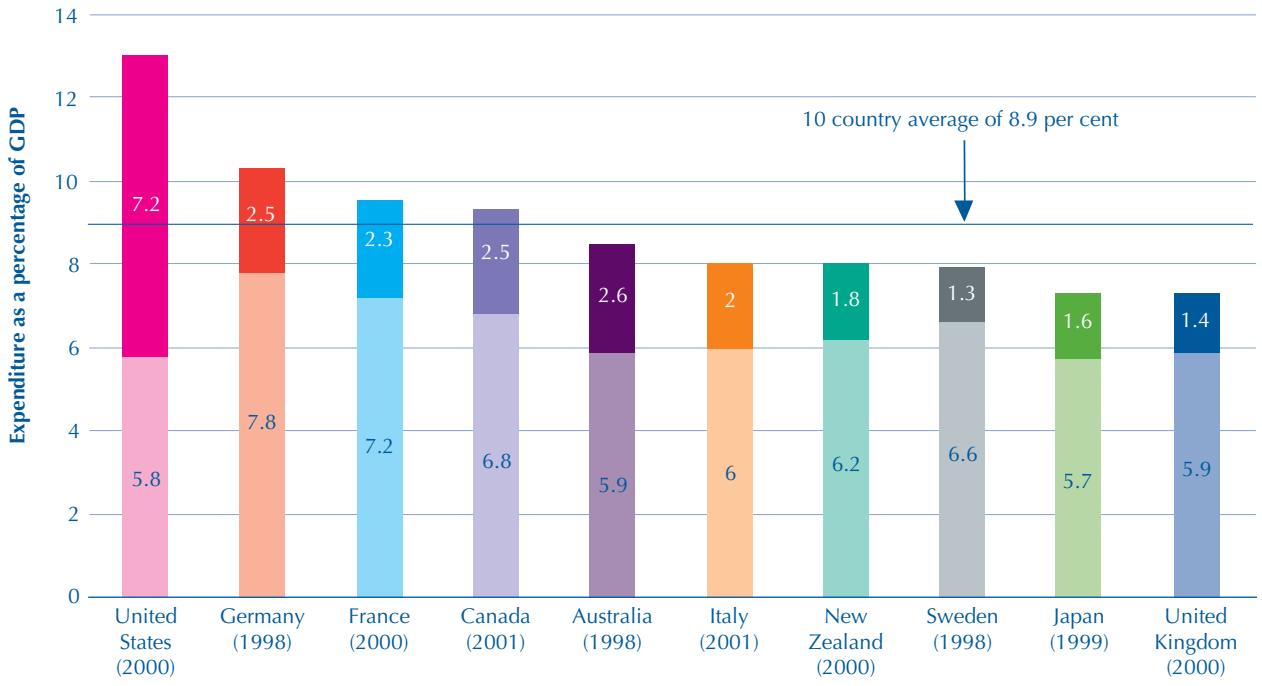
Expenditure on health

2.2 A widely used means of comparison is expenditure as a proportion of GDP. The OECD data presented here for expenditure include public and private expenditure, but there are however definitional and timing differences that may distort the statistics.

2.3 For Australia, Canada, France, Germany, Japan, the United Kingdom and the United States, reported data closely follow the OECD guidelines for reporting health expenditure according to a common international standard. Thus the data are believed to be fairly comparable. For New Zealand the definition of healthcare is sufficiently different that its information is of limited comparability. For Italy and Sweden, the differences are such that the OECD believes they are not well suited for international comparisons.

2.4 **Figure 2** shows that total healthcare expenditure as a proportion of GDP varied from 7.3 per cent to 13 per cent and was 8.9 per cent on average across the 10 countries. Total health spending in recent years as a percentage of GDP was lower in the United Kingdom

2 National expenditure on health as a percentage of Gross Domestic Product (GDP) in recent years



The darker tinted bars represent private expenditure. The lighter tinted bars represent public expenditure.

Source: OECD Health Data 2002

than in other comparator countries except Japan. The United Kingdom Government has subsequently announced increased spending in the 2002 Budget. The Government estimates that this will increase total spend on healthcare to 9.4 per cent of GDP by 2007-08, up from 7.3 per cent in 2000[8].

2.5 Spending in all countries has increased as a percentage of GDP over the last 20 years or so, with the exception of Sweden where it has fallen over a number of years. The trends are shown in **Figure 3**. As a result of differing rates of growth of spending, the spread in percentage GDP spent across the 10 countries has increased from 3.5 per cent in 1980 to 5.7 per cent in 2000. The United States and New Zealand both saw very rapid growth in the late 1980s.

2.6 Health expenditure per head is an alternative way of measuring the resources devoted to healthcare but is subject to the additional uncertainty of relying on a particular exchange rate to make the comparisons. The caveats to the figures for healthcare as a proportion of GDP figures apply equally: definitional differences as to what is included in expenditure, timing differences, and figures may be affected by demographic factors. Age standardised spends per head are not available.

2.7 **Figure 4** shows the OECD's 2002 estimates based on a United States $ exchange rate[9]. There is a greater than four fold variation between the highest and lowest figures for health expenditure per head, which range from over $4,600 per year per person in the United States to just over $1,000 in New Zealand. Average expenditure per head of population is $2,220. The United Kingdom figure is some 86 per cent of the average of $2,028 for the five European countries covered (Germany, Sweden, France, the United Kingdom and Italy in descending order of spend per head).

Financing arrangements in different countries

2.8 An important difference between healthcare systems is the extent to which individuals have private insurance. In the United States, private insurance is the only means of cover for much of the population, whilst in other countries it is held mainly by high income groups who opt out of social insurance coverage. In Canada private insurers are generally prevented from offering coverage that duplicates that provided by the Government, while in the United Kingdom private insurance is held in addition to cover provided by the Government. In France and New Zealand, private insurance is widely used to cover out of pocket payments, such as some prescription costs.

2.9 Figure 2 also shows that public spending dominates in nine of the comparator countries. Sweden (with public expenditure of 84 per cent of total expenditure) and the United Kingdom (81 per cent) have the highest publicly financed share of total health spending among the comparator countries. Public spending is the lowest in the United States (45 per cent), and private funding therefore makes up more than half of total health expenditure. It is the only country where this is the case - excluding the United States, privately financed healthcare accounts for 23 per cent of the total on average across the other nine countries.

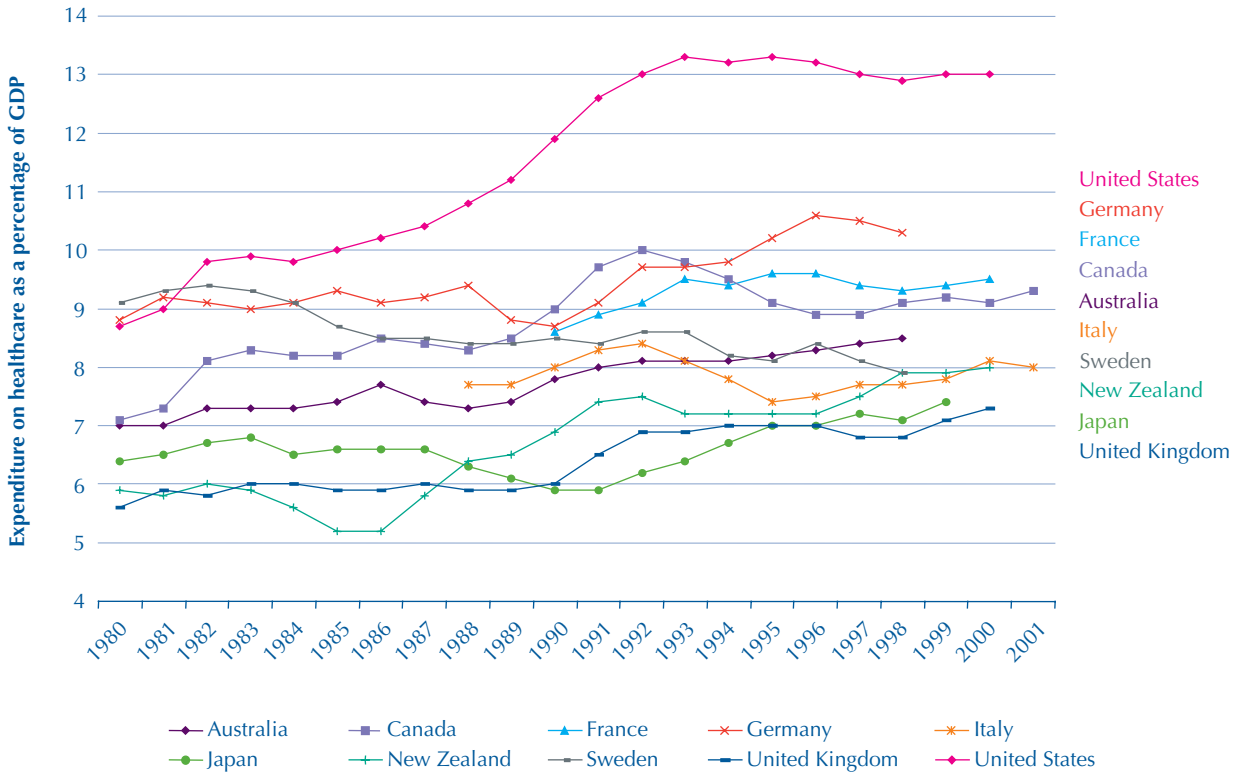
2.10 The methods of public and private financing vary between countries, but are usually a combination of general taxation, social insurance, out of pocket payments and private insurance. **Figure 5** gives a further breakdown of the figures in Figure 2 for the comparator countries. The United Kingdom is one of six comparator countries (Australia, Canada, Italy, New Zealand, Sweden) in which general taxes are the main source of public funds. France, Germany and Japan finance the majority of health spending through specific social insurance contributions. Private insurance is third lowest in the United Kingdom, just above Italy and Japan, accounting for just 4 per cent of total funding and highest in the United States, followed by France. United Kingdom out of pocket payments are slightly higher than in France but lower than in other comparator countries. Out of pocket expenditure is highest in Italy, as a proportion of total spend, followed by Australia and the United States.

2.11 Further details of the funding arrangements are given in **Figure 6.**

8 Budget Report 2002, HM Treasury, Chapter 6.

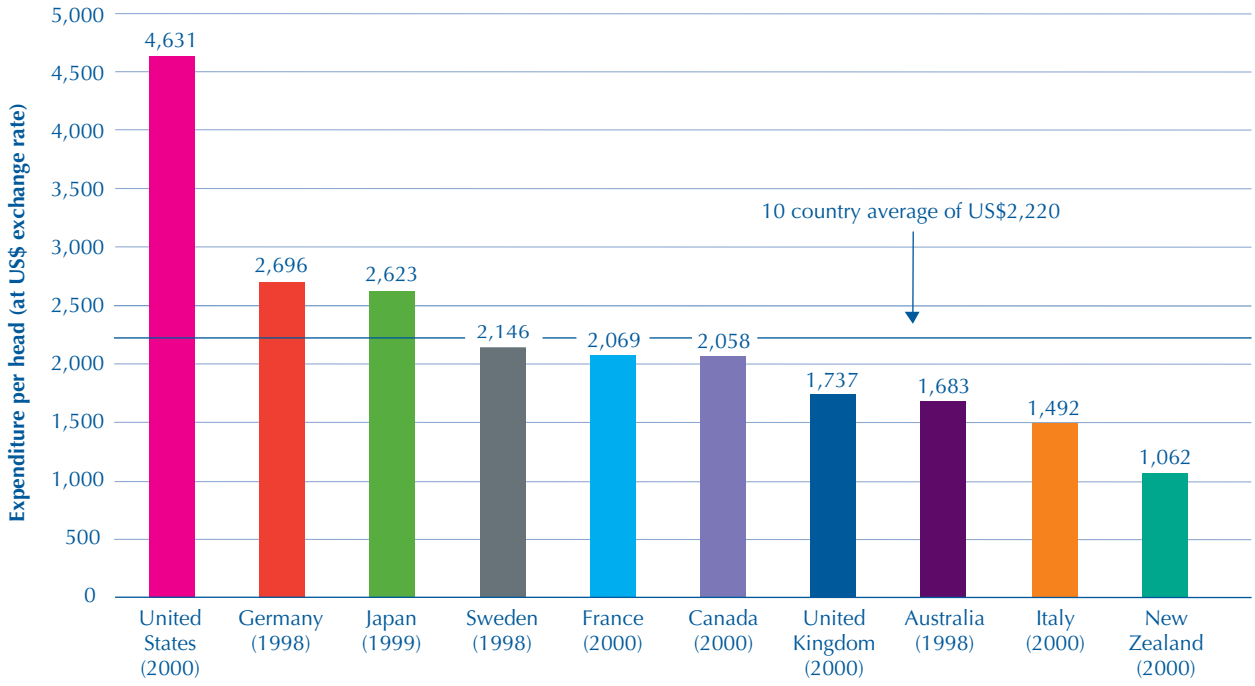
9 The exchange rates have been calculated by the International Monetary Fund. They are par or market rates averaged over the year.

3 Health expenditure as a percentage of GDP, 1980 to 2001



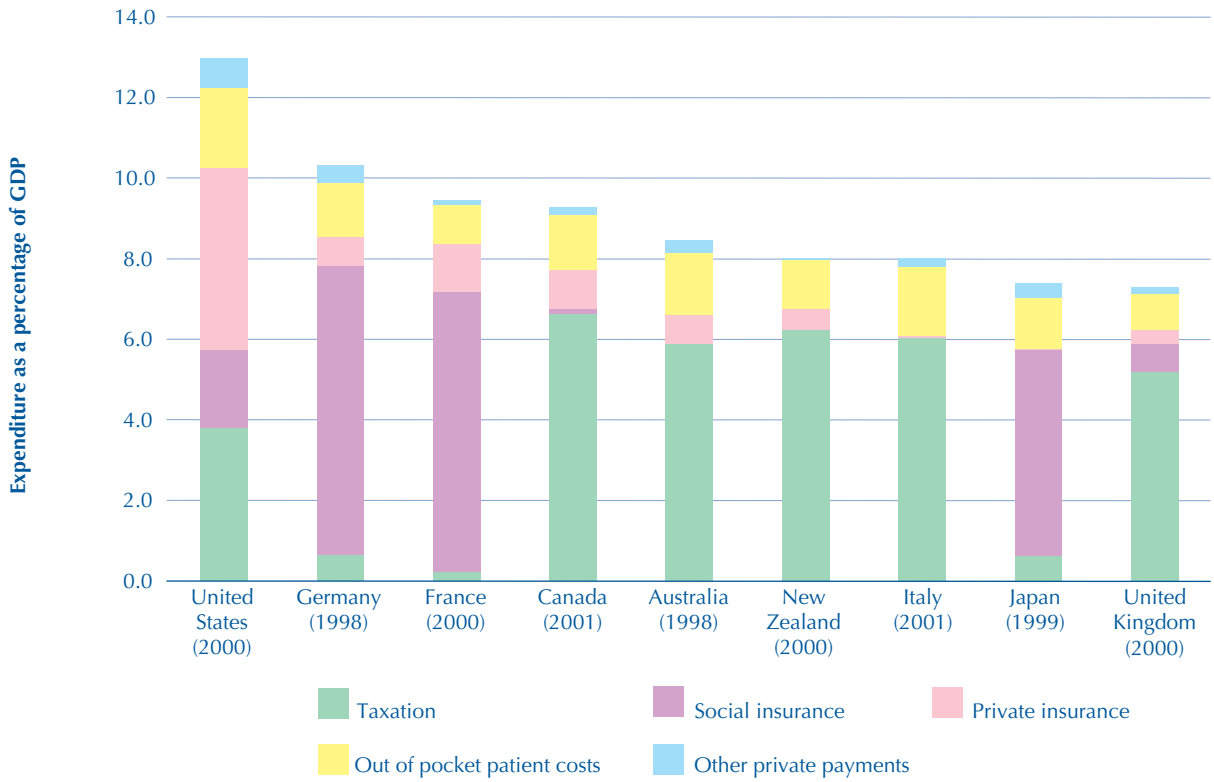
Source: OECD Health Data 2002

4 Health expenditure per head



Source: OECD Health Data 2002

5 Sources of health expenditure



NOTE

No further recent breakdown of the source of funds is available for Sweden beyond that for public/private expenditure in Figure 2.

Source: OECD Health Data 2002

6 The methods of financing healthcare

Australia

Public finances are raised from a general and compulsory health tax levy on income, through Medicare, the public health insurance system. Medicare reimburses 75 per cent of the scheduled fee for private in-patient services and 85 per cent of ambulatory services, including GP consultations.

Out of pocket payments (16 per cent of total health expenditure), are for pharmaceuticals not covered under the Pharmaceutical Benefits Scheme, patient contributions for pharmaceuticals, dental treatment, the gap between the Medicare benefit and the schedule fee charged by physicians, and payments for other services such as physiotherapy and ambulance services, not covered by Medicare.

Private insurance accounts for about 8 per cent of health care expenditure and about 45 per cent of the population have private insurance (mostly supplementary). Mainly not-for-profit mutual insurers cover the gap between Medicare benefits and schedule fees for in-patient services. Doctors may bill above the scheduled fee. Private insurers also offer private hospital treatment, choice of specialists and avoidance of queues for elective surgery.

Canada

National health insurance plans (Medicare) are funded by general and dedicated taxation and cover all medically necessary physician and hospital services.

The majority of the population has supplementary private insurance coverage through group plans, to include dental care, prescription drugs, rehabilitation services, private care nursing and private rooms in hospitals.

France

Public health finances come from taxes and compulsory social health insurance contributions from employers and employees. The Sickness Insurance Funds cover 99 per cent of the population. The population have no choice of insurer. They are automatically affiliated to a health insurance scheme on the basis of their professional status and place of residence.

Mutual Insurance Funds provide supplementary, voluntary insurance to cover cost-sharing arrangements and extra billings. Salaried workers purchase voluntary insurance from their employers, but this can be purchased on an individual basis. The mutual funds cover 80 per cent of the population, which means that for most of the population, 100 per cent of the cost of the majority of normal medical procedures is reimbursed.

Private insurance is voluntary for those who do not contribute to the national health insurance system.

There are patient contributions for ambulatory care (around 30 per cent for GP and specialist visits), drugs (between 35 per cent and 65 per cent depending on the therapeutic value) and 40 per cent for laboratory tests. Out of pocket payments account for 10 per cent of health care expenditure.

Germany

General taxation and compulsory Social Insurance Fund contributions account for the majority of healthcare funding. Employers and employees make contributions equally. The unemployed, homeless, and immigrants are covered through a special sickness fund financed through general tax revenues.

Private insurance, based on voluntary individual contributions, covers 8 per cent of the population (the affluent, self-employed and civil servants).

Cost-sharing is mainly for drugs. Ambulatory care and preventative dental care do not require any patient contributions. User charges apply to the first 14 days in hospital or rehabilitation each year, ambulance transportation, non-physician care and some dental treatment, but some groups are exempt (e.g. low income and elderly).

Italy

Taxation is the main source of public finance. There are patient contributions for pharmaceuticals, diagnostic procedures and specialist visits and direct payments by users for the purchase of private health care services and over the counter drugs.

Mutual fund contributions and private insurance (corporate and non-corporate) account for 9 per cent of health expenditure.

6 The methods of financing healthcare (continued)

Japan

Japan's health care system is predominately publicly funded. The majority of public finances comes from the Employees' Health Insurance System (Government and non-governmental bodies) and National Health Insurance (self-employed, pensioners, trade associations and others not covered by workplace based insurance). Most employees and their dependents obtain health insurance through their employers, financed largely through mandatory payroll contributions from both employers and employees.

New Zealand

Public hospital out-patient and in-patient services are free, but most people meet some costs of primary health care (although some groups are exempt or have health concession cards) and make a payment for pharmaceuticals. Income-related patient contributions are required for GP services and non-hospital drugs.

Private insurance is mainly not-for-profit covering private medical care and complementary, used to cover cost-sharing requirements, elective surgery in private hospitals and specialist out-patient consultations. It does not offer comprehensive health cover. It covers about a third of the population.

Sweden

The majority of funding comes from taxes and is supplemented by grants from the national Government. There are direct patient fees for most medical services (flat rate payments), for example, consultation with public physicians in the primary sector, specialists in a hospital, in-patient stay and consultations with private ambulatory doctors. There is a national ceiling on out of pocket amounts payable by individuals in any one year. After the ceiling is reached the patient pays no further charges.

The voluntary health insurance market is very small.

United Kingdom

The United Kingdom's healthcare system is predominately public sector with the majority of the funds coming from general taxation and some from national insurance contributions. About 11.5 per cent of the population have supplementary private medical insurance, usually for reasons of faster access.

National Health Service care is free at the point of delivery, but charges are levied on prescription drugs, ophthalmic services and dental services. There are exemptions, for example, for children, elderly, and the unemployed and 85 per cent of prescriptions are exempt from the charge.

United States

The United States' healthcare system is predominately privately funded, with 55 per cent of the revenue from private sources. Individuals can purchase private health insurance or it can be funded by voluntary premium contributions shared by employers and employees on a negotiable basis. It covers 58 per cent of the population.

Public funds (payroll taxes, federal revenues and premiums) fund Medicare, a social insurance programme for the elderly, the disabled, and end stage renal patients. It covers 13 per cent of the population and accounts for 20 per cent of total health expenditure.

Medicaid, a joint federal-state health insurance programme covers certain groups of the poor. It covers 17 per cent of the population and accounts for 20 per cent of total health expenditure.

Sources: Securing Our Future Health: Taking a Long-Term View, Wanless, Interim report, November 2001, Final report April 2002; Health care systems in eight countries: trends and challenges European Observatory on Health Care Systems,2002; Multinational comparisons of health systems data, Anderson G.F. and Hussey P.S., The Commonwealth Fund, 2000

Part 3

Providing healthcare

3.1 This Part of the compendium sets out comparative figures on how healthcare is provided in terms of healthcare personnel, medical technology, drugs, the number of medical procedures carried out and preventative medical programmes.

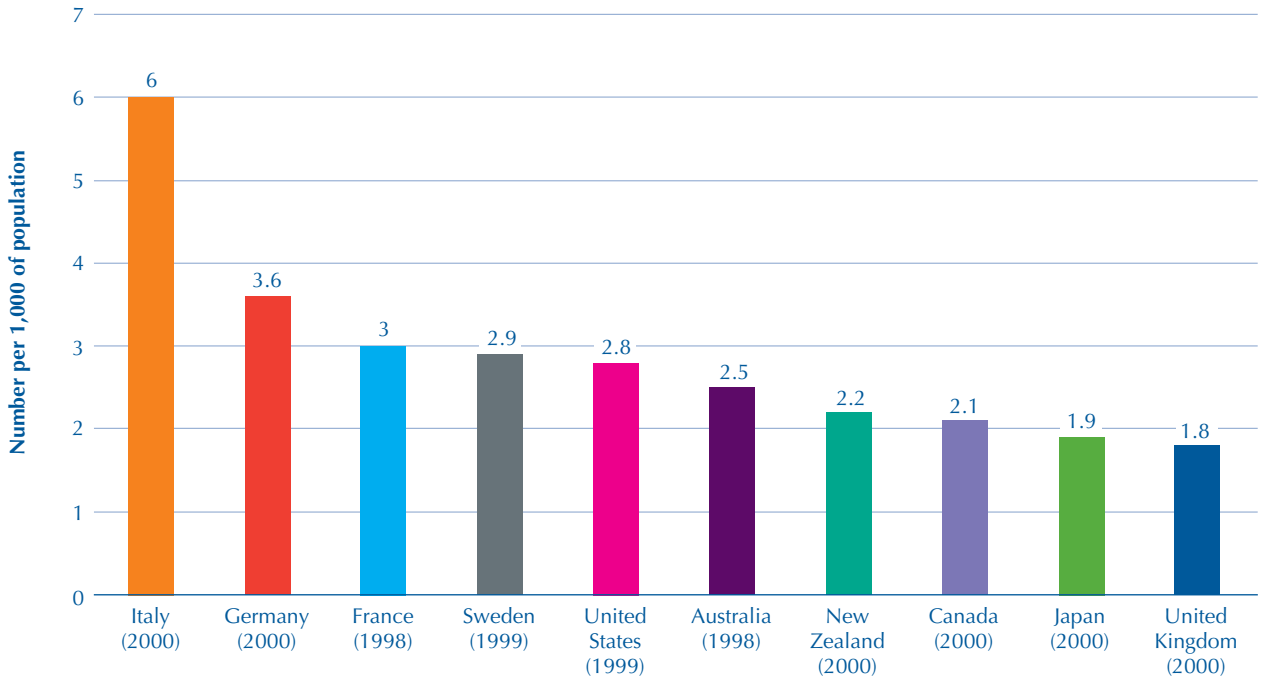
Health personnel

Doctors and nurses

3.2 Recent OECD research has concluded that the number of doctors is the second most important variable (after occupation) in terms of explaining variations in premature mortality (deaths under the age of 70) across countries and over time. They also found that a 10 per cent increase in the number of doctors, holding all other factors constant, would result in a reduction in premature mortality of almost four per cent for women and about three per cent for men[10].

3.3 **Figure 7** provides information about the number of practising physicians per 1,000 people in the population. The statistics need very careful interpretation because there are significant definitional differences. For the United Kingdom, the figures shown update those in the Wanless Review of the future needs of the NHS[11] which also used OECD data. The figures are based on doctors working in the NHS and exclude private sector doctors, locums and clinical academics. In Italy, retired physicians continue to be classified as 'practising', and this leads to anomalies. Italy has one of the lowest expenditures per head on healthcare (see Figure 4), but it has the highest recorded ratio of doctors to the population.

7 Number of practising physicians



Source: OECD Health Data 2002

10 *Exploring the effects of health care on mortality across OECD countries, OECD Labour market and social policy - Occasional Papers No. 46, January 2001, paragraph 45.*

11 *Securing our Future Health: Taking a Long-Term View, Interim report, November 2001.*

3.4 The OECD data show the United Kingdom as having the lowest number of practising physicians at 1.8 per 1000 persons, considerably below the mean of 2.5 (excluding Italy). Taking into account data provided by the general Medical Council on the number of practising physicians, the Department of Health estimated in 1996 that there were 2.6 doctors per 1,000 of population, compared with the OECD reported figure for the United Kingdom of 1.7. For 1996, Germany reported 3.4 and France 3.0 practising physicians per 1,000 of population.

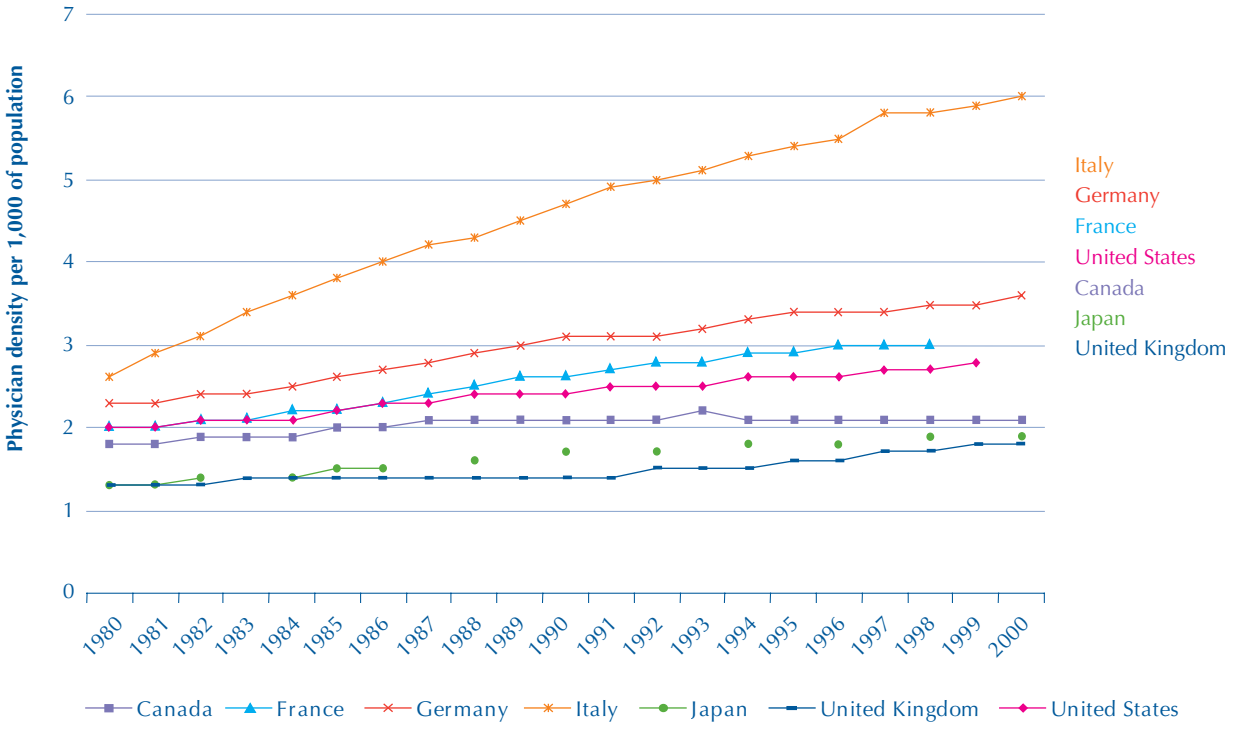
3.5 The number of physicians in the United Kingdom has increased steadily over the last 20 years - by 40 per cent over this period, **Figure 8**. But reported provision in other countries has generally increased at a faster rate. The result is that the countries have moved further apart and, discounting Italy for definitional reasons, the spread of provision has increased from 1.0 per 1,000 to 1.8 per 1,000.

3.6 As well as having the lowest reported number of doctors per head, the United Kingdom also has the second lowest reported number of practising nurses in relation to the population, **Figure 9**, although the UK nurse numbers are for the NHS only. The Department of Health told us that UK qualified private sector nurses account for about a quarter of all qualified nurses. The Department also noted that different countries still use different classifications as to what constitutes a nurse and that while the UK uses full time equivalents, other countries use headcounts. Germany, which has a high number of doctors, also has a high number of nurses in relation to the population. These ratios cannot, however, be taken as direct measures of the adequacy of provision as the figures take no account of the pattern of healthcare provision in different countries. Factors such as the rate of day case procedures or length of stay can have a major impact on the need for in-patient admissions and throughput. Length of stay in the United Kingdom is one of the lowest among the 10 comparator countries.

3.7 Acute admission rates are shown in **Figure 10**, which puts the United Kingdom in the centre of the 10 country range. These figures can be used in conjunction with those for numbers of nurses to standardise for the rate of admissions and length of stay as in **Figures 11** and **12**.

3.8 In terms of nurses per acute admission, the United Kingdom comes at the low end of the range, but both France and Italy have lower provision, Figure 11. In terms of nurses per acute day, the United Kingdom is above the other European countries in its provision, Figure 12.

8 Level of practising physicians, 1980 to 2000

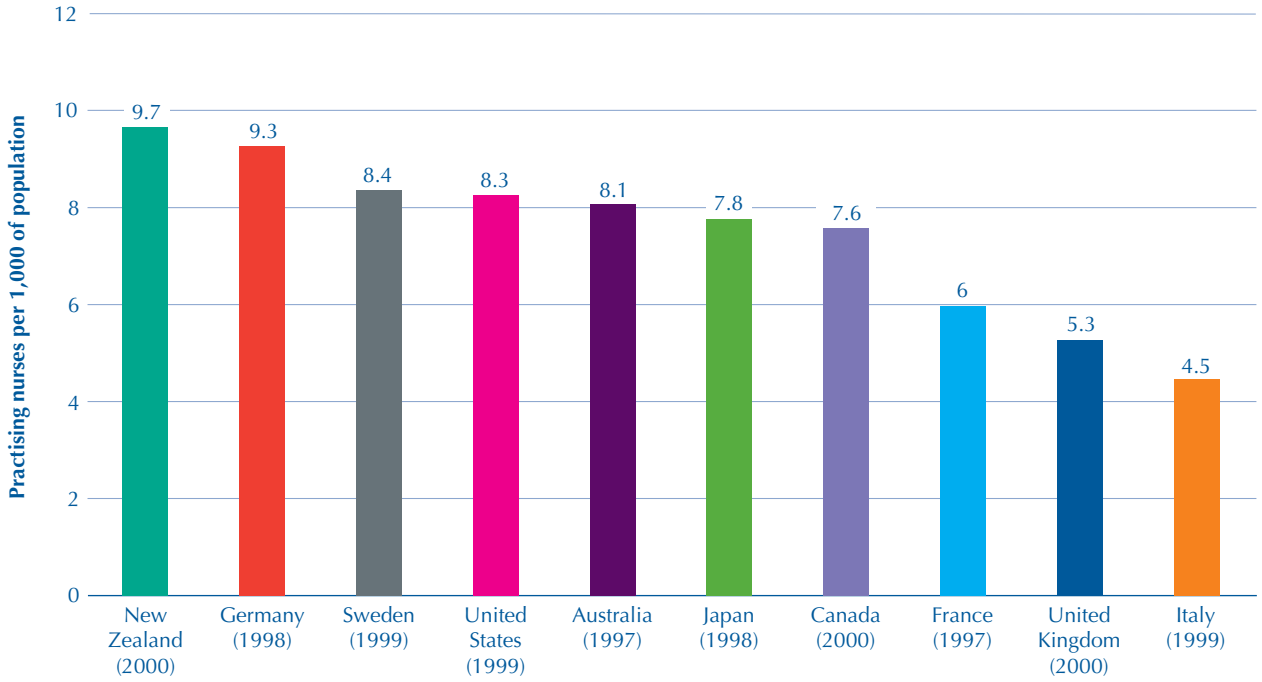


NOTE

Data are not available for all years for Japan

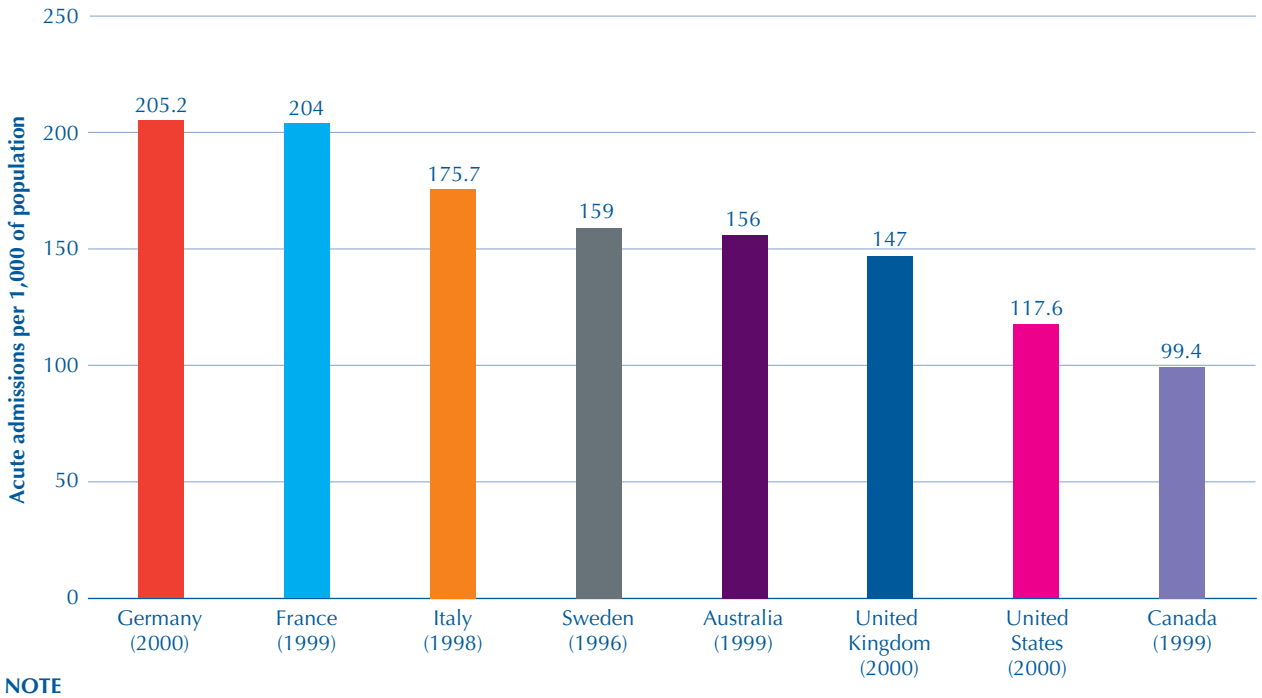
Source: OECD Health Data 2002

9 Number of practising nurses



Source: OECD Health Data 2002

10 Acute hospital admissions



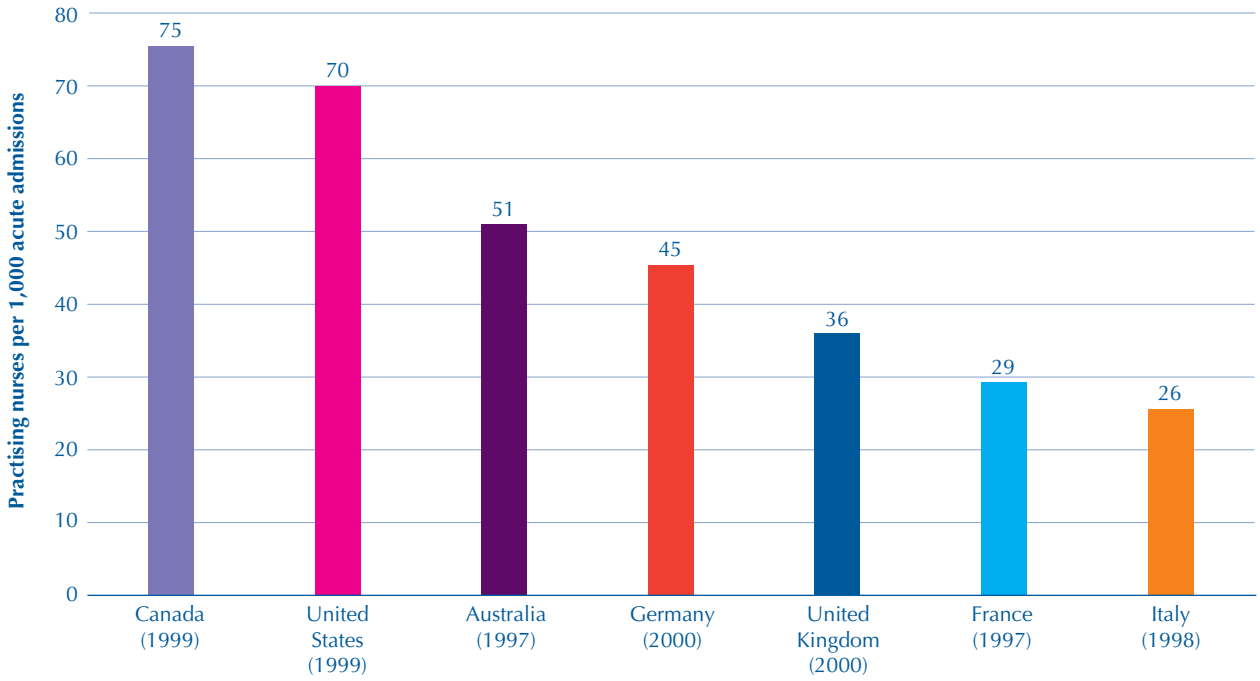
NOTE

Acute care is one in which the principal intent is one or more of the following:

- to manage labour (obstetrics)
- to cure illness or to provide definitive treatment of injury
- to perform surgery
- to relieve symptoms of illness or injury (excluding palliative care)
- to reduce severity of an illness or injury
- to protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- to perform diagnostic or therapeutic procedures

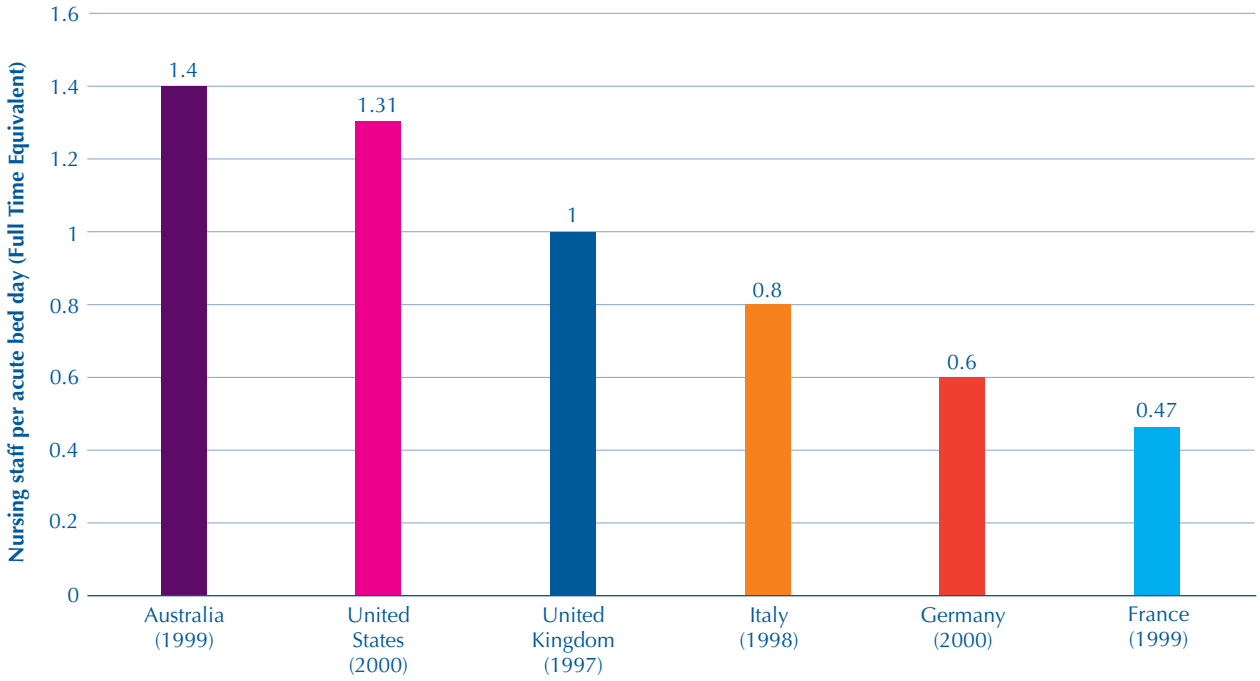
Source: OECD Health Data 2002

11 Practising nurses per 1,000 acute admissions



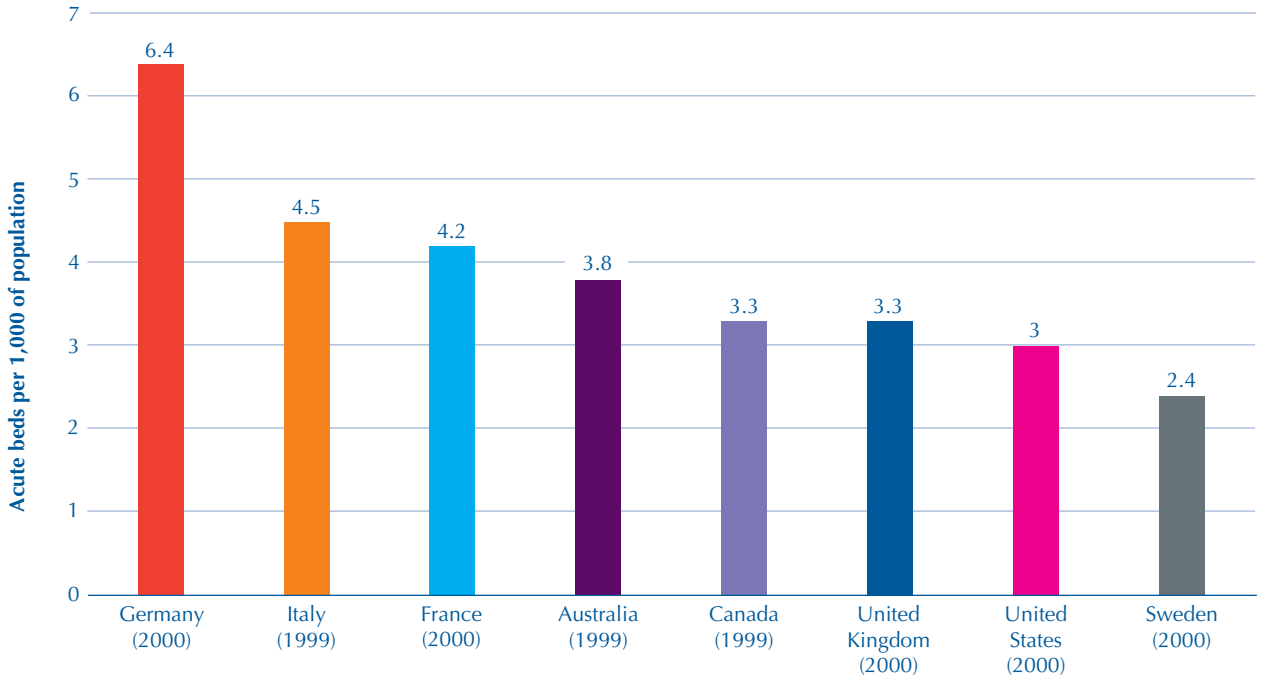
Source: OECD Health Data 2002

12 Practising nurses per acute bed day



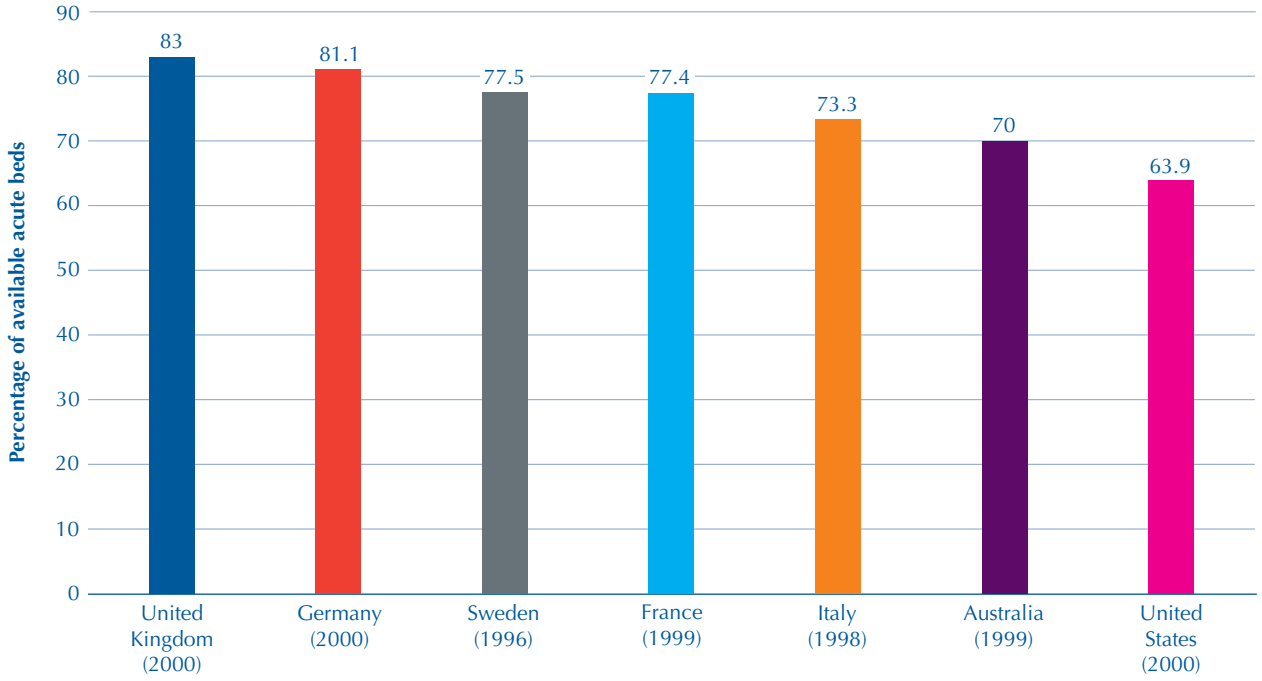
Source: OECD Health Data 2002

13 Number of acute hospital beds per 1,000 of population



Source: OECD Health Data 2002

14 Bed occupancy for acute beds



Source: OECD Health Data 2002

Medical infrastructure

3.9 A basic measure of healthcare capacity is the number of beds per head, though it suffers from the same problems as the statistics for medical staff in being affected by patterns of health care. The ratios shown in **Figure 13** range from 6.4 beds per 1,000 of population in Germany, to 2.4 in Sweden with the United Kingdom at the lower end of this range.

3.10 Taking account of the use made of acute hospital beds, the United Kingdom has the highest occupancy of such beds of the countries for which information is available, **Figure 14**.

3.11 Magnetic Resonance Imaging units stand as a proxy for investment in new technology and how up to date medical facilities are. In relation to the size of the population, the figure for England of 3.9 per million people is a little over half of the 10 country average of 6.9 per million people. However, **Figure 15** shows that the average is influenced by very high provision in Japan. Canada has the lowest provision with about two-thirds the numbers in England. Since 2000 there has been an increase in the provision of MRI units in the United Kingdom, partly through support from the New Opportunities Fund.

Medicines and drugs

3.12 Medicines are an essential component of healthcare. But as with other measures, comparisons can be very misleading. The United Kingdom has pursued a policy of prescribing generic drugs which are considerably cheaper than branded ones and expenditure may not be a good measure of volume. The effects of different price regulation systems is another factor, as is the availability of over the counter drugs in some countries that would be prescription only in others.

3.13 **Figure 16** shows expenditure on what countries classify as public funding for drugs and other medical non-durables prescribed for hospital out-patients. There is a wide range of spending across countries, with the highest spending per head in France and Japan at almost three times that in Australia and the United States.

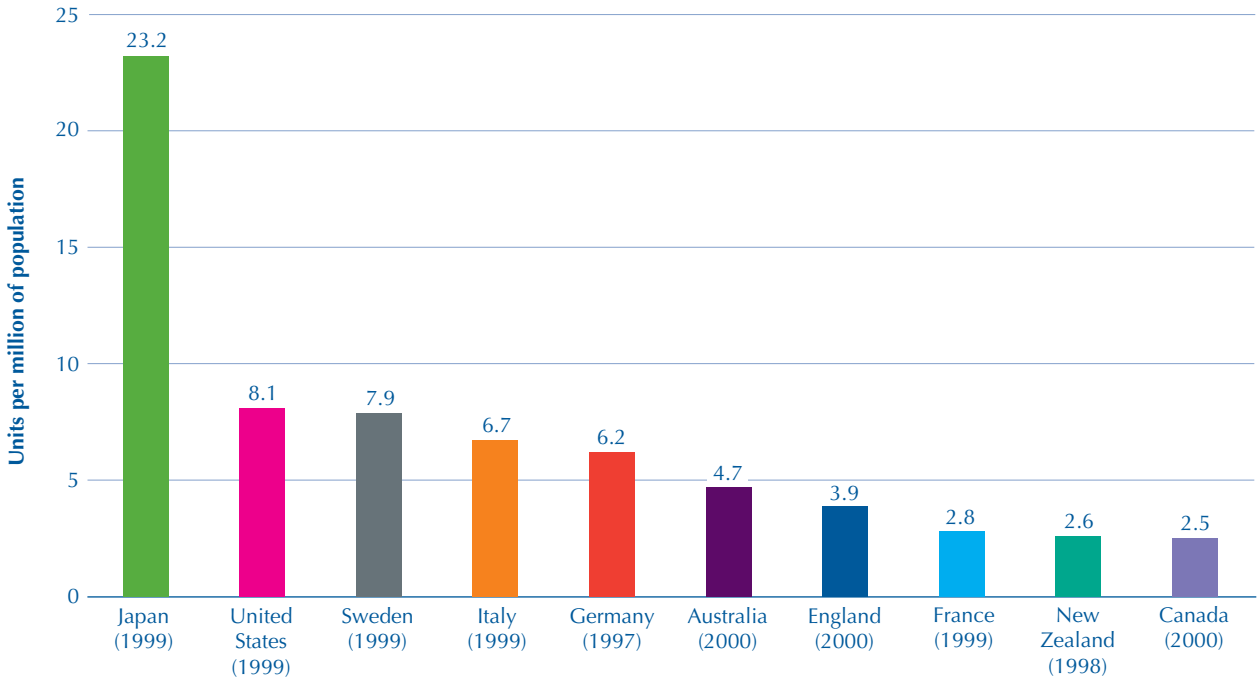
Medical procedures carried out

3.14 Comparable information on individual procedures across different countries is limited but is available for coronary bypass procedures in eight comparator countries. The United States carries out almost five times as many of these operations as in the United Kingdom per head of population, **Figure 17.** If the United States is excluded as an outlier, the average rate for the other countries is just over 60 procedures per 100,000 of population.

Preventative medical programmes

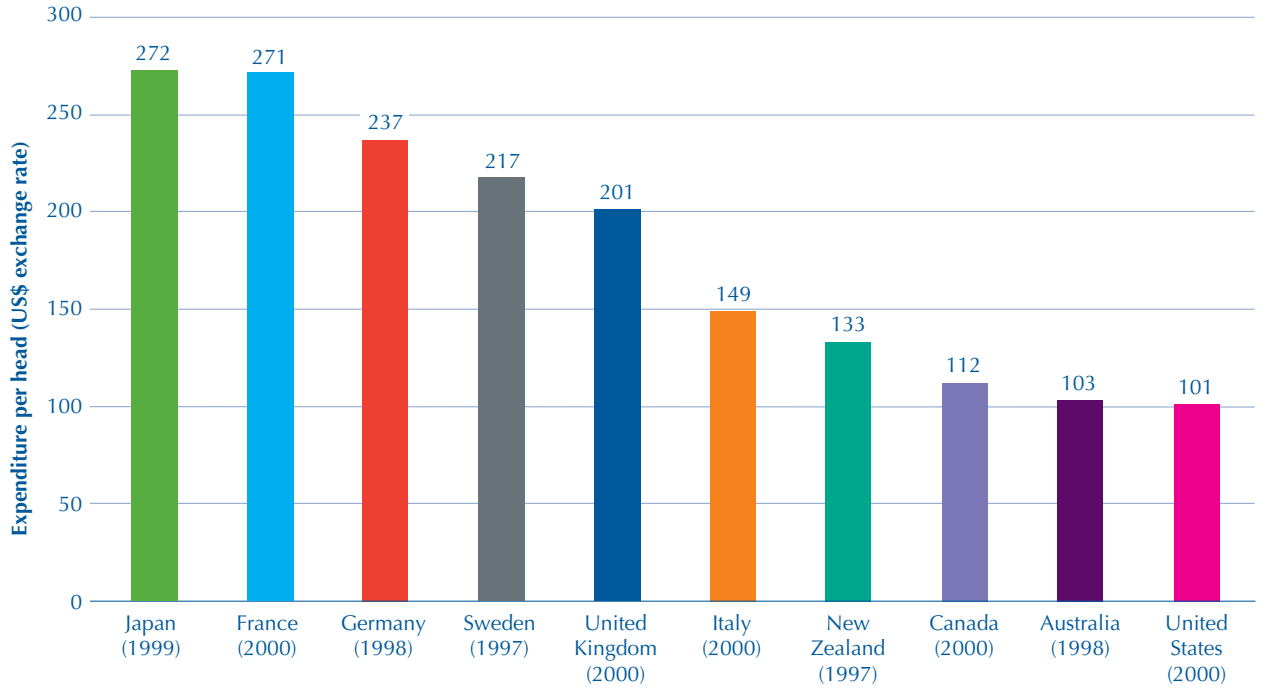
3.15 A measure of the extent of preventative health measures is the extent of childhood immunisation. A range of caveats applies including issues such as public perception of the safety of immunisation and the authorities' policy on when or whether this should be carried out.

15 Availability of Magnetic Resonance Imaging units



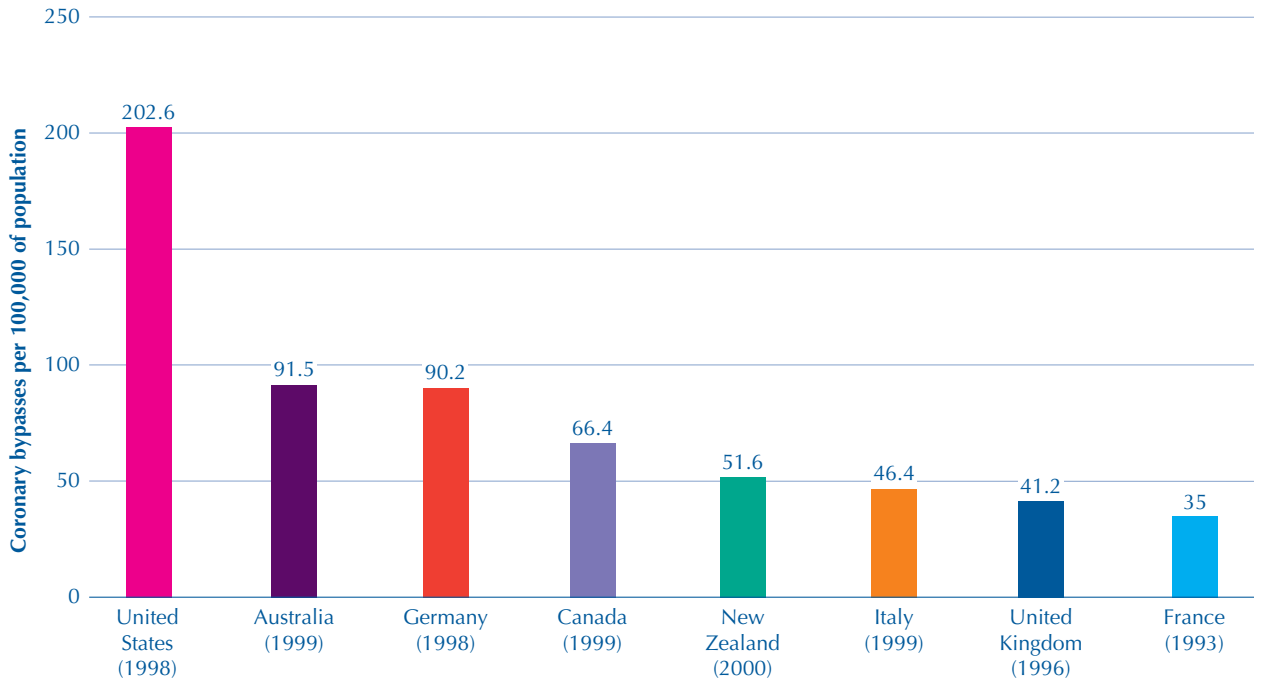
Source: OECD Health Data 2002

16 Public expenditure on pharmaceuticals and other medical non-durables prescribed for out-patients



Source: OECD Health Data 2002

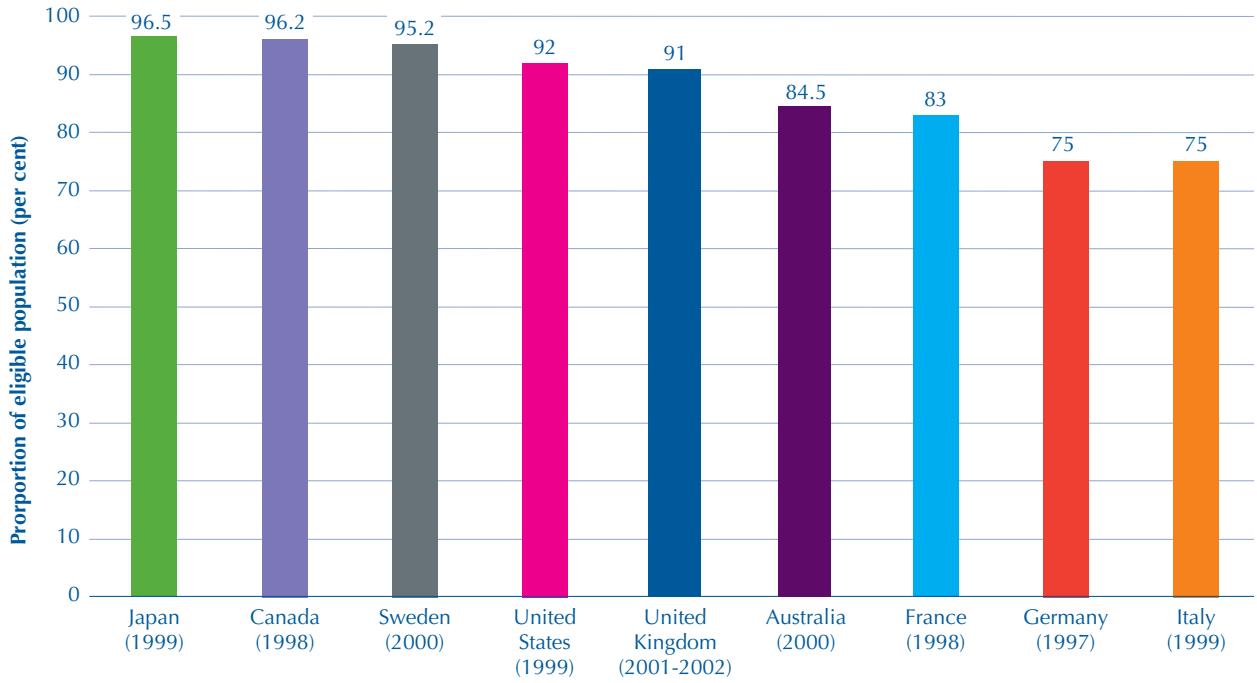
17 Coronary bypass procedures per 100,000 of population



Source: OECD Health Data 2002

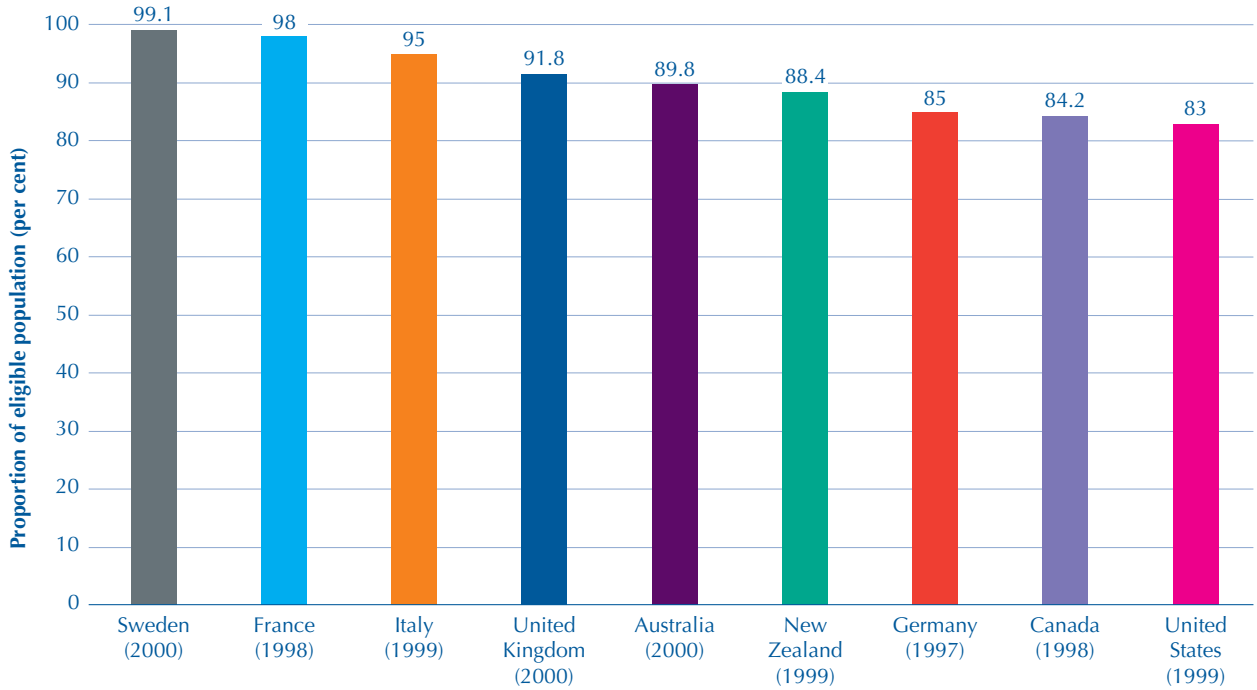
3.16 Immunisation against measles is reported as close to universal in Japan, Canada and Sweden, though it falls below 90 per cent in Australia, France, Germany and Italy, **Figure 18**. Immunisation against diphtheria, tetanus and whooping cough is generally higher and the United Kingdom achieved a rate in excess of 91 per cent. Sweden achieved a rate of 99 per cent, while the lowest rate was in the United States at 83 per cent, **Figure 19**.

18 Percentage of children immunised against measles



Source: OECD Health Data 2002 and Department of Health. Figure for United Kingdom is for Measles, Mumps and Rubella coverage at 24 months

19 Percentage of children immunised for diphtheria, tetanus and pertussis (whooping cough)



Source: OECD Health Data 2002 and Department of Health. The United Kingdom figure relates to diptheria, tetanus and polio rather than pertussis but the OECD has calculated that this figure is only marginally different to those given for other countries

Part 4

Health achievements

4.1 This Part presents comparative information relevant to how well healthcare systems perform. A first measure is the state of health in countries, though this is determined by many factors other than the healthcare system. A second measure is the extent to which healthcare systems improve health. Limited comparative information is available on this, though data are available about survival rates after cancer treatment.

Life expectancy

4.2 A fundamental measure of health in a particular country is life expectancy though while healthcare systems have an influence on life expectancy, it depends equally if not more on a wide range of other factors such as personal income, lifestyle, education, nutritional standards, and housing quality. One way of measuring life expectancy is the number of years that individuals born 'now' can on average expect to live if current patterns of mortality and disability continue to apply. The measure has the limitation of applying only to the current birth cohort. Life expectancy has generally risen over time, so life expectancy for the population as a whole will be lower than indicated by the most recent statistics.

4.3 **Figure 20** shows that life expectancy at birth (in recent years) ranges between about 79 and 85 years for women across the 10 comparator countries, and between 74 and 78 years for men. This amounts to an 8 per cent range for women and 5 per cent for men. Japan has the longest expected life span, followed closely within European countries by France and Sweden and then Italy and Germany. The United Kingdom comes towards the lower end of the fairly small range for both men and women. The United Kingdom has, however, one of the smallest differences in life expectancy between women and men at 4.8 years, with France at 7.5 years being the largest.

4.4 An alternative way of assessing life expectancy is based on the calculation of 'Potential years of life lost'. This measure assumes that all those who die before the age of 70 die prematurely. This figure needs to be seen in the context of the currently expected life spans at birth of around 80 years for women and 75 years for men.

4.5 The United States loses more potential life years than the other countries in the comparator group, **Figure 21**. There is a considerable variation across countries, and in contrast to the data on life expectancy at birth, where the United Kingdom is among the lowest, on the years lost measure, the United Kingdom ranks fourth lowest behind Sweden, Japan and Italy. This illustrates the dangers of relying on single indicators to draw conclusions.

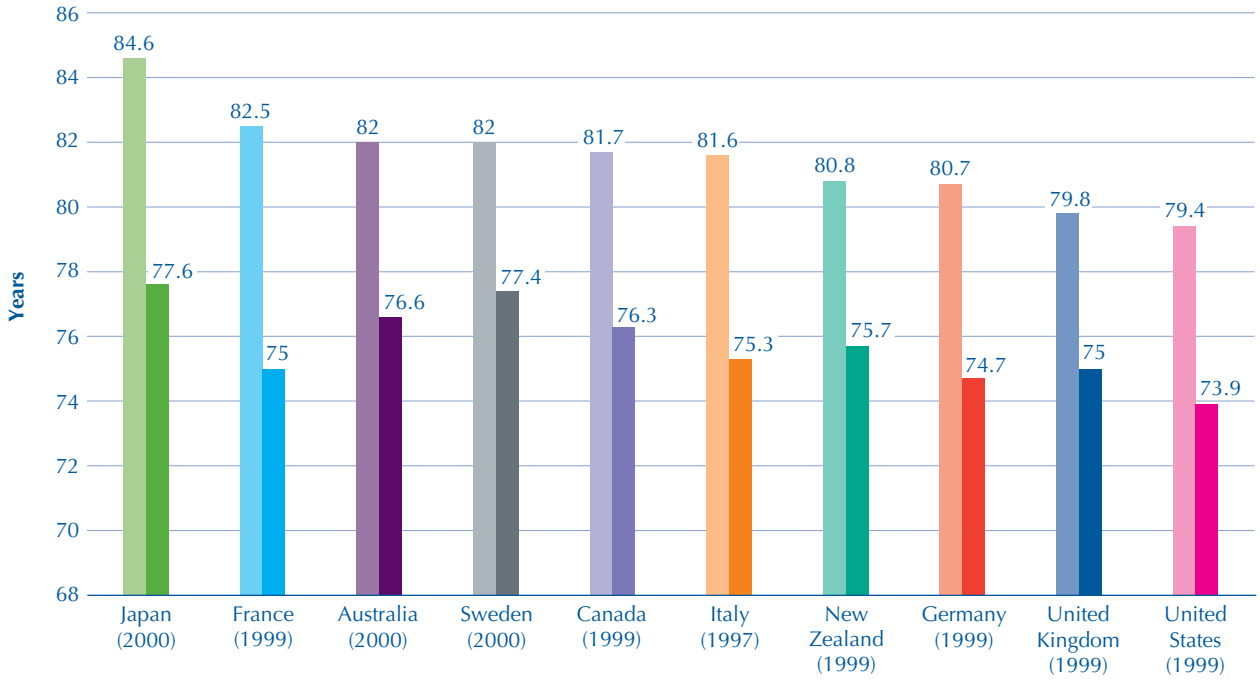
4.6 For both sexes, the highest number of years lost (per 100,000 population) is some 80 per cent above the lowest one. There are also marked differences in the number of years of life lost by men and women. In the United Kingdom, potential years of life lost for males are 64 per cent higher than for females.

Infant and perinatal mortality

4.7 An important reason for increased life expectancy at birth has been a decline in infant mortality. Among the explanations for this are better ante and post-natal care and widespread immunisation against childhood diseases - influences within the control of health policy makers. Recent research suggests that the number of doctors per capita appears to be the second most important variable (behind occupation) in explaining both perinatal and infant mortality. The results indicate, all else equal, that a 10 per cent increase in the number of doctors would result in almost a 6 per cent decrease in perinatal mortality and a 6½ per cent decrease in infant mortality[12]. The research found that the overall level of public financing also appears to be a significant factor in reducing both infant and perinatal mortality[13]. The OECD hypothesis is that this may reflect the likelihood that publicly funded systems provide more equitable health service provision.

12 *Exploring the effects of health care on mortality across OECD countries, OECD Labour market and social policy - Occasional Papers No. 46, January 2001, paragraph 55.*
13 *ibid paragraph 56.*

20 Life expectancy at birth



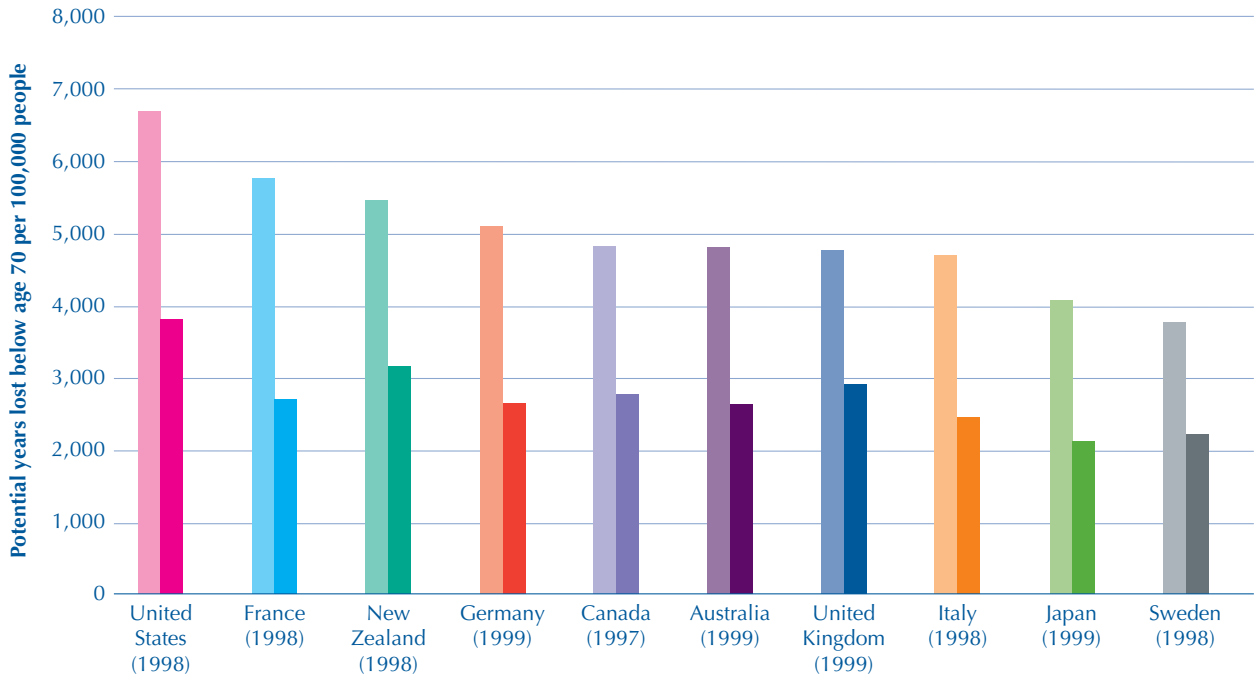
The lighter tinted bar represents female patients. The darker tinted bar represents male patients.

NOTE

The life expectancy is calculated on the assumption that age-specific mortality levels remain constant.

Source: OECD Health Data 2002

21 Potential years of life lost



The lighter tinted bar represents male patients. The darker tinted bar represents female patients.

Source: OECD Health Data 2002, based on World Health Organization data

4.8 **Figures 22** and **23** show the strong decline in perinatal and infant mortality over the 1980s and the continued but less marked decrease across most comparator countries since then. All these countries have made steady progress over the last 20 years, with those having the highest rates in 1980 reducing rates a little faster. The result has been that the spread between the countries for perinatal mortality has reduced from 9.1 deaths per 1,000 total births in 1980 to 4.5 per 1,000 in 2000. From 1993, the United Kingdom started to count mortality after 24 weeks gestation, rather than the 28 weeks used by other countries.

Main causes of death

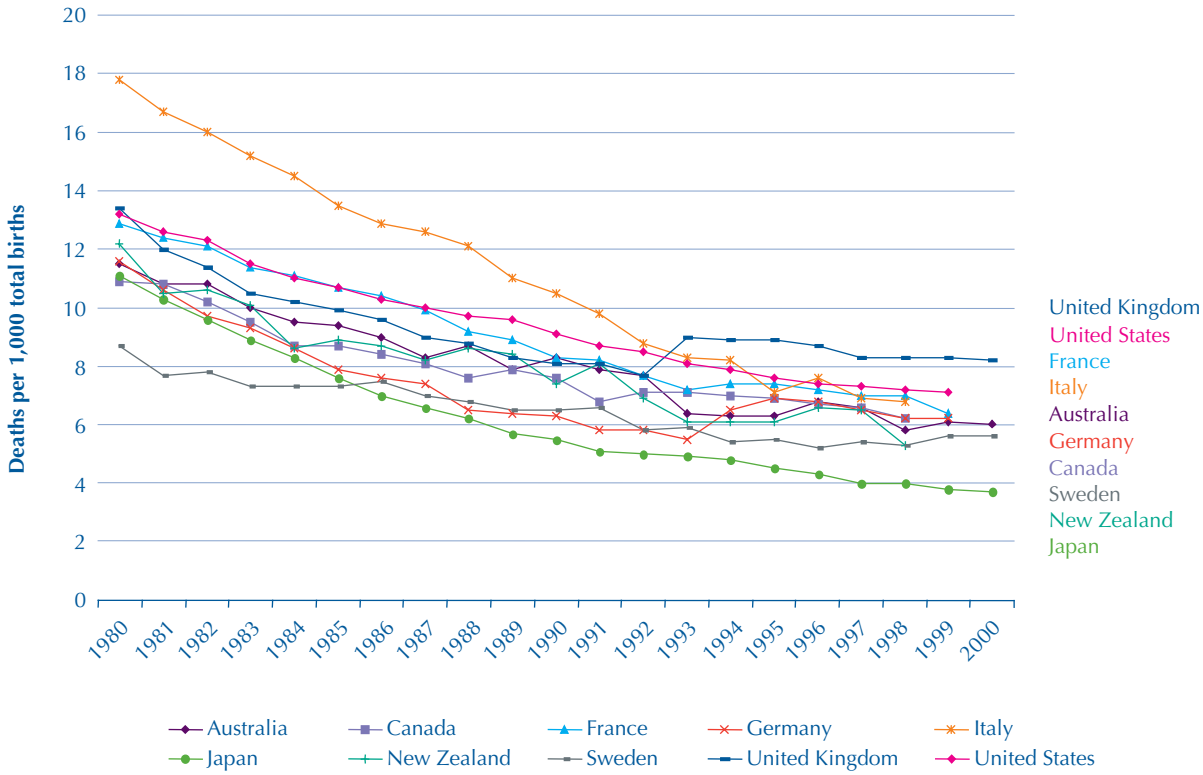
4.9 The main causes of death for the comparator countries are shown at **Figure 24**. The most significant causes of death from disease in developed countries are cancer (malignant neoplasms) and cardio-vascular illness, and patterns are similar in all countries.

Deaths from cancer

4.10 Analysis of cancer mortality statistics is a difficult area and variations across countries need careful interpretation. The chances of dying from cancer depend on how quickly patients recognise and act on symptoms, the impact of measures affecting lifestyle (such as smoking habits) and the existence of screening programmes. There are also marked differences in cancer mortality rates between socio-economic groups, (which correlate with some of the other factors mentioned). However, the quality of medical intervention is also an important factor, recognised for example for the United Kingdom in the NHS Cancer Plan[14].

4.11 Cancer is an illness in the United Kingdom subject to active measures to improve performance and this needs to be borne in mind when considering the statistics. As part of the performance improvements expected as a result of the increased funding announced in the 2002 Budget, the Government requires the NHS to reduce mortality rates from cancer by at least 20 per cent in people under 75 by 2010.

22 Perinatal mortality, 1980 to 2000



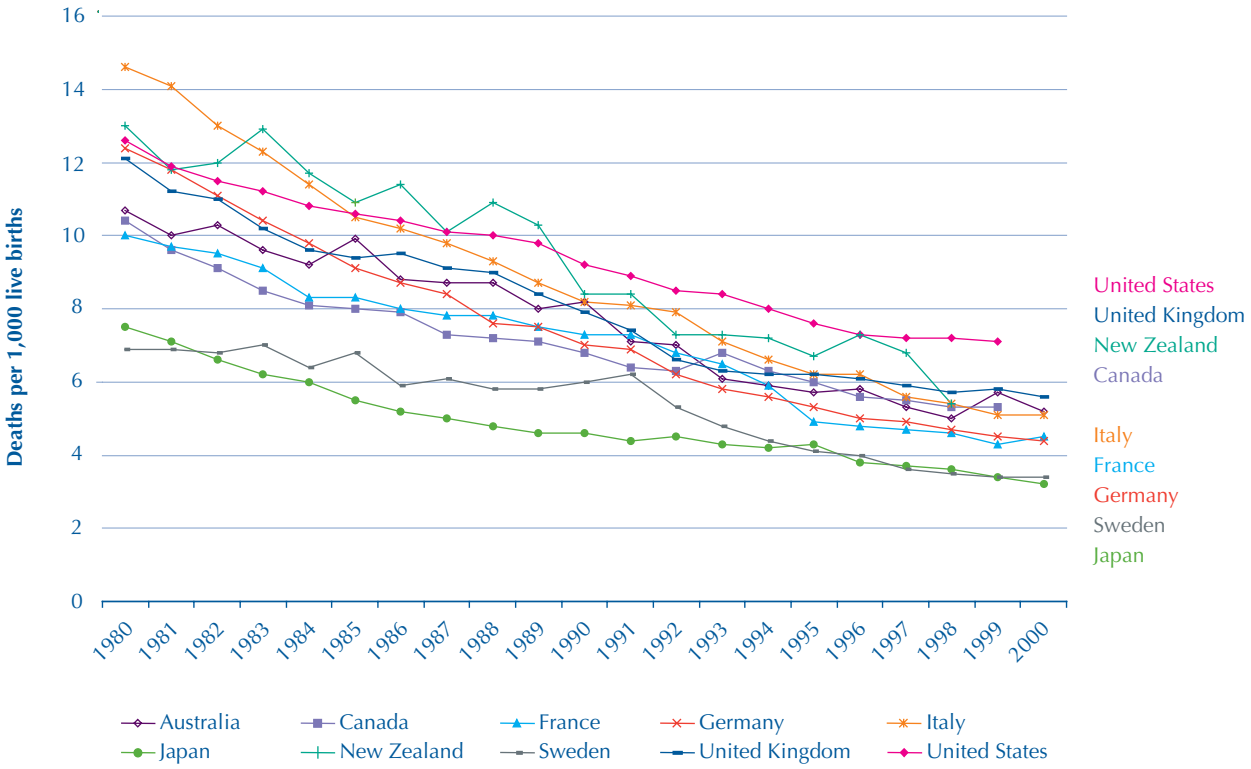
NOTE

Perinatal mortality is the number of deaths within seven days of birth plus foetal deaths of 28 weeks of gestation or more per 1,000 total births (live and stillbirths). The UK includes deaths from 24-28 weeks of gestation while other countries do not.

Source: OECD Health Data 2002

14 *The NHS Cancer Plan, Department of Health, September 2000.*

23 Infant mortality, 1980 to 2000



NOTE

Infant mortality is the number of deaths of babies aged under one year that occurred during a year per 1,000 live births during the same year, expressed as a rate.

Source: OECD Health Data 2002

4.12 **Figure 25** shows the trend in cancer deaths for the 10 comparator countries over the last two decades. For the last year of complete comparisons, the United Kingdom and New Zealand jointly had the highest death rates, although the rates in both countries are on a downward trend.

4.13 Recent data for death rates from all cancers (against a standardised age profile to take account of different demographics in countries) are shown in **Figure 26**. New Zealand and the United Kingdom report comparatively high death rates. The rate (per 100,000 population) in France and Germany is about 2½ and 5 per cent lower than in the United Kingdom respectively. The rate in Sweden, the country with the lowest cancer death rate among the 10 countries, is about 18 per cent below that of the United Kingdom.

4.14 **Figure 27** shows the mortality rates for the four main cancer killers in the comparator countries. Overall, the United Kingdom is in the top group for overall deaths although it has the highest rate only for breast cancer.

4.15 Further comparative information on death rates from the main cancers over time is given in Appendix 2. **Figures 28** and **29** show death rates from lung and breast cancer.

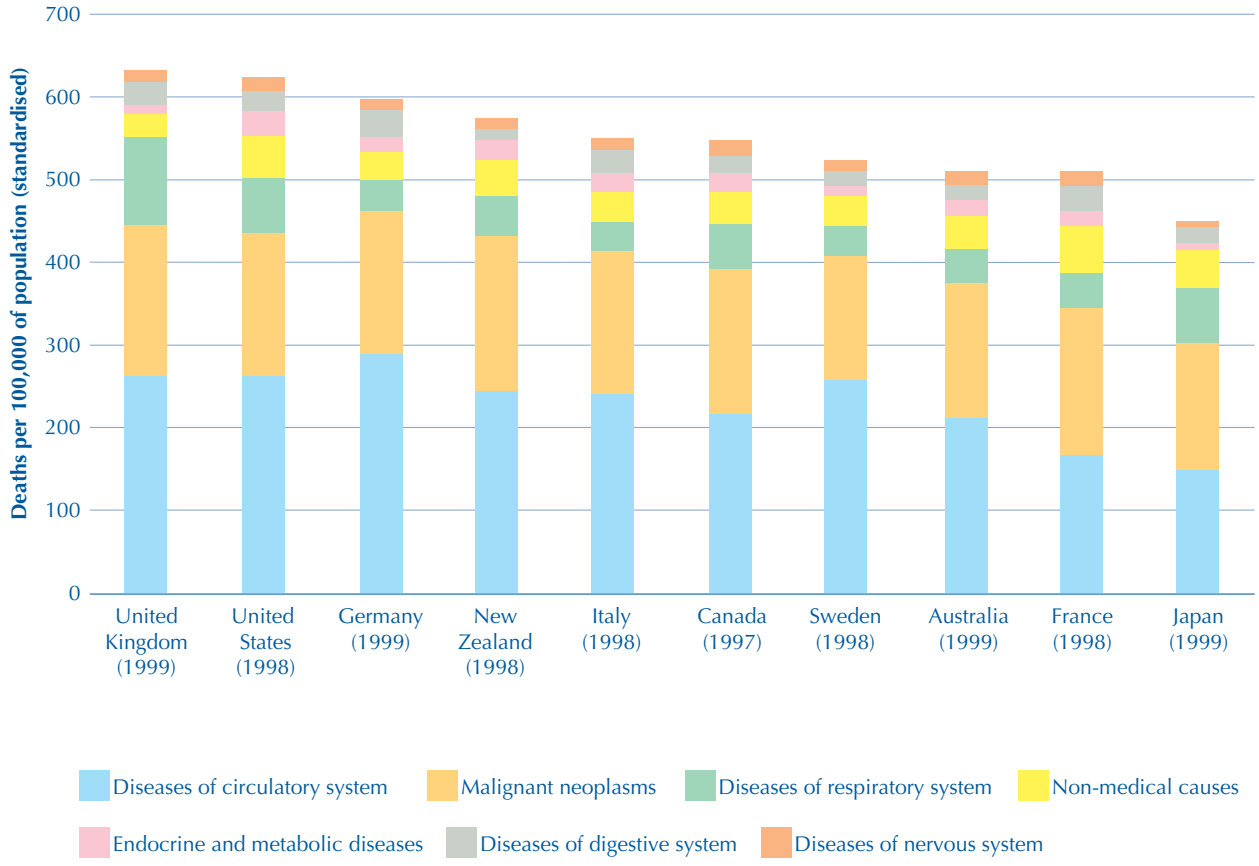
4.16 United Kingdom mortality comes towards the middle of the range for lung cancer, but is above all of these comparator countries for breast cancer.

Deaths from circulatory diseases

4.17 Cardio-vascular diseases include ischaemic heart disease, myocardial infarction and cerebro-vascular diseases[15]. As part of the performance improvements expected as a result of the increased funding announced in the 2002 Budget, the Government requires the NHS to reduce substantially mortality rates from heart disease by at least 40 per cent in people under 75 by 2010.

15 'Ischaemia' means an inadequate supply of blood and is usually the consequence of the gradual narrowing of the arteries supplying blood and oxygen. If a narrowed coronary artery blocks off suddenly - as it may if a blood clot forms in it - the part of the heart muscle supplied by that artery may die and cause severe chest pain. This is a 'heart attack', also known as a myocardial infarction ('myocardium' referring to the heart muscle and 'infarction' referring to the death of a part of it). There are two main forms of cerebro-vascular disease leading to stroke - resulting from either ischaemic disease affecting the blood circulation system of the brain, or from haemorrhage of surface blood vessels.

24 Main causes of death



NOTE

Age-standardised death rates take into account the differences in age structure of the populations

Source: OECD Health Data 2002

4.18 United Kingdom death rates are highest, second highest and third highest respectively across the group of countries for the three circulatory conditions included in **Figure 30**. The overall death rate is two and a half times that of France, with that for ischaemic heart disease being four times the rate reported from Japan.

4.19 Trends in most countries for ischaemic heart disease have been downward, most markedly in countries with highest death rates at the start of the period from 1980 shown in **Figure 31**.

Health outcomes

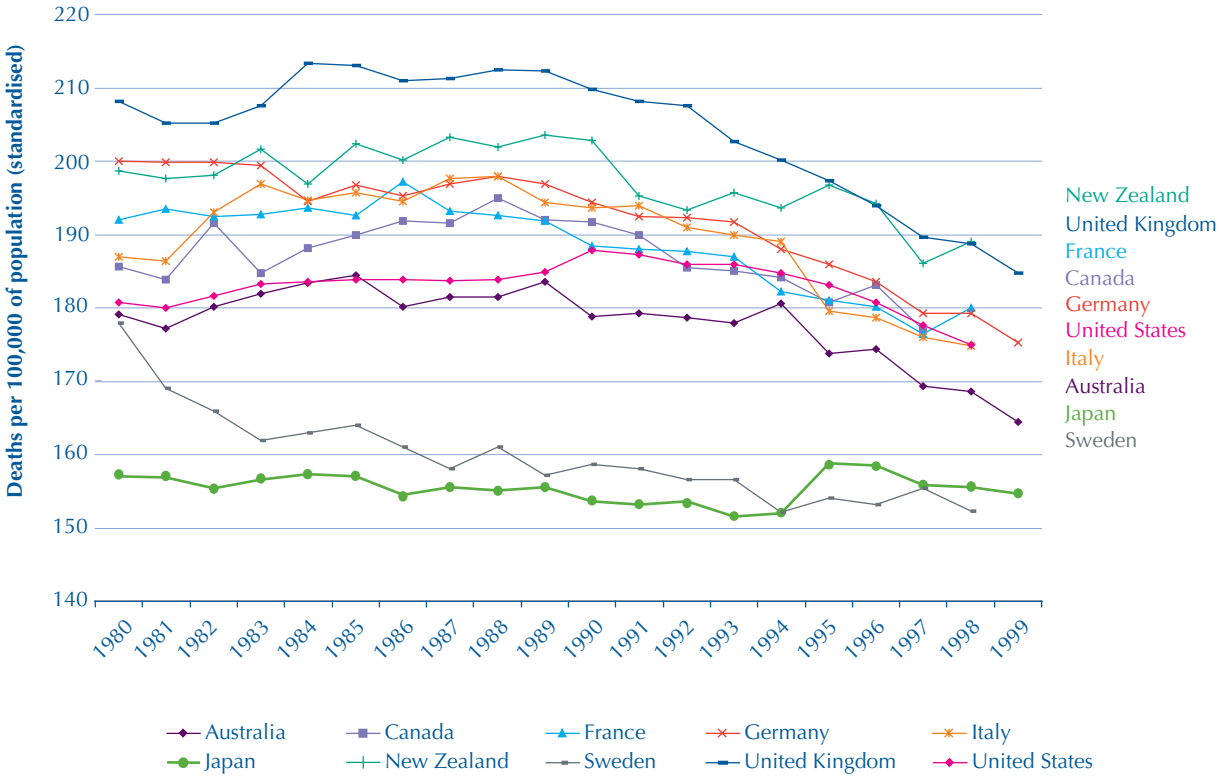
4.20 Information about the value added by healthcare systems in general or in relation to specific interventions is very limited. The most comprehensive international data relate to cancer survival rates. The standard measure is the percentage of cancer patients alive five years after treatment. This measure has potential drawbacks, as increases in five-year survival rates may be the result of better and earlier diagnosis, rather than represent a real postponement of death.

4.21 **Figures 32** to **35** show the five-year survival rates for the four main cancer killers. The performance of England is consistently at or near the bottom for the comparator countries, alternating bottom position with Scotland. These are based on historical data for patients diagnosed between 1985 and 1989. The implementation of the Calman/Hine report (1995) and the NHS Cancer Plan (2000) is not, therefore, reflected in these figures, but is expected to affect incidence, survival and mortality rates.

Performance of healthcare systems

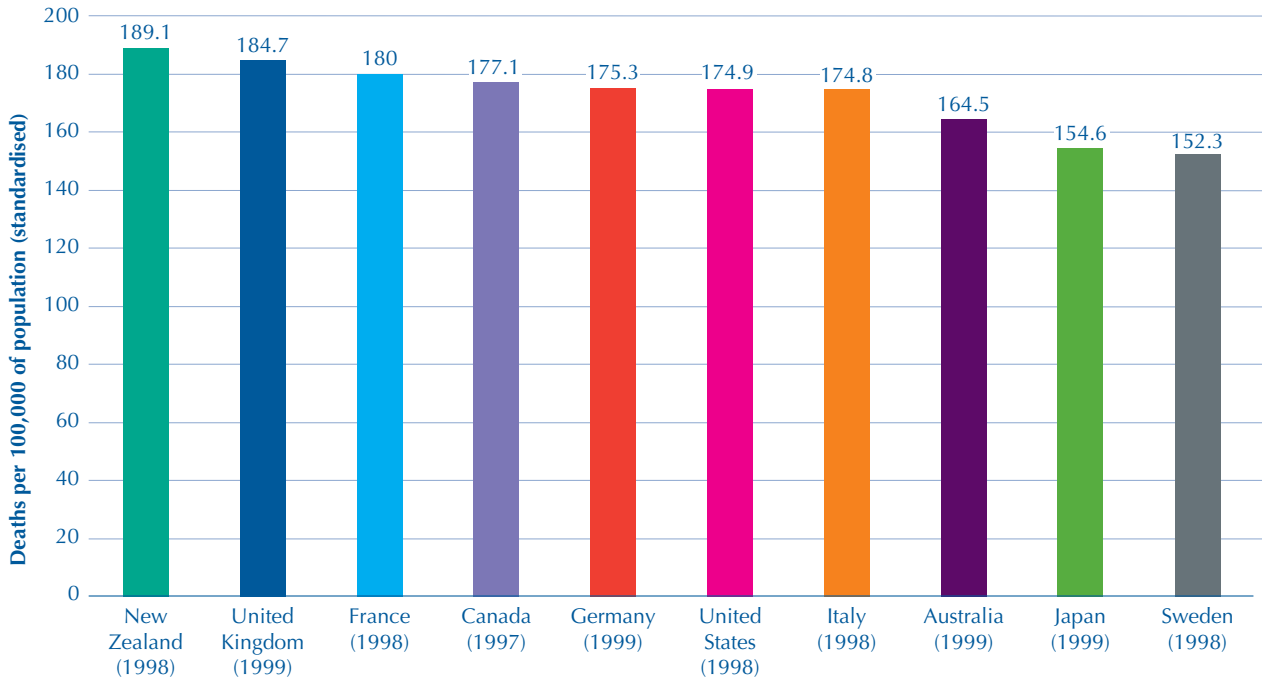
4.22 Healthcare systems are complex and making judgements about their performance overall is very difficult. Average length of stay is often used as an indicator of the efficiency with which a system treats patients, alongside the assumption that all medically appropriate treatment is delivered to clinically acceptable standards and discharges are medically approved. On this basis, a lower length of stay indicates better efficiency in the use of acute beds. Germany has the longest length of acute (hospital) stay at 9.6 days, while the United Kingdom is in the middle of the range of countries at 6.2 days, **Figure 36**.

25 Deaths from cancer, 1980 to 1999



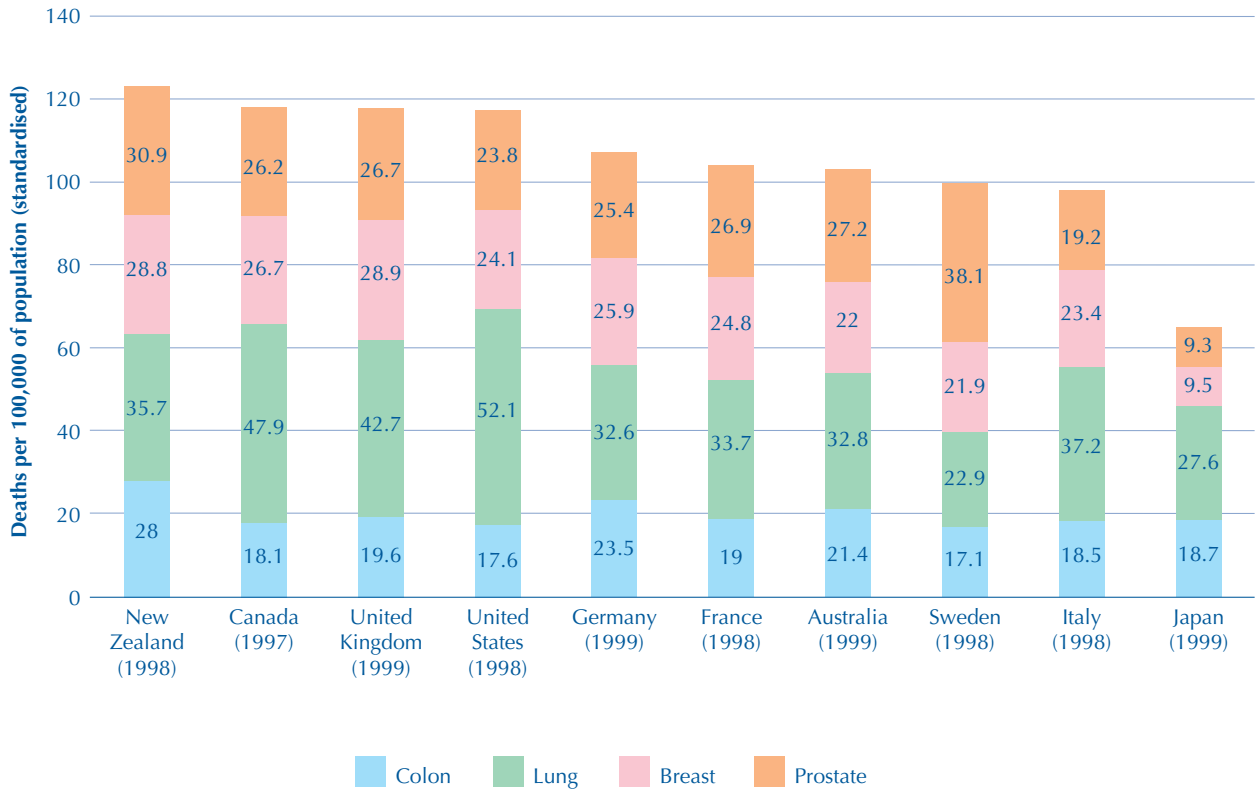
Source: OECD Health Data 2002

26 Latest known mortality for all cancers



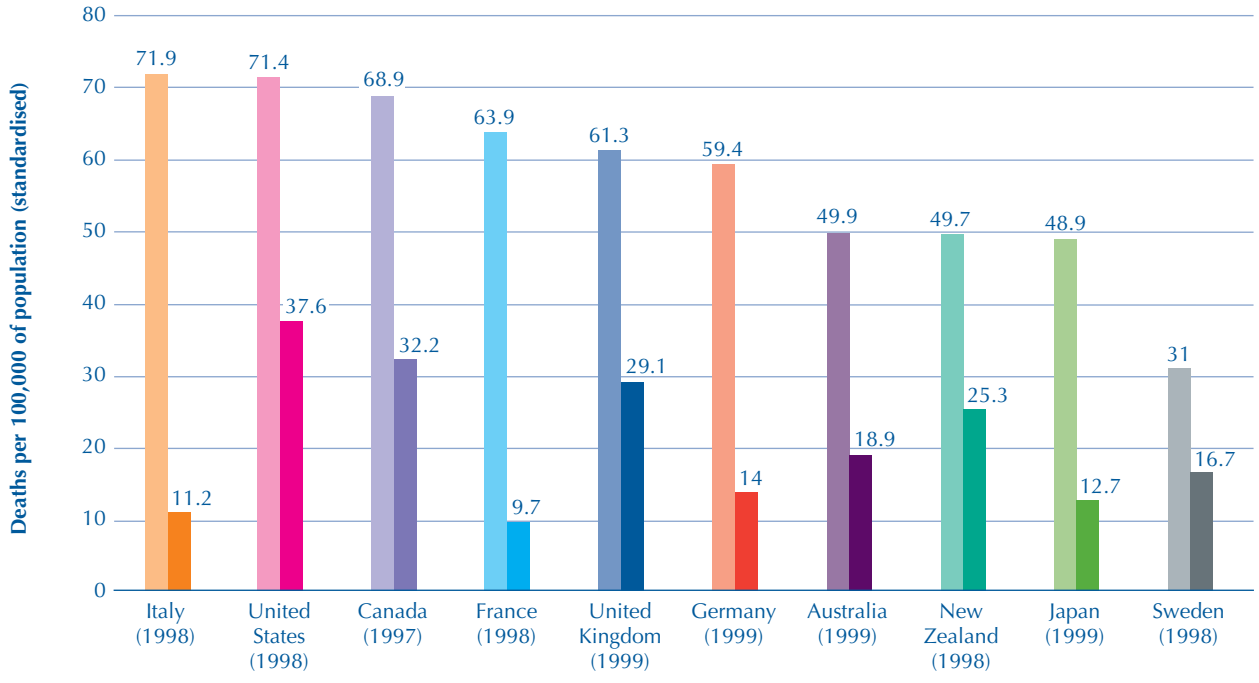
Source: OECD Health Data 2002

27 Main cancer killers with death rates



Source: OECD Health Data 2002

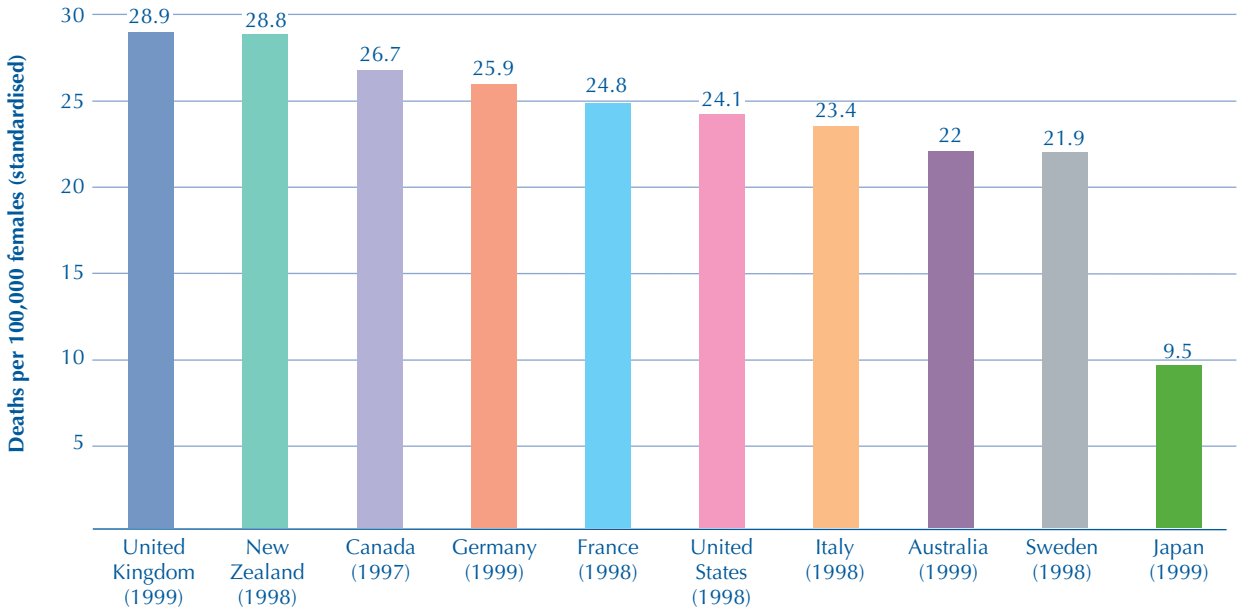
28 Deaths from lung cancer



The lighter tinted bar represents male deaths. The darker tinted bar represents female deaths.

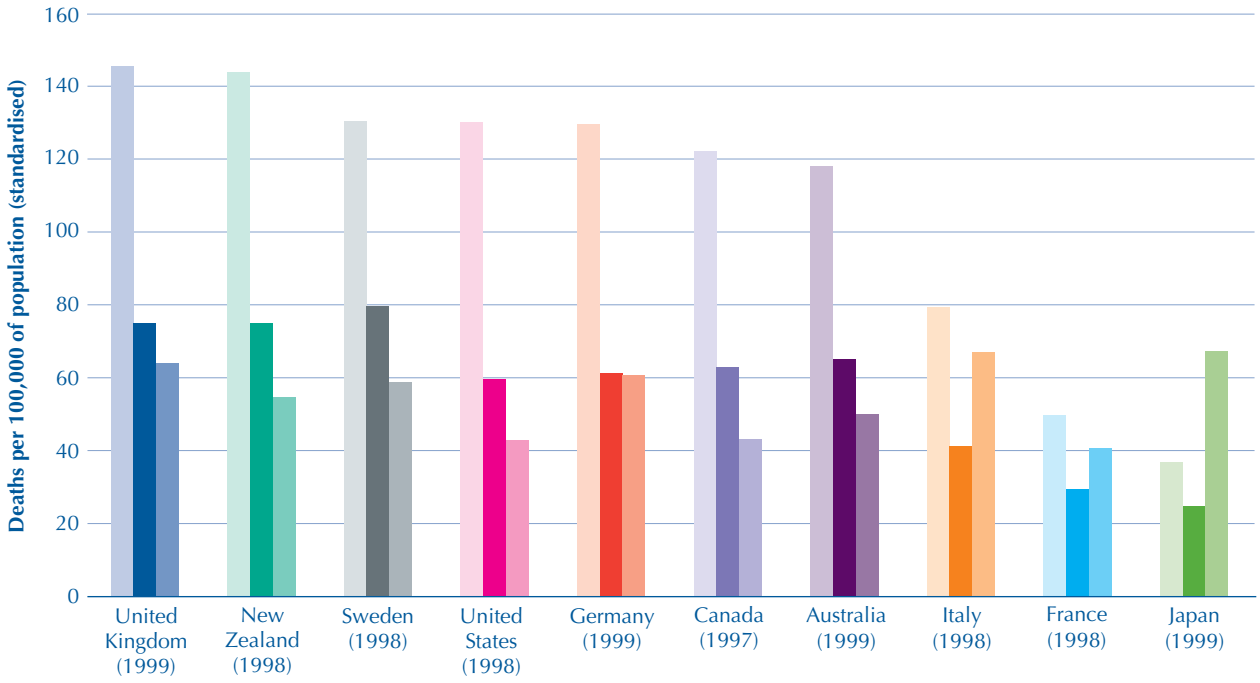
Source: OECD Health Data 2002

29 Deaths from breast cancer



Source: OECD Health Data 2002

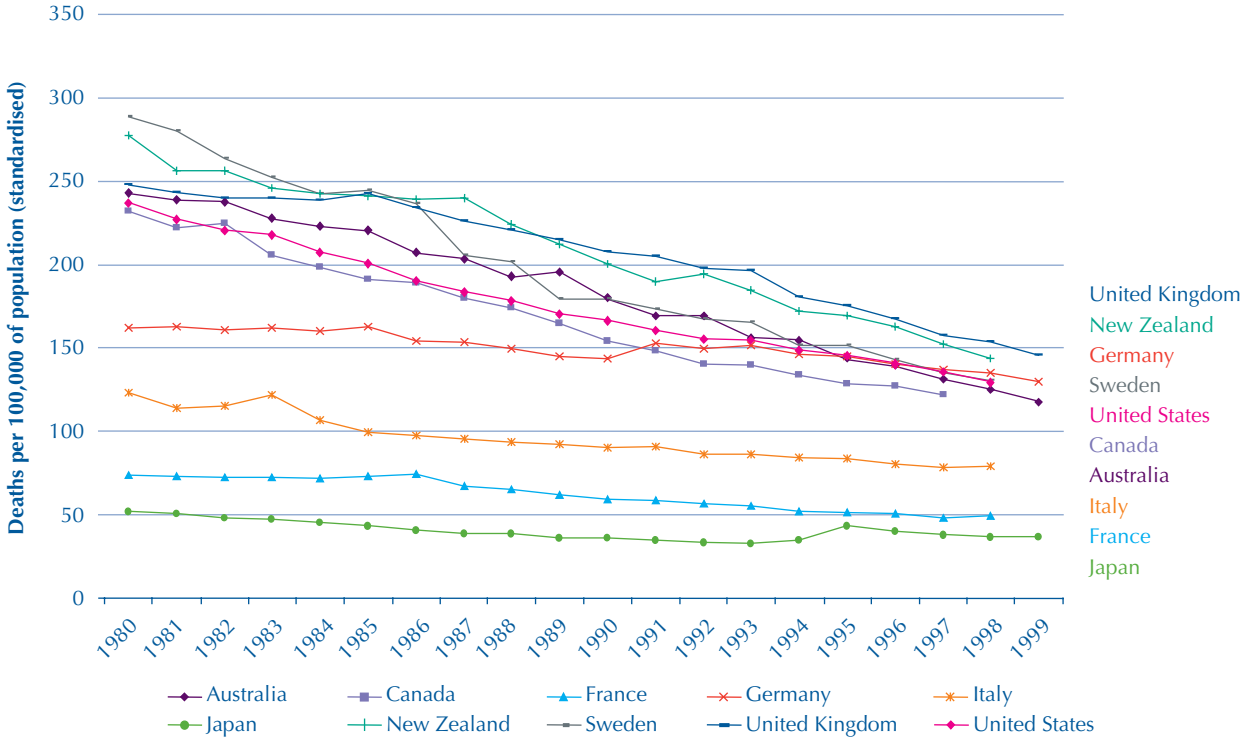
30 Deaths from main circulatory diseases



The lightest tinted bar represents ischaemic heart disease.
The darkest tinted bar represents acute myocardial infarction.
The medium tinted bar represents cerebro-vascular disease.

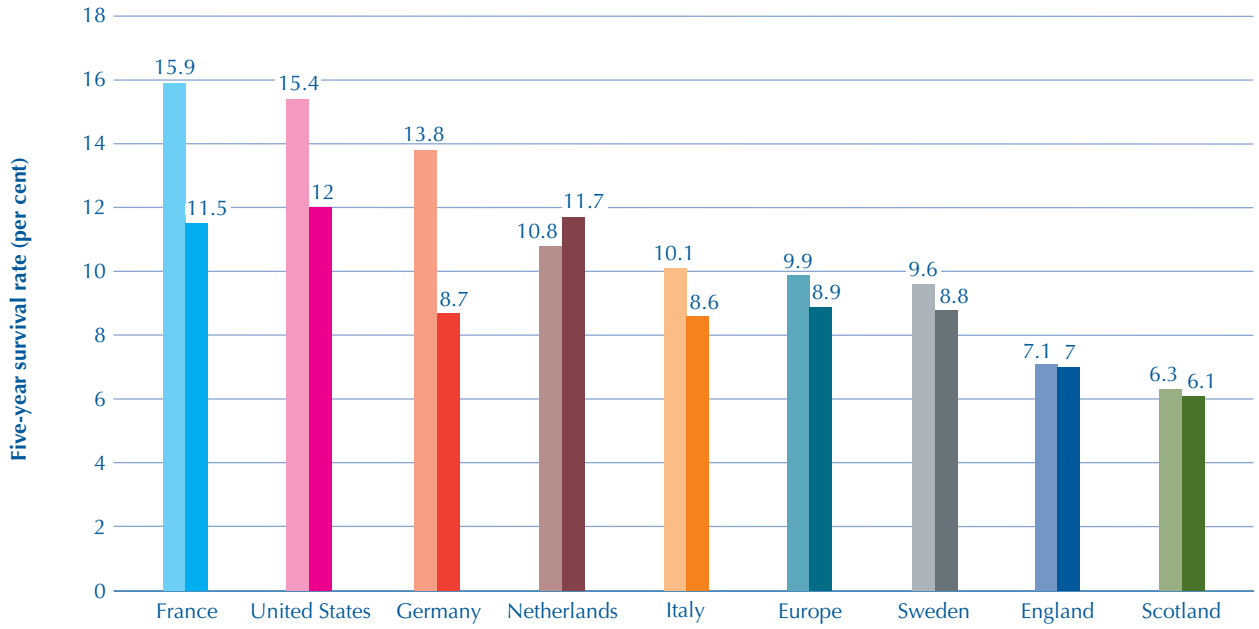
Source: OECD Health Data 2002

31 Deaths from ischaemic heart disease, 1980 to 1999



Source: OECD Health Data 2002

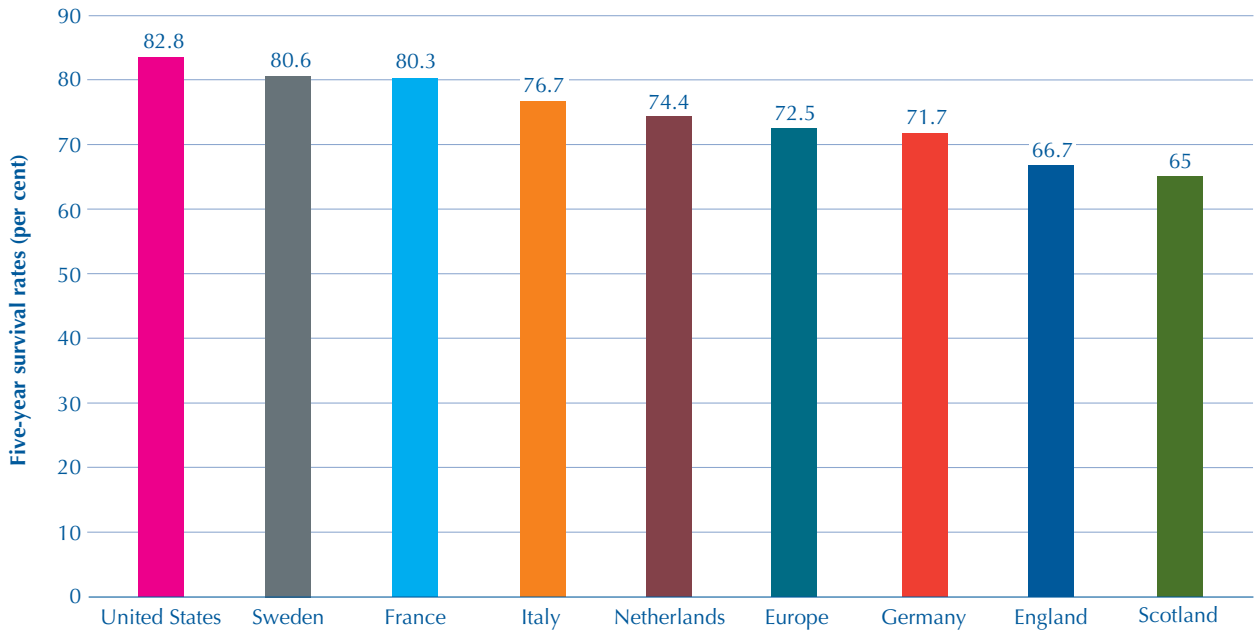
32 Five-year survival rates for lung cancer



The lighter tinted bar represents female deaths. The darker tinted bar represents male deaths.

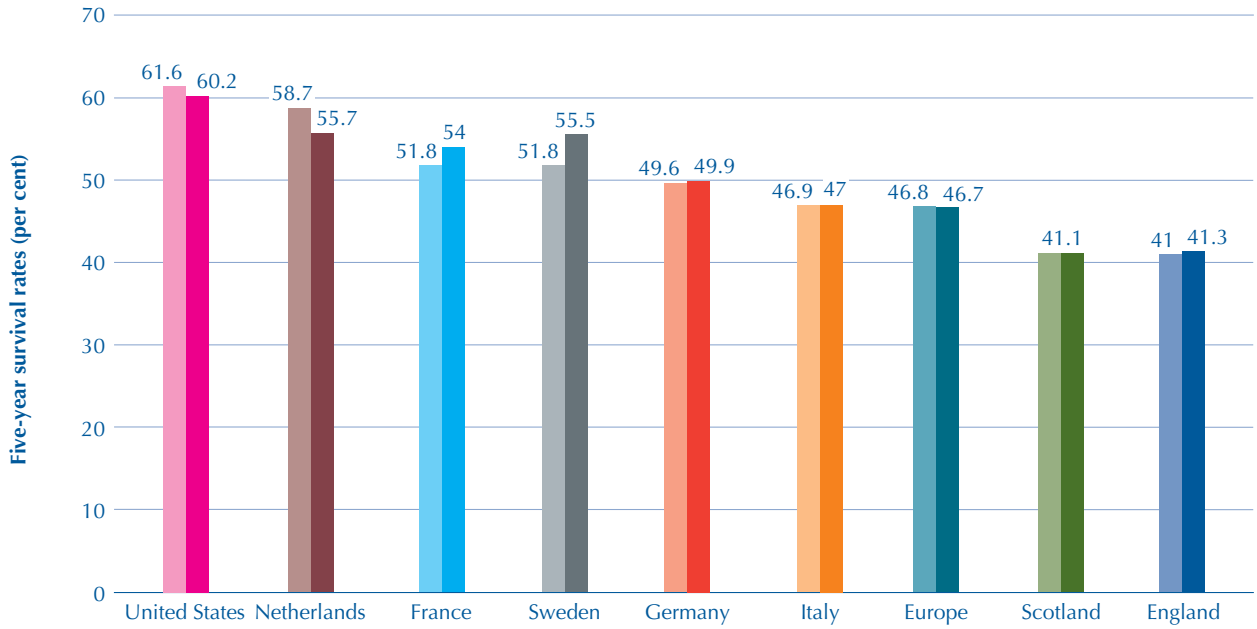
Sources: United States figures from SEER Cancer Statistics Review 1973-1999, National Cancer Institute, 2002, cancer first diagnosed between 1986 and 1988. All other countries from Survival of cancer patients in Europe: the EUROCARE-2 study, 1999, cancer first diagnosed between 1985 and 1989

33 Five-year survival rates for breast cancer



Sources: United States figures from SEER Cancer Statistics Review 1973-1999, National Cancer Institute, 2002, cancer first diagnosed between 1986 and 1988. All other countries from Survival of cancer patients in Europe: the EUROCARE-2 study, 1999, cancer first diagnosed between 1985 and 1989

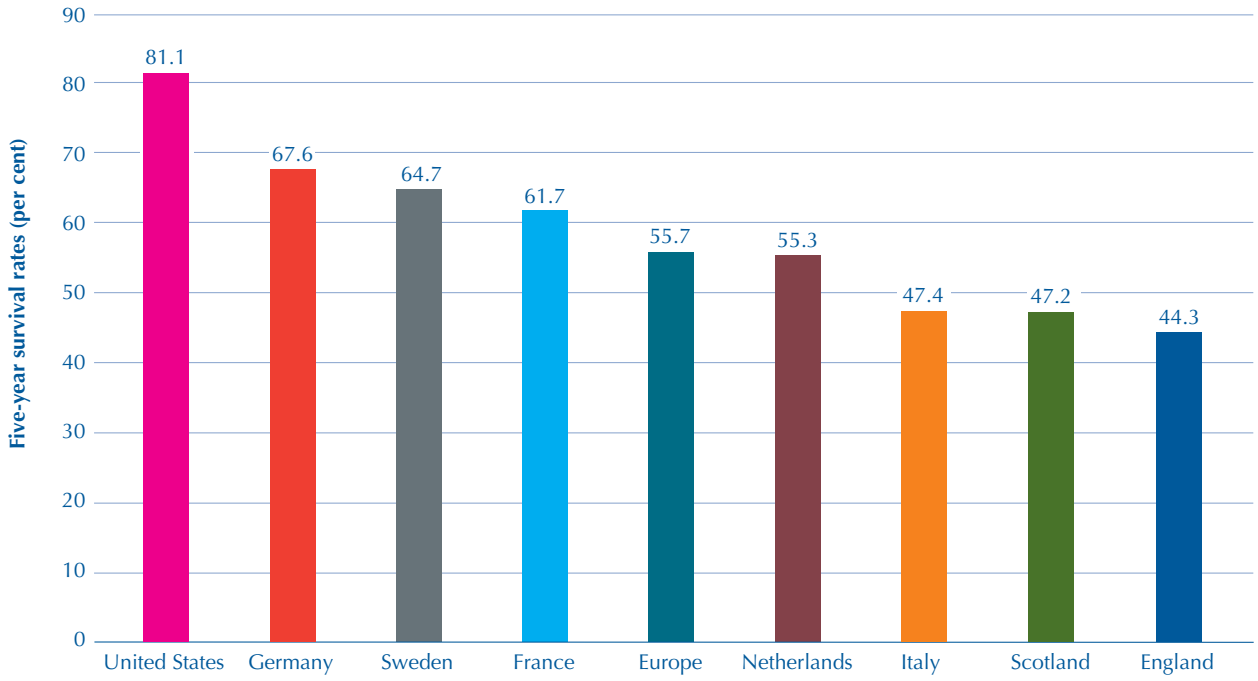
34 Five-year survival rates for cancer of the colon



The lighter tinted bar represents male patients. The darker tinted bar represents female patients.

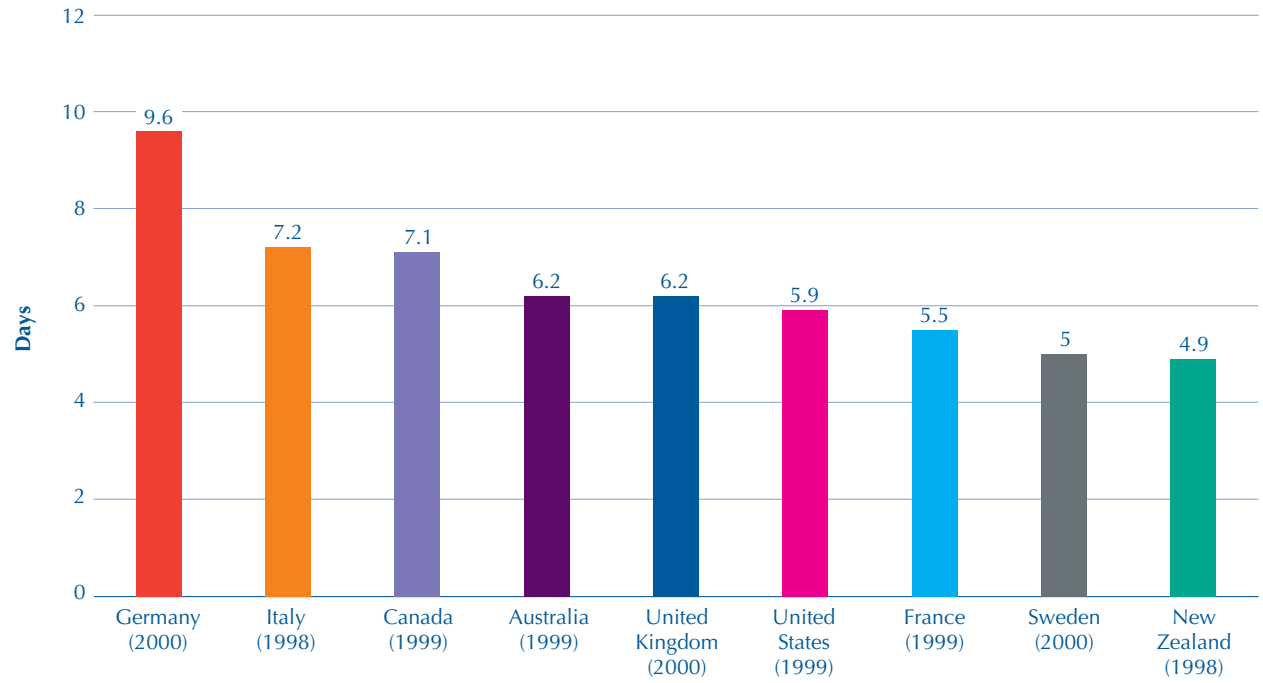
Sources: United States figures from SEER Cancer Statistics Review 1973-1999, National Cancer Institute, 2002, cancer first diagnosed between 1986 and 1988. All other countries from Survival of cancer patients in Europe: the EUROCARE-2 study, 1999, cancer first diagnosed between 1985 and 1989

35 Five-year survival rates for prostate cancer



Sources: United States figures from SEER Cancer Statistics Review 1973-1999, National Cancer Institute, 2002, cancer first diagnosed between 1986 and 1988. All other countries from Survival of cancer patients in Europe: the EUROCARE-2 study, 1999, cancer first diagnosed between 1985 and 1989

36 Average length of stay for acute care



Average length of stay is computed by dividing the number of days stayed (from the date of admission in an in-patient institution) by the number of separations (discharges and deaths) during the year.

Source: OECD Health Data 2002

Appendix 1 Healthcare delivery systems

1.1 This appendix sets out the health care delivery systems in the ten comparator countries. The main sources used to compile it were: Health Care Systems In Eight Countries: Trends and Challenges, European Observatory on Health Care Systems, 2002; Multinational Comparisons of Health Systems Data, Anderson G.F. and Hussey P.S., The Commonwealth Fund, 2000; and, Securing Our Future Health, Wanless D., Interim Report, November 2001. We also used material from the European Observatory web-site and from web-sites of Government health departments of the countries.

Australia

1.2 Australia offers universal access to health care to all residents through Medicare. Individuals eligible for Medicare receive free ambulatory medical care and free accommodation and medical, nursing and other care as public patients in state funded hospitals. Alternatively they may choose treatment as private patients in public or private hospitals, with some assistance from Medicare. **Figure 1.1** shows the health care delivery system and flows of finance in Australia. Australia has complex health care system with many types of services and providers and a range of funding and regulatory mechanisms. There is a large and vigorous private sector in health services.

Role of the Government

1.3 The federal Government has control over hospital benefits, pharmaceuticals, and medical services. The States are primarily responsible for funding and administering public hospitals and mental and community health services, and pay for public hospitals with federal Government assistance.

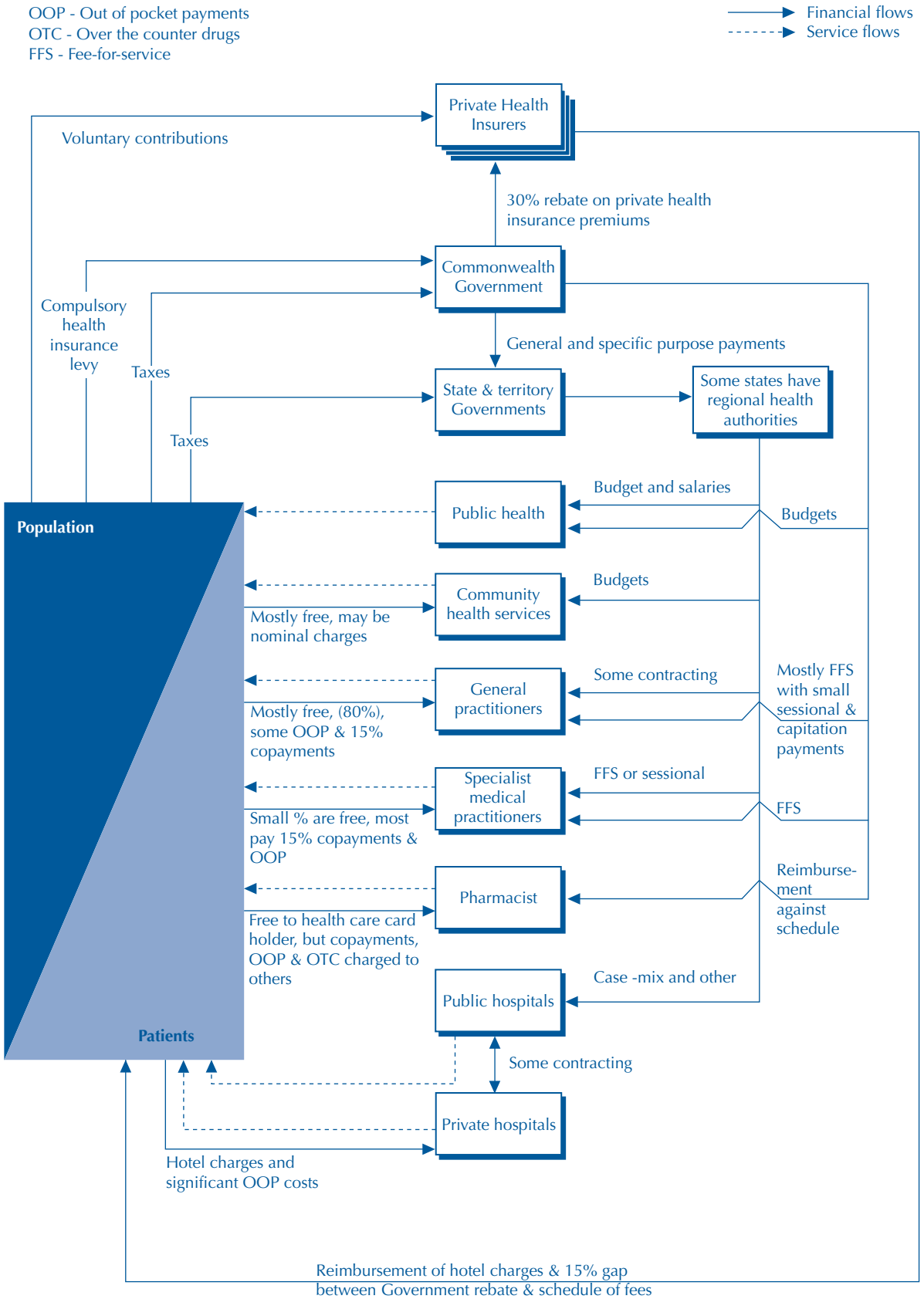
Primary care

1.4 Private practitioners provide most community-based medical and dental treatment and there is a large private hospital sector. The bulk of primary medical care is provided by GPs. They are mostly self-employed and run their practices as businesses. They are reimbursed by a fee-for-service system. Patients have a choice of GP with no restrictions and may consult more than one GP since there is no requirement to enrol with a practice. GPs act as gatekeepers to in-patient and out-patient services.

In-patient/secondary care

1.5 In-patient care is provided by public hospitals (70 per cent of stock of acute care beds). Patients with private health insurance may chose to be admitted to either public or private hospitals and may also choose their specialist. Medicare subsidises medical costs but not accommodation costs. Physicians in public out-patient hospitals are either salaried (but may have private practices and fee-for-service income) or paid on a per session basis.

1.1 Financing of healthcare in Australia, 1999



Source: OECD Secretariat

Source: OECD Health Data 2002

Canada

1.6 Although predominately publicly funded, healthcare is largely delivered by private providers, particularly in the primary care sector, **Figure 1.2**.

Role of the Government

1.7 The federal Government requires that provincial health insurance plans cover all medically necessary physician and hospital services. The provincial governments have the authority to regulate health providers. However, they delegate control over physicians and other providers to professional "colleges" whose duty is to license providers and set standards for practice.

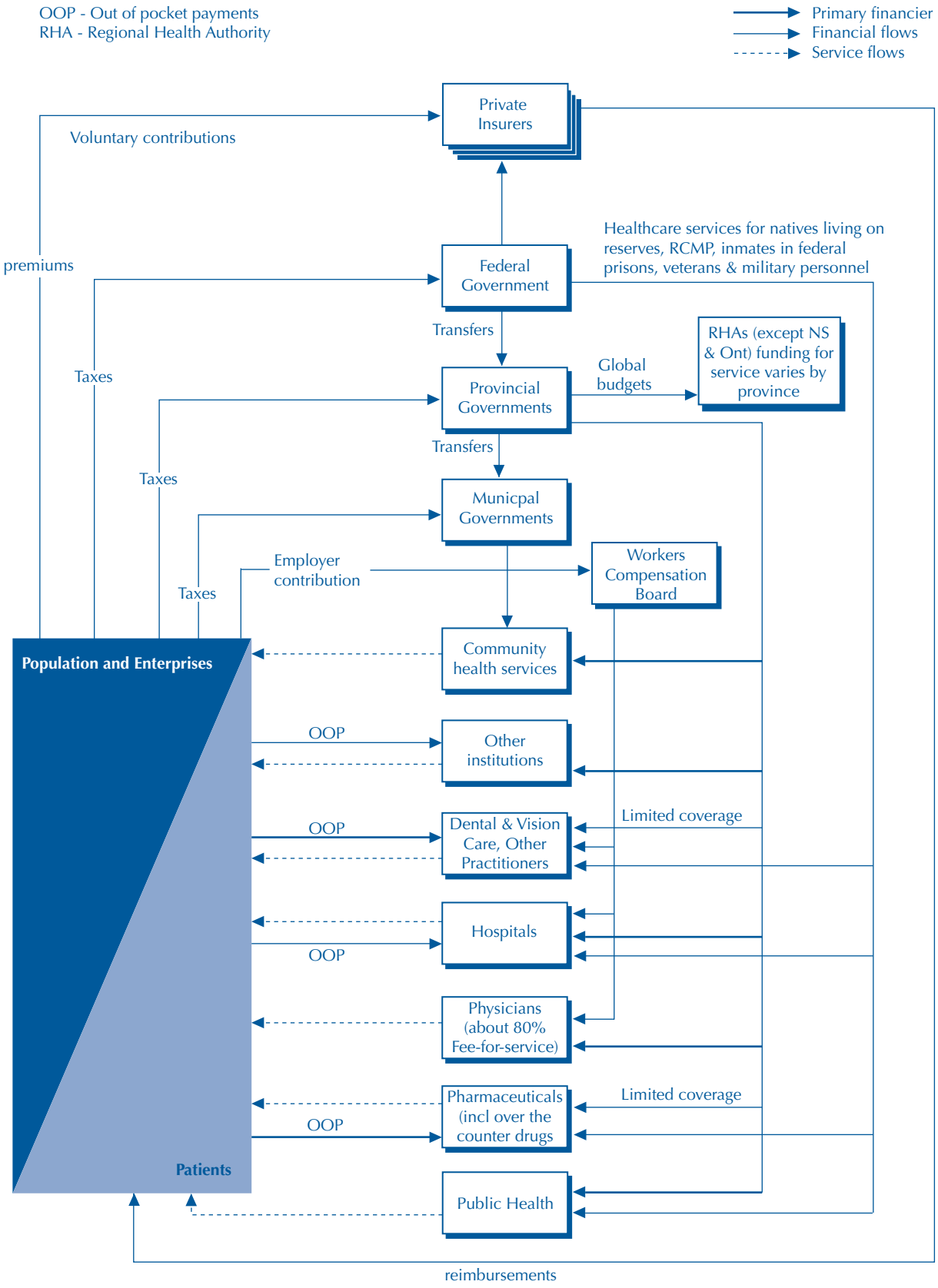
Primary care

1.8 Most primary physicians are in private practice and are remunerated on a fee-for-service basis. Provincial medical associations negotiate the fee schedules for insured services with provincial health ministries. Physicians must opt out of the public system of payment to have the right to charge their own rates.

In-patient/secondary care

1.9 In-patient care takes place in public and private non-profit hospitals that operate under global budgets or regional budgets with some fee-for-service payment. Less than 5 per cent of Canadian hospitals are privately owned and are mainly long-term care facilities.

1.2 Financing of healthcare in Canada, 2000



Source: OECD Secretariat

Source: OECD Health Data 2002

England

1.10 OECD system information is only available for England. Other constituent parts of the United Kingdom have their own structures for delivering a largely publically funded health service, free at the point of use.

1.11 Primary care services are mainly provided by GPs and multi-professional teams in health centres (under a capitated budget), **Figure 1.3**. Hospitals are mainly publicly owned with independent trust status. Private hospitals mainly provide services to privately insured patients or those who are willing to pay directly.

Role of the Government

1.12 The Government is responsible for health legislation and general policy matters and is a purchaser and provider of health care.

Primary care

1.13 GPs act as gatekeepers and are brought together in Primary Care Groups/Trusts with budgets for all care of enrolled populations. Most ambulatory care is provided by GPs in group practices. Private general practice is very small. Physicians are paid directly by the Government through a combination of methods: salary, capitation, and fee-for-service.

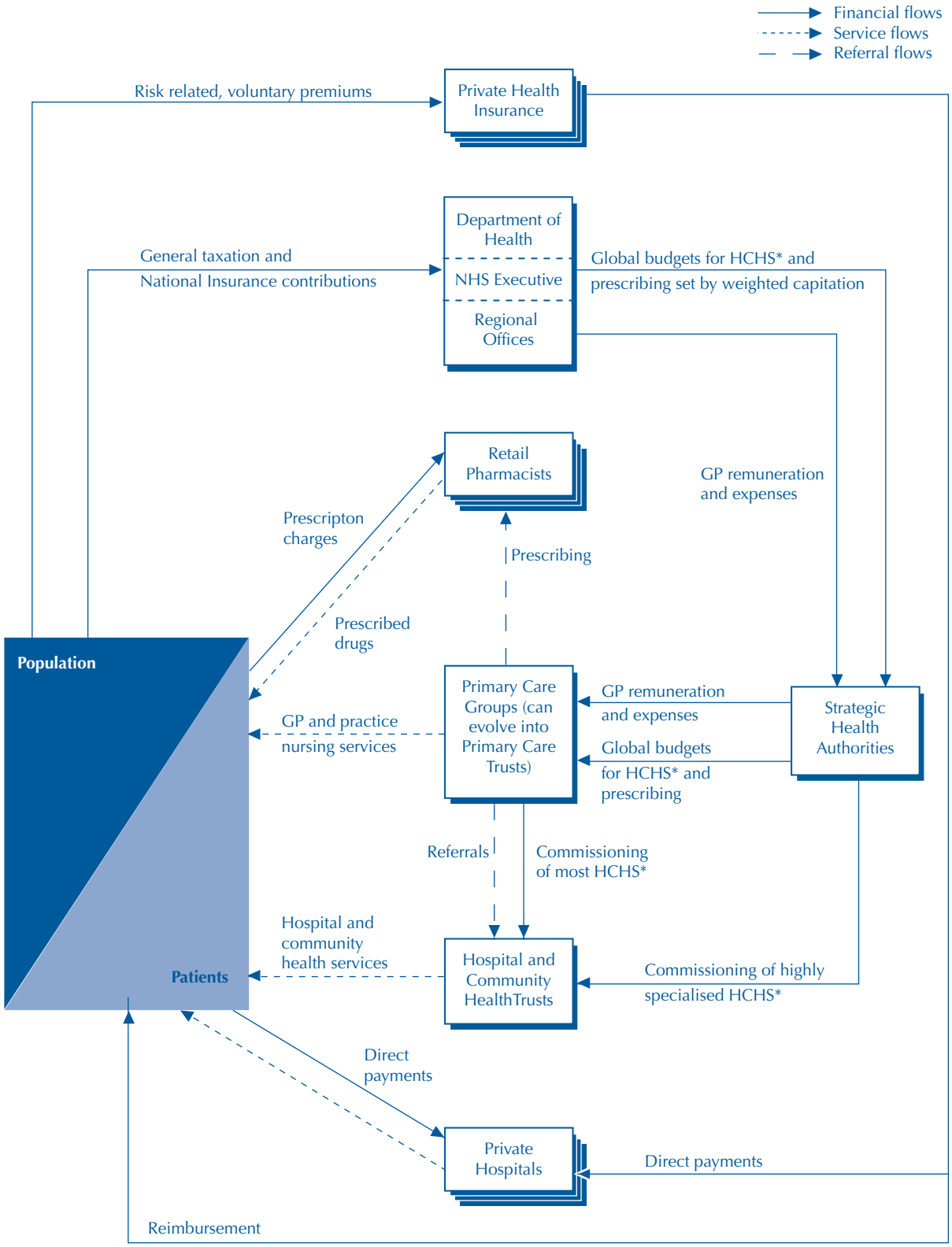
1.14 Ambulatory care is also provided in 36 walk-in clinics and there is a 24-hour telephone helpline service (NHS Direct) as a first point of contact.

In-patient/secondary care

1.15 Access to emergency care is through personal attendance at Accident and Emergency departments in acute hospitals. Patients may walk in to such departments or use the free ambulance service in cases of extreme urgency. Patients may also be advised to attend Accident and Emergency departments by their GP or NHS Direct.

1.16 Access to in-patient care is through GP referral. Most referrals are made to local hospitals and follow contractual arrangements between health authorities, Primary Care Trusts and the hospital. Secondary care is provided in general acute NHS trusts, small-scale community hospitals and highly specialised tertiary level hospitals. Hospitals are semi-autonomous self-governing public trusts that contract with groups of purchasers. Consultants are salaried.

1.3 Financing of healthcare in England, 1999



Source: Department of Health, England

NOTE

* HCHS: Hospital and Community Health Services

Source: OECD Health Data 2002

France

1.17 All legal residents are covered by public health insurance. They have no choice to opt out. Most have additional private insurance to cover areas that are not eligible for reimbursement by the public health insurance system and many make out of pocket payments to see a doctor. Health care is purchased and paid for by health insurance schemes and the Government and provided by private (self-employed) practitioners and public and private (for-profit and not-for-profit) hospitals, **Figure 1.4**.

Role of the Government

1.18 The French Government regulates contribution rates paid to sickness funds, sets global budgets and salaries for public hospitals, and supervises national fee schedule negotiations.

Primary care

1.19 French patients have free choice of provider. They can visit any GP or specialist practising privately or working in hospital out-patient, without referral or any limit on the number of consultations. Ambulatory care is mainly provided by professionals practising privately. Most GPs and specialists are paid on a fee-for-service basis according to agreed fee schedules. Patients pay physicians' bills and are reimbursed by sickness funds (public reimbursement model). GPs have no formal gatekeeper function. The Government introduced a non-obligatory gatekeeping mechanism in 1987 but only 1 per cent of the patients and 10 per cent of GPs signed up to this.

In-patient/secondary care

1.20 In-patient care is provided in public and private hospitals (not-for-profit and for-profit). Doctors in public hospitals are salaried whilst those in private hospitals are paid on a fee-for-service basis. Some public hospital doctors are allowed to treat private patients in the hospital, within limits. A percentage of the private fee is payable to the hospital.

1.21 Most out-patient care is delivered by doctors, dentists and medical auxiliaries working in their own practices (62 per cent are in sole practice, the remainder are in groups). Out-patient care is also provided to a lesser extent in hospitals and marginally in health centres (run by local authorities or mutual associations).

NOTES FOR FIGURE 1.4 (OPPOSITE)

Fully private health insurance concerns only a minority of extra-territorial workers, or cross border workers.

(1) ACOSS = Central Social Security Account

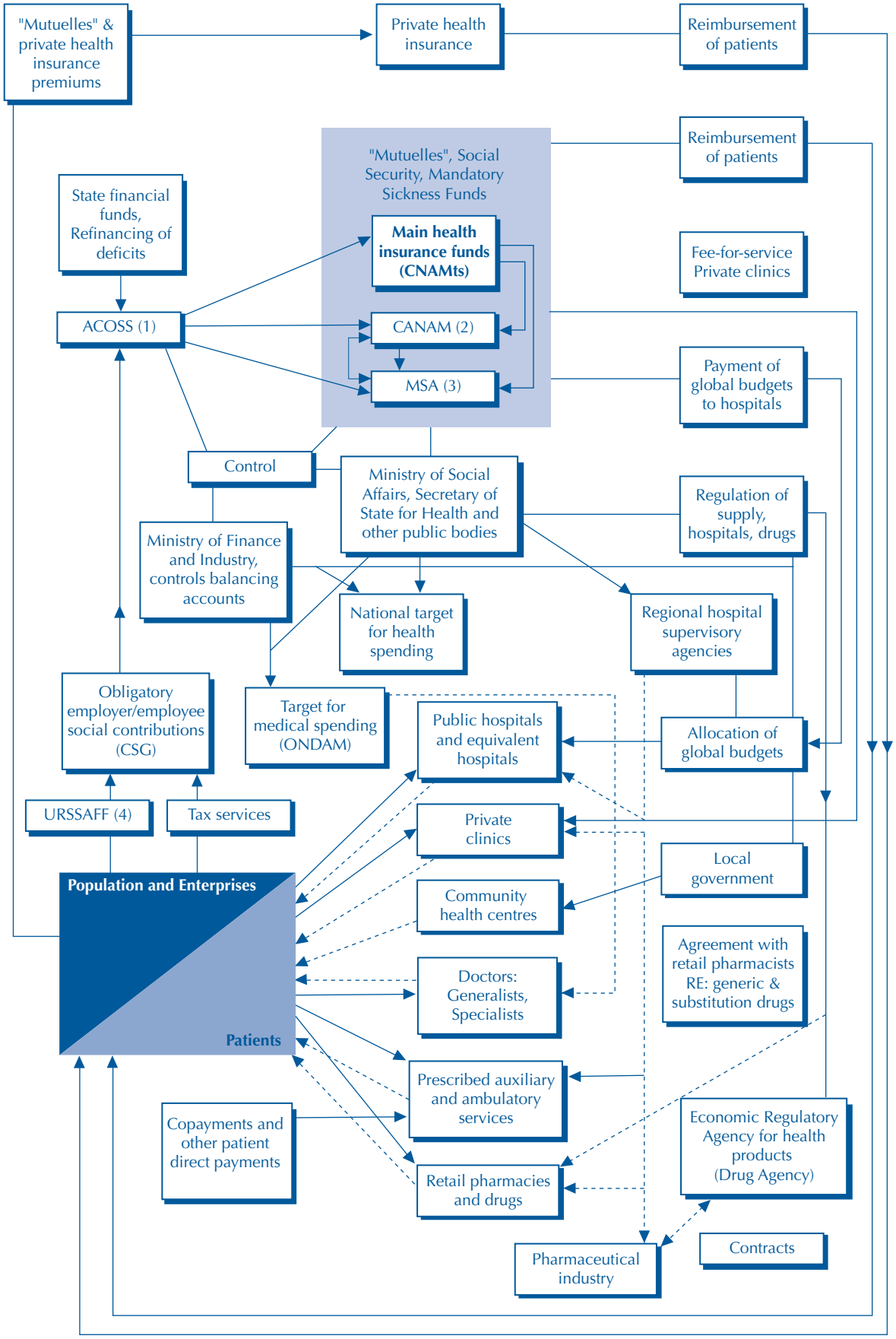
(2) CANAM = Health Insurance Fund for self-employed

(3) MSA = Health Insurance Fund for farmers

(4) URSSAFF = Body collecting social contributions

Source: OECD Secretariat

1.4 Financing of healthcare in France, 1999



Source: OECD Health Data 2002

Germany

1.22 92 per cent of the population is covered by statutory health insurance, and just under 8 per cent by private health insurance but 0.2 per cent is not covered at all. Ambulatory care and hospital care have traditionally been distinct domains with almost no out-patient care delivered in hospitals, **Figure 1.5**. Ambulatory care is delivered by private office-based physicians (generalists and specialists). Hospital in-patient care is provided by a mix of public and private providers, although only a small proportion of total beds is in for-profit hospitals.

Role of the Government

1.23 The Government regulates the sickness funds. However, it has increasingly tended to reduce its interventions in favour of a self-regulating system.

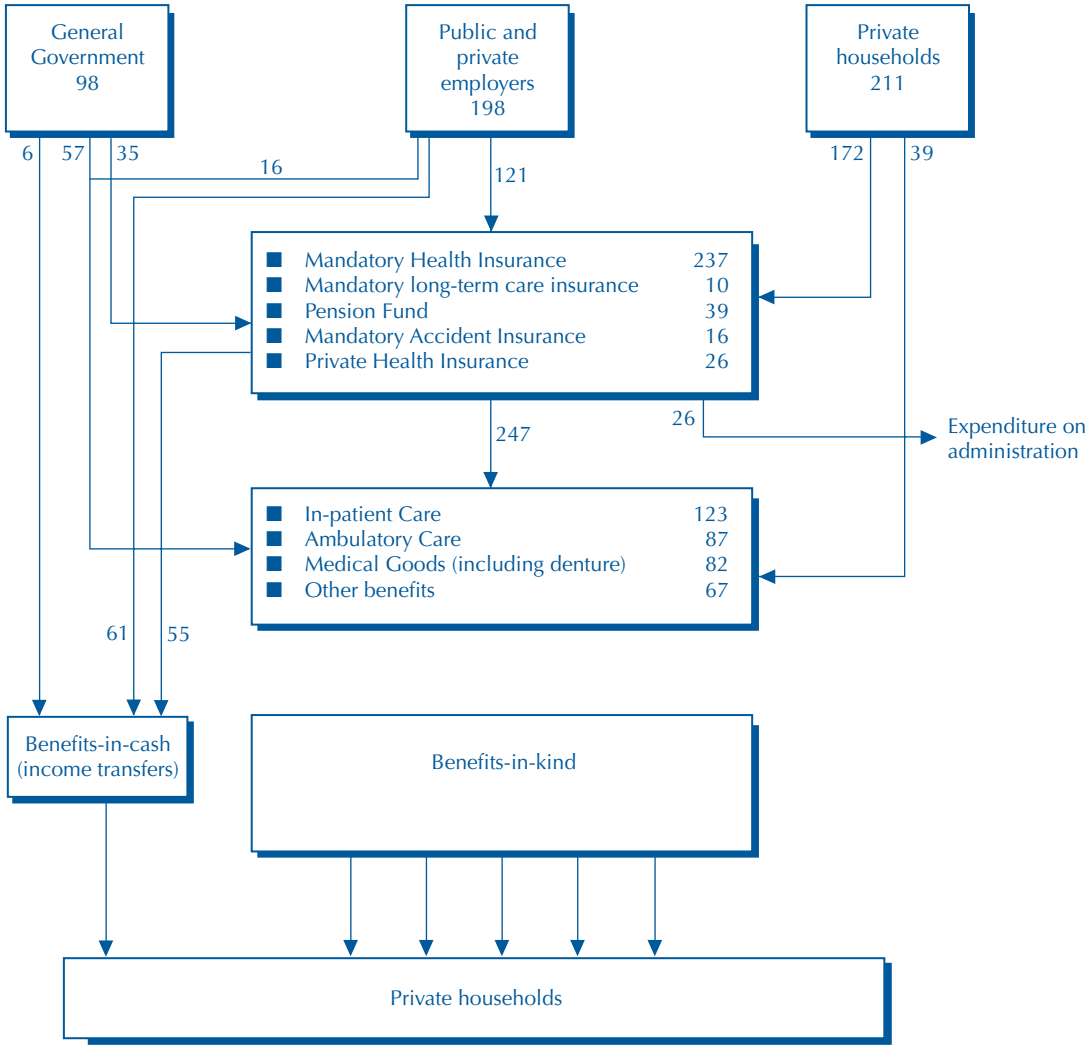
Primary care

1.24 All ambulatory care, including both primary care and out-patient secondary care has been organised almost exclusively on the basis of office-based physicians. Their premises, equipment and personnel are financed by the physicians' associations. Ambulatory physicians offer almost all specialties with all technical equipment up to MRI scanners. Besides GPs, the most frequented specialists are internists, gynaecologists and paediatricians. They are paid on a fee-for-service basis. All treat public and private patients. There is no formal gatekeeping system as patients are free to choose their doctor.

In-patient/secondary care

1.25 Except in emergency conditions, access to in-patient care requires a referral from an ambulatory physician. Hospitals are public and private (for-profit and not-for-profit). They are staffed with salaried junior doctors and fee-for-service senior doctors.

1.5 Financing of healthcare in Germany, 1995 (Values in Billion DM)



Source: Adapted from Federal Office of Statistics, 1998

NOTE

The benefits-in-cash which are not included in most of the diagrams are included here.

Source: OECD Health Data 2002

Italy

1.26 The main providers are local health units (consisting of health districts, hospitals and health promotion divisions), public hospital trusts and private accredited hospitals, **Figure 1.6**. Local health units are responsible for maintaining the balance between the funding provided by the regions and expenditure for service.

Role of the Government

1.27 Regional government, through regional health departments, is responsible for ensure the delivery of a benefit package through a network of local health units and public and private accredited hospitals.

Primary care

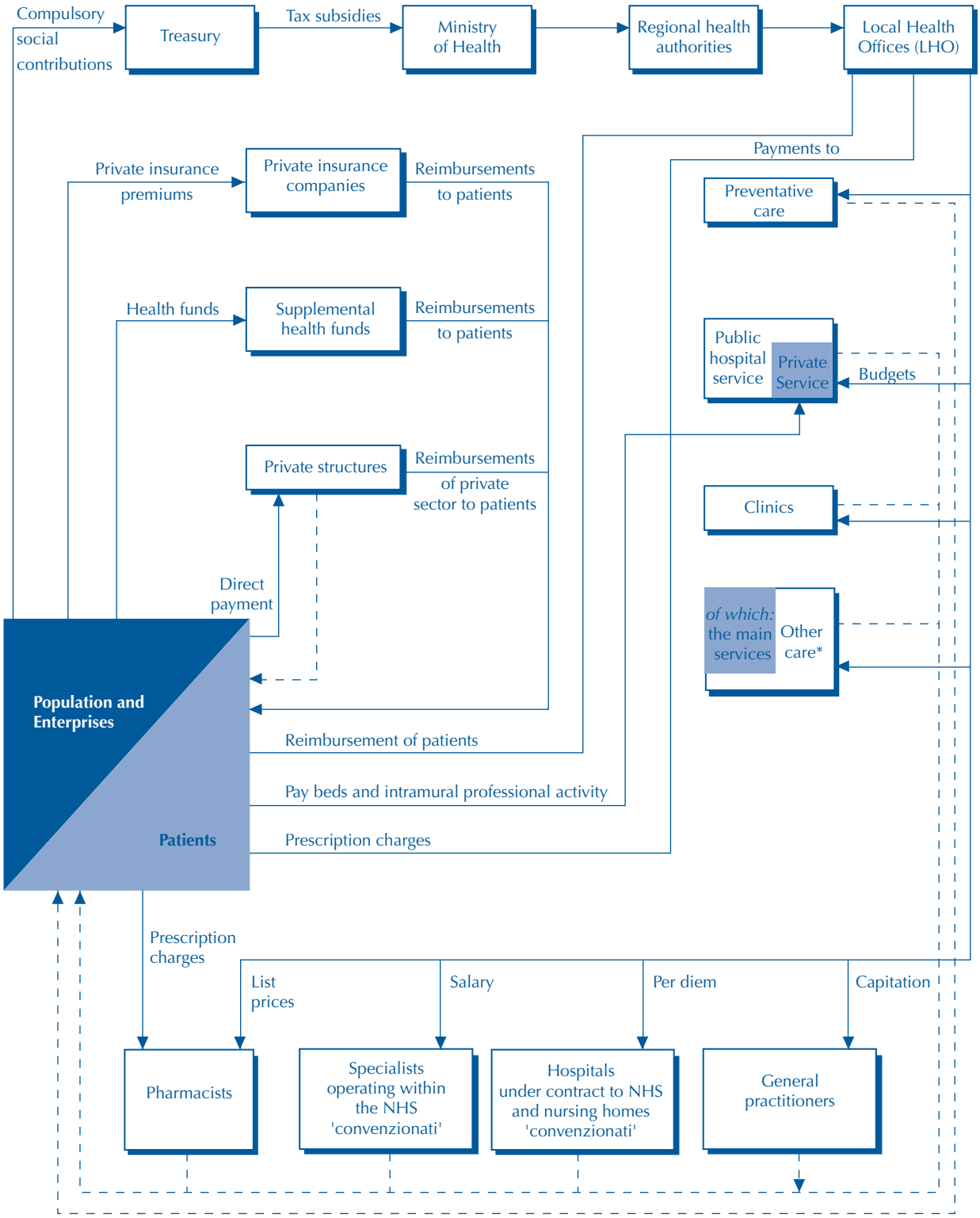
1.28 Primary care is provided by general practitioners, paediatricians and self-employed and independent physicians working alone under a Government contract who are paid a capitation fee based on the numbers on their list.

In-patient/secondary care

1.29 Access to secondary care is through a GP referral. Referred patients are free to choose their provider among those accredited by the health service. Specialised ambulatory services are provided either by local health units or by accredited public and private facilities with which local health units have agreements and contracts.

1.30 In-patient care is provided by hospitals. The major hospitals are given the status of independent trusts. The rest of the public hospitals are kept under the direct management of local health units. Hospital physicians delivering secondary care earn a monthly salary.

1.6 Financing of healthcare in Italy, early 1990s



Source: Salvini, R. (1991), Il sistema sanitario italiano, ISPE, not published and Hoffmeyer et al, Financing Health Care, Romel, NERA 1994.

NOTE

* Out-patient care, household advisory bureau, therapeutic appliances and thermal services, care for poor people, for Italians who live abroad and for foreigners who live in Italy.

Source: OECD Health Data 2002

Japan

1.31 Japan's healthcare system offers universal coverage and stresses preventative care. Provision is mainly private, with 80 per cent of Japan's hospitals and 94 per cent of its physician run clinics being privately owned, **Figure 1.7**. Investor-owned for-profit hospitals are prohibited. Patients are free to select care providers.

Role of the Government

1.32 The Japanese Government acts as regulator and insurer. It determines a fee schedule in consultation with providers and consumers. All doctors receive the same salary regardless of experience. It also subsidises health care spending for the elderly, small business employees, and the self-employed.

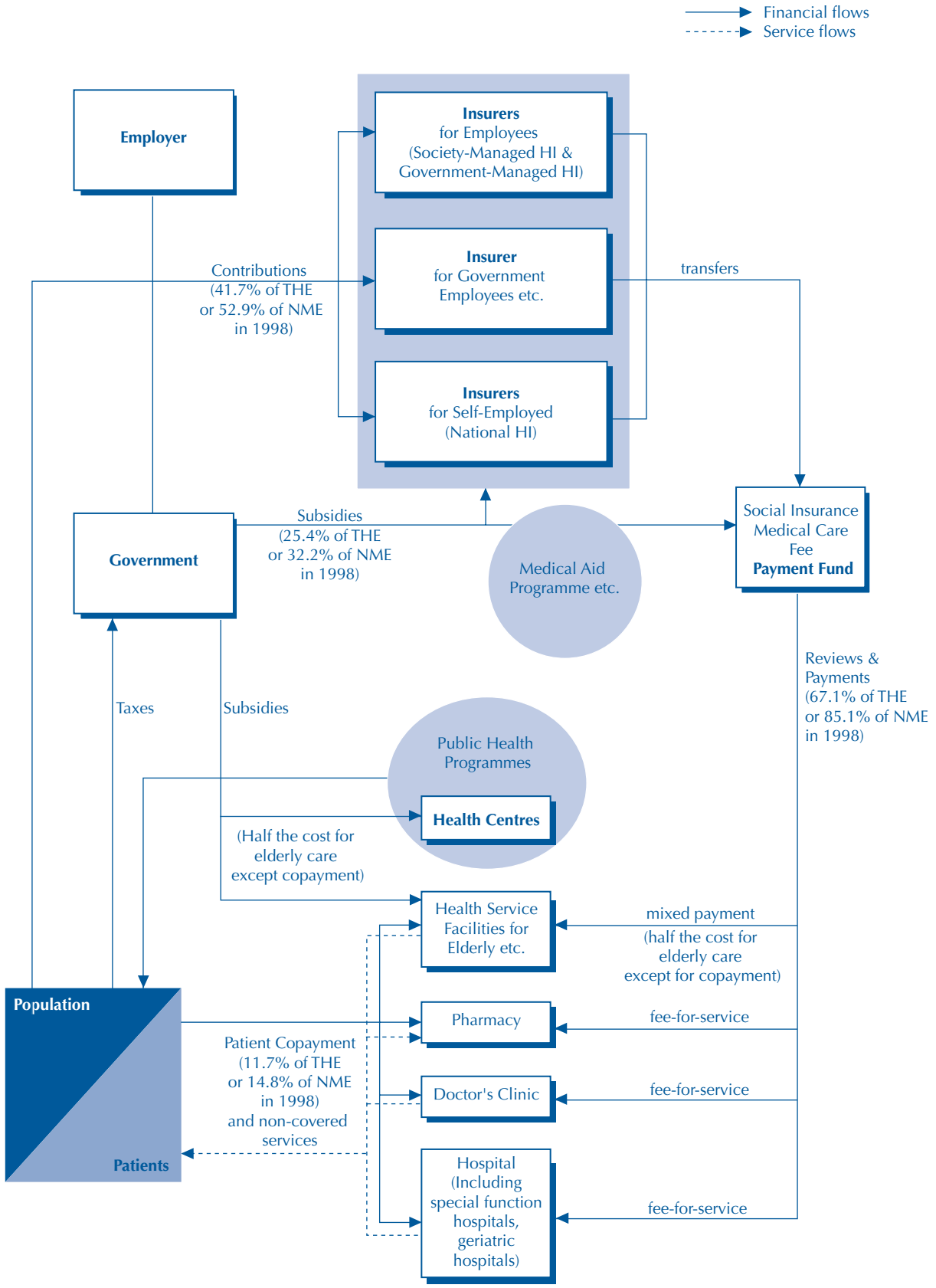
Primary care

1.33 Physicians have no formal gatekeeper function. Most are in private practice and are paid through a uniform fee schedule. Medical and pharmaceutical practices are often combined, and a large proportion of physicians' incomes is derived from prescriptions.

In-patient/secondary care

1.34 Hospitals are mainly private, although there are some public ones. Hospitals combine acute and long-term care functions and are paid according to a uniform fee schedule. Hospital based physicians are salaried.

1.7 Financing of healthcare in Japan, early 2000



Source: OECD Health Data 2002

New Zealand

1.35 New Zealand's healthcare system covers all residents. All essential services, including hospital and out-patient, are provided free through the public health system, with the exception of dentistry and ophthamology. Public hospitals account for just over half the total bed stock including the large tertiary sector. The costs of primary health care are met or subsidised for certain groups. About 40 per cent of the population hold concession cards (usually low-income patients, children and higher users of the services). Health services are delivered by a mix of public and private providers, **Figure 1.8**.

Role of the Government

1.36 New Zealand's Government is a purchaser and provider of healthcare and has responsibility for legislation and general policy matters.

Primary care

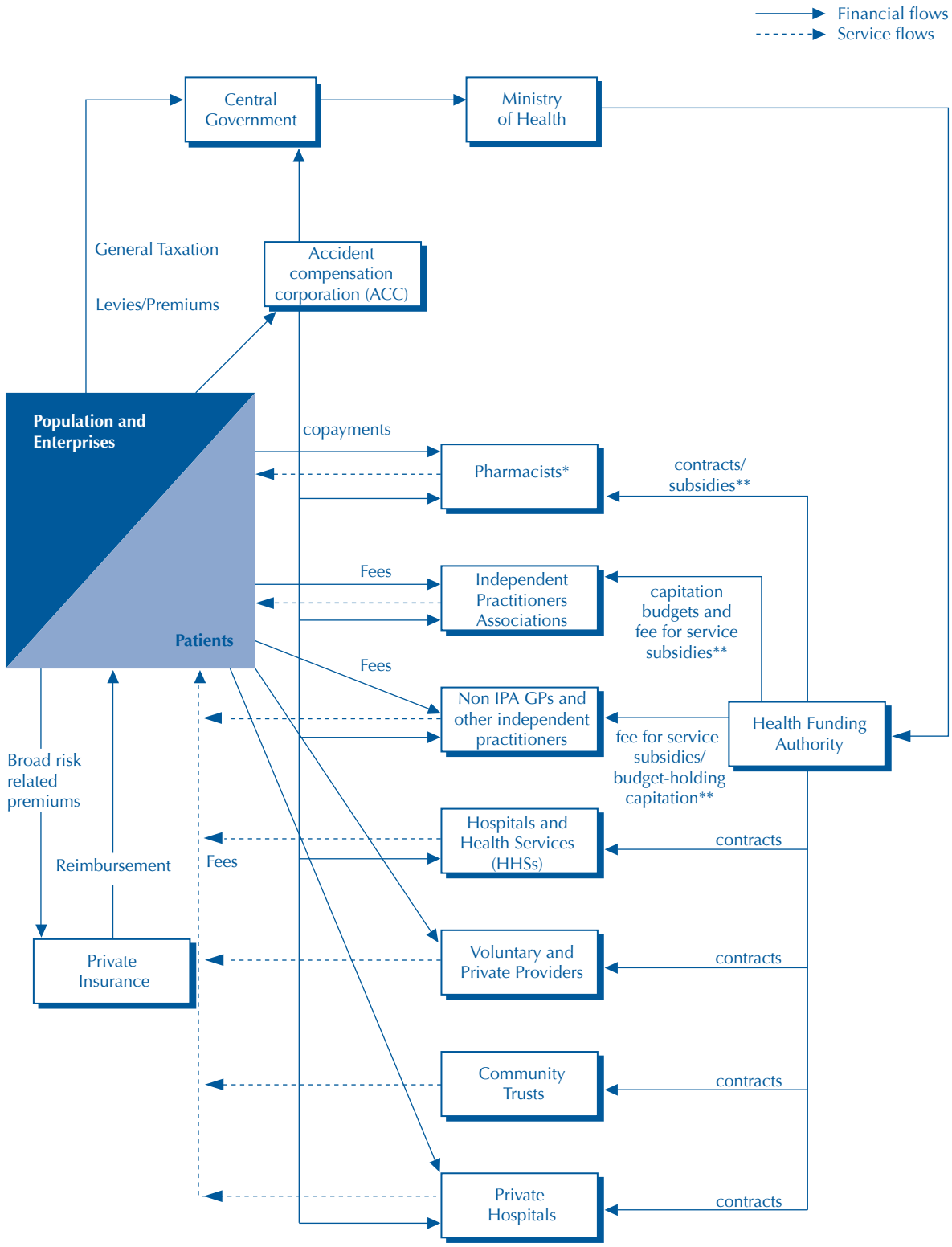
1.37 General practitioners act as gatekeepers and are predominately private practitioners with two-thirds working in group practices. Patients have a choice of GPs and are free to see more than one GP, although in practice continuity of care is high. They provide most primary medical services. They are self-employed and are paid through a combination of payment methods: fee-for-service, partial Government subsidy, and negotiated contracts with Health Funding Authority through Independent Practitioner Associations.

In-patient/secondary care

1.38 Patients access secondary care via a GP referral. Specialist physicians and surgeons provide ambulatory care in community-based public or private clinics or in hospital out-patient departments. Hospital out-patient departments play a larger role in the health system than in other countries since treatment is free while consultations with community based practitioners are charged.

1.39 Publicly owned hospitals provide most secondary and tertiary care, while the growing private sector specialises mainly in elective surgery and long-term care. Public hospitals are not permitted to treat private patients. Hospitals are semi-autonomous Government owned companies that contract with the Health Funding Authority. Consultants are salaried.

1.8 Financing of healthcare in New Zealand, 1998



* and other providers such as laboratories and radiology clinics
** relating to contracts with the Health Funding Authority

Source: OECD Health Data 2002

Sweden

1.40 Ambulatory care is provided by a mix of public doctors, private doctors and hospital out-patient departments. Hospitals are publicly owned but have independent status, with the extent of privatisation varying between counties, **Figure 1.9**.

Role of the Government

1.41 The county councils are responsible for the purchasing of health services and either act as purchasers themselves or devolve this responsibility to other purchasing agents.

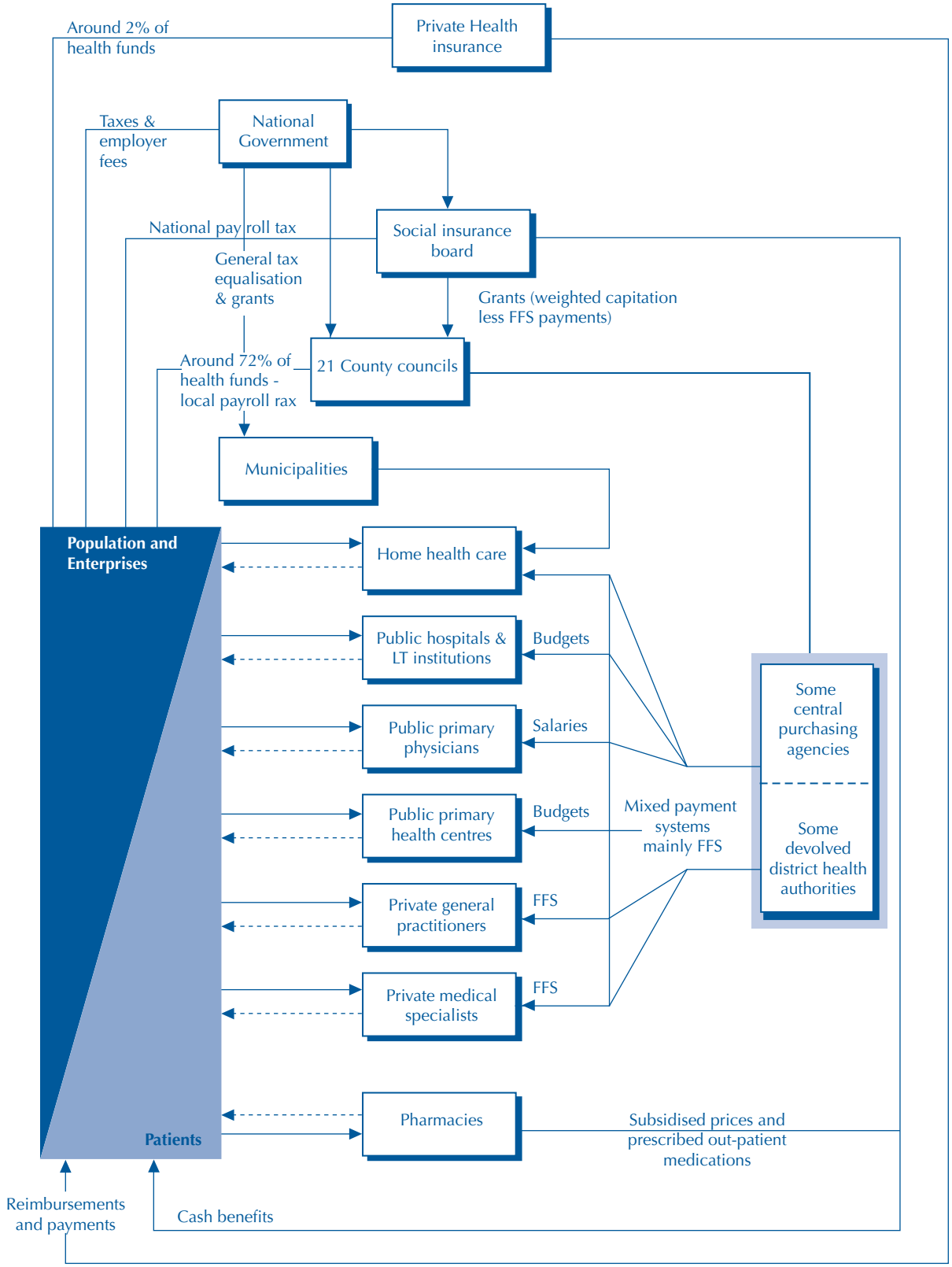
Primary care

1.42 Patients can choose between primary care centres or hospital out-patient departments as the first point of contact. Higher fees are applicable for out-patient visits compared to visits to primary care centres.

In-patient/secondary care

1.43 Patients can access secondary care directly through a hospital out-patient department. In many counties patients can also select which hospital to be treated at, and in some cases, without referral. Most hospitals are publicly owned.

1.9 Financing of healthcare in Sweden, 1999



Source: OECD Health Data 2002

United States

1.44 Health care services are mainly provided by private practitioners, **Figure 1.10**.

Role of the Government

1.45 The federal Government is the single largest health care insurer and purchaser. There are two principal schemes in which the Government is involved: Medicaid and Medicare. Medicaid is a jointly-funded, Federal-State health insurance programme for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Medicare is a health insurance programme for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). It currently covers some 39 million Americans.

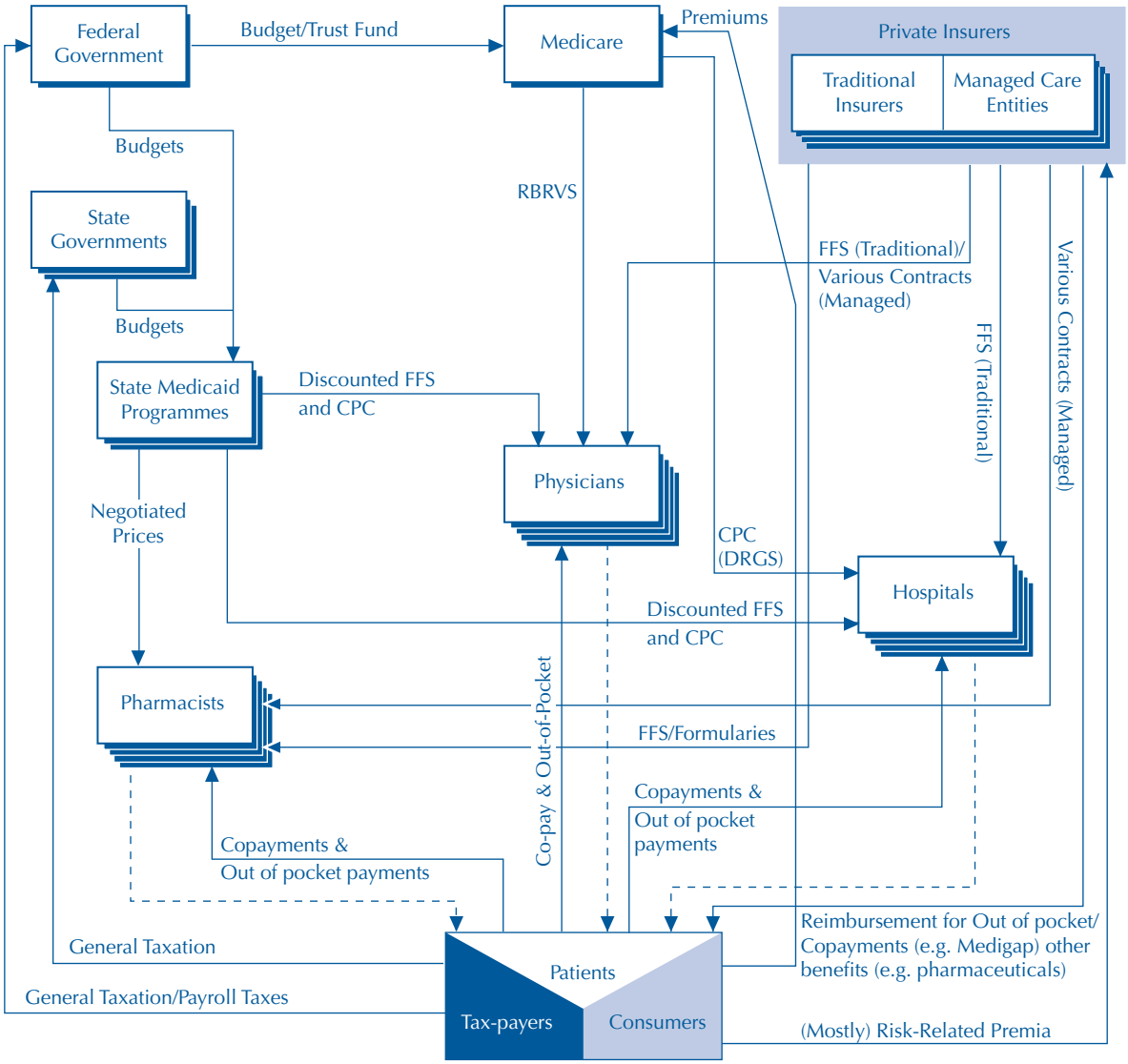
Primary care

1.46 General practitioners have no formal gatekeeper function, except within some managed care plans. The majority of physicians are in private practice and are paid through a combination of charges, discounted fees paid by private health plans, capitation rate contracts with private plans, public programmes, and direct patient fees.

In-patient/secondary care

1.47 In-patient care is provided in public and private hospitals (for-profit and not-for-profit). Hospitals are paid through a combination of charges, per admission, and capitation.

1.10 Financing of healthcare in the United States, early 1990s



Source: Financing Health Care, Volume II, Hoffmeyer et al., 1994

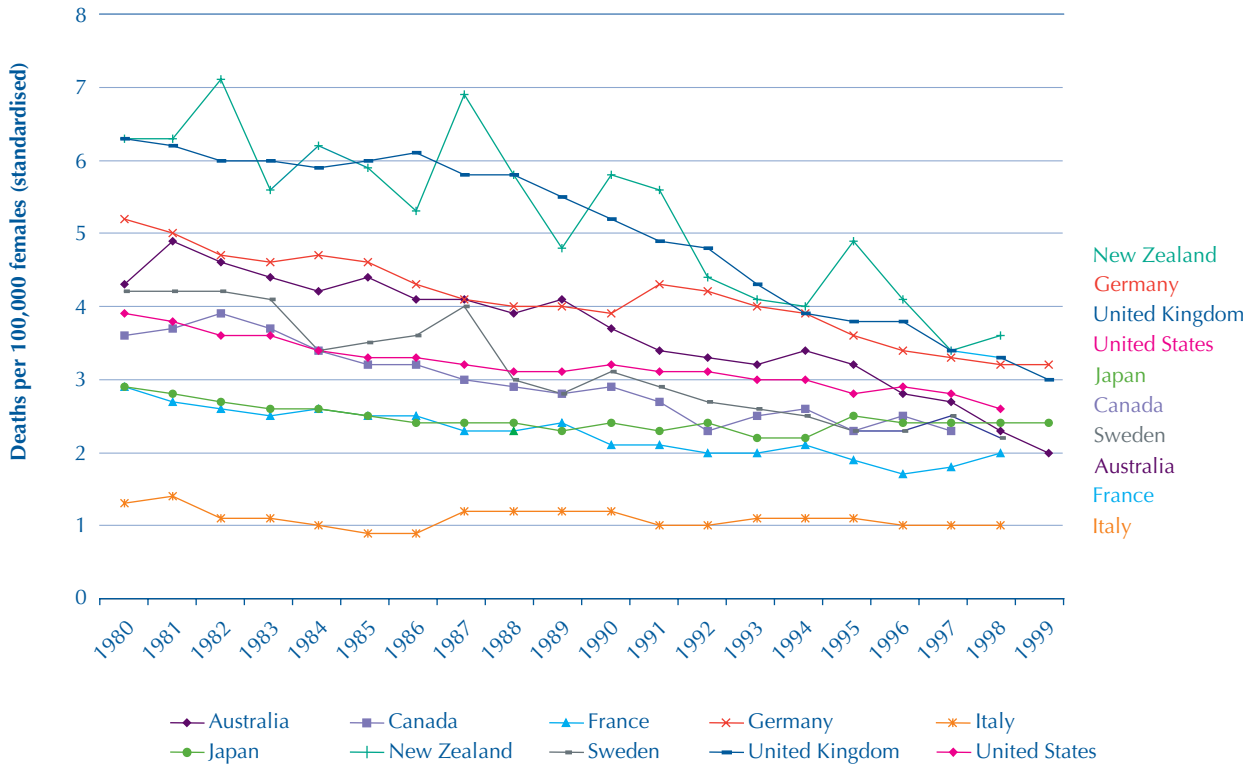
CPC: Cost-per-case
FFS: Fee-for-service
RBRVS: Resource-based relative value scale

Source: OECD Health Data 2002

Appendix 2

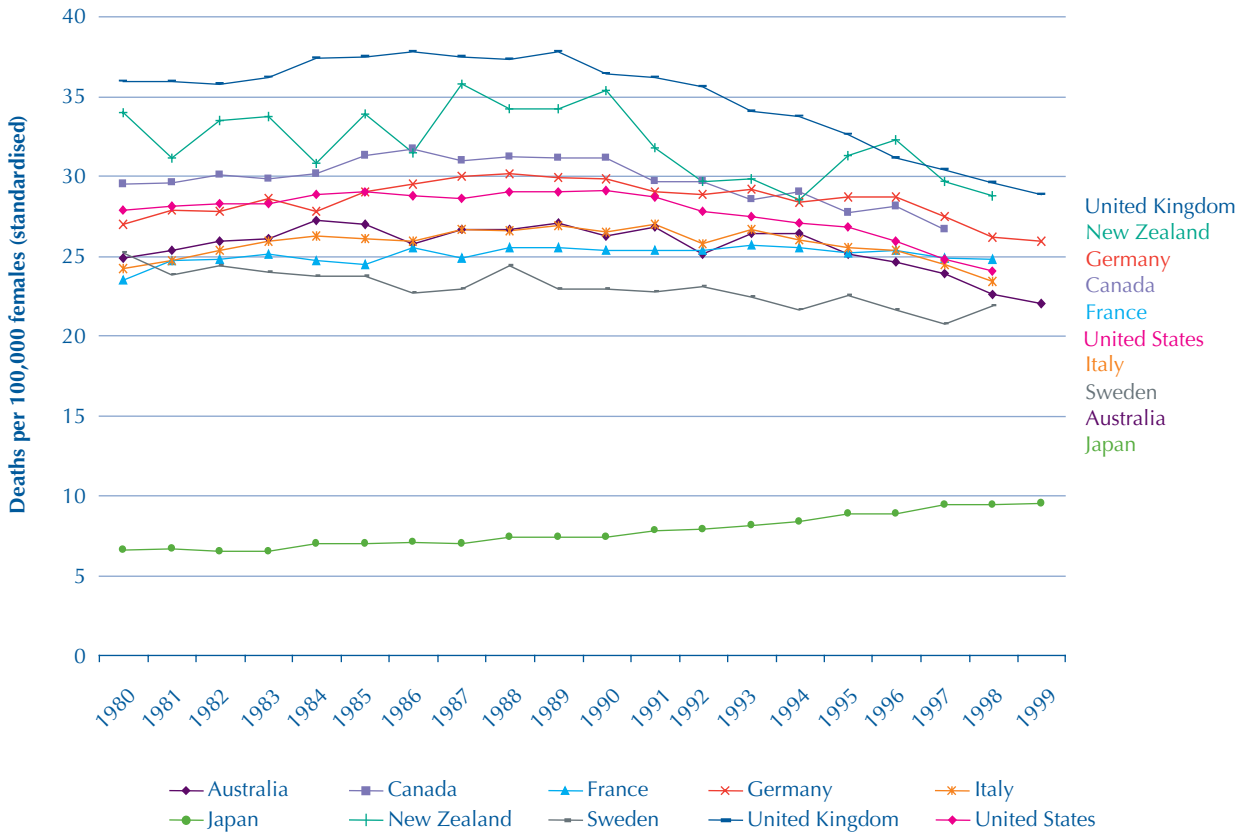
Death rates from the main cancers over time

2.1 Deaths from cervical cancer, 1980 to 1999



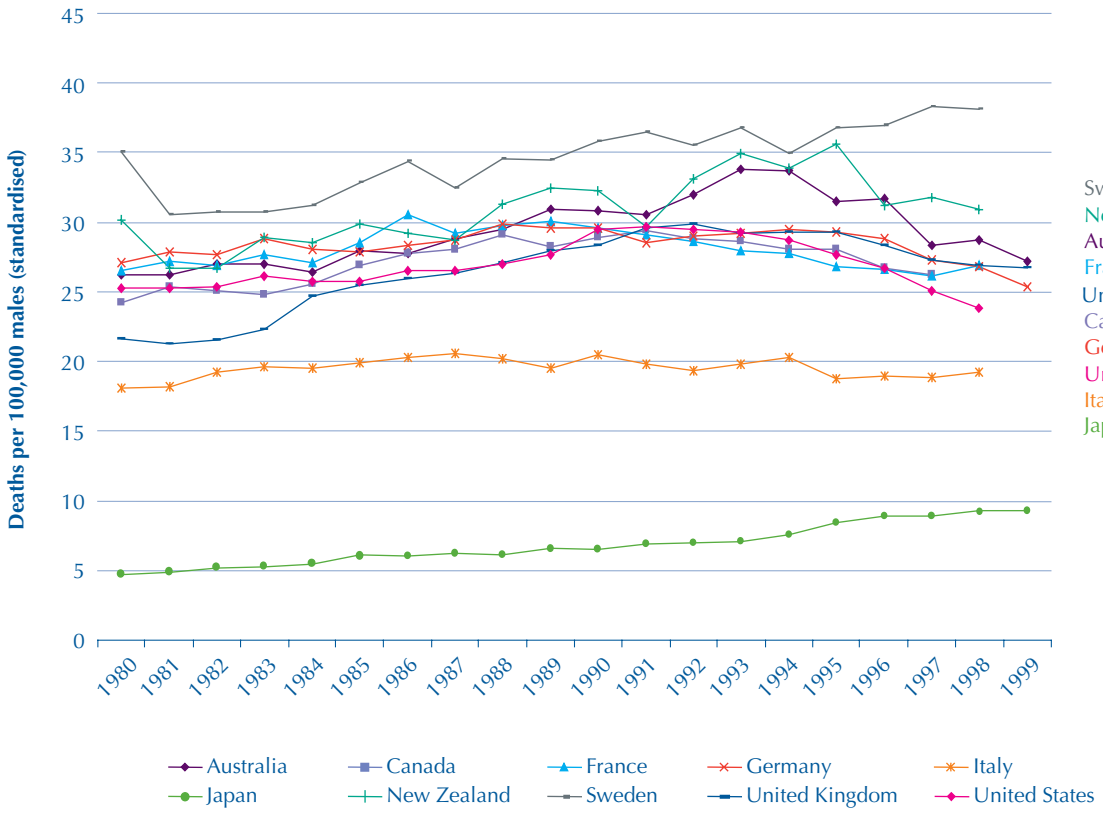
Source: OECD Health Data 2002

2.2 Deaths from breast cancer, 1980 to 1999



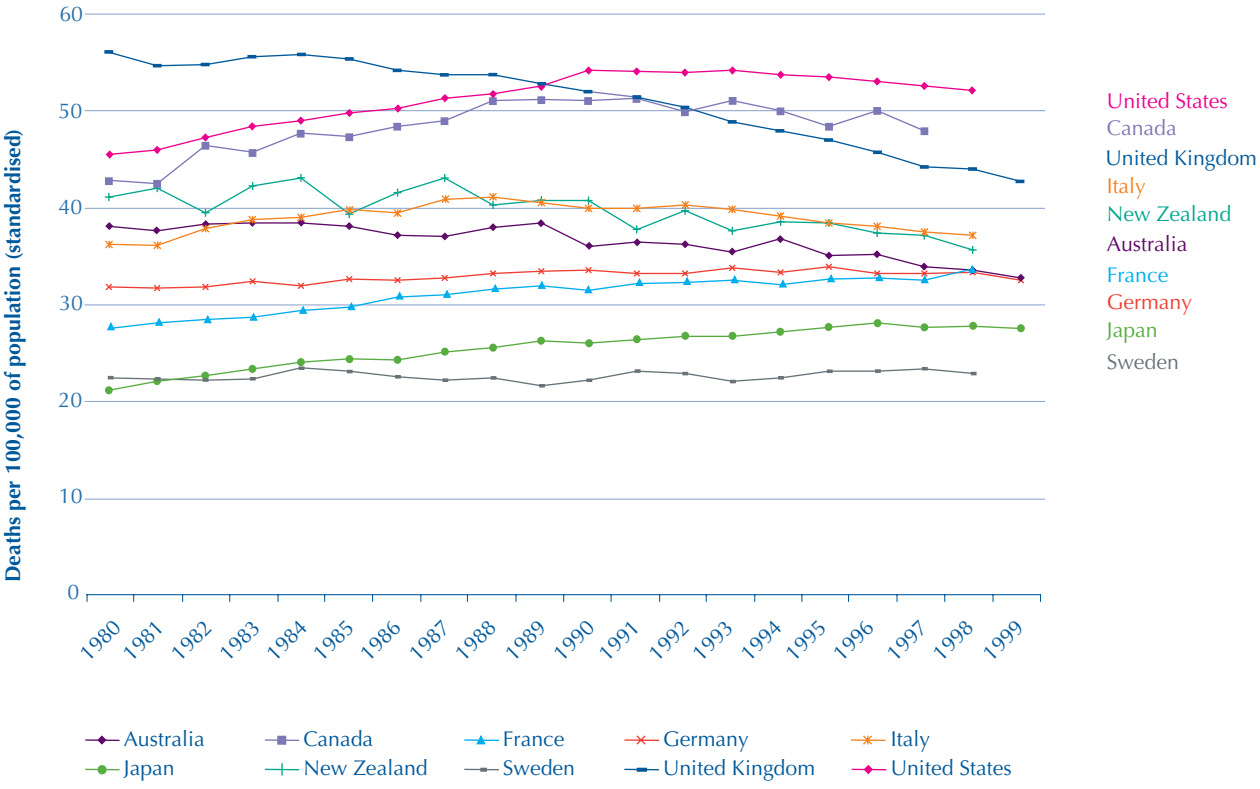
Source: OECD Heath Data 2002

2.3 Deaths from prostate cancer, 1980 to 1999



Source: OECD Health Data 2002

2.4 Deaths from lung cancer, 1980 to 1999



Source: OECD Health Data 2002