

OUTLOOK ON SOCIAL AND HEALTH POLICY PRIORITIES IN OECD COUNTRIES

Introduction

The opening of the Joint OECD-Korea Centre on Asian Social and Health Policies is a fantastic opportunity for countries to learn from each others' experiences. This goes to the core of the OECD's function in the world economy: it exists to help countries to learning from one another. Our day-to-day work consists of putting information about policies and outcomes into a form that enables the experience of different countries to be compared. The 30 OECD Member countries have a huge variety of policy approaches and outcomes, and that means that the comparisons that we can do are very rich and informative. They will be even better if we can also take into account the experience of other countries. That is why the opening of the Joint OECD-Korea Centre is so exciting -



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existing OECD members can learn from other Asian countries, and vice versa.

In practice, OECD work on social and health policy can be divided into three parts. First is data collection and standardisation. This takes up the majority of resources devoted to social and policies. Second is analysis of this data to identify key trends and policy developments. Third, this analysis forms the basis for exchanges of views by policymakers on the strategic direction which policy should take.

This paper is structured in the opposite way. First, it considers the 'strategic' direction of policies across the OECD in the area of health and social policy, as recently discussed in meetings of OECD Ministers. Then it moves on to look at some key policy challenges in the areas of health and social policies. Finally, it emphasises the importance of the data work upon which all objective discussions of social and health policies must be based.

Key messages

Health Policy

Ministers of Health Policy in the OECD met (for the first time) in 2004. They argued that OECD countries should be proud of the progress made in the past decades in improving the health performance of their countries. Accessibility of health services to the population has been increased enormously. Population health status has improved. Advances in medical capability and improvements in health care have been rapid. As a result, life expectancy of a child born now is 9 years longer than that of someone born 40 years ago.

Yet in some respects, performance of health systems has been

unsatisfactory. The quality of health care is not as good as it could be. Patients want more from their health-care systems, and they want the systems to be more responsive. Above all, health systems are facing major cost and financing challenges. Health care costs are growing faster than economies as a whole in many countries. Health care expenditure now accounts for over 9% of GDP, compared with 5% in 1970. This health-cost growth pressure will continue, with new treatments being developed and population ageing continuing, challenging the affordability and sustainability of health systems. There is evidence that there is great scope for improving efficiency by increasing productivity, reducing waste and enhancing cost-effectiveness. Yet achieving the necessary efficiency improvements has proven to be very difficult.

The conclusions drawn by Ministers are the essential starting point for ongoing work at the OECD. They set as their goal the objective of 'High-performing health systems'. Their main concerns about how to achieve this objective were:

- illness prevention and promotion of healthy lifestyles in the face of rising threats to health, such as obesity, tobacco, alcohol and drug abuse, mental disorders and traffic accidents
- reducing the lingering disparities in health and access to healthcare in OECD countries;
- securing the financial sustainability of their health care systems;
- where private health insurance plays a role in financing health care, it requires a well-designed regulatory framework to support its development;
- striving to achieve the gains in productivity that are required to contribute to financial sustainability and to improve quality of care;
- doing more to encourage industry to develop innovations which

meet health needs in an affordable way;

- ensuring that long-term care offers quality and choice, and is affordable;
- making sufficient investment in human resources and their professional development to meet the future demand for health care.

Social Policy

OECD Social Policy Ministers met on 31 March-1 April, 2005. The central theme of their deliberations was that social policies must be pro-active, stressing investment in people's capabilities and the realisation of their potential, not merely insuring against misfortune. Effective social policies are necessary to generate economic dynamism and contribute to flexible labour markets, by ensuring that childhood experiences promote full integration into the labour market and society; and by ensuring a sustainable system of support for the elderly.

In practice, they identified a number of areas of particular concern:

- Social and family policies must help give children and young people the best possible start to their lives and help them to develop and achieve through their childhood into adulthood. Providing all parents with better choices about how to balance work and family life extends opportunities, especially for women, and creates economic gains. More family-friendly policies could also help raise birth rates in those countries where they are too low.
- Attaining a better social balance between generations is, and will long remain, one of the most important challenges facing OECD countries. The social and financial sustainability of pension systems need to be improved.
- Family breakdown, the need to care for family members, illness, or

the loss of a job can all lead to long-term joblessness unless appropriate social supports are in place. Social policy can, lower poverty by reducing barriers to employment, supporting self-sufficiency, and by providing adequate benefits for those who cannot work. We should end the unjustified assumption that some groups such as lone parents, older workers, people with disabilities and people on social assistance for a long time cannot or should not work.

- These social policy challenges must be a shared responsibility. Common purpose is needed among all concerned (including employers, workers, their respective representative organisations, all levels of government, individuals, community, and a broad range of non-government organisations) in order to better align economic dynamism with social objectives. Individual beneficiaries of social programmes have responsibilities to contribute to their own development.

The importance of social and health policy

These issues identified by ministers are hugely important for the future of our societies and economies. The first reason why it is so important to get them right is that they account for such a large proportion of GDP - on average, 22 per cent of GDP across the OECD (though substantially less, of course, in Korea and in most other Asian economies). Given that so much of economic production is diverted to social causes, it is trivially the case that an inefficient social/health policy means an inefficient economy, in the same way as inefficiency in any equivalently large sector of the economy would hold back growth.

But the importance of social and health policies goes way beyond

this. We also need these policies to work well because otherwise people will not be as productive as they could be. And this has been a theme of our social and health policy work at the OECD - how to ensure that the problems that people inevitably face - sickness, being a parent, getting old - do not stop people from contributing to their own well-being and to society. Good social and health policies can help people cope with difficulties. Bad policies deal with symptoms, not causes, leaving problems to fester and deepen.

The rest of this paper deals in turn with some key policy challenges that are under debate at the OECD. No policy solutions are suggested - the work described is ongoing. The OECD looks forward to including more Asian country experience in its analysis of these problems and potential solutions.

Selected issues in OECD social policy

Family policies

Just a few years ago, family policies were given quite low importance by most OECD social policy ministries. This has changed dramatically: the number one social policy challenge in a majority of these countries is now: How can we best help families, so as to prevent child poverty, increase work by mothers, and support fertility rates?

It is increasingly hard to over-rate the importance of this topic. Child poverty rates are over 10% and have been edging up over time. Indeed, ending the pattern of many years, child poverty rates exceed those of the population as a whole. Of course, there is huge variation across countries: child poverty rates in the United States exceed 20%,

and they are just 2 or 3% in the Nordic countries (Forster and Mira d' Ercole, 2005). But everywhere that good quality studies have been undertaken, the consequences of child poverty are being emphasised. Child poverty is associated with poor learning in schools, and permanent subsequent damage to life chances.

One way to avoid child poverty is of course to spend lots of public money on benefits. This does work, to some extent, but the budgetary transfers required are high and not all countries are prepared to go down this route. Fortunately, there are alternatives. Putting in place more effective local services to help parents deal with problems in their parenting, to tackle truancy, and to improve child nutrition have proved effective in some countries. Even more strikingly, helping parents, and especially mothers, to earn, is an extremely effective means of avoiding child poverty.

This is a particularly promising policy avenue for governments to explore, because it helps address another area of great policy concern in a large number of OECD countries -- what is happening to fertility rates.

Many countries have had falls in fertility rates, with particularly rapid falls taking place in Japan and Korea, as well as southern Europe. Declines in fertility have been less rapid in the United States and northern Europe.

Low fertility rates are something to be worried about. Convincing evidence is available that suggests that family size is significantly lower than people would like. What is more, the size of the gap between desired and actual fertility has increased over time. The conclusion must be that something has changed which makes it more difficult to bring-up children in modern societies. From the point of view of society as a whole, there are also good reasons to think that population shrinkage - the inevitable corollary of fertility rates

significantly below the replacement level - will lead to lower growth rates, even when measure by GDP per capita.

OECD work suggests that fertility rates do respond to economic incentives and that means that policy changes can affect fertility rates. In particular, fertility rates are lowest in those countries where employment rates of women and mothers are lowest. Women want to work and to have children. If they cannot combine both, then the result is both low employment rates and low fertility rates. The key to boosting fertility rates in the future is to reduce barriers to maternal employment.

Retirement income policies

How can we get sustainable retirement income systems? Many countries got their pension policies badly wrong. They ended up with systems which were unsustainable for one of two reasons. Most commonly, it was because the pension promise was set at too high a level. The transfers between the working-age population and those of retirement age would have put an enormous brake on economic activity, and might have caused inter-generational discord. But in a minority of countries, the opposite problem has been encountered - transfers set at so low a level that pensioner poverty became a serious social problem. As the weight of older voters in elections has come to count more heavily, the response has been to raise minimum pensions towards a more socially-acceptable level.

These problems can be illustrated by considering the level of the pension promise in relation to previous earning. OECD (2005) shows that in Greece, Turkey and Luxembourg, people who worked for 40 years would get a pension worth more than their earnings. At the other extreme, people in Ireland and New Zealand would get just 40%

of their previous earnings in pension income.

A new consensus about pension policies has been emerging. Most countries appear to be moving towards a situation in which the mandatory pension guarantees an income of between 50 and 70% of previous earnings for someone around the average salary, with some private provision encouraged - or even mandated - on top of that.

Getting the level of the pension promise wrong was not the only way in which countries got their retirement income policies wrong: they also got the incentives wrong about the timing of retirement. In effect, policies were pushing people out of employment at an ever-earlier age.

In 1970, people in OECD countries worked until they were between 64 and 69 on average. They now retire between 5 and 7 years earlier. Over the same period, life expectancy at age 65 has gone up by about 8 years. Hence people are spending up to 15 more years in retirement on average than they were. Reversing this trend is not easy. It requires a change in the incentives embodied in the pension system, for sure, but this is insufficient. The whole issue of the role of elderly people in our society, as workers, carers or people needing care needs rethinking.

Selected issues in OECD health policy

How can efficiency of health care delivery, including both hospital and primary care, be improved?

As mentioned above, spending on health is high and is going increasing faster than spending on other items. Health expenditures take up an ever greater proportion of national wealth.

This is not surprising. As people become richer, they will value their health more and spend more on preserving it. Furthermore, medical technology, broadly defined, has been advancing. In principle, when there are technological advances in other industries, sometimes people are induced to spend more on them, reflecting the gains in utility they provide. We do not worry about increases in expenditure due to technological gains, or increases in income, in other areas of the economy, and to some extent the same should be true when we consider health expenditures.

However, in practice, we know that much health spending is wasted. The linkage between expenditure and outcome in the health care system is very poorly understood, but we know enough to know that the health care system is often inefficient, especially when there are links between different parts of the system - the flow from primary care to hospitals, for example.

It is tempting to think that a change to a more market-oriented approach to financing health care might reduce these inefficiencies. However, OECD work on one such alternative - private social health insurance - suggests that it is no magic bullet which will inexorably push efficiency improvements. Many of the agency problems which public-sector health-care financing has to address are encountered by private insurers, and the authorities will in any case wish to regulate the market in order to ensure access is widespread. Private health insurance premiums tend to be regressive in their impact. There is a role for private finance of health care - some sort of private provision exists in every country in the OECD - but it is naive to think that in itself it solves the financing problems which all countries face.

What are trends in disability among the elderly and what are the cost implications?

Women aged 65 today will live on average an additional 20 more years; men of the same age another 15 years. As health care advances, so life expectancy has grown, but some time is spent in disability. Health systems need reorienting in order to put more emphasis on ensuring that disability is limited and to help families cope with the problems of having to look after a disabled relative.

People need protection against the risk of incurring large expenses for long-term care. Different approaches can work, such as mandatory public insurance (Luxembourg, the Netherlands, Japan), a mix of public and mandatory private insurance (Germany); tax-funded care allowances (Austria) and tax-funded in-kind services (Sweden, Norway). The market for private long-term care insurance is small, but could increase with the right policy support.

A number of countries are experimenting with policies to provide consumers with more choice in long-term care services and to help patients get care at home, rather than in an institution. This can be done, for example, by providing funds to be spent on care, rather than payment for services, so allowing (for example) funds to be used to support family care-giving. The result is flexibility, and reduced feelings of dependency. Unfortunately, such consumer-directed spending policies are likely to be more expensive than traditional approaches.

The importance of data

Underlying all this work is our work on data collection and classification. By far the largest amount of resources which the OECD

Secretariat - and, for that matter, the member countries of the OECD - devote to OECD work relates to data. On the social policy side, collection of social expenditure statistics is our most important programme. This feeds in to our compendium of social statistics, published as *Society at a Glance*. Other important data collection exercises relate to the modelling of the tax and benefit system (*Benefits and Wages*), the modelling of national pension systems (*Pensions at a Glance*), and the development of policy-related databases of family and disability policies.

On the health side, the main activity has been OECD Health Data - the world-renowned collection of statistics on health expenditures, other health care inputs, and health outcomes. Much work has been undertaken creating a System of Health Accounts which is consistent with the system of national accounts and permits a more precise mapping of how inputs and outputs relate to one another. This is an extremely important development, promising more soundly-based and convincing policy analysis to be developed in the future.

The collection of data for economies in the Asian region on a basis which permits comparisons with the OECD member countries is an objective of OECD countries. It is to be expected that a major portion of the work of the Joint OECD-Korea Centre for Asian Social and Health Policies will be devoted to ensuring that such comparisons can take place.

요약

OECD 아시아 사회정책센터(이하 OECD RCSP)의 설립은 국가간 서로의 경험을 공유하고 정책적 함의를 얻을 수 있는 좋은 기회를 마련해 준다. 이것은 세계 경제에 있어 국가 간 경험의 공유를 촉진하는 OECD의 역할과도 일맥상통하는 부분이며 나아가 비회원국가의 경험을 추가함으로써 그 가치는 더욱 커질 것이다. 이러한 점에서 OECD RCSP의 설립은 매우 의미 있는 일이 될 것이다.

1. 주요쟁점

1) 보건정책

2004년 OECD 보건장관들은 지난 수 십 년간 보건분야의 발전에 관하여 긍지를 느끼며 의료 서비스에 대한 국민의 이용이 훨씬 용이해졌고 전반적인 국민 건강 수준이 향상된 것을 확인하였다. 아울러 국민의료비의 증가가 당연과제임도 확인하였다. 국민의료비의 증가는 새로운 치료법의 도입과 인구의 노령화, 의료제도의 수용성 및 지속성 위기를 고려할 때 이 추세는 앞으로도 지속될 전망이다.

장관급 회의에서는 '높은 성과를 산출하는 보건제도(High-performing health systems)'를 목표로 설정하고 이를 달성하기 위하여 8가지 사항에 주목하였다.

2) 사회정책

2005년 OECD 사회장관들은 사회정책이 단순한 사후적 보장이 아닌 보다 적극적인 사회정책으로서 개인의 능력에 대한 투자 및 잠재력의 실현이 되어야 한다는 것을 확인하였다. 특히 효과적인 사회정책은 유년의 경험이 성장 후 노동시장과 사회로 완전히 통합되도록 연계하고 노후에 대한 체계적이고 지속적인 지원을 통해 경제적 역동성과 노동시장의 유연성을 보장하는 것이어야 한다고 본다. 회의를 통해 사회정책과 가족정책, 세대 간 균형, 그리고 가정의 해체 등에 대해 관심사를 확인하였다.

3) 사회 및 보건 정책의 중요성

한국을 비롯한 아시아 국가들의 경우 사회 및 보건정책이 GDP에서 차지하는 비중이 상대적으로 낮지만 OECD 국가에서는 평균적으로 GDP의 22%에 해당한다. OECD국가의 경우 경제적 산출물의 상당 부분이 사회적 목적으로 이전되고 있는 상황을 고려한다면 경제적으로 비효율적인 분야에 많이 투자되는 것 같이 보인다.

그러나 이러한 정책이 제대로 시행되지 않으면 경제의 생산성이 보장될 수 없다. 질병, 출산, 노령화 등과 같은 불가피한 문제들로 인해 복지와 사회활동이 방해받지 않도록 하는 것은 OECD 보건 및 사회정책의 핵심적인 주제가 되어왔다. OECD는 이러한 문제와 잠재적인 해결책의 모색에 있어 보다 많은 아시아 국가들의 경험을 포함시키려고 한다.

2. OECD 사회정책의 주요 이슈들

1) 가족정책

현재 대부분 국가의 사회 정책의 쟁점은 유아빈곤을 방지하고 기혼여성의 근로 기회를 확대하며, 출산율을 유지하는 정책이다. 출산율 저하의 속도는 남부유럽뿐만 아니라 일본, 한국 등에서도 심각하며, 반면 미국과 북유럽의 경우는 이보다 느리게 진행되고 있다. 장기적으로 볼 때, 출산율을 끌어올리는 방법은 기혼여성에 대한 고용 장벽을 제거하는 것이다.

2) 퇴직연금정책

어떻게 퇴직 후 지속적으로 수입을 보장할 수 있는가? 대다수 국가의 연금정책의 문제점은 너무 높은 수준으로 연금 지급수준을 정한 것이다. 그러나 소수의 국가에서는 그 수준이 너무 낮아 연금수급자의 빈곤이 사회문제가 되기도 한다. OECD(2005) 연구결과에 따르면 40년 동안 근로하는 그리스, 터키, 룩셈부르크 등의 국가에서는 퇴직전 소득에 비해 더 높은 수준의 연금을 받는 것으로 드러난

반면, 아이슬란드, 뉴질랜드에서는 퇴직자 임금의 40% 정도를 받는다.

최근 연금정책에 관한 새로운 합의가 도출되고 있다. 대부분의 국가들이 법정 연금을 통해 퇴직전 소득의 50~70%의 소득을 보장하고 일부 민간연금 등을 통해 그 이상 되도록 하고 있다.

3. OECD 보건 정책의 주요 이슈들

주요 이슈로는 두 가지를 제시하고 있다. 첫째, 장기요양 및 일차의료를 포함한 의료 서비스의 효율성을 향상시킬 수 있는 방법은 무엇인가, 둘째, 최근 노인층의 장애와 관련된 현상과 이로 인한 비용은 무엇인가 이다.

4. 데이터의 중요성

위에서 살펴본 모든 활동은 우리가 수행하는 자료의 수집과 분류에 기초를 두고 있다. 지금까지 OECD 사무국과 회원국이 수행한 업무의 대부분은 데이터와 연관되어 있다. OECD 회원국과 비교 가능한 아시아 지역의 데이터 수집은 OECD 국가들이 추구하는 목적이 되어왔다. OECD RCSP의 주요 활동 역시 그러한 비교 가능한 데이터의 수집이 될 것으로 기대한다. 