

Health Spending And Outcomes: Trends In OECD Countries, 1960–1998

Do Americans get more from their health care system for the larger share of wealth they spend on health?

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150

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EACH YEAR THE Organization for Economic Cooperation and Development (OECD) releases data on health care systems in industrialized countries.¹ Each year governments, researchers, and others analyze the data from multiple perspectives and publish analyses comparing spending, access to care, and, where possible, outcomes.²

In this paper we present 1998 data on health care spending in twenty-three of the twenty-nine OECD member countries. For six countries (Hungary, Korea, Mexico, Poland, Portugal, and Turkey) 1998 data were unavailable. In addition, we make an initial attempt to compare the outcomes and responsiveness of health care systems. We attempt to go beyond the traditional health status measures of longevity, infant mortality, and others, to compare outcome measures that are more likely to be influenced by the medical care system.

After presenting a summary of the new data, we compare the distribution of health care spending across the twenty-three countries, focusing on the distribution between hospital, physician, and pharmaceutical spending. We analyze whether the twenty-

three countries allocate their health care resources differently. Second, we examine trends in health care spending from 1960 to 1998. Third, we analyze some of the factors that could be associated with higher spending levels: the volume and intensity of services. Finally, we evaluate some new evidence on the association between the level of health care spending and quality of care—specifically, certain health outcomes and the length of time that patients wait for certain services. The data suggest that additional U.S. health spending may indeed generate benefits that are not evident from comparisons of traditional health status measures.

Health Spending In 1998

U.S. per capita health spending was \$4,270 in 1998, compared with \$2,000 in the median of the twenty-three countries (Exhibit 1).³ The next-highest level of spending occurred in Switzerland (\$2,740). The United States spent 14 percent of its gross domestic product (GDP) on health care in 1998, compared with 8 percent in the median country. The only two other countries spending more than 10 percent of GDP on health care in 1998 were Ger-

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EXHIBIT 1**Health Care Spending in Twenty-Three Countries, Selected Years 1960–1998**

	Total health spending per capita ^a			Spending as percent of GDP		
	1960	1990	1998	1960	1990	1998
Australia	\$517	\$1,647	\$2,040	4.9%	8.2%	8.7%
Austria	352	1,503	2,000	4.3	7.2	8.3
Belgium	292	1,556	1,850	3.4	7.5	7.6
Canada	600	2,115	2,250	5.4	9.2	9.3
Czech Republic	– ^b	717	950	– ^b	5.4	7.2
Denmark	369	1,777	2,100	3.6	8.3	8.0
Finland	297	1,612	1,600	3.9	8.0	7.4
France	396	1,920	2,120	4.2	8.9	9.6
Germany	495	1,999	2,400	4.8	8.7	10.6
Greece	116	876	1,270	3.1	7.6	8.7
Iceland	275	1,714	2,190	3.3	7.9	8.3
Ireland	193	947	1,390	3.8	6.7	6.1
Italy	270	1,648	1,660	3.6	8.1	7.6
Japan	143	1,350	1,780	3.0	6.1	7.4
Luxembourg	– ^b	1,865	2,440	– ^b	6.6	7.0
Netherlands	369	1,654	2,030	3.8	8.3	8.6
New Zealand	495	1,169	1,440	4.3	7.0	8.0
Norway	253	1,703	2,090	2.9	7.8	7.5
Spain	77	1,017	1,240	1.5	6.9	7.5
Sweden	490	1,861	1,820	4.7	8.8	8.6
Switzerland	479	2,196	2,740	3.1	8.3	10.2
United Kingdom	407	1,191	1,450	3.9	6.0	6.9
United States	820	3,491	4,270	5.2	12.6	14.0
OECD median	369	1,648	2,000	3.8	7.9	8.0

SOURCE: OECD Health Data 99 (Paris: Organization for Economic Cooperation and Development, 1999) and subsequent updates.

NOTE: GDP is gross domestic product.

^a In 1998 U.S. dollars, adjusted by purchasing power parities (PPPs).

^b Not available.

many and Switzerland.

A comparison between GDP and health spending per capita, using economywide purchasing power parity (PPP) rates to convert GDP and health expenditures in national currency units to U.S. dollars, finds that more-affluent countries spend proportionally more on health care.⁴ It also finds that only a few countries deviate from the trend line. The United States is the most notable outlier, spending 56 percent more on health care per capita than its per capita GDP would predict.

■ **Distribution of spending.** Spending for inpatient services, physician services, and pharmaceuticals represented almost three-quarters (72.9 percent) of health spending in the median OECD country in 1997 (Exhibit

2). From 1990 to 1997 the distribution of spending has changed little in most countries. However, countries differ greatly in how resources are allocated.

Inpatient hospital services represent the largest proportion of health spending in nearly every country; most countries spent 40–46 percent on inpatient services (median country, 42.6 percent; United States, 41.5 percent). Between 1990 and 1997 changes in the share spent on inpatient services did not show any consistent pattern across the twenty-three countries. This suggests that the U.S. trend of moving many services out of the hospital setting has not been adopted universally. In the United States inpatient spending declined from 44.0 percent in 1990 to 41.5

EXHIBIT 2

Distribution Of Health Spending In Twenty-Three Countries, By Type Of Service, 1990–1997

	Percent of total health expenditures, 1997			Percent change, 1990–1997		
	Inpatient services ^a	Physician services ^b	Prescription drugs ^c	Inpatient services	Physician services	Prescription drugs
Australia	43.2%	19.2%	11.6%	-3.9%	1.7%	2.7%
Austria	20.9	15.2	15.1	-0.4	-3.1	1.9
Belgium	39.4	- ^d	18.4	6.6	- ^d	2.9
Canada	43.7	14.2	13.8	-5.0	-0.9	2.5
Czech Republic	35.6	- ^d	25.3	- ^d	- ^d	4.3
Denmark	67.6	7.7	8.7	6.8	0.7	2.0
Finland	41.2	- ^d	14.9	-3.0	- ^d	5.5
France	44.9	11.7	17.2	0.5	-0.5	0.5
Germany	35.0	16.4	12.3	0.2	-1.3	-2.0
Greece	41.1 ^a	18.0 ^a	14.1	12.7	5.6	-2.8
Iceland	55.0	15.2	16.0	0.1	0.7	0.3
Ireland	54.2	- ^d	17.9	- ^d	- ^d	6.2
Italy	49.4	21.0	19.4	4.1	1.4	1.1
Japan	28.5	34.4	20.8	-4.5	-1.7	-0.6
Luxembourg	32.9	12.8	25.9	6.5	-8.8	11.0
Netherlands	52.6	8.3	10.9	0.3	-1.3	1.3
New Zealand	45.1	11.1	14.3	- ^d	-2.6	-0.7
Norway	40.9	- ^d	15.2	-20.7	- ^d	8.0
Spain	45.0	- ^d	20.7	0.9	- ^d	2.9
Sweden	41.9 ^b	12.2 ^a	12.7	- ^d	-2.2	4.7
Switzerland	49.3	17.5	7.7	-0.2	0.0	-0.5
United Kingdom	42.0	15.5	16.7	-1.9	0.3	2.9
United States	41.5	19.9	10.0	-2.5	-1.0	1.4
OECD median	42.6	15.2	15.1	-1.6	0.0	1.3

SOURCE: OECD Health Data 99 (Paris: Organization for Economic Cooperation and Development, 1999) and subsequent updates.

^a Data for Australia, Austria, Germany, Japan, Luxembourg, New Zealand, Spain, Switzerland, and the United Kingdom are from 1996. The value for Greece is from 1994. The value for Sweden is from 1995 and includes public expenditures only. These figures typically do not vary greatly from year to year, as is also the case in Notes b and c.

^b Data for Australia, Austria, Denmark, Germany, Japan, Luxembourg, New Zealand, and the United Kingdom are from 1996. Data for Greece and Sweden are from 1994.

^c Data for Australia, Greece, Ireland, Japan, Luxembourg, and Norway are from 1996.

^d Not available.

percent in 1997.

In the median country, physician services were 15.2 percent of health care spending in 1997.⁵ The U.S. level was higher than that of most other countries (19.9 percent). Data suggest that the United States has approximately the same number of physicians but that the incomes of U.S. physicians are much higher.⁶ Between 1990 and 1997 the percentage spent on physicians was relatively stable in most countries; it declined slightly (from 20.9 to 19.9 percent) in the United States.

Drugs accounted for 15.1 percent of health care spending in the median country. There is a wide range among countries in the amount spent on drugs—from more than 25 percent in the Czech Republic and Luxembourg to

less than 10 percent in Denmark and Switzerland.⁷ Compared with most of the other countries, the United States spends relatively less on pharmaceuticals (10 percent). In most countries the percentage spent on drugs increased during the 1990s; it increased from 8.6 percent to 10 percent in the United States between 1990 and 1997.

Spending Trends, 1960–1998

Between 1960 and 1998 the average annual rates of increase in real health spending in the United States and the median were nearly identical (Exhibit 3).⁸ Somewhat surprising, however, is that real spending growth was slower in the United States than the median

EXHIBIT 3**Average Annual Real Growth In Per Capita Health Spending In Twenty-Three Countries, Selected Years 1960–1998**

	Percent average annual real growth	
	1960–1998	1990–1998
Australia	3.7%	2.7%
Austria	4.7	3.6
Belgium	5.0	2.2
Canada	3.5	0.8
Czech Republic	– ^a	3.6
Denmark	4.7	2.1
Finland	4.5	–0.1
France	4.5	1.2
Germany	4.2	2.3
Greece	6.5	4.8
Iceland	5.6	3.1
Ireland	5.3	4.9
Italy	4.9	0.1
Japan	6.9	3.5
Luxembourg	– ^a	3.4
Netherlands	4.6	2.6
New Zealand	2.8	2.6
Norway	5.7	2.6
Spain	7.6	2.5
Sweden	3.5	–0.3
Switzerland	4.7	2.8
United Kingdom	3.4	2.5
United States	4.4	2.6
OECD median	4.5	2.4

SOURCE: *OECD Health Data 99* (Paris: Organization for Economic Cooperation and Development, 1999) and subsequent updates.

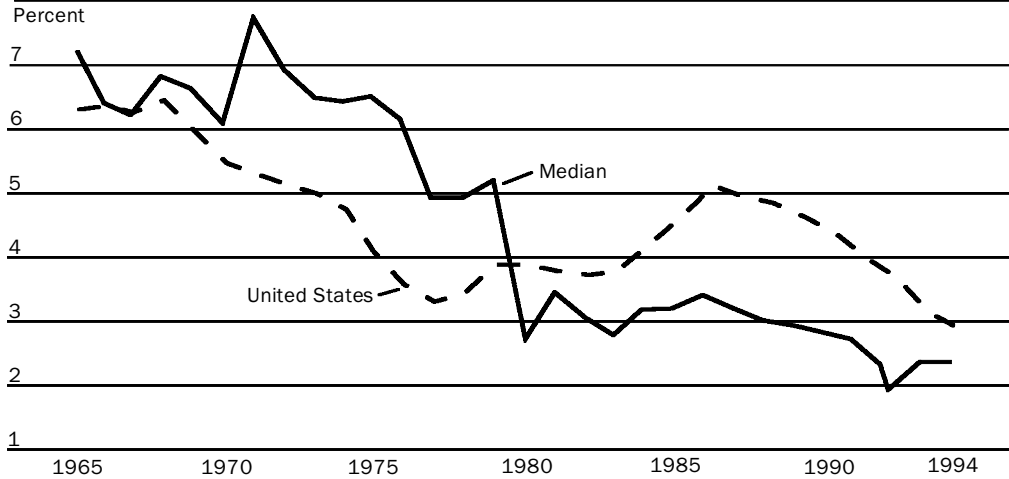
^a Not available.

from 1960 to 1980 and more rapid from 1980 to 1994. In each year since 1994, real health spending has grown more slowly in the United States than in the median OECD country.⁹

Exhibit 4 shows the annual rate of real health spending growth from 1965 to 1994 for the United States and the OECD median. Because of considerable year-to-year variation in health spending growth, we used a nine-year moving average. For example, the value for 1994 represents mean annual growth in health expenditures for 1989 to 1998. Real health spending growth shows a relatively consistent decline from 1960 to 1998 in both the median country and the United States. This suggests that all countries have been gradually slowing the rate of growth in real health spending over the past forty years, from an

average of 7 percent to 3 percent.¹⁰

The rate of increase in real health care spending as a percentage of GDP varied across the twenty-three countries. Between 1960 and 1990 it more than doubled in the median country (from 3.8 percent to 7.9 percent) (Exhibit 1). Every country showed large increases in the percentage of GDP spent on health. However, between 1990 and 1998 it remained relatively constant in the median country, increasing only from 7.9 percent to 8 percent. Between 1990 and 1998 the average annual rate of spending growth in the median country slowed down considerably (2.4 percent) (Exhibit 3). Real health spending actually decreased in Sweden and Finland during this period; it rose the most rapidly in Ireland and Greece (Exhibit 1).

EXHIBIT 4**Real Annual Growth In Total Health Spending Per Capita, United States And Twenty-Three-Country Median, 1965-1994**

SOURCE: OECD Health Data 99 (Paris: Organization for Economic Cooperation and Development, 1999) and subsequent updates.

NOTE: Nine-year moving average, based on 1998 U.S. dollars, adjusted by economywide purchasing power parities (PPPs).

Explaining The Higher U.S. Spending Levels

U.S. health spending per capita was more than double that of the median of the twenty-three OECD countries in 1998. Longitudinal data show that U.S. per capita spending has been well above the median for the past forty years—56 percent higher than the value predicted by GDP per capita in 1998. That raises the question: What accounts for the higher level of U.S. health spending? Here we examine some of the possible explanations.

■ **Volume and intensity of services.** The available evidence suggests that the volume of activity, measured by patient/physician contacts, is similar in the United States to activity in the average OECD country. For example, physician visits per capita were 6.0 in the United States in 1996, compared with an OECD average of 5.9. The reported percentage of the population with a hospital admission was only 12.2 in the United States, compared with an OECD average of 16.0. However, the U.S. figure excludes outpatient (day) surgery activity, which is likely to have been included as inpatient activity in some other countries.

However, there is ample evidence to suggest that the intensity of health care activities is unusually high in the United States. For example, in 1996 there were 3.9 full-time-equivalent (FTE) staff per U.S. hospital bed, compared with an OECD median of 2.0.¹¹ This partially explains why U.S. hospital spending per inpatient day was five times the OECD median in 1996. Also, there is evidence that the United States enjoys far higher capacity in high-technology facilities than is true of most other countries. For example, the United States had sixteen magnetic resonance imaging (MRI) units per million population, compared with an OECD median of 2.8 units per million in 1995. The United States had 26.9 computed tomography (CT) scanners per million population, compared with an OECD median of 11.6 units per million in 1993.¹² Also, the United States has tended to adopt new medical technologies more rapidly than other countries have, thereby incurring much of the incremental cost associated with medical innovation.

■ **Health outcomes.** The more important question, however, is whether the higher level of U.S. health spending yields better re-

sults—specifically, better health outcomes and greater responsiveness to patients. Earlier studies have shown that on conventional health status measures (such as life expectancy and infant mortality), the United States is generally in the bottom half of the OECD countries, and its relative ranking has been decreasing over time.¹³ On at least one indicator the United States does better. For example, a study that has examined life expectancy at age eighty showed that the United States ranks higher than Sweden, France, the United Kingdom, and Japan.¹⁴ However, these indicators depend upon many factors in addition to medical care, such as education, income, and lifestyle. Measures are needed that are more closely linked to medical care interventions.

Some outcome measures are now becoming available on country-specific survival rates following the onset of severe acute illnesses. Studies have suggested that both the United States and Canada have seen declines in mortality following heart attack. However, the United States has adopted high-technology procedures for heart attack patients at a faster rate than Canada has. Current discussion is focused on whether there are significant differences in outcomes—as measured by thirty-day mortality and one-year mortality following heart attack—across these countries, despite the more intensive use of resources in the United States.¹⁵

Preliminary data on five-year relative cancer survival rates have been published for several OECD countries. One such analysis, not shown here, arrays five-year relative survival rates following a diagnosis of breast cancer against total health spending per capita for sixteen OECD countries, including the thirteen European countries participating in the EURO CARE study.¹⁶ Analysis of these data suggests that there could be a positive relationship between health spending per capita and breast cancer survival.¹⁷ The United States appears to have the highest survival rate; however, it is only marginally ahead of Japan, Australia, and Sweden, which spend much less on health care.

International comparisons should be inter-

preted cautiously because of definitional and methodological differences in the data across countries. Differences across countries in the time at which breast cancer is diagnosed could affect these estimated survival rates. Also, variations in other factors such as screening and treatment patterns may explain some of the variation.¹⁸ Data on spending related to breast cancer treatment were not available, so total health spending was used as a proxy.

■ **Waiting times.** International data on health care systems' responsiveness to patients are also relatively scarce. One way of measuring this is to ask patients about their satisfaction with aspects of the health care process, such as waiting times.¹⁹ On the whole, such surveys tend to reveal high levels of satisfaction with recent care, so they are not very discriminating. Also, expectations may vary across countries. An alternative is to seek data on actual experiences rather than on satisfaction. For example, how long do patients spend with the primary care doctor? How long do they wait to see a specialist after a referral or for nonemergency surgery? A certain amount of comparative information on such patient experiences exists across a selection of OECD countries, some collected from patients and some from providers. Unfortunately, such data have been collected for only a few countries.

Several studies comparing waiting times for coronary artery bypass graft (CABG) surgery have been published.²⁰ These differ in their methodologies, but all contain data reported by physicians from one or more cardiac surgery facilities in each country. Analyses comparing waiting times with total health spending per capita for eight OECD countries found a statistically significant inverse association between per capita health spending and waiting times.²¹ The United States, with the highest per capita spending, had the shortest estimated waiting time.

Data obtained from consumers on waiting times for nonemergency surgery can be taken from the five-nation survey reported in *Health Affairs* by Karen Donelan and colleagues last year.²² Here a consistent methodology has

been employed across the five countries. Respondents answered a question on waiting times for nonemergency surgery for themselves or a family member. Average waiting times for each of the five countries were constructed from the interval data reported in the paper; a plot of waiting times and per capita health spending suggests an inverse relationship.²³

FOR MANY YEARS it has been well known that health spending per capita is higher in the United States than in other OECD countries. Very little evidence was available until recently to show any impact of greater U.S. health care spending on health status, consumer experience, or well-being in this country. Some preliminary international data on outcomes and quality are now available and have been presented here. So far, the results suggest, however tentatively, that Americans may, on average, enjoy better results from their health care system than do residents of other countries whose health spending per capita is lower. Given the scantiness and frailty of the data concerned, these findings should be treated less as conclusions than as raising questions for future researchers to pursue.

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NOTES

1. Organization for Economic Cooperation and Development, *OECD Health Data 99: A Comparative Analysis of Twenty-nine Countries* (Paris: OECD, 1999). This report can be obtained from the OECD Information Center, Suite 605, 2001 L Street, N.W., Washington, DC 20036-4922, tel.: 202-785-6323; fax: 202-785-0350; e-mail: washcont@oecd.org. Some of the data presented here are updated from the initial release, which is available on CD-ROM (see www.oecd.org/els/health/software99.htm). Some of the expenditure figures for 1997 are estimates. All expenditure figures for 1998 are projections of the OECD Secretariat.
2. G.F. Anderson and J.P. Poullier, "Health Spending, Access, and Outcomes: Trends in Industrial-

ized Countries," *Health Affairs* (May/June 1999): 178-187; and G.F. Anderson, "In Search of Value: An International Comparison of Cost, Access, and Outcomes," *Health Affairs* (Nov/Dec 1997): 163-171.

3. All spending data were adjusted for cost-of-living differences to U.S. dollars using purchasing power parities (PPPs). PPPs are based on the cost of an identical basket of goods in each country (broad-based, not limited to health). Countries included in the calculation of the median were Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Spain, Sweden, Switzerland, the United Kingdom, and the United States.
4. See, for example, R.E. Leu, "The Public-Private Mix and International Health Care Costs," in *Public and Private Health Services*, ed. A.J. Culyer and B. Jonsson (Oxford: Basil Blackwell, 1986), 41-62; and P. Barros, "The Black Box of Health Care Expenditure Growth Determinants," *Health Economics* 7, no. 6 (1998): 533-544.
5. In some countries it is difficult to disentangle hospital and physician expenditures because physicians are paid by the hospital. No data on spending for physician services are available for Belgium, the Czech Republic, Finland, Ireland, Norway, and Spain. The calculation of the median does not include these countries.
6. Anderson and Poullier, "Health Spending."
7. Data from Luxembourg should be viewed cautiously, because the country is much smaller than most of the others in the comparison and because there is considerable cross-border provision of medical care, which is difficult to trace.
8. Time-series data on health expenditures presented in Exhibit 1 differ from the values presented in past papers in this series because they have been adjusted for inflation to 1998 dollars using the Consumer Price Index. Also, some countries have updated their information.
9. From 1994 to 1995 real health expenditures grew 2.4 percent in the OECD median and 1.0 percent in the United States; from 1995 to 1996, 1.4 percent in the median and 1.0 percent in the United States; from 1996 to 1997, 5.0 percent in the median and 1.9 percent in the United States; and from 1997 to 1998, 3.4 percent in the median and 2.7 percent in the United States.
10. Health spending per capita is associated with GDP per capita, so differences in the growth of GDP per capita between the United States and the median could explain some of the differences in growth of health spending per capita. Real growth in GDP per capita was 1.8 percent per year in the United States between 1965 and 1980, compared with 0.9 percent per year in the me-

dian. It was 1.4 percent per year between 1980 and 1994 in the United States, compared with 0.8 percent in the median. Since the difference was roughly the same between 1965 and 1980 as between 1980 and 1994, that suggests that this is not the reason for the differences in growth of health spending in these periods. Real growth in GDP per capita was calculated using data from the OECD database on GDP per capita adjusted for inflation to 1995 currency units by the GDP price deflator, then adjusted by economywide PPPs.

11. Anderson and Poullier, "Health Spending."
12. Ibid. Japan has more MRIs and CT scanners per capita than the United States has.
13. Ibid.
14. K.G. Manton and J.W. Vaupel, "Survival after the Age of 80 in the United States, Sweden, France, England, and Japan," *New England Journal of Medicine* (2 November 1995): 1232-1235.
15. M. McClellan and D. Kessler, eds., *A Global Analysis of Technological Change in Health Care: Heart Attacks* (Ann Arbor, Mich.: University of Michigan Press, forthcoming); and J. Tu et al., "Use of Cardiac Procedures and Outcomes in Elderly Patients with Myocardial Infarction in the United States and Canada," *New England Journal of Medicine* (22 May 1997): 1500-1505.
16. See M.J. Quinn et al., "Variations in Survival from Breast Cancer in Europe by Age and Country, 1978-1989," *European Journal of Cancer* 34, no. 14 (1998): 2204-2211; R. Supramaniam et al., *Survival from Cancer in New South Wales in 1980 to 1995* (Sydney: NSW Cancer Council, 1998); *SEER Cancer Statistics Review 1973-1996*, National Cancer Institute, online at www-seer.ims.nci.nih.gov; and H. Tsukuma et al., "Statistics on Survival from Osaka Cancer Registry," *Japanese Journal of Cancer Research* 89, no. 10 (1998). For health expenditure per capita, 1989 figures from *OECD Health Data* are used for all countries except Poland, where 1990 data are shown. For the United Kingdom, health expenditure data are for the United Kingdom, whereas survival data are for England only.
17. A significant linear regression line can be fitted to these data. However, difficulties exist in interpreting them on an international level. First, collection of survival data in cancer registries differs. The EURO-CARE study has presented comparable data on survival rates for European countries. However, caution should be used when comparing the United States, Australia (New South Wales), and Japan among each other and with European countries. Second, different time periods are presented for each country. EURO-CARE data represent female breast cancer cases diagnosed between 1985 and 1989. U.S. data come from the SEER registry and represent female cases diagnosed between 1986 and 1991. Japanese data come from the Osaka Cancer Registry representing female cases diagnosed between 1987 and 1989. Australian data come from New South Wales and represent female cases diagnosed between 1988 and 1995. Because survival rates have been increasing over time, rates from earlier time periods may be less than they would have been in more recent periods. Third, variations in screening levels may affect the date of diagnosis as well as survival.
18. The OECD project on Ageing-Related Diseases will collect cross-national data on treatment, costs, and outcomes as well as qualitative data on economic incentives and institutional characteristics, to investigate the causes and consequences of variations in treatments for a selection of diseases affecting the elderly across OECD countries. This project has been initiated and funded by the National Institute on Aging (IAG YI-AG-8363-01) and is being developed in close collaboration with the National Bureau of Economic Research (NBER).
19. K. Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* (May/June 1999): 206-216.
20. See, for example, R.J. Carrol et al., "International Comparison of Waiting Times for Selected Cardiovascular Procedures," *Journal of the American College of Cardiology* 25, no. 3 (1995): 557-563; S. Silber et al., "Mortality and the Length of Stay on the Waiting List for Coronary Artery Bypass Surgery: The Munich Experience," *Herz* 21, no. 6 (1996): 389-396 (in German); S.J. Bernstein et al., "Waiting for Coronary Revascularization: A Comparison between New York State, the Netherlands, and Sweden," *Health Policy* 42, no. 1 (1997): 15-27; and M.A. Fitzpatrick, "Audit of Prioritisation for Coronary Revascularisation Procedures: Implications for Rationing," *New Zealand Medical Journal* 105, no. 932 (1992): 145-147.
21. Although the data show a significant inverse relationship between waiting time for CABG surgery and health spending per capita, they were not strong enough to determine the functional form of the relationship. A linear trend line with an equation of $y = -0.0099x + 26.9$ was fitted with an R^2 of 0.71. A curvilinear trend line with an equation of $y = 68.1e^{-0.0013x}$ was fitted with an R^2 of 0.88.
22. Donelan et al., "The Cost of Health System Change."
23. The regression equation used was $\text{Waiting Time (months)} = 2.28 - .0004 \text{ Total Health Expenditure (adjusted by economywide PPPs)}$. The slope coefficient was significant at the 95 percent level, and the R^2 was 0.72.