Executive Summary

OECD countries have made tremendous strides in improving population health over recent decades. Life expectancy at birth has increased, rising on average by ten years between 1960 and 2008. Today, a woman aged 65 can expect to live another 20 years, and a man an additional 17 years. And although socio-economic inequalities in health status and access to care remain, reductions in child mortality and gains in population health have continued to improve at a steady pace. These achievements can in part be attributed to increased incomes and higher levels of education. But a good portion of these gains comes from improvements in health care itself – through technological progress and evidence-based treatment, in particular.

Health systems are now more effective and of higher quality than ever before. Access to care, too, has continued to improve. Mexico and Turkey have recently introduced reforms to provide coverage for the poor or uninsured. The United States has just passed legislation that will mandate health insurance coverage for almost everyone. OECD countries are closer than ever before to achieving universal or near universal coverage for a core set of services. Such reforms have particular importance during recessions, when incomes are lower for some families, making the costs of poor health particularly hard to bear.

The economic crisis has led to increased pressure on public finance. Given that the largest share of health spending is funded from public budgets, fiscal constraints will heighten the need for governments to control costs and improve value for money for health spending. However, these short-term objectives come in the context of longer-term trends: pressures for increased health spending will be unrelenting, fuelled by technological changes, population expectations and ageing.

Governments have available to them a wide range of policy tools to control costs. Short-term "command and control" policies can hold expenditures down in the short term, but they often have unfortunate consequences in the long term. In addition, they do little or nothing to moderate the underlying pressures which are pushing health spending up over the medium term. There are promising avenues for controlling health spending in the longer term by improving value for money, particularly the quality of health care. Moreover, to reap these potential gains often requires new investments upfront. Hence, many countries face a dilemma: short-term and long-term policy priorities sometimes point in different directions.

This publication takes on the subject of how best to structure health policies to get the best results from what is invested, providing in-depth analysis of the health expenditure patterns and policy options to improve value from health spending in both the short and long term. It reviews several promising new areas for improving value for money in health.

What does health care spending look like in the OECD?

With three-quarters of health spending funded from public budgets, concerns about the allocation of resources and the efficiency of spending come to the forefront, especially so when money is tight and governments face difficulties in financing public sector deficits. Chapter 1 shows that health spending represents 9% of OECD economies (2008). It exceeds 10% in seven OECD countries – the United States, France, Switzerland, Austria, Germany, Canada and Belgium. While the rate of increase in health spending has slowed in the period 2003-08, health expenditure growth has still exceeded economic growth in almost all OECD countries in the past 15 years. Factors exerting upward pressure on health spending (technological change, population expectations, increased incomes and, to a varied extent across countries, population ageing) will continue to drive health spending higher in the future. According to OECD projections, public health spending could increase by between 50% and 90% by 2050, depending on the assumptions made.

What are OECD countries doing in the face of financial constraints and what should they be doing next?

This review comes in the context of one of the deepest recessions on record, when OECD countries are focussing on how to enhance the efficiency and effectiveness of health care systems to ensure that goals of access to and quality of health care continue to be met. Chapter 2 looks at policy options available to governments to tackle the financial sustainability of health systems and assesses their possible impact.

In most OECD countries, governments have considerable control over the supply of health inputs and their prices. Measures that control inputs, set caps to budgets, or freeze prices, can lead to significant cost cuts or strongly moderate the rate of growth in health spending. These tools have been utilised widely, albeit with different intensity over time and across countries. Most OECD countries impose health expenditure caps, particularly in the hospital sector. They appear to be most successful particularly in single-payer systems or countries with integrated health financing and supply.

Wage controls – typically occurring in the context of broad public-sector pay restrictions – have more commonly been implemented in countries with integrated health systems and those with salary-based remuneration for health professionals (for example, Denmark, United Kingdom and Ireland for hospitals, but also Finland, Spain and Sweden). In fee-for-service environments, most OECD governments have maintained oversight over price setting or set prices administratively (*e.g.* Japan, Korea), sometimes in response to a break-down of negotiations with providers (*e.g.* Australia, Belgium, Canada, France, Luxembourg).

Policy tools addressing the demand side are also commonly used. For example, restricting the scope and depth of the benefit package of essential health services can lessen pressures on public expenditures. This includes government decisions about the benefit package (what is or is not covered) but also greater cost sharing by patients. Greater out-of-pocket spending, however, falls most heavily on the poor and may hinder access to care. Targeted programmes may be needed to help protect the most vulnerable in society.

The experience of countries which promptly reduced health expenditure after previous recessions suggests that the impact is short-lived. It is even possible that measures taken to restrict costs in the short run can increase long-run spending – if necessary investments are delayed and desirable prevention policies are not implemented. Many of the short-term policies can result in reduced access to care, less equitable provision of services, less responsive care, poorer quality, and delayed access to desirable new technologies.

Medical care: does it work and is it worth it?

Patients, providers and payers have a common interest in ensuring that health care systems do not waste resources. Many studies have observed significant variations in medical practice within and across countries that are not always fully explained by variations in epidemiological needs. According to the United States Institute of Medicine, half of health care services are still provided without any evidence about their effectiveness. In addition, where there is strong evidence of effectiveness, people do not always receive appropriate treatments. For instance, the Rand Corporation estimated in 2001 that more than half of the care received by American adults for a set of 30 acute and chronic conditions was not consistent with recommendations of evidence-based medicine.

Chapter 3 suggests that large efficiency gains could be achieved by introducing more rational decision making into clinical care. Evidence-based medicine (EBM) and health technology assessment (HTA) can be used to inform decision making at the patient level (clinical guidelines) or at the system level (to inform coverage decisions). EBM and HTA help answer two fundamental questions regarding a health care service: does it work, and is it worth it?

Though countries have been paying more attention to such issue, many have not yet realised the full potential of EBM and HTA. Only a few countries produce and actively disseminate clinical guidelines to inform decision making at the doctor and patient levels. Even in countries with advanced institutions and practice of HTA, clinical recommendations are not always diffused in an efficient manner, guaranteeing doctors' and patients' adherence. Many OECD countries have adopted explicit structures or processes to help purchasers make informed decisions on coverage of pharmaceuticals or costly new technologies, but other types of services are less scrutinised. EBM and HTA have already increased the transparency of decision making and helped to ensure that new investments are worth their cost, but there is scope to do more.

Can incentives improve performance and efficiency?

Chapter 4 looks at OECD countries which are experimenting with new methods of paying providers and sometimes patients to improve the quality of health care, often known as pay for performance (P4P) or payment for results. There are growing numbers of schemes testing new models for rewarding quality: in OECD countries like the United States, United Kingdom, and Germany; in middle-income countries like Brazil, China, and India; and in low-income countries like Rwanda. These P4P schemes are testing whether new ways of paying providers (hospitals, primary care, integrated systems) that use some type of

synthetic measure of quality show improvements in the *quality* of care and also improve *value for money* in health.

P4P programmes have been widely introduced across OECD countries, yet the research designs to evaluate them are often inadequate to provide a definitive answer about the effect of P4P programmes on quality and costs. Ironically, the best evaluated P4P schemes are in low-income countries supported by the World Bank administered Health Results Innovation Trust Fund. Evidence suggests that giving incentives for priority public health interventions like cancer screening works. P4P also appears promising in getting physicians to follow evidence-based guidelines for chronic conditions like diabetes and cardiovascular diseases. But there are still challenging measurement and design issues.

Can better co-ordination of care make a difference?

Chapter 5 looks at the increasing complexity of health care systems in OECD countries – in terms of multiple layers of caregivers, a diverse range of settings and a complex combination of public and private insurance funds that handle payments. Multiple providers, lack of adherence to care protocols, inconsistencies in reimbursement and decentralised medical records are still the norm in most OECD health systems. With more patients receiving care from multiple providers for chronic conditions, there is a growing problem of fragmentation within health systems. This results in poor patient experiences, coupled with ineffective and unsafe care.

The health problems systems have to deal with have evolved too. Chronic diseases, including cardiovascular diseases, cancers, respiratory conditions, diabetes, and mental disorders, now account for the largest segment of the burden of disease and a large percentage of health care costs. The WHO estimated that 60% of deaths were due to chronic diseases worldwide (not including HIV/AIDS) and for 86% of deaths in the European region. The economic and medical progresses that have extended life spans have accompanied certain lifestyle trends that contribute to the development of chronic diseases such as diabetes, heart disease and cancer. In essence, health care has become good at keeping people alive with diseases that would in the past have killed them, and even in the recent past.

So far, the complexity of financing streams and the difficulty in transferring electronically medical records from one provider to another have proven to be barriers to greater co-ordination of care. It can also be difficult to provide the right incentives to hospital and primary care providers to co-ordinate. To overcome these barriers, a number of innovative schemes have been tried, including integrating primary care and hospitals together, and rewarding physicians if they manage to co-ordinate care more effectively. Results have been mixed, however. Some initiatives have reduced costs somewhat, but a more common finding is an improvement in the quality of care (and hence improving value for money).

Specific areas appear to be promising such as mental health care, particularly for depression and schizophrenia, and palliative care for patients with multiple disorders. The models that work in these areas include multiaxial teams linking primary and specialist care, a care co-ordinator and greater patient empowerment. Also, the use of "predictive modelling" tools to target costly disease management programmes to those who will be

most likely to benefit can improve the cost effectiveness of these programmes. The failure to achieve cost savings in other areas of care reflects in part the fact that co-ordination itself is expensive, but also that it is unrealistic to expect cost savings in treating those with extensive co-morbidities.

The role of patients in the care process has also taken on much greater importance in recent years. Yet it has been very difficult to determine the best way to involve patients in their own care, not least because people vary greatly in their responsiveness to information, advice and treatment guidelines.

How to draw all the benefits from pharmaceutical spending?

Chapter 6 reviews recent developments in pharmaceutical policies in OECD countries, which generally try to achieve a balance betwen three broad objectives: make medicines accessible and affordable to patients; contain public spending growth; and provide incentives for future innovation.

Pharmaceutical spending accounts for 17% of total health spending on average in OECD countries, ranging from only 8% of total health expenditure in Norway to 32% in Hungary. In the past, pharmaceutical spending has risen at a faster pace than total health spending but this trend has now reversed: between 2003 and 2008, real pharmaceutical expenditure has grown by 3.1% per year on average in OECD countries, while total health spending has increased by 4.5%. Over this period, growth in pharmaceutical spending surpassed growth in total health expenditure in only nine OECD countries.

Policy makers have attempted to contain pharmaceutical expenditure growth via a mix of price and volume controls, as well as policies targeting specific products (*e.g.*, through product rebates) or increasing the share of cost borne by users. Recently, reductions in drug prices for reimbursed pharmaceuticals have been announced in several countries (*e.g.* Ireland and Greece).

The main concern of policy makers now is that current pharmaceutical pricing and reimbursement policies may not always deliver good value for money. Several countries for instance do not exploit the full potential of off-patent markets. In 2008, the share of generics in pharmaceutical markets ranged from a low of 15% in Ireland to a high of 75% in Poland. OECD countries have implemented policies to promote generic uptake: physicians have been given the possibility to prescribe in international non-proprietary name, and pharmacists the right to substitute generics for brand-name products in almost all countries. However, OECD countries with low generic penetration may need stronger incentives for providers and patients to foster generic use. In some more mature generic markets, price competition does not always benefit consumers and payers as discounts agreed by generic manufacturers to pharmacists are not passed on. A few countries have tried to tackle this issue through tendering processes (*e.g.* Germany, the Netherlands) or through periodic revisions of reimbursement prices reflecting market dynamics (*e.g.* Australia).

Decision makers are also increasingly concerned by the introduction of new drugs with very high costs and low or uncertain clinical effectiveness. While these drugs may be important for future innovation, public payers are not always willing to pay for medicines with low cost effectiveness and/or uncertain benefits. At the same time, public pressure to

cover new treatments is often high. As a response to this dilemma, public payers are now using innovative payment methods: product-specific agreements are concluded to share the risks (of negative clinical response) with manufacturers or to cap public spending. These agreements are promising, but should be subject to rigorous and public evaluation.

What can information technology do for health care in terms of cost and value?

ICT has great potential to increase value for money in health, yet the health sector lags far behind other parts of the economy in exploiting the productivity benefits of ICT. Chapter 7 shows how ICT can make significant improvements in health care delivery – reducing medical errors, improving clinical care through adherence to evidence-based guidelines, and preventing duplication and inefficiency for complex care pathways. It examines barriers to getting the maximum benefit from ICT, including privacy concerns and the lack of common standards and co-ordination across systems, as well as the reasons why the implementation of electronic health records is slow in most countries.

The most immediately promising applications are improving the co-ordination of care for managing chronic diseases where health professionals could share information to manage complex diseases; and enabling patients to have more involvement in their own care.

There is a need for new business model for ICT which allocates funds from those who benefit from ICTs to those to have to bear the costs. In the current environment, providers bear most if not all of the costs and yet receive little benefit, which are mainly improved patients outcomes and reduced acute care costs.

There are also often weaknesses in the governance of ICT. Managing complex projects is notoriously difficult, and Ministries of Health do not have a good record in this respect. The ultimate objective of transforming the way in which health care is delivered is often forgotten in face of technical design issues. Governments need to establish commonly-defined and consistently-implemented standards to ensure communication between health care providers. While health care organisations have access to an ever increasing number of information technology products, their systems often cannot speak to each other, thus preventing the gains from sharing information. “Linkages” remain a serious problem. Electronic health record systems must be interoperable, and clinical information must still be meaningful once transferred, both between systems and between versions of the same software. It must also be gathered consistently if secondary analysis is to be performed effectively. Only if information is widely shared can ICT achieve the wider benefits of improved patient outcomes at lower cost.

Conclusions

Given the state of government finances, some countries may need to restrict urgently public health spending. Past experience shows that this can be done. Past experience also shows that it can be done badly, compromising important health policy goals, but also by simply deferring spending to the future. In deciding how to tackle the short-term issue of reducing spending, countries must not lose sight of the long-term issues.

These long-term issues are in reality much more worrying than the conjunctural fiscal situation. Increases in health spending are inevitable. Health policy makers have to ensure

that these increases deliver real value for money. This will not happen automatically; health systems are not a "normal" part of the economy, where market forces can, within reason, be expected to drive innovation, responsiveness, cost efficiency and quality. To ensure that health systems continue to deliver improvements in health outcomes at reasonable cost, governments have to ensure that the basic framework for health care is right, and this requires some big changes in how health systems operate. As described in this book, some of these changes may require more spending now in order to achieve bigger efficiency gains in the future. Not the least of the dilemma's facing policy makers is how to realise these gains at a time when money for health is tight.