

Introduction

The six chapters in this volume were prepared for a one-day conference, “Improving Health System Efficiency: Achieving Better Value for Money”, held on 17 September 2008 in Brussels. Jointly organised by the European Commission and the OECD, the purpose of the conference was to assess policies leading to more rational use of resources in the health care sector and the potential of such policies to promote long-term sustainability of health systems. Attendees included officials of the two hosting institutions and other international organisations, representatives of their member countries who hold policy-setting positions and technical experts.

Both organisations have emphasised that health-care systems are coming under pressure due to rising expectations for high-quality care in a period of population ageing and rapid technological change. Member countries of the OECD and of the European Union have highlighted the need for better value for money in health systems during the deliberations of the OECD Health Committee and through the European Commission’s Open Method of Co-ordination (OMC) on Social Protection and Social Inclusion.¹ The September 2008 meeting drew on the experiences of both organisations. In case of the European Union, a wide range of policies to encourage more rational resource use were identified in the 2006 National Strategy Reports and the 2007 Joint Report on Social Protection and Social Inclusion (European Commission, 2007).² These included: strengthening primary care provision and referral systems to secondary care; shifting care to an outpatient basis; increasing the productivity and quality of inpatient care; improving care co-ordination, improving incentives in payment systems and greater use of information and communications technologies (ICT) and e-health solutions. The OECD has been conducting in depth policy work on strategies for improving the performance of health-care systems, focusing on, among other things, care co-ordination, pharmaceutical pricing, and health information systems and information and ICT.³

Policy questions

Absolute growth in health expenditure and its growth in relation to national income raise the difficult question of whether and how to constrain it. Can systems become more efficient in how they spend their money? Where can savings be achieved without doing harm to the health of people in need of care, for example by reducing access to health care? As technological advances change the very nature of health care delivery, policy makers face difficult decisions about the additional expense associated with new life saving and life enhancing therapeutic agents, vaccines, imaging, and surgical techniques. How do the potential advances in health status and health services delivery weigh against the additional strain on societal resources?

The key policy question is “How can health systems improve efficiency of resource use and, thereby, help ensure the financial sustainability of health care systems?” In considering the policy approach most appropriate in any country, policy makers can benefit from a clear articulation of the problem, the potential solutions, the trade-offs they must make in pursuing various goals and the experiences of other countries. Thus, one important aim of the conference was to help policy makers as they grapple with these issues by identifying a checklist of policies or good practices worthy of consideration by national administrations. The six chapters in this volume provide analyses of multinational datasets, case studies of policy innovations, and discussion of both the challenges and opportunities to enhance value for money.

Unraveling cross national differences in health expenditures

In Chapter 1, “Patterns of Health Care Spending Growth”, David Morgan and Howard Oxley of the OECD set the context for the chapters that follow. Drawing on the most recent OECD data, the chapter summarises trends in health expenditure among OECD countries since 1995. The authors note that, while growth in health spending was slow in the early part of the 1990s, the latter half of the decade was marked by strong growth in overall health spending across OECD countries, with health expenditure outstripping economic growth by almost two to one. Since 2003, this growth has abated but it remains unclear whether this is a temporary phenomenon or the beginning of a new trend. As of 2006, average health spending among OECD countries amounted to 9 % of GDP, up from just over 5% in 1970 and around 7% in 1990.

The chapter also looks at the components of growth and documents the substantial differences across OECD countries in expenditure, prices, volume, and types of services. For example, ten OECD countries spend more than 10% of GDP on health goods and services, including (in descending order) the United States, Switzerland, France, and Germany. By contrast, the Czech Republic, Korea, Mexico, Poland, and Turkey spend less than 7%.

A significant portion of the chapter focuses on the potential reasons for cross country variation, searching, in effect, for clues about areas that appear most promising for policy intervention. As they note, “although the research evidence is not conclusive, policy makers still must make choices in their search for improved performance, focusing on either demand or supply related factors, or a combination of both.” The chapter assembles a vast array of data on both demand and supply factors, ranging from national income, age distribution, and disease prevalence to the supply of health care professionals, remuneration of professionals, and the intensity of care and technological capacity. For example, an exploratory study in ten OECD countries of hospital costs associated with several conditions found wide variations and suggested that, on average, if unit costs were reduced to the level of the best performers, average costs could potentially be reduced by 5% and 48%. Similarly, data on the number of cardio-vascular procedures performed show the United States at twice the OECD average. By contrast, the rate in Switzerland is less than half the OECD average.

Market mechanisms: promise and limitations

In Chapter 2, “Market Mechanisms and the Use of Health Care Resources”, Peter C. Smith of the Imperial College Business School (London) considers whether market mechanisms can lead to more rational use of health care resources. Smith points out the many ways in which the market for health care services departs from the neoclassical model, including the lack of information for consumers to make choices about care, the role of physicians and other professionals acting as agents for consumers, constraints on exit and entry into the market, financing of education and research as public goods, and the fact that patients rarely bear the full cost of the care they receive. But he also notes that “sole reliance on non-market mechanisms, such as the public sector, also gives rise to serious problems...There are unclear lines of accountability, between patients, providers, governments, taxpayers, and provider institutions such as hospitals, that offer enormous opportunities for opportunistic behaviour and inefficiency.” The issue for policy makers thus is not whether markets are good or bad, but determining whether fostering some aspects of competition

and markets in the health sector can lead to more rational use of resources, and which aspects of competition have the greatest potential to get results.

Smith examines the research evidence from experience with markets and competition to date. The chapter analyses three types of competition that give rise to quite different sets of incentives: competition for health insurance, competition for collectively purchased health services, and competition for individual patients. He points to a number of findings from the research literature that may be useful to policy makers, for example that provider markets respond to the priorities of purchasers, the choice of services that are the subject of competition have profound implications for system performance, and providers are responsive to payment incentives. He also offers some words of caution about the impact of provider competition for individual patients on cost competition. He concludes with some insights on policy designs that could take advantage of the power of markets while mitigating some of their more damaging effects. For example, Smith notes that pursuing competition in insurance requires creation of both risk sharing arrangements (to discourage cream skimming) as well as processes for quality assurance. He notes, however, that creating incentives for insurers to undertake long-term activities to foster population health outcomes may prove difficult, suggesting that such responsibilities may be better left to governments. He is more optimistic about the potential of market forces to yield cost efficiencies if purchasers have the ability to contract selectively with providers.

Care co-ordination

In Chapter 3, “Improving Health Care System Performance through Better Co-ordination of Care,” Howard Oxley (OECD) addresses the scope for improving cost efficiency and quality of care through better care co-ordination, issues that are particularly important given the growing number of individuals living with chronic disease and the elderly who may have difficulty navigating fragmented health care systems or who are in need of long-term institutional care. Co-ordination problems can happen throughout health systems but most particularly at the barriers between primary, specialist, acute inpatient and long-term care.

Oxley presents a broad overview of care co-ordination issues and approaches from OECD countries plus several other nations that are part of the European Union. Common themes include widespread concern about care co-ordination, the importance of policies affecting referrals, and the key role of primary care providers in managing care, even when the arrangements are not formal. Drawing on a survey to which 26 of these countries responded, he also identifies the key impediments to care

co-ordination such as fragmented financing, limitations on different providers' scope of practice, and spanning levels of care. The chapter also examines whether targeted programmes, primarily those structured to provide disease or case management, can improve the quality and cost-efficiency or cost-effectiveness of health care systems. Oxley concludes by suggesting four key areas are critical for achieving improvements in care co-ordination and in overall system performance: improved information technology and communication infrastructure for information transfer; review of the adequacy of resources devoted to ambulatory and primary care; reconfiguring provider systems and incentives to enhance care co-ordination, and breaking down barriers between levels and components of care. Discussion at the September 2008 conference noted the need for policy makers to carefully consider culture, history, and specific aspects of system design when making reforms to improve care co-ordination.

Pharmaceutical policy: finding the right balance

Although accounting for a relatively small portion of health expenditure for OECD countries, spending on pharmaceuticals is growing at an average annual rate of 5.7%, outstripping growth both for other types of health care and gross domestic product (GDP). Policy makers are thus increasingly concerned about pricing and reimbursement policies for drugs. In Chapter 4, "Ensuring Efficiency in Pharmaceutical Expenditures", Elizabeth Docteur and Valerie Paris of the OECD explore options as to how to structure these policies to promote cost efficiency. The global nature of the pharmaceutical industry, however, creates special concerns since policies in one country can have repercussions in others.

Policy making with respect to pharmaceuticals must deal with the twin objectives of promoting innovation in drug development while also securing the best possible price for consumers and payers. As they note, "perhaps the most difficult trade-off in pharmaceutical policy is that between static efficiency (maximising consumer welfare by getting the most health value from today's expenditures constrained by the limits of present technological capability) and dynamic efficiency (creating incentives for research and development of products that improve capacity to prevent health conditions and cure diseases in the future)." An additional concern is whether the distribution system, which can account for a third or more of the retail price, is functioning efficiently.

Docteur and Paris provide an overview of current policies related to coverage, pricing, and other techniques to influence the demand and mix of pharmaceuticals. The section on pricing is particularly rich, sketching the variation across OECD countries in the use of external benchmarking,

Notes

1. See http://ec.europa.eu/employment_social/spsi/the_process_en.htm for more information on the process.
2. See http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm for the Joint Reports on Social Protection and Social Inclusion 2007 and http://ec.europa.eu/employment_social/spsi/strategy_reports_en.htm for the National Strategy Reports.
3. For a more complete description on the work conducted by the OECD, see www.oecd.org/document/60/0,2340,en_2649_33929_37103164_1_1_1_1,00.html

