

## HEALTH SYSTEMS: MEASURING AND IMPROVING PERFORMANCE

The past three decades have been a period of change and expansion for modern health systems. Most OECD countries have attained universal coverage for a core set of health services and have improved the accessibility of those services to the population. Population health status has improved steadily, even dramatically, driven by economic and social development as well as concerted efforts to reduce the prevalence of risk factors and promote healthy living. Advances in medical capability and improvements in healthcare have had direct benefits in terms of both cure and prevention of disease.

Nevertheless, it is desirable and possible to improve the performance of health systems still further. Serious shortcomings in the quality of healthcare – at levels that would not be tolerated in other high-risk industries – have recently come to light. Patients and healthcare consumers are demanding more responsiveness to their expectations and preferences. In a number of countries, there are barriers that make it difficult for disadvantaged groups to achieve equitable access to healthcare services and the health improvements such access brings.

Furthermore, health systems are facing major cost and financing challenges. Healthcare costs are growing faster than economies as a whole in most countries, posing problems for public budgets. All signs indicate that countries must expect continued upward pressure on health costs, reflecting development of new treatments that can be expensive and generate new demand. Population ageing will have implications for the financing of health and long-term care services, and is likely to increase the demand for both, raising questions as to the affordability and sustainability of health systems. One possible solution is to increase efficiency in health systems. There is great scope to do so by increasing productivity, reducing waste or enhancing the cost-effectiveness of care, yet achieving efficiency improvement has proven difficult.

Health systems differ in their design, in the amounts and types of resources they use, and in the health outcomes and other results they attain. But health policymakers share common goals and can learn from each other's experiences as to what works – and what does not – when making changes to health systems intended to improve performance. The three-year OECD Health Project, which culminates in a May 2004 meeting of health ministers, has sought to add to the evidence base and provide guidance that policymakers can adapt to their own national circumstances for use in their efforts to improve health-system performance.

### **Sustainable costs and financing**

Richer countries tend to spend more on health, but there is great variation in spending among countries with comparable incomes. Even more importantly, the highest spending systems are not necessarily the ones that do best in meeting performance goals.

Countries have slowed cost growth using a combination of budgetary and administrative controls over payments, prices and supply of services. Although sophisticated payment systems can be technically difficult to employ, there are numerous examples of successful systems – such as discharge-based payment systems for hospitals – that can promote productivity without harming outcomes. On the other hand, systems that keep health-sector wages and prices artificially low are likely to run into problems eventually, such as lower quality, difficulty with recruitment and retention of healthcare practitioners, or shortfalls in the supply of services and innovative medical products.

Spending growth is not necessarily undesirable, particularly if the added benefits exceed the extra costs. But because three-quarters of OECD health spending comes from the public purse, growth strains government budgets. Financing will come under increased pressure as populations age and the share of the population participating in the workforce drops. Using general taxation revenue to finance expansion of healthcare provision increases the burden on taxpayers or diverts resources from other publicly-financed services and programmes. In order to relieve future public-financing pressure, individuals may be called upon to play a larger role in financing their own healthcare.

Cost-sharing requirements for users of health services can reduce the burden on public financing systems. But major savings from user fees are unlikely, particularly as vulnerable populations must be exempted to avoid restrictions on access that could be costly in the long run. Such exemptions impose administrative costs. Apart from this, consumers are likely to skimp on preventive care and appropriate treatments unless they are given incentives to do otherwise.

### **The role of private health insurance**

Complementary private health insurance can help to ensure access to care where cost-sharing requirements are large. But it can also drive up consumer demand and overall costs.

Private health insurance can offset some of the costs that would otherwise be borne publicly. However, subsidies are sometimes needed to encourage purchase of insurance and other interventions may be needed to promote the use of privately-financed services by those with publicly-financed coverage. Even in countries where a sizeable share of the population is privately insured, private health insurance has tended to represent a relatively low share of total health spending, as it often concentrates on minor risks, rather than more costly cases and treatments.

Flat-rate health insurance premiums are a regressive source of financing compared with income-based taxes or social insurance contributions. When premiums reflect health-status factors, they can be as regressive as direct out-of-pocket payments. Nonetheless, private insurance does provide individuals with a means of pooling healthcare risks and avoiding catastrophic expenditure. Complex regulations imposing restrictions on risk selection or targeted subsidies can improve the equity outcomes of private health insurance markets, in terms of both financing and access to care, but require either public subsidies or high premiums for low-risk customers.

### **Value for money in health systems and care**

Ultimately, increasing efficiency may be the only way of reconciling rising demand for healthcare with public financing constraints. Cross-country data suggest that there is scope for improvement in the cost-effectiveness of healthcare systems. This is because the health sector is typically characterised by market failures and heavy public intervention, both of which can generate excess or misallocated spending. The result is wasted resources and missed opportunities to improve health. In other words, changing how health funding is spent, rather than mere cost-cutting, is key to achieving better value.

Recent work by the OECD has identified ways in which the efficiency of health systems can be increased. These include managing demand for elective surgery and other discretionary services, employing pricing systems that reward cost-effective choices among similar medications, using technology assessment to improve the information base needed to manage technology, and employing sophisticated payment systems that reward productivity, appropriate use of services, and contributions to improving health outcomes.

Value for money is a moving target. Increasing value requires experimentation and conscientious performance measurement using actionable and specific indicators. Benchmarking within and across countries, and mutual observation, can help identify effective practices and the circumstances in which they work.