



Business and Industry Advisory Committee to the **OECD**

Comité Consultatif Economique et Industriel Auprès de l'**OCDE**

BIAC Statement to the OECD Health Ministerial “Towards High-Performing Health Systems”

12-14 May 2004

BIAC appreciates the opportunity to participate in the 2004 OECD Health Ministerial. We also recognise the release of the OECD Report Towards High-Performing Health Systems, in conjunction with the Ministerial meeting, and congratulate the OECD on this important work.

To address the issues being covered at this year’s Ministerial, our statement comprises three parts:

- I. Introduction: A Framework for Well Managed Health Care Systems*
- II. BIAC Response to Questions Addressed by Ministers*
- III. BIAC Recommendations for Future OECD Work on Health*

I. Introduction: A Framework for Well Managed Health Care Systems

Companies depend upon a well functioning cost effective health care system. The health of employees at an affordable cost is essential to the competitiveness of companies just as it is crucial for the competitiveness of our economies.

As users and providers of health care products and services, tax and premium payers, and leaders in technology development and innovation, companies remain concerned that health expenditures are sustainable, achieved through the efficient use of resources.

We recognise that healthcare systems face increased health expenditures and at the same time public resource constraints. In particular, demographic change, including aging populations is bringing about increased demand for medical products and services. These circumstances combined with the development of new products will continue to put pressure on public budgets. In this climate, governments must strive for a new balance brought about by innovation, medical progress, and productivity gains through more efficient management of our health care systems.

To provide context for our response to the issues being discussed at this year's Health Ministerial, the following points outline our vision of a well managed health care system, which we believe depends upon the right policy frameworks, clear objectives, and the means to achieve desired goals. These points include:

1. Policy frameworks for health care systems should be:

- **Innovation based** because producers of innovative goods and services related to health care provide added value to the economy. Business strives to bring new products, services and coverage schemes to the market based on maximum value for cost.
- **Well managed** because management capability by governments to steer the progress and implement health reforms, as well as to find ways to effectively evaluate the effects/gains of reforms, is key to adapting healthcare systems to necessary change.
- **Based on competition** because competition is indispensable for better resource allocation and the permanent emergence of value adding new products, services and organizational methods in health care. Competition should be based on a greater role for consumers with respect to input on issues, responsibility and choice.

2. Objectives of health care systems should be focused on:

- Effective, efficient and equitable access to health care that should be a reality for all.
- **Sustainable funding** that relies on an environment of quality, productivity and responsiveness. Sustainable funding is an essential goal in the face of rising health care costs.
- **Health care systems as a source of economic growth** because no OECD country can afford to see its healthcare system only as an economic burden.

Health care systems should embody both the collective willingness to provide health care services and at the same time serve as an important sector of the economy.

3. Means to achieve the objectives of health care systems:

- **Productivity gains** will have a positive impact on expanding resources and in finding answers to new needs. Sustained enhanced productivity is the appropriate answer to cost pressure.
- **Quality improvement** is an immediate means for decreasing costs, improving the efficiency of care and the satisfaction of patients.
- **Responsiveness to patients' needs** should be the fundamental goal of health care systems and will allow for an optimal allocation of resources.

While each health care system has unique social, economic and cultural characteristics, BIAC would like to stress the necessity of the elements outlined above to aid health care professionals and policy makers to face current and future challenges of effectively managing health care systems for the benefit of all.

II. BIAC Response to Questions Addressed by Ministers

The following are BIAC responses to the questions being addressed by Ministers during the course of the Health Ministerial as outlined in the Issues Paper for the meeting.

Session 1: Better Health Through Prevention and High Quality Care

What population health and prevention strategies have been shown to be cost-effective?

Available evidence indicates that many prevention strategies have been cost effective. Mass vaccinations against infectious diseases such as polio, smallpox, TB, and childhood diseases have saved millions of lives and reduced disability. Vaccinations against hepatitis A and hepatitis B have also made a huge impact on the cost of these diseases and there is hope that one day a vaccine might be effective against AIDs and certain cancers. Pre-natal and post-natal care are another example of highly successful cost-effective interventions.

Chronic diseases such as diabetes, heart disease and stroke, asthma, cancers, and back pain are largely responsible for the rising health care expenditures in OECD countries. Individual behaviour and lifestyle choices such as high calorie diet, lack of physical activity, and excessive alcohol and tobacco use influence the development of these chronic conditions. Public and private efforts and programs designed to promote healthy behaviours have paid off as illustrated by the reduction in heart disease as a result of anti-tobacco campaigns.

Early detection such as screening against breast and colon cancers, checking for blood sugar and cholesterol levels, or for bone density, have also proven cost effective when direct and indirect costs are taken into account. Diagnostics, medical

devices and innovative medicines are particularly useful in managing the impact of these chronic diseases: statins that lower cholesterol, and pace makers in the control of cardiac arhythmias are but two examples.

This is also demonstrated by cost saving health promotion and disease prevention programmes initiated by private employers throughout the OECD area. These programs have been shown to improve employee health, increase productivity and yield a significant return on investment for the employer. For example, a recent U.S. review of such programmes found benefit- to-cost ratios ranging from \$1.5 to \$5 for every dollar spent on them.¹

BIAC supports the aims of the OECD Health Ministerial Issues Paper in seeking to focus future Member State prevention in these key areas. We also believe that there may be a role for countries to share experiences on both public and private health interventions and disease management programmes and to share methodologies about their assessment. The experience of innovative private companies might serve as a suitable model for communities, schools, health care providers and insurers, and vice-versa.

How can improved quality-of-care standards and implementation of best practices be encouraged?

Information, clear guidance and incentives that support quality standards are key elements in a successful strategy to promote best practices. Over the long term, attention to quality should lead to reduced costs system wide.

Information is important both for ensuring that physicians are kept up to date with best practice and as a way of communicating with patients. For example, where best practice can be defined, patients are often able to obtain information on how physicians/hospitals are adhering to best practice. This is a tool for helping patients to choose between different health care providers and for encouraging competition on quality between providers.

The increased application of more targeted “personalised medicine” is also important in improving the efficiency and quality of care. Best practices may be derived from personalised medicine that can contribute to the overall efficiency to the health care sector.

Management methods that promote and measure quality management and incentives to implement quality standards are key. For example, the way health care providers are reimbursed should not undermine incentives to ensure quality. Just the opposite, it should promote seeking higher quality by instituting “quality-based” systems of remuneration. Instead of being rewarded for the number of acts, the quality-based payment system should reward value. Health purchasers can be more innovative in how they write contracts to include elements of quality. Insurers could also be subject to better incentives when they steer patients to better care and better facilities that lead to quality improvement.

¹ “Prevention Makes Common “Cents”, U.S. Department of Health and Human Services, 2003.

Competition should take place on the basis of quality and efficiency. Benchmarking also has a role to play, as does the practice of setting targets and aligning incentive payments to encourage the attainment of targets. For example, the new UK GP contract system, where additional payments are made to physicians who meet targets such as for the management of patients with cardiovascular heart disease, is one such example.

It is important, however, to ensure that health targets do not become goals in themselves as these can distort decision making, especially if meeting the target is achieved at the expense of what really matters to patients. In this regard, it is imperative that blunt cost containment policies are not imposed in the name of quality standards.

Quality standards should be developed with medical professionals, and must not consist of centrally imposed bureaucratic rules that constrain physician autonomy. Public administrations should ensure policy frameworks that promote setting quality standards and their application, including monitoring of these frameworks, on an ongoing basis.

BIAC believes that there needs to be more focus on measuring quality and the effectiveness of healthcare systems and we would support further OECD work on this point.

Dinner Discussion: Ensuring Financial Sustainability of Health Systems

How can the rising trend in health spending/GDP ratio be contained without damage to health outcomes and equity of access?

The rising trend in health spending/GDP ratio does not automatically mean that it should be contained. The central issue in discussions of health care financing must address the value of health care services relative to other non-health goods and services. We must focus on the overall cost of disease and the broader economic and productivity implications of not treating many preventable conditions.

Spending more on health is not necessarily bad public policy. Growth of health care spending relative to GDP might be “affordable” within a given economy, if such growth is collectively desired by society. Increasingly in the OECD, citizens are expressing a willingness to contribute more but only if it results in a responsive and more patient-focused system.

In many parts of the health system, little is known about what works and what doesn't. Often, resources are not being well used. In most OECD countries, the emphasis is on treatment. Within this, the emphasis is on visible acute services rather than the management and prevention of costly chronic conditions.

Some steps that BIAC suggests should be considered in assessing how well resources are being used include:

- Initiating a dialogue with all stakeholders on the effectiveness of the entire range of health interventions,

- Considering where early intervention provides a more effective approach to managing conditions rather than relying on reactive acute interventions,
- Ensuring that the incentives for stakeholders and the allocation of resources support this approach,
- Ensuring that all health care providers and insurers search for productivity gains and quality enhancement.

Silo budgeting that separates out spending on different inputs to health care services such as drugs or devices is a poor solution to managing rising health care costs. For example, the use of innovative medicines or medical devices can result in reduced costs elsewhere in the health care system, especially over time.

For many OECD countries, where government is the principal funder of treatments, the easy option appears to be to control or cap drug or medical device budgets, but this never produces the structural changes that lead to permanent savings. As a result, governments frequently shift strategies and impose new controls on expenditures without warning. This has a destabilizing impact on the investment planning cycle based on the long lead times required for R&D in new health technologies.

Is it undesirable if health care expenditure does increase faster than GDP?

Growth of health care expenditure at rates faster than GDP is not by definition undesirable as it may conceal different underlying trends. With growing prosperity, the countries are expected to devote a larger portion of GDP to health, especially in view of the aging population. The issue is whether the higher rate of expenditure growth signifies a higher value or purely inflationary phenomena, and whether it reflects societal preferences for spending on health as opposed to other goods and services.

Hence, BIAC believes that the focus should be on the value and not only on costs along the following lines:

- The health sector must strive for continual improvement and productivity gains and systematically squeeze out pockets of inefficiency,
- The health sector must be innovation based, allowing the diffusion of innovation,
- The health sector must improve the quality of life,
- The public bodies must have the possibility to shift resources from others sectors to health care if real improvements in health care can be gained by doing so,
- Health coverage should remain competitive, providing choice to both employers and employees,
- Tax and regulatory systems should encourage private financing and provide support to those in need.

Is it necessary or desirable that private financing and private insurance play a greater role in financing health expenditure?

Private finance and private insurance are part of nearly every health care system. Private spending on health care products and services is an important source of funding that sustains health care systems in an era of fiscal restraint.

In most of the OECD countries, the funding of the healthcare system is not limited to the public bodies and is not limited by the public budget constraints. While the OECD Report on Health states that there has been an expansion in access to health related services, BIAAC believes that has occurred as a consequence of greater reliance on private health insurance. This is one significant way to generate new funding for necessary health interventions.

Continued growth in public spending on health, including mandatory health insurance premiums may be fiscally unsustainable in light of OECD members' ageing populations.

However, surveys consistently show that patients are willing to spend more on public services and that support rises significantly when that spending is earmarked for health care.

At the same time, however, patient dissatisfaction in many public systems is growing because the link between what is paid via taxes or mandatory premiums, what flows to health care, and what is delivered in return is very unclear. The dissatisfaction is partly driven by the constraints imposed under the commitment to equity, where a one-size-fits-all approach necessarily implies that contributing more via tax or social insurance does not necessarily mean you see something in return.

It is entirely possible that public support for spending more will falter unless real improvements in health care delivery are seen. This raises the role of private funding/insurance in filling the gap. With private funding, the link between what an individual pays and what they are entitled to receive in return is much more transparent than in public funding. Hence, private funding is better able to tap into an individual's willingness to spend more on health care. Competition for private funds within and appropriate regulatory framework should ensure that services are responsive to what patients want as well.

The degree to which this is allowed to happen will depend in part on the debate about equity, which in BIAAC's view is distorted when private funding is erroneously typified as undermining this principle. One option is to start a debate about what society really means by equity and consider options for defining a core package of publicly funded services that satisfy this view, with private funding (or supplementary funding) accounting for anything additional.

Session 2: How can value for money in health care systems be improved?

What role should competition play in improving efficiency in health care systems?

BIAAC believes that competition is a powerful tool that needs to be applied with a full understanding of what it means. For example:

With respect to **health care coverage**, competition is a mechanism for giving patients choice and ensuring that health care funders compete to win enrollees. In practice it is often heavily managed competition, with insurers having to offer the same access to services or with limited scope for varying premiums. It has the advantage of making a more explicit link between what an individual pays for services and what they are entitled to receive. It has scope for setting strong incentives for the downstream provision of services. It does raise issues of equity due to the alleged reliance of insurers on “cream-skimming” tactics to select the best risks. But it is not clear how much of a problem this is, as in most OECD systems individuals do not have problems enrolling with a social insurer and risk adjustment mechanisms can work well. It is also important to recognise that non-competitive tax funded health systems face the same issue, but in a less explicit way, as resources have to be allocated to health purchasers and risk adjustment mechanisms are used to inform this allocation.

In the **provision of health care**, competition can deliver specific benefits in the form of greater efficiency and higher quality. Evidence from the U.S. and from France, where provider competition is the norm, is particularly strong on this score. Introduction of competition in other countries has sometimes been difficult. For example, information about costs and quality is lacking and those doing the purchasing (sometimes primary care physicians) often have little or no support. There are also political pressures to maintain existing purchasing patterns to avoid the closure of a local hospital, which undermines the power of competition to improve efficiency. An important lesson is that competition needs to be given time to settle (the administration burden is often high during transition) for efficiency benefits to become apparent.

For BIAC the key success factors of a competition based healthcare system are:

- A level-playing field for private and public entities involved in health care,
- Pro-competitive regulatory frameworks for health care,
- Freedom of choice and education/information to inform patients.

How can the public debate about health care performance be better informed, and what role can international cooperation play in this?

Perhaps the best way to advance the debate on health care performance is to ensure that patients have access to more and better information about particular health interventions, and health care systems generally. Patients must be empowered, by making accessible the information they need to make choices and then act on them.

The OECD Health Project is a good example of international cooperation on health issues, and provides an important basis for taking forward discussion on health related issues within the OECD countries and in cooperation with other international organisations.

With respect to health care performance, the debate needs to get away from comparing high-level outcomes like life expectancy as the sole measure of health performance. Similarly, comparisons of intermediate outcomes, such as procedure rates or waiting lists, can be misleading.

At the level of particular types of intervention or policy, there is much that can be learnt from the experiences of other stakeholders in the health system. Knowledge about efficient ways of providing particular interventions can be transferred from one country to another. Where countries have implemented policies in their health systems, there are typically things that work badly and things that work well. The introduction of competition into health systems is a prime example where policymakers can learn from the mistakes of others during a transition, but where the benefits of “settled” competition can be seen (e.g. in parts of the U.S. and the French systems).

This is not to say that ideas can be simply transposed from one system to another. But the reality is that health systems face common problems and the solutions share common themes even if they are not identical.

There also needs to be more debate about how to measure health system performance. There is an emphasis currently on monitoring the health outcomes of physicians or other providers, but it is a controversial area. The OECD Health Project has addressed this issue as its central focus, but the research conducted over the past three years indicates that the discussion has only started. In BIAC’s view, insufficient attention has been paid in this first stage to the role that the continuous flow of new health technologies and innovation in general play in enhancing system performance over time. We hope that focused attention is devoted to this critical issue in the next phase of the Project.

III. BIAC Recommendations on Future OECD Work on Health

Introduction

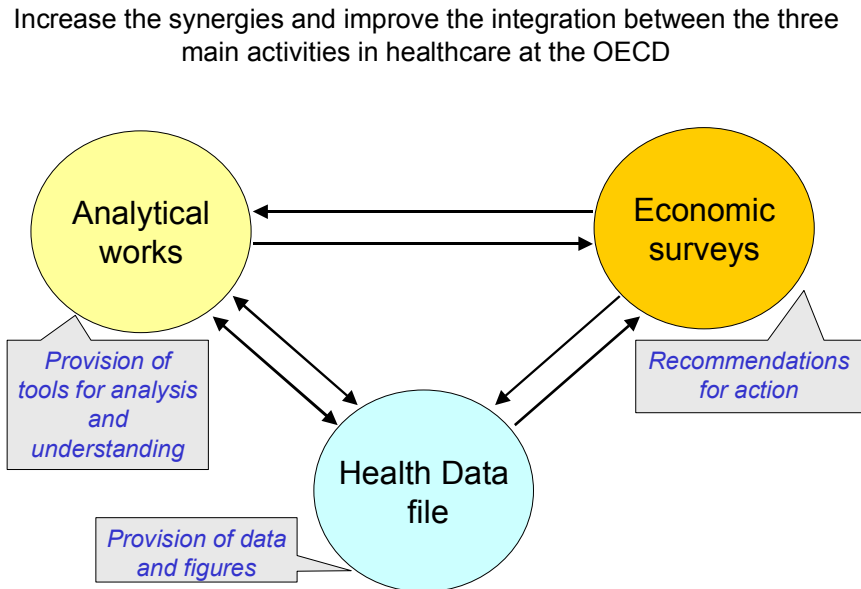
BIAC appreciates the opportunity to provide comments on possible OECD future work on health.

We recognise that any OECD future work on health care will depend on many factors, including the prioritisation of issues and funding. From the BIAC perspective, the following are suggestions regarding general approaches to any OECD future work on health:

- BIAC strongly supports establishing a Committee on Health to take forward any future work.
- A long-term strategy and stable resources are necessary to support future work.
- Any future work should be based on strategy of improved integration of the health data files, analytical work, and economic surveys (OECD core competencies). This integration will allow strengthen OECD’s distinctive capabilities. The OECD should build all its future work on health on this base.
- The scope of the OECD Health Data File should be expanded in order to be more balanced and robust.

- BIAC recommends increased frequency and visibility of economic surveys dealing with the health sector.

The following figure illustrates what we believe are the necessary synergies of these core OECD activities in health care:



Objectives of Future OECD Work on Health:

In this context, through continued work on health care at OECD, BIAC seeks to identify opportunities for:

- Productivity increases in the health care sector, including improved management of both private and public sector operations,
- Enhanced product and organisational innovation,
- Improved steering capabilities of governments, including the implementation of healthcare reforms and public health policies,
- Increased competition in and between both the public and the private segments of the health care sectors,
- Greater use of information networks and technologies while protecting the privacy of medical data,
- Pro-competitive regulatory reform in the health care sector,
- Encouraging wider consumer access to innovative healthcare technologies,
- Increasing patients involvement and responsibility for their health,
- Sustainable funding of the health systems through a better balance between private and public insurance and through innovation in coverage schemes.

BIAC Recommendations for Future OECD Projects on Health:

The following are a number of specific recommendations for future OECD work on health:

Health Data File

BIAC supports the work of the OECD centred on the OECD Health Data File, including related publications such as *Health at a Glance*. BIAC stresses the central role played by the OECD data file. The data file represents a unique asset for the OECD in the health sector benefiting from an international reputation.

A project including the governments and the various stakeholders in the health sectors should be designed in order to define the needs and the means of a long-term project on health data. This project should be undertaken in close coordination with others international organisations providing data (WHO and EU).

This project could comprise three steps:

- Definition of the needs of the various stakeholders, choice of positioning and forecasting the necessary resources,
- Widening of the scope of the health data according to the needs and the positioning,
- Mobilisation of the actors and resources, either public, private or not for profit.

BIAC members stand ready to assist the OECD in improving some of the statistical series by offering expertise, validation or possibilities of further useful breakdown of data.

Increasing Efficiency in the Hospital Sector

The Hospital Sector is an important area with hospital costs still accounting for the most important share of total healthcare costs.

With respect to any future work in this area, it is crucial to consider health facilities both from the viewpoint of the global efficiency of the system and from the perspective of citizens' health protection. For instance, social costs resulting from an inadequate quality of care must be taken into account. The problem of cost must not prevail on quality concerns; it is of the highest importance to examine the appropriate connection between these two determinants.

It would be also important to study competition mechanisms. In BIAC's view this means competition with respect to the delivery of services, speed of response, and quality of care. On the side of services production, particularly in the hospital sector, the relation between cost, quality and outcomes, should be examined in depth. Competitive incentives within the hospital sector should be evaluated with reference to quality standards and productivity performances, resulting from efficient management. Another issue of study could be to understand the way competition among providers on the supply side and choice on the demand side can contribute to maintain a satisfactory quality level by squeezing out waste caused by inefficiency.

In addition, the role of the consumer choice as a quality driver should be studied.

At a higher level, the study should show how competition among a plurality of providers could increase productivity and therefore increase the amount of available resources.

Ultimately the project should study what mechanisms could ensure:

- Equity in access conditions for citizens and in accreditation conditions for providers,
- Quality through rigorous and equal controls for all providers,
- Efficient funding of the providers determined by fair remuneration criteria for all the contributing institutions, public or private,
- Relevant information for citizens about services supply,
- Transparency on services, on quality and on costs for the actors involved in the funding of healthcare providers.

Health Care Related Innovation Policy

Innovations resulting from breakthroughs in science and technology fuel economic growth, as aptly demonstrated by the work of the OECD. The pioneering work of the OECD is beginning to show that a growing share of those innovations comes in the form of health-related applications. This is because as the OECD countries are getting richer, the demand for health, education and leisure is expected to grow. Thus the agenda for economic growth is closely tied to innovation in these areas for which there is growing demand, including health.

While economic growth is highly valued, there is less appreciation for the contribution of innovations in biomedical technology. This is because technological change in medicine brings benefits such as increased longevity, improved quality of life and less absence from work that are more difficult to measure using our existing economic tools of analysis. This simply means that these tools of analysis should be sharpened to remedy these weaknesses. The measure of direct economic benefits in terms of GDP is after all designed to capture the overall well being of the population.

It would be reasonable to expect that the OECD as is particularly well suited to address and develop aggregate measures of output and productivity in health care not limited to the current material gains.

Medical Technology and Devices

Information on utilisation of medical technology and devices, illustrating their role in health care provision, is currently available only in a limited format in the OECD Health Data.

BIAC encourages OECD to improve information on these technologies in the health data and offers its support for that endeavour which may require a closer look at the underlying nomenclature and improvement of data collection and reporting at the national level.

Information and Communication Technology Applications in Health Care

BIAC strongly supports the study of ICT applications in any future work. ICT applications offer a great potential in addressing the challenges currently faced in health care. It offers better information to and about the patient, opportunities to match the particular demands of the patient, ease inequities, increase compliance, strengthen individual responsibility, reduce waste and paperwork. It promotes and enables research and development in biomedicine and research collaboration, enabling solutions to specific health problems. It offers methods of evaluation of and education unheard of before.

As ICT networks reach beyond the borders of individual countries, a project would allow the OECD to consider solutions that are international and cooperative. It would also introduce the considerations of creating security, confidentiality and trust that are a precondition of such developments on a larger scale. ICT networks should be based on the principle of flexibility, modularity, redundancy with back up systems to cover breakdowns and upgrade ability to avoid obsolescence.

Major national infrastructure initiatives such as in the UK with a centralized hub and spoke system may lack flexibility whereas the Canadian approach of co-funding projects may give more flexibility but be more difficult to control. The OECD should analyse various national initiatives and recommend optimal approaches to developing an ICT network.

The reduction in the number of error prone tasks and an acceleration of digital workflow will mean faster examinations and more accurate results for patients. Correct identification of patients, procedures and results with continuity and integrity of dataflow from admission to reporting and billing and the identical presentation of patients results wherever displayed will be a major benefit for physicians. The reduction of manual interventions throughout the dataflow, improvement in efficiency of the healthcare process and a remarkably simplified process of expansion of the information systems even when using different vendors' products, will strongly benefit the healthcare enterprise.

Competition in Markets for Health Care and Health Insurance

BIAC supports the work done by the private health insurance project, and encourages the OECD to continue work on this issue. We agree with the OECD that private health insurance can help to fund health care costs, and that private insurance can encourage individuals to take more personal responsibility to cover health care needs. Likewise, we understand that a comprehensive regulatory framework is needed to support the development of private health insurance schemes.