

# “Measuring Up”

Improving Health Systems Performance in OECD Countries



## Performance measurement and improvement: issues and challenges

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# Why the quest for improved performance?

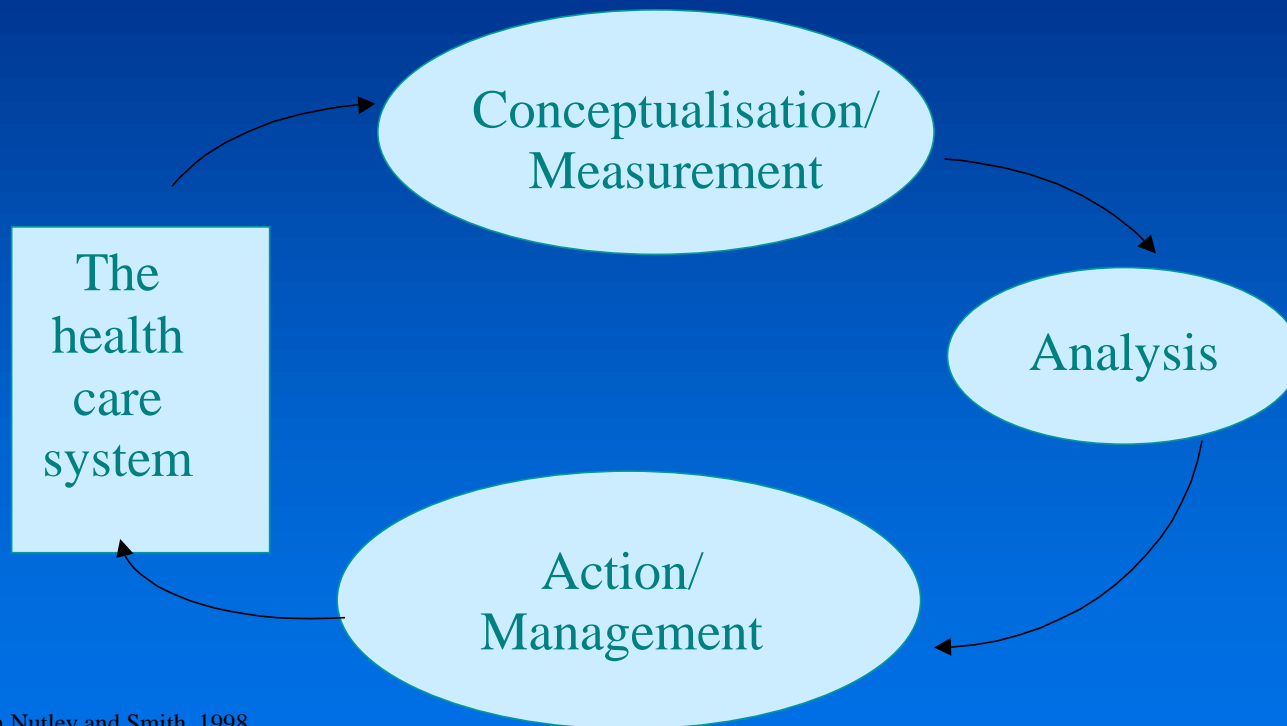
- Health systems are under stress
  - Increasing expectations
  - Reluctance to pay more
  - Concerns about safety and quality
  - Concerns about equity

# Why the emphasis on measurement?

- To improve the decision making of key actors
  - evidence-based consumption
  - evidence-based medicine
  - evidence-based management
  - evidence-based policy
- Applies equally to prevention, treatment and long term care

# Chart 1.

## The performance measurement and management cycle



Adapted from Nutley and Smith, 1998.

# Chart 2.

## Health System Objectives

	Average level	Distribution
<b>Health improvement/outcomes (+)</b>	✓	✓
<b>Responsiveness and access (+)</b>	✓	✓
<b>Financial contribution/health expenditure (-)</b>	✓	✓
	<b>Efficiency</b>	<b>Equity</b>

Adapted from Murray, C.J.L and Frenk, J. (2000)

# Measurement of health improvements/outcomes

- survival rates following life-threatening events
- avoidable mortality
- avoidable morbidity
- process measures (e.g. V&I, screening)
- adverse events

# Measurement of responsiveness

- satisfaction versus experience
- patient-centredness
  - e.g. information about choice of therapy
- timeliness
  - e.g. waiting times

# Measurement of efficiency

- maximizing the ratio of a weighted sum of health improvements and responsiveness to a given level of health expenditure
  - determined mainly by micro behaviour
- setting the 'right' level of health expenditure
  - often determined mainly by governments
- difficult to operationalise either

# Measurement of equity

- equity of health
- equity of access
- equity of payment for health care

# Analysis

- isolating causes of variations
- risk adjustment
- identifying policy levers
  - level of resources
  - mix of services/real resources
  - institutional characteristics/incentives
  - regulation/self-regulation
- assessing ex ante and ex post the cost-effectiveness of interventions
- setting and reviewing targets

# Action

- 4 sets of key actors
  - consumers
  - professional providers
  - managers
    - purchasers
    - providers
  - government

# Example: geographical equity in access to hospitals in England

- Little progress first 25 years NHS
- Demonstration of 'Inverse care law', 1970
- Resource Allocation Working Party 1975
- Very gradual achievement of equitable funding
- New objective, 2000 - equity of health

# Informing actions

- in an ideal market all actors would be perfectly informed
- but incomplete and asymmetric information characterises health care
- hence ‘agency’ role for providers and incomplete contracts
- importance of self regulation

# Incentivising actions

- In an ideal world all actors would be properly incentivised
- But public insurance separates the citizen as patient from the citizen as taxpayer
- Insured patients are heavily subsidised
- because of information deficiencies, it is difficult to pay providers by results

# The roles of actors and the nature of incentives differ across OECD health systems

- mixes of 3 main types of sub-system
  - private market
  - public contract
  - public integrated
- Impact of performance measures will vary
  - e.g. consumers in the US versus consumers in the UK
  - e.g. government in the US compared with governments in Canada or the Netherlands

# Chart 3.

## Type 1 - Health systems with private health insurance and private providers.

### Key actors in relation to objectives.

Objectives /\nActors	Respon- siveness	Health Outcomes	Prices and unit costs	Level of health expenditure	Equity
Consumers	<b>V</b>	v	v	v	
Professional providers	<b>V</b>	<b>V</b>	<b>V</b>		
Provider managers	<b>V</b>	v	<b>V</b>		
Purchaser managers	v		<b>V</b>	<b>V</b>	
Government				v	<b>V</b>

## Chart 4.

**Type 2 - Health systems with social health insurance and private or mixed providers.  
Key actors in relation to objectives.**

Objectives Actors	Respon- siveness	Health Outcomes	Prices and unit costs	Level of health expenditure	Equity
Consumers	<b>V</b>	v	v		
Professional providers	<b>V</b>	<b>V</b>	v		
Provider managers	<b>V</b>	v	<b>V</b>		
Purchaser managers	v		<b>V</b>	<b>V</b>	
Government				<b>V</b>	<b>V</b>

## Chart 5.

**Type 3 - Health systems with general taxation funding and public providers. Key actors in relation to objectives.**

Objectives Actors	Respon- siveness	Health Outcomes	Prices and unit costs	Level of health expenditure	Equity
Consumers		v			
Professional providers	<b>V</b>	<b>V</b>	v	v	
Provider managers	<b>V</b>	v	<b>V</b>		
Purchaser managers	v		<b>V</b>	<b>V</b>	
Government				<b>V</b>	<b>V</b>

# Case studies of applying performance measures in different systems

- Netherlands
- Sweden
- UK
- US

# Be alert for tradeoffs

- quantity at the expense of quality
- efficiency at the expense of equity (and vice versa)
- paperwork at the expense of service delivery
- extrinsic motivation at the expense of intrinsic motivation

# Be alert for unwanted side effects

- misrepresentation and fraud
- tunnel vision
- myopia
- complacency
- gaming

# Exploiting international comparisons

- OECD's project on the causes and consequences of different rates of diffusion of technologies for specific diseases
- WHO's comparisons of performance and what determines the variations

# Key questions?

- How do we overcome the lack of health outcome measures?
  - Speed up the introduction of record linkage and electronic patient records?
- How do we better align incentives with policy objectives?
  - pursue payment by results?
- How do we reconcile self-regulation with accountability?
  - Give more support to self-regulation, establish a presumption of ‘no blame’, but require more openness?