

## **IX Forum International de la gestion de la santé organisé par les Echos**

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Ladies and gentlemen,

Thank you for inviting me to address your Forum today.

The reform of health systems is high on the agenda of all countries across the OECD. I would like to use my time today to share with you some of the main messages that are emerging from the comparative work on reforms to health care systems that we have been conducting at the OECD over the past three years or so and that we will be concluding in spring 2004. In doing so, I will try to give you some impressions on how the French health system compares from an international perspective.

### ***First message: All OECD countries face rising health costs...***

1. Health care costs have risen steadily over the past decade in all OECD countries (Chart 1) and in most countries real health expenditure increased at a faster rate than real GDP. In 2001, for the OECD as a whole, health expenditure represented an average of 8.4 percent of GDP, up from 7.7 percent in 1990 and 7.1 percent in 1980. In France, total health spending accounted for 9.5% of GDP, above the OECD average, but lower than in the United States (which spent 13.9% of its GDP on health in 2001, the highest share among OECD countries), in Switzerland, Germany and Canada.

*...reflecting advances in real income...*

2. Growth in health spending is attributed to several factors. Importantly, per capita health spending is linked to per capita growth in GDP. In general, OECD countries with higher per capita GDP tend to spend more per capita on health (Chart 2). However, there is significant variation across countries. France ranks above the OECD average in terms of total health spending per capita. But here as well, health spending per capita in France remains much lower than in the United States. It is also lower than in several other European countries (for instance, in Switzerland, in Germany and in the Netherlands) and in Canada.

*... improvements in medical technology...*

3. Advances in the capability of medicine to treat and prevent health conditions are widely agreed to be a major factor driving health cost growth. Recent developments in imaging, biotechnology, and pharmacology suggest that this trend is likely to continue. For instance, the number of magnetic resonance imaging (MRI) units which are used to diagnose a wide range of diseases has more than tripled on average across OECD countries during the 1990s, rising from 1.7 per million population in 1990 to 6.5 in 2000. While the number of MRI units has also increased in France, their number was lower in 2000 (2.6 per million population) than in most other OECD countries.

4. As well, the rise in pharmaceutical spending has been one of the factors behind the increase in total health spending in many OECD countries. For example, between 1990 and 2001, the share of health expenditure spent on pharmaceuticals in France increased from 16.9% of total health spending to 21%, one of the steepest increases among OECD countries (Chart 3). In 2001, only the United States spent more per capita than France on pharmaceuticals.

5. Most OECD countries have been applying a mix of tools for controlling the rise in pharmaceutical expenditure over the past two decades. An increase in cost-sharing for pharmaceuticals has been a common feature. In France as in other OECD countries, the number of drugs not reimbursed has increased, mainly

for “comfort” drugs or those without proven therapeutic value. But the degree of cost-sharing has been increased for many other drugs as well.

***...and population ageing***

6. Population ageing is also expected to play an important role in driving future growth in health spending. Across OECD countries, the share of the population aged 80 and over now exceeds three percent and is growing in most OECD countries. It is not clear whether population ageing will itself place greater strains on the acute care system, as there is evidence that care costs are concentrated in the last two years of life.

7. However, even if acute care costs do not escalate, the growth in the absolute number of older people does mean that the number of people in need of assistance with daily living is likely to grow. Until now, most long term care of the elderly has been provided by other family members. In most countries, elderly people have a strong preference for “ageing in place” and prefer to avoid institutionalisation as long as possible.

8. The tendency over recent decades has been to reduce the number of institutionalised beds, in favour of increasing support for people remaining in their own homes as long as possible. However, the demographic changes which have led to ageing also mean that the capacities of families to provide such care could decline in the future.

9. Overall, the OECD has projected recently that total health-care spending will increase by an average of nearly 2 percent of GDP over the period 2000 -- 2050 as a direct result of population ageing. This implies that either the income of elderly people themselves will have to meet some of the burden or that other means (such as the introduction of a new pillar in the welfare system, an option currently contemplated in France) will have to be found.

*... which are putting pressure on public budgets*

10. More broadly, concerns about health cost growth reflect the pressure such growth places on public budgets. Given the predominance of publicly financed health insurance coverage or direct public financing of care in most OECD countries, the public sector accounts for the greatest part of health spending in all countries except Korea, Mexico, and the United States (Chart 4). And even in the United States, where the private sector plays an unusually large role in financing, public spending on health represents 6% of GDP, comparable to the OECD average percentage represented by public spending.

11. In France, 76% of health spending in 2001 was funded by public sources, slightly above the average in OECD countries. Private sources accounted for the remaining 24%. Private insurance (including the *mutuelles* and other private insurance) accounted for about 13% of total health spending, a larger share than in most other OECD countries, except in the United States (35%) and the Netherlands (15%). The share of health spending paid directly by consumers represented about 10% of total health spending in France, a lower level than in most other OECD countries.

***Second message: there has been a general trend towards improved access to care***

12. A rising health spending to GDP ratio is not necessarily problematic from a policy perspective. Indeed, an emerging dilemma facing governments is judging the “appropriate” level of health spending. On the one hand, social welfare may well be improved by increased government spending, particularly if it translates into improvements in access to care, in the quality of care and in the resulting health outcomes.

13. Work conducted at the OECD under the three year Health Project has confirmed that by using various mixes of public and private health insurance, most OECD countries have achieved great improvements in access to care. However, this has not always been enough to ensure full and fair access across the entire population. We identified various remaining barriers to access in some countries

including: user fees which affect the poor more than the rich; maldistribution of services in relation to certain rural areas; and low take up by certain vulnerable populations.

14. The French health system compares well in the area of access to care. Unlike other countries, France does not suffer from long waiting times for elective surgery. The French health system offers patients a great range of choice of both generalist and specialist care and a choice of public and private hospitals under universal health insurance. Utilization of health services in France is mainly very equitable across income groups. And the introduction of the CMU (Couverture Maladie Universelle) has reinforced this trend. However, as in many other countries, there is slight 'pro-rich' inequity in visits to specialists and in visits to dentists.

***Third message : there have been dramatic improvements in health outcomes but not enough attention is paid to preventive as opposed to curative actions***

15. Partly as a result of improvements in access, combined with technological advances in health care, there have been dramatic gains in health status in all OECD countries in the past 40 years in the OECD area as a whole. For example, life expectancy at birth increased from 68.5 years in 1960 to 77.2 years in 2000. However, it is hard to say how much of this gain was due to better health care and how much was due to, say, rising standards of living and better diets. France had one of the longest expectations of life for women among OECD countries in 2000 (82.7 years) and had above average life expectancy for men (75.2 years). Japan had the highest life expectancy among OECD countries, with 81.2 years, followed by Switzerland, Sweden and Iceland with a life expectancy close to 80 years.

16. However, in France, the gender gap in life expectancy at birth was 7.5 years, a much wider gap than in most other OECD countries (Chart 5). France ranks equal second with Spain in life expectancy at birth among women, but it ranks only fifteenth for men. This gap reflects at least partly the relatively high mortality rates among French men due to violent deaths (for instance, road traffic accidents and suicides) and to diseases associated with excessive tobacco and alcohol consumption. Over the past two decades, the

proportion of daily smokers among adults has declined in most OECD countries. In France, the proportion has also fallen but more slowly than in other countries and while it was lower than the OECD average in 1980, it is now higher. And while the percentage of women who report smoking every day has declined in most OECD countries, it has increased in France over the past two decades.

17. Looking at infant health, the infant mortality rate has fallen greatly in most OECD countries over the past few decades, reflecting improvements in the living conditions of mothers and newborns as well as medical progress. The infant mortality rate in France stood at 4.6 deaths per 1 000 live births in 2000, below the OECD average.

18. However, across the OECD, general improvement in health status has been accompanied by a rise in the prevalence of some chronic diseases. This can be attributed to several causes, an important one being that not enough attention is devoted to preventive care. On average OECD countries spend less than 10 per cent of total health expenditure for prevention. I have already mentioned the issue of tobacco and alcohol use, which, as we all know, are related to the incidence of many cancers. Another important problem, which is becoming particularly worrisome, is high and rapidly rising levels of obesity, a risk factor for numerous chronic health conditions. Obesity rates have increased in recent decades in all OECD countries (Chart 6). In France, the obesity rate among adults remains lower than in most other developed countries, although it is rising to 11.3% in 2003, up from 8.2% in 1997. Among OECD countries, obesity rates are highest in the United States (31% en 1999), the United Kingdom (22% en 2001) and Australia (21% en 1999).

***Fourth message: improvements in the quality of care have not always been linked to higher spending***

19. Clinical outcomes, such as cancer survival rates and rates of disability among those with chronic conditions, serve to reflect more directly the effectiveness of care received, as compared with health status measures. International comparisons of outcomes for conditions such as ischaemic heart disease have uncovered significant differences in case mortality (Chart 7). Among European countries, France and

Austria (equally) have the highest percentage of male patients alive 5 years after diagnosis of all cancers (57.9%).

20. However, the best outcomes have not always been found to be linked with greatest resource use or volume of services, suggesting that there may be opportunities in some countries to simultaneously reduce costs while maintaining or even improving quality and health outcomes.

21. Indeed, there have been reports from a growing number of countries of concern with the quality of care, indicating that services are overused, underused and delivered in a technically poor manner. For example, evidence has been found in the United States of failings to deliver recommended clinical care, even when it is cheap to do so, such as provision of aspirin to patients following a heart attack. Another example which is common in many countries concerns unnecessary or repeated diagnostic tests and procedures that add to cost, often at little or no potential benefit to patients.

22. As a result, there has been a growing interest in some countries in developing indicators of outcomes in order to base treatment decisions on evidence and not customs as well as in holding providers to account beyond the traditional agenda of professional self regulation, for example by introducing external reviews of quality and informing consumers about quality to aid their choice of insurer or provider.

***Fifth message: there is great scope for improving efficiency***

23. Because of continued pressure for cost increases and some evidence that the same or better outcomes could be obtained at lower costs, OECD countries are striving to increase value for money in health systems. A number of efforts are being made in this area. Let me just give you a few examples of some the issues currently under discussion in member countries.

24. First, what is clear is that the productivity and responsibility of the health workforce is critical to efficiency in health care. And there is some evidence that medical practitioners' productivity is affected by

types of payment methods. In ambulatory care, there is a growing interest in rewarding physicians for quality of care and outcomes. A new contract for general practitioners based on payment for quality has for instance been introduced in the UK.

25. Similarly, in hospitals there is now a widespread move across countries – including France – towards adopting prospective, case-related payments to hospitals based on diagnosis-related group (DRGs) rather than fee for service or simple global budgets in order to reward hospitals that better respond to demand without necessarily increasing costs.

26. Second, a major problem in the vast majority of OECD countries is that consumers and patients do not feel the effects of increasing prices because of minimal cost-sharing requirements. The poor and the sick, who are the highest users of health care services, are often exempted from any payments so as to facilitate their access to services. And even for the healthier, higher-income populations, price sensitivity is low given that private and complementary health insurance covers most out of pocket payments. Many countries are now reflecting on ways to increase consumers' sensitivity to incurred costs.

27. There are many other options being contemplated to improve efficiency, such as finding the optimal mix of skills among the medical workforce, i.e. the respective roles of doctors and nurses. As well, many countries are currently reflecting on the optimal distribution of acute and long-term care beds and on the continuum of care between ambulatory and hospital care. But let me finish by giving you one example where there is evidence of at least one dramatic improvement in efficiency. The Veterans Health Administration (VHA) is a large, tax funded public provider of health care in the US, which underwent a major transformation in the mid 1990s. There was a shift from hospital care to ambulatory care of patients and from treatment to prevention. The emphasis was on keeping people, especially those with chronic diseases, out of hospital. Under performance guidelines and targets, there was a sharp increase in effectiveness and quality. Satisfaction among patients increased significantly. All of this was achieved with a flat budget from 1995 to 1999. Expenditure per patient fell by 27%. A key instrument in achieving these

efficiency improvements was the introduction of comprehensive electronic patient records. Similar reforms are now being taken up by private plans in the US. There may be lessons here for many health systems in other countries.

28. Improvements in efficiency remain one of the most attractive options for reform because they offer the way ahead to raise access and quality while holding or even reducing costs. What is clear though is that as France and other countries face these important choices, reforms will only succeed if all actors of health systems are fully informed about the challenges ahead and become active and responsible actors in the reform process.

***To conclude***

29. Health systems differ widely in their design, in the inputs they employ and the outcomes they attain. Yet policy makers across the OECD have endorsed very similar performance objectives and virtually all countries are facing a common objective of improving the performance of their health systems. They are all grappling with the issues of how to assure sustainable financing of health care, maintain equitable access to services, attain better health outcomes, increase responsiveness to consumer expectations and improve value for money. In 2001, the OECD initiated the Health Project to address these challenges and to help member countries better understand the sources of these problems and their potential solutions. I believe that the work conducted under the auspices of the OECD Health Project is very valuable. By comparing health systems across countries, it tries to identify best and worst practices, it allows governments and other stakeholders to share information on what works and what does not depending on the circumstances, and it is contributing to the public debate. Results of this project will be presented to Health Ministers in spring next year in a report that will assess policy options and will point to avenues for improvement.

Thank you for your attention.