



More value for money: Improving efficiency in OECD health systems

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Health Systems - Approaching the Future, Berlin

20 January 2004



The context for reform

Rising health expenditures

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Growing challenges to financing sustainability

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Increasing demand to improve performance

(e.g. responsiveness, quality, patient satisfaction)

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Motive for reform to improve health system efficiency, or
“value for money”

Efficiency of OECD health systems: what do we know?

- Complexity, market failures, extent of government intervention suggest potential for distortions that reduce efficiency
 - Some inefficiency may be an acceptable trade-off with other policy goals, such as equity in financing or access to care
- Very large cross-country variation in resources, activity and health system performance
 - Highest spending and activity levels do not always translate into best results (e.g. health-care outcomes, waiting times, patient and consumer satisfaction, equitable access to care)

Efficiency of health systems (cont'd)

- Example: acute hospital care
 - Acute-care beds per 1000 pop. varied from 1.0 (MEX) to 6.7 (LUX) in 2000 (DEU 6.4, OECD average 4.0)
 - Hospital discharges per 1000 pop. varied from 40 (MEX) to 284 (AUS) in 2000 (DEU 197 in 1999, OECD average 144)
 - Average length of acute-care stay varied from 3.6 (MEX) to 11.0 (KOR) in 2000 (DEU 9.6, OECD average 6.9)
 - Cardiac bypass procedures per 100 000 pop. Varied from 1 (MEX) to 205 (USA) in 2000 (DEU 90)
- Example: waiting times for elective surgery
 - In general, lowest-spending OECD countries have the longest waiting times and highest-spending countries have no waiting
 - However, one high-spending country has relatively long waiting; one low-spending country has low waiting. Of mid-spenders, four have waiting times and three do not.

Examples of potential inefficiency, or opportunities to increase value

Symptom

Excessive waiting times for elective surgery

High costs & use (procedures, medicines) with no better outcomes

High administrative costs

Underlying problem

Shortfalls in surgical capacity or productivity

Excessive productivity (diminishing marginal returns)

Complexity, redundancy, or fraud and abuse

Lessons from the reform experience

- Demand-side reforms
- Supply-side reforms
- Structural reforms

Demand-side reforms to health systems

- Managed-care techniques and demand management can be effective administrative controls
 - e.g. gatekeepers to specialist services, prior approval systems, case management and disease management programs
- Modest patient cost-sharing or user fees can help
 - Can reduce demand, although a blunt instrument, as long as PHI does not cover patient responsibility
 - Can reduce public finance burden
 - Need to protect access for poor (exemptions) and finances for sick (caps)
 - Sophisticated cost-sharing requirements can reward efficiency in patient choices
- Future directions: experimentation with education and information campaigns steered to guiding consumers and patients to cost-effective care, limited experience to date

Supply-side reforms to health systems

- Developments in health-care purchasing and payment arrangements
- Attention to service mix and quality of care
- Effort to harness power of competitive markets in health care and health insurance markets
- Management of health technology

Supply-side reforms: purchasing and payment

- Contractual and payment arrangements changed to better align incentives of providers with output goals
 - Move from cost-based reimbursement systems to prospective payment systems
 - Move to activity-based financing systems, including DRG-based payments for hospitals and blended payment arrangements for physicians
 - Productivity increases create pressure for health cost growth
 - New frontier: performance-based payments
- Trend towards increased sophistication in purchasing of health care services by social and private insurers
 - Interest in selective contracting, which may be best suited to multiple-insurer systems

Supply-side reforms: service mix and quality of care

- Attention to the array of services furnished
 - Changing the balance between disease prevention and health promotion/ acute health care
 - Need for better integration of acute care and long-term care
- Increased policy attention on health-care quality
 - Quality monitoring systems, using performance measures and better data, are fundamental key to reform
 - Tendency to move away from reliance on professional self-regulation
 - Evidence-based practice guidelines and accreditation programmes
 - Potential of information and communication technology applications for health care (e.g. electronic medical record, error prevention)
 - Experience has shown that quality improvements can be cost-reducing

Supply-side reforms: competition

- Efforts to introduce price competition among hospitals have not proved successful in most cases
 - Lack of excess capacity, concerns about local access, resistance from health workforce
 - Exception of United States, in some markets
- Some public-contract systems have tried to introduce competition in insurance markets
 - Difficulty overcoming incentive to compete on basis of risk, rather than value
 - Developments have not fed through into provider markets
 - Concerns about the long-term sustainability of competition in these markets because of cream skimming

Supply-side reforms: technology

- Management of technology has large implications for efficiency, costs, and outcomes
 - Health technology largest factor driving cost growth, also responsible for quality improvements
 - Use of health technology assessment in decisions regarding adoption, coverage, payment
 - Increasing effort to take value into account in decision-making
 - More cross-country cooperation in evidence-sharing possible
 - Conditional acceptance, combined with risk-sharing, can assure access to new tech while new information developed
 - Pharmaceutical pricing methods can encourage cost-effective prescription choices and reward true innovations

Structural reforms to health systems

- Within tax-financed, publicly administered health systems, several approaches have been used to better replicate normal economic markets
 - Separation of public responsibilities (purchaser, provider)
 - Increased managerial capacity and independence, combined with responsibility, within public hospitals
- Outcome of centralisation/decentralisation changes has varied across countries
 - Local decisionmaking may improve matching of needs, resources
 - Some functions best performed centrally

Lessons from the efficiency reform experience

- Better information systems and performance data are needed to support assessment and improvement of health care efficiency
- Increasing efficiency may require some additional, targeted investments (for example, in information systems or management improvements)
- Experience has shown that quality improvement can be cost-saving

Lessons from the efficiency reform experience (cont'd)

- Great scope to better align incentives of health system with desired outputs
- Systems could benefit from move away from blunt cost-containment instruments to more sophisticated approaches that take quality, outcomes, and value into account
- Important to adopt an evidence-based approach
 - Evidence-based medicine
 - Evidence-based policy making