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HEALTH CARE SYSTEMS: GETTING MORE VALUE FOR MONEY

Economics Department
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Health care systems: getting more value for money

The OECD has assembled new comparative data on health policies and health care system efficiency for its member countries. The aim is to better identify strengths and weaknesses of each country's health care system and assess whether there is scope for improving value for money and the policy reforms that will boost efficiency. Key findings are as follows:

⇒ There is room in all countries surveyed to improve the effectiveness of their health care spending.

⇒ On average across the OECD, life expectancy at birth could be raised by more than two years, while holding health care spending steady, if all countries were to become as efficient as the best performers. By way of comparison, assuming no reform, a 10% increase in health care spending would increase life expectancy by only three to four months.

⇒ There is no health care system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed. Both market-based and more centralised command-and-control systems show strengths and weaknesses.

⇒ Health outcomes are highly disparate across individuals and such inequalities can be reduced without sacrificing efficiency. Inequalities tend to be relatively low in countries with a well-regulated private insurance-based system. Centrally-managed systems can also deliver good equity outcomes at the same time as keeping spending low.

⇒ There is no "one-size-fits-all" approach to reforming health care systems. Policymakers should aim for coherence in policy settings by adopting best practices from the many different health care systems that exist in the OECD and tailor them to suit actual circumstances.

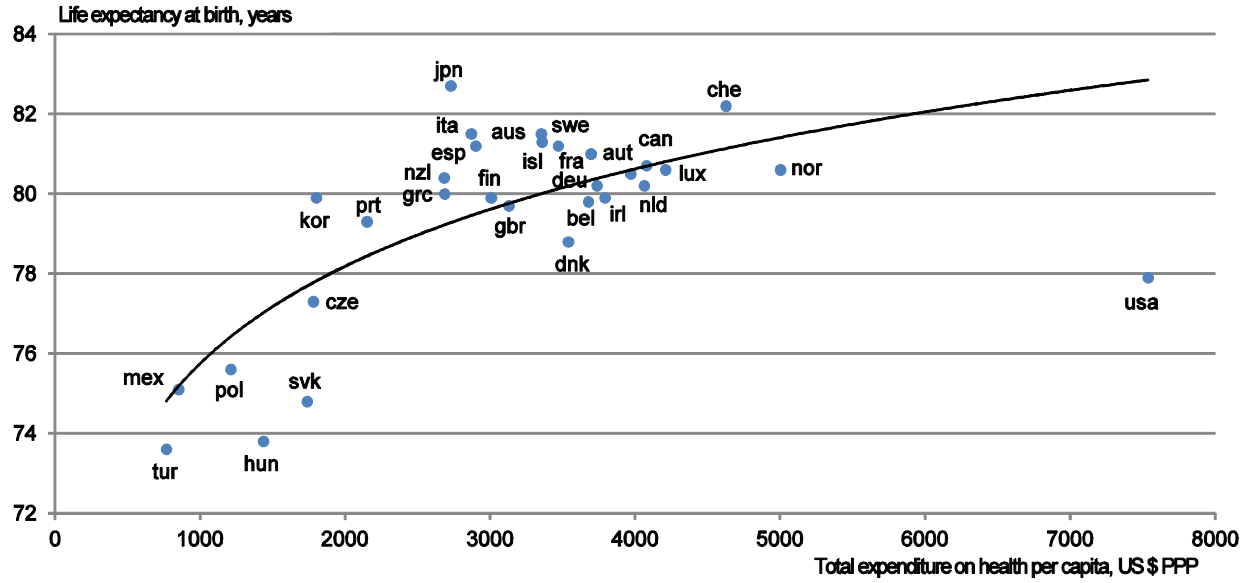
⇒ By improving the efficiency of the health care system, public spending savings would be large, approaching 2% of GDP on average in the OECD.

There is a clear need to contain public spending on health care

1. Achieving value for money in the health care sector is an important objective in all OECD countries. Health care spending per capita has risen by over 70% in real terms since the early 1990s. This is reflected in a significantly healthier population – as shown by increased life expectancy and lower mortality for diseases such as cancer. Indeed, life expectancy has increased, on average, by about 1 year every 4 years since the early 1990s. But, as a result of the run-up in outlays, total spending on health care now absorbs on average over 9% of GDP in the OECD, though with a wide cross-country variation. And the countries that spend the most are not necessarily the ones that fare best in terms of health outcomes (Figure 1), suggesting that there is scope to improve the cost-effectiveness of spending.

2. Health care spending indeed needs to become more effective. Otherwise, health care demand will undermine public finances. The recent crisis and its impact on public budgets have heightened pressures for reform and made it more urgent. Public spending on health care is one of the largest government spending items – on average it absorbed 15% of general government spending in 2007 (more than 6% of GDP), up from 12% in 1995. Furthermore, population ageing, rapidly rising health care prices and costly developments in medical technology are putting upward pressures on health care budgets. The OECD projects that public health care spending could increase by 3.5 to 6 percentage points of GDP by 2050 across the OECD countries.

Figure 1. **There are large differences in life expectancy and health care spending across OECD countries** 2008[1]



1. Or latest year available.
Source: OECD Health Data 2010.

The efficiency of health care systems could be increased significantly, helping fiscal consolidation

3. Governments care both about the health status of populations and budget sustainability. There is no doubt that healthier populations are important for thriving economies, but could better health outcomes be achieved while reining in spending pressures? New research suggests that all OECD countries could get better value for money from their health care spending. One way of gauging the efficiency of health care spending treats life expectancy as the outcome of health spending. True, it is only a partial indicator since it does not reflect the prevalence of disease, disability or quality of life and data constraints are significant. Nevertheless, as research by Joumard *et al.* (2008) shows, life expectancy is highly correlated with other indicators of health status, including infant and premature mortality and better quality of life due to improved medical treatment. Life expectancy reflects not just health spending but also choices of lifestyle, such as tobacco and alcohol consumption and education levels. These factors have been taken into account when assessing the efficiency of health care spending. Various methods and assumptions about the effect of health care spending on life expectancy have been tested and the results are robust. Overall, they suggest that:

⇒ On average across the OECD, life expectancy at birth could be raised by more than two years – holding health care spending steady – if all countries were to become as efficient as the best performers. By way of comparison, a 10% increase in health care spending would increase life expectancy by only three to four months.

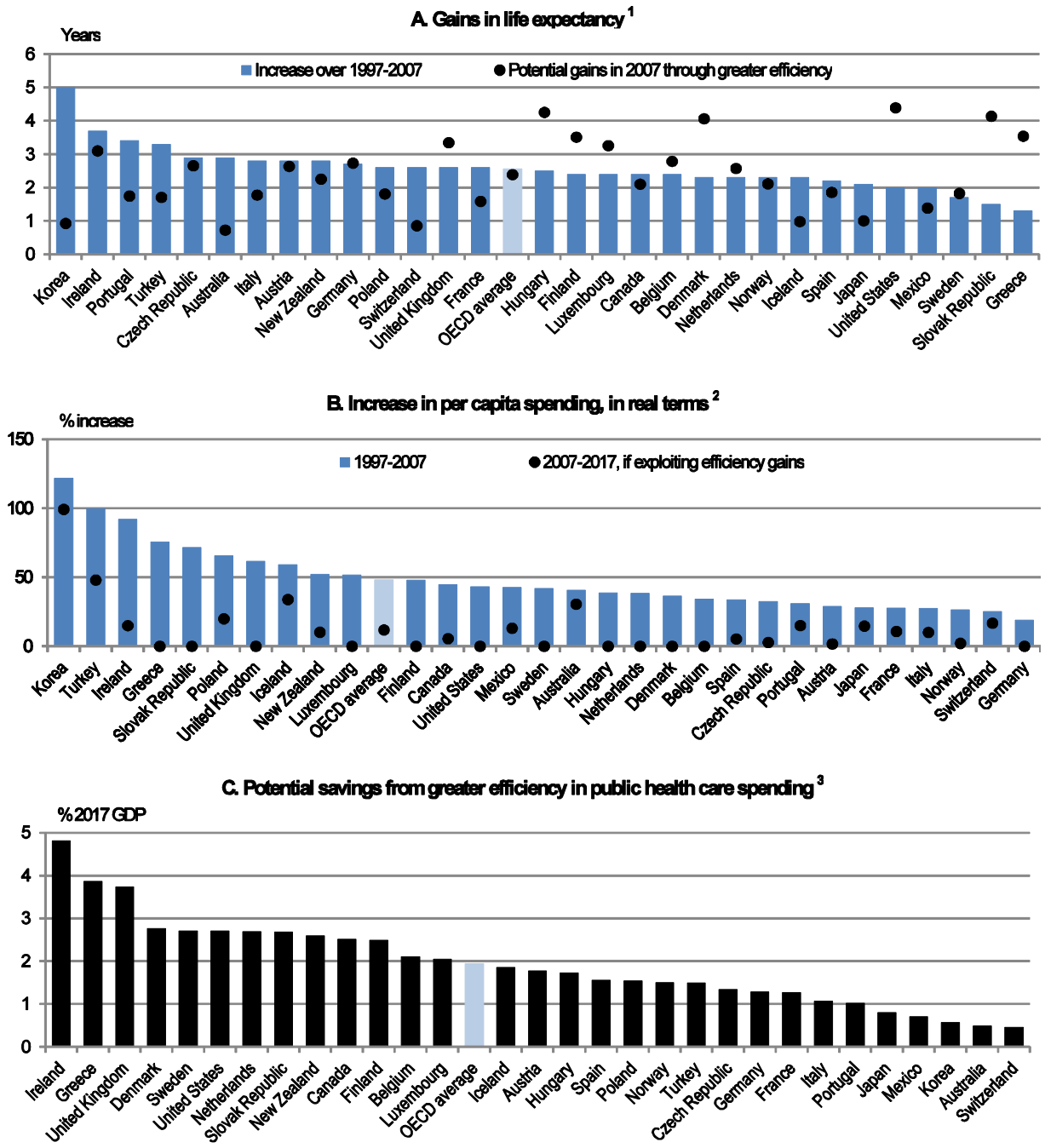
⇒ The potential for efficiency gains varies widely across countries, from less than one extra year of life expectancy in Australia to over 4 years in Hungary (Figure 2, Panel A). Australia, Iceland, Japan, Korea and Switzerland perform best in transforming spending into health outcomes.

⇒ In more than one third of OECD countries, exploiting efficiency gains in the health care sector would allow improving health outcomes as much as over the previous decade while keeping spending constant (Figure 2, Panel B). Germany, the United Kingdom and the United States fall into this group. In a majority of OECD countries, however, continuing to improve health outcomes would require increasing health care spending, though by a smaller amount than over the previous decade.

⇒ By improving the efficiency of the health system, public spending savings would be large as compared to a no-policy-change scenario, amounting to almost 2% of 2017 GDP on average in the OECD. It would be over 3% for Greece, Ireland and the United Kingdom (Figure 2, Panel C).

⇒ There is no trade-off between achieving more equal health outcomes within countries and raising the average health status of the population. Indeed, the countries with the lowest health inequalities also tend to enjoy high health status – Iceland, Italy, and Sweden are good examples.

Figure 2. **Achieving efficiency gains would help contain spending over time**



1. Potential gains are derived from an output-oriented data envelopment analysis (DEA) performed with one output (life expectancy at birth) and two inputs (health care spending and a composite indicator of the socio-economic environment and lifestyle factors). They are measured by the number of years of life that could be saved if efficiency in country i were to be raised to the level implied by the estimated efficiency frontier while holding inputs constant and under the assumption of non-increasing returns to scale.
2. For the period 2007-17: assuming that countries exploit estimated potential efficiency gains, life expectancy over the period 2007-17 could increase at the same pace as over the previous ten year period but at a much lower cost in many countries.
3. Potential savings represent the difference between a no-reform scenario and a scenario where countries would become as efficient as the best performing countries.

Source: OECD Health Data, 2009; OECD calculations.

Policies and institutions to steer the demand and supply of health care services differ

4. The new dataset on health policies and institutions reveals that:

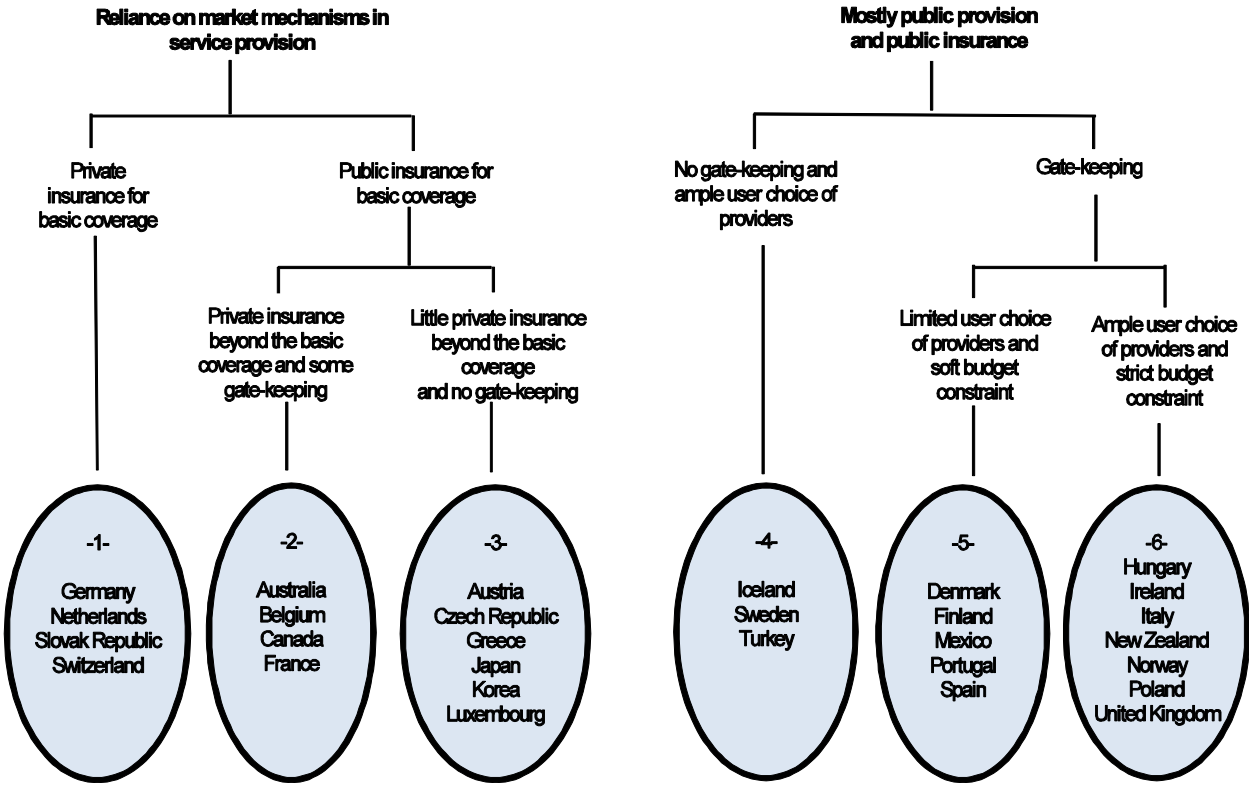
⇒ The basic insurance coverage – measured by population covered, services included and the degree of cost-sharing – is fairly similar across countries. Mexico, Turkey and the United States are the exceptions, with still a large share of the population not covered in 2009.

⇒ Some OECD countries rely heavily on centralised command-and-control systems to steer the demand and supply of health care services while in a few countries regulated market mechanisms, such as fee-for-services, competition driven by user choice and private insurance, play a dominant role. But more and more countries rely on a mix of the two.

⇒ Different sets of policy instruments often work in a complementary way: for instance, countries that use fee-for-services also rely on private providers while command-and-control systems which pay set wages rely on standard-setting and rules, such as family doctors who act as gate-keepers to the wider health system and quotas for medical students.

⇒ Six groups of countries sharing broadly similar institutions – or health care systems – have been identified (Figure 3).

Figure 3. **Groups of countries sharing broadly similar institutions**



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The countries on the left such as Germany and the Netherlands tend to rely on market mechanisms to supply health care whereas those on the right such as Finland and the United Kingdom depend more on public command and control. Apparently diverse countries fit the same group; the rules in Iceland, Sweden and Turkey for instance all provide for ample user choice, even if in practice there are geographical and other constraints. Note that the United States did not participate in the survey.

There is no superior health care system

5. Several important differences in outcome and spending levels across groups can be identified. In particular:

⇒ Spending levels tend to be high in countries relying most on market mechanisms (groups 1 and 2) and while some of these countries have a long life expectancy as Figure 1 shows, they are not alone.

⇒ Inequalities in health status are high in several countries. Interestingly, inequalities tend to be relatively low in three of the four countries with a private insurance-based system – Germany, the Netherlands and Switzerland. One reason may be that regulations in these countries – such as the requirement on insurers to enrol any applicant and equalisation schemes across insurers to compensate for high risk enrolees – can help limit the hunt for better-off patients and the desire to shed bad risks (so-called "cream-skimming"). These and other potential biases can be caused by market mechanisms if left unchecked. Note that inequalities are often caused by factors that have little to do with the health care system itself, such as social status and education.

⇒ Administrative costs tend to be higher in those countries where private insurance plays the predominant role (group 1). They also exceed the OECD average by a considerable margin in Belgium, France, Luxembourg, Mexico and New Zealand, signalling a potential for reducing spending in these countries.

6. There is no health care system that performs systematically better in delivering cost-effective health care. In fact, the efficiency estimates vary more within country groups sharing similar institutional characteristics than between groups. In other words, big-bang reforms are not warranted. Rather, it may be more practical and effective for each country to adopt the best policy practices implemented by countries in its own group while borrowing the most appropriate elements from other groups.

Moving towards best practice could yield substantial efficiency gains

7. Across and within country-group comparisons allow spotting strengths and weaknesses and identifying areas where achieving greater consistency in policy settings could yield efficiency gains (see Box for a concrete example). The key results from the indicators are as follows:

⇒ Reinforcing priority setting would contribute to improved efficiency. This would require particular attention in countries such as Austria, Greece, Luxembourg, Mexico and Sweden that neither define the health benefit basket precisely nor use health technology assessments.

⇒ Assigning responsibility across government levels and/or agencies in a more consistent manner would lead to less duplication and/or better accountability in Australia, Canada, Denmark, Italy, Mexico, Sweden, Switzerland and the United Kingdom.

⇒ More balanced provider payment schemes, for instance between performance-related pay and set wages, would lead to a better match between demand and supply in health care in many countries.

⇒ A quality out-patient care sector is a necessary condition for achieving high efficiency in several countries (including Austria, Finland, Hungary and Poland). Targeting spending on this sector would bring more value for money by, for instance, reducing costly hospital admissions for conditions such as asthma and cataract surgery.

⇒ Belgium, France and Ireland, where activity-based payment systems for hospitals have recently been introduced, may need to ease regulations on hospital staffing and equipment to improve the system's ability to respond to demand and improve efficiency. By contrast, such regulations may need to be strengthened where hospitals work with relatively flexible budget limits, such as in Finland.

⇒ In Japan, Luxembourg, Poland and Switzerland where choice is abundant, providing better user information on the quality and prices of health care services would foster competition.

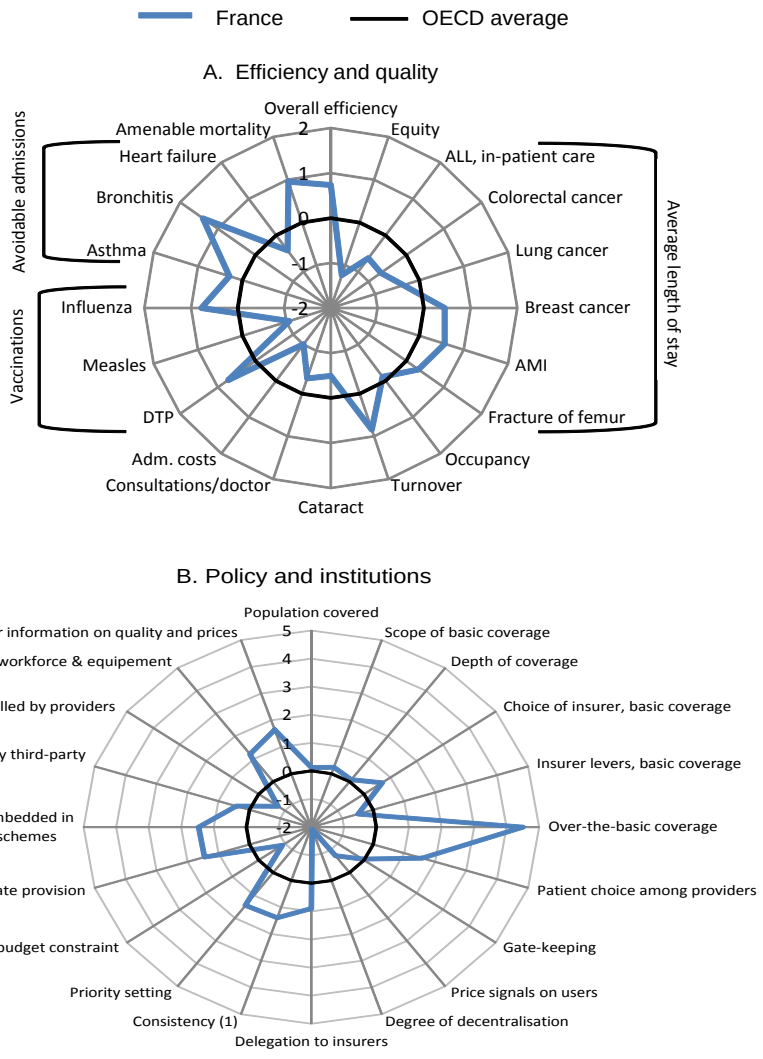
⇒ More stringent gate-keeping would reduce the number of consultations in the countries where they are particularly high, including the Czech Republic, Korea and Japan, or limit spending in the in-patient care sector in countries such as Belgium and Iceland.

How to use the new health care indicators: the case of France

The set of indicators reveals that, overall, the French health care system performs relatively well. Spending on health care is high but so is life expectancy. France even scores best among the OECD countries on amenable mortality – that is, mortality that could be avoided thanks to timely and effective health care. Looking at performance at the sector level reveals that the quality of out-patient and preventive care is high, as shown by the low number of avoidable hospital admissions (in particular for asthma and chronic bronchitis). Efficiency in the acute care sector – as measured by disease-specific length of stays as well as the turnover rate for acute care beds – also tends to be above the OECD average. Still, various indicators (including the large share of spending devoted to in-patient care and that of cataract surgeries performed in the in-patient care sector) point to a lack of co-ordination or mis-allocation of resources between the in- and out-patient care sectors. And inequalities in health status and administrative costs are high by OECD standards.

Looking at the policy and institutional indicators, France stands out for relying heavily on complementary private health insurance as well as for the multiplicity of insurance funds providing the basic coverage. These may lead to health inequalities and high administrative costs. In the hospital sector, global budgeting has been gradually replaced by an activity-based payment system, which should prompt hospitals to seek efficiency gains. However, staffing and equipment in hospitals remain heavily regulated and this may hamper the re-allocation of resources and thus limit the ability of hospitals to exploit efficiency gains.

France: a subset of health care indicators



Note: In Panel A, data points outside the average circle indicate that France performs better than the OECD average. Data points represent the deviation from the OECD average and are expressed in number of standard deviations. In Panel B, data points outside the average circle indicate that the level of the variable is higher than for the average OECD country (*e.g.* France offers users more choice among providers). They are simple deviations from the OECD average. For more details, see Joumard *et al*. (2010).

1. Consistency in responsibility assignment across levels of government.

Source: OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009.

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