

Executive summary

Improving health care systems, while containing cost pressures, is a key policy challenge in most OECD countries. The recent economic and financial crisis has weighed heavily on fiscal positions – with gross government debt projected to exceed 100% of GDP in the OECD area by 2011 – and reinforced the need to improve public spending efficiency. Public spending on health care is one of the largest government spending items, representing on average 6% of GDP. Furthermore, health care costs are escalating rapidly, driven by population ageing, rising relative prices and costly developments in medical technology. Public health care spending is projected to increase by 3.5 to 6 percentage points of GDP by 2050 in the OECD area. Against this background, exploiting efficiency gains will be crucial to meet rapidly growing health care demand, without putting the public finances on an unsustainable path.

The OECD has assembled new comparative data on health care system performance and health policies. They allow the identification of strengths and weaknesses of each country's health care system and the policies that will boost efficiency. The first chapter of this book reviews existing measures of, as well as recent developments in, health care outcomes and spending. The second chapter presents two approaches to derive cross-country comparisons of health care spending efficiency and compare these indicators with existing performance indicators. The third chapter provides a brief overview of the main health policy instruments and institutional features which affect health care system efficiency and presents indicators built on the basis of a questionnaire completed by 29 OECD countries. The fourth chapter identifies empirically different types of health care systems. It then investigates the links between policy settings and health care system efficiency. The principal messages of each chapter are summarised below.

Assessing health care outcomes across OECD countries and over time

Health care spending per capita has risen by over 70% in real terms in the OECD area since the early 1990s. To what extent has this contributed to improve health care outcomes? Defining health care outcomes is challenging since health care policy pursues many objectives, in particular reducing premature mortality, the prevalence of diseases and disability as well as promoting equity. Health care outcomes can further be measured at the system level (*e.g.* longevity), at a disease level (*e.g.* survival rates for specific cancers) or at a sub-sector level (*e.g.* number of hospital discharges). And many factors

affect the health status of the population – including socio-economic and lifestyle factors. And these should be taken into account when assessing the efficiency of health care spending. This book shows that:

- The population health status has increased dramatically over the past decades in the OECD area. An illustration is the increase in life expectancy about one year every four years since the early 1990s. The reduction in premature and infant mortality has also been rapid and a similar conclusion holds when using mortality rates after specific diagnoses such as cancer or acute myocardial infarction.
- Significant cross-country variation in health status persists, however, and the countries that spend the most are not necessarily the ones that fare best. As an example, Japan spends less on health care per capita than the majority of OECD countries but the Japanese enjoy a very high health status. This suggests that there is scope to improve the cost-effectiveness of spending.
- There is generally no trade-off between achieving more equal health outcomes and raising the average health status of the population. Indeed, the countries with the lowest inequalities in health status also tend to enjoy the highest average health status – Iceland, Sweden and Italy are good examples.

Drawing cross-country comparisons of health care system efficiency

Spending on health care has risen steadily over the past decades but are all countries as efficient in transforming health care resources into better health status? Can best practice and potential efficiency gains be identified? One way of gauging the efficiency of health care spending treats life expectancy as the outcome of health spending. Life expectancy reflects not just health spending but also choices of lifestyles, 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:

- Life expectancy at birth could be raised by more than two years on average in the OECD area, holding health care spending constant, 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 if the extent of inefficiency remained unchanged.
- Although estimates of health care spending efficiency are subject to considerable uncertainty, they suggest that Australia, Japan, Korea and Switzerland perform best in transforming money into health outcomes. Margins for improving outcomes while keeping spending constant are the largest in Denmark, Greece, Hungary, the Slovak Republic and the United States.
- 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. Efficiency gains would

be large with estimates suggesting that public spending savings could amount to almost 2% of 2017 GDP on average for the OECD area and over 3% for Greece, Ireland and the United Kingdom.

Building indicators for health policies and institutions

To assess the influence of health policies and institutions on health care system efficiency, a unique set of information on health policies and institutions has been gathered from 29 OECD countries. This dataset covers incentives and regulations affecting the behaviour of producers, users and insurers, insurance coverage as well as the degree of decentralisation and approaches to contain spending. It reveals that:

- The basic insurance coverage – measured by the population covered, services included and the degree of cost-sharing – is substantial and fairly similar across OECD 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. While market-based and regulatory approaches are often presented as two distinct models, in practice incentives and regulations are more often combined than used in isolation.
- Some policy levers tend to be implemented simultaneously, signalling potential complementarities across them. For example, those countries relying extensively on private providers to deliver health care services also tend to implement activity-based compensation schemes for providers and offer users a choice among providers.
- In contrast, some policy instruments are used independently of the other regulatory and market features. The degree of reliance on out-of-pocket payments provides an example. This suggests that, when setting user fees, political economy, fiscal and equity considerations play a greater role than willingness to ensure consistency in policy settings.

Characterising health care systems and assessing the link between efficiency and policies

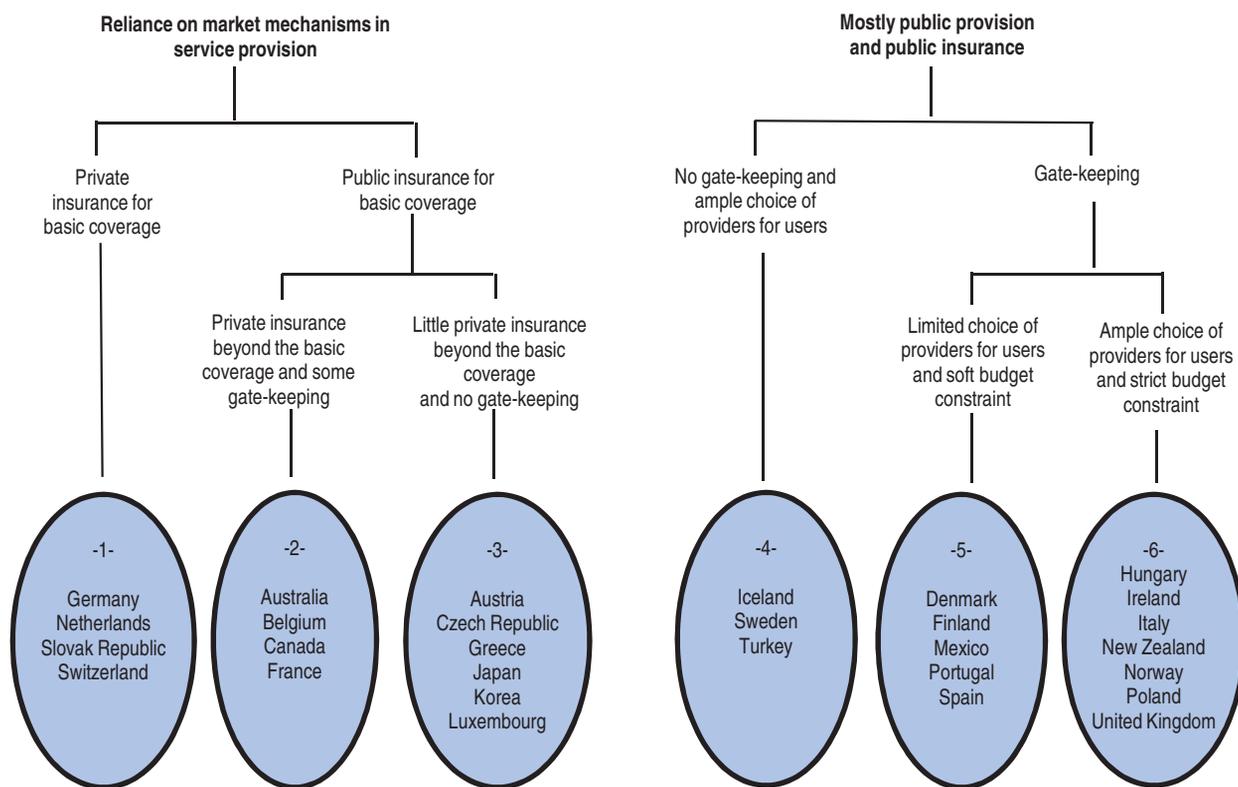
A key contribution of this book is to provide an empirical characterisation of health care systems, which goes beyond classifications based on a few institutional features and to recognise the complexity of institutional features and complementarities across them. Groups of countries sharing broadly similar institutions are identified and performance across and within groups is compared. Some suggestions for policy reform that could raise value-for-money in the health care sector are then derived for each country. The main conclusions can be summarised as follows:

- Six groups of countries sharing broadly similar institutions have been identified (Figure 0.1): one group of countries relies extensively on market

mechanisms in regulating both insurance coverage and service provision; two groups are characterised by public basic insurance coverage and extensive market mechanisms in regulating provision, but differentiated by the use of gate-keeping arrangements and the degree of reliance on private health insurance to cover expenses beyond the basic package; a group where the rules provide patients with choice among providers, with no gate-keeping but extremely limited private supply; and two groups of heavily regulated public systems, separated by differing degrees of the stringency of gate-keeping arrangements and of the budget constraint.

- Efficiency estimates vary more within country groups sharing similar institutional characteristics than between groups. This suggests that no broad type of health care system performs systematically better than another in improving the population health status in a cost-effective manner. Still, within-group comparisons allow the spotting of strengths and weaknesses for each country and identifying areas where achieving greater consistency in policy settings could yield efficiency gains.
- Some suggestions for policy reform apply to many countries, independently of their group. In particular, better priority setting, improved consistency of responsibility assignment across levels of government or agencies, better user information on the quality and price of health care services and better balanced provider payment schemes would be reform options to consider in many OECD countries.
- For some policy instruments, a “one-size-fits-all” approach to reform is not advisable as increasing consistency in policy settings entails implementing different approaches. As an example, regulations concerning the hospital workforce and equipment may need to be softened in some countries and hardened in others.
- Administrative costs tend to be higher in most of those countries relying on market mechanisms to deliver a basic insurance package (Germany, the Netherlands and Switzerland). However, they also exceed the average level by a considerable margin in a few others (Belgium, France, Luxembourg, Mexico and New Zealand), signalling a potential for reducing spending.
- Inequalities in health status tend to be lower in three of the four countries with a private insurance-based system – Germany, the Netherlands and Switzerland – indicating that regulation and equalisation schemes can help mitigating cream-skimming and the effects of other market mechanisms which can raise equity concerns.

Figure 0.1. Groups of countries sharing broadly similar institutions



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.

Source: OECD.