Towards High-Performing Health Systems: The OECD Health Project

Visit of the Swedish Finance Ministry

27 May 2004

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Overview of presentation

- The OECD Health Project: What and why?
- Main findings from the Health Project
- Future OECD work on health

The OECD Health Project: Why?

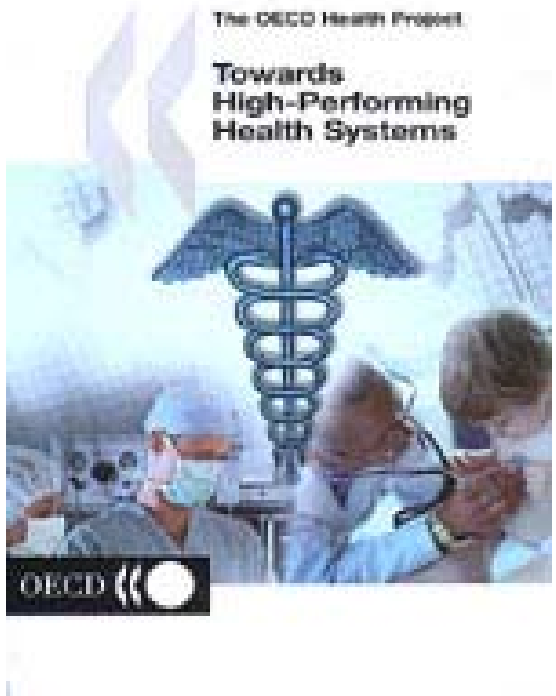
- Health is large & growing share of OECD economies
  - 8.5% on average in 2002, above 10% in 3 countries, 14.6% in US
- Common policy goals
  - Health care that is accessible and of high quality
  - Health systems that are affordable, responsive & good value for money
- Significant cross-country variation
  - Inputs, outputs, system design
- Opportunities to learn from experience, share best practices, develop tools to improve
- OECD comparative advantages
  - Focus on issues key to developed countries
  - Expertise to address questions of health economics

The OECD Health Project: What?

- A new venture for the OECD in 2001
  - Voluntary funding + contribution from OECD Central Priorities Fund
- Work programme guided by Ad Hoc Group on Health
  - 12 studies on health policy issues (reforms, waiting times, workforce)
  - New performance data and indicator development
  - Applied studies of health-system performance
- Work conducted on a horizontal basis
  - Directorate for Employment, Labour and Social Affairs
  - Economics Department
  - Directorate for Science, Technology and Industry
  - Directorate for Financial and Enterprise Affairs
- Ministerial meeting to discuss results, 12-13 May 2004
  - First-ever meeting of OECD Health Ministers, joint dinner with Economics/Finance Ministers

OECD Health Project products

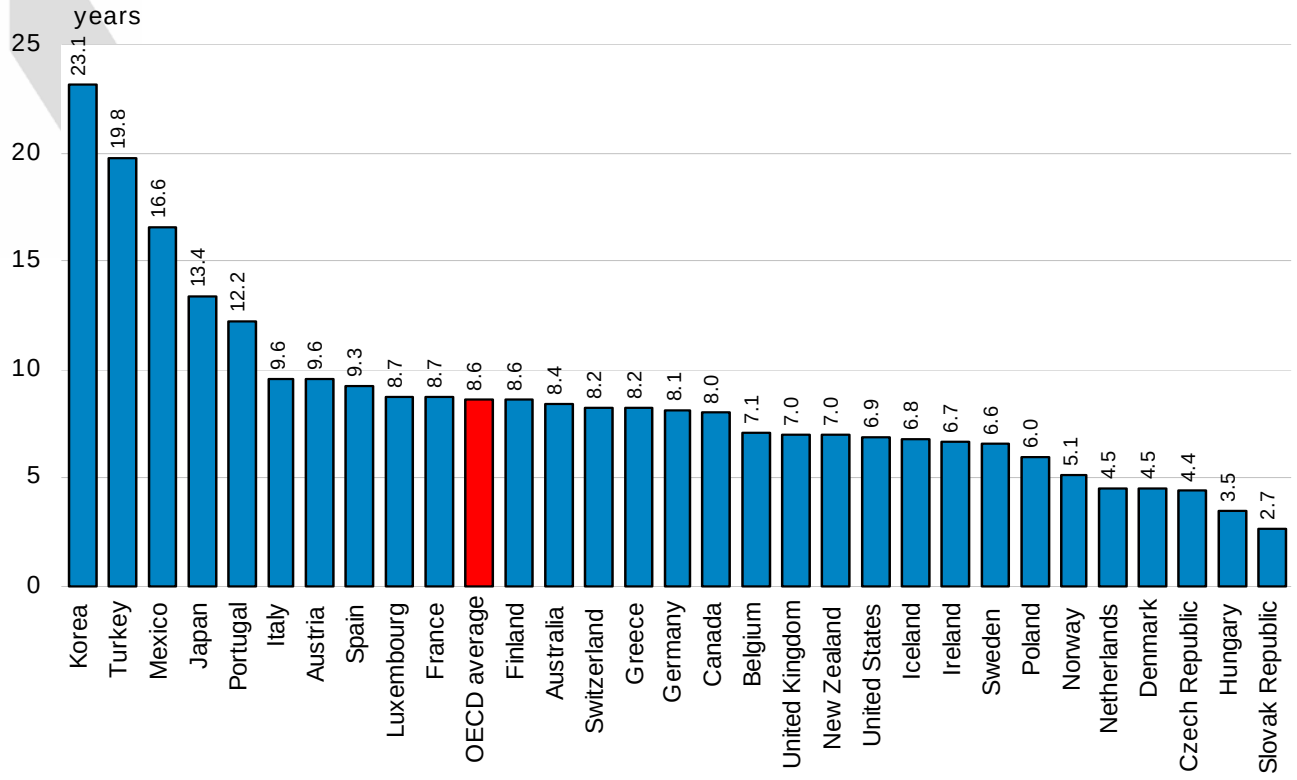
- *Towards High-Performing Health Systems*
  3 related publications:
  Final Report to Ministers
  Summary Report
  Policy Studies compendium
- *Private Health Insurance in OECD Countries*
- *Health Technologies and Decision Making*
- *Long-Term Care for Older People*
- New *OECD Health Working Paper* series (14 releases to date)



“Health systems are victims of their own success.”

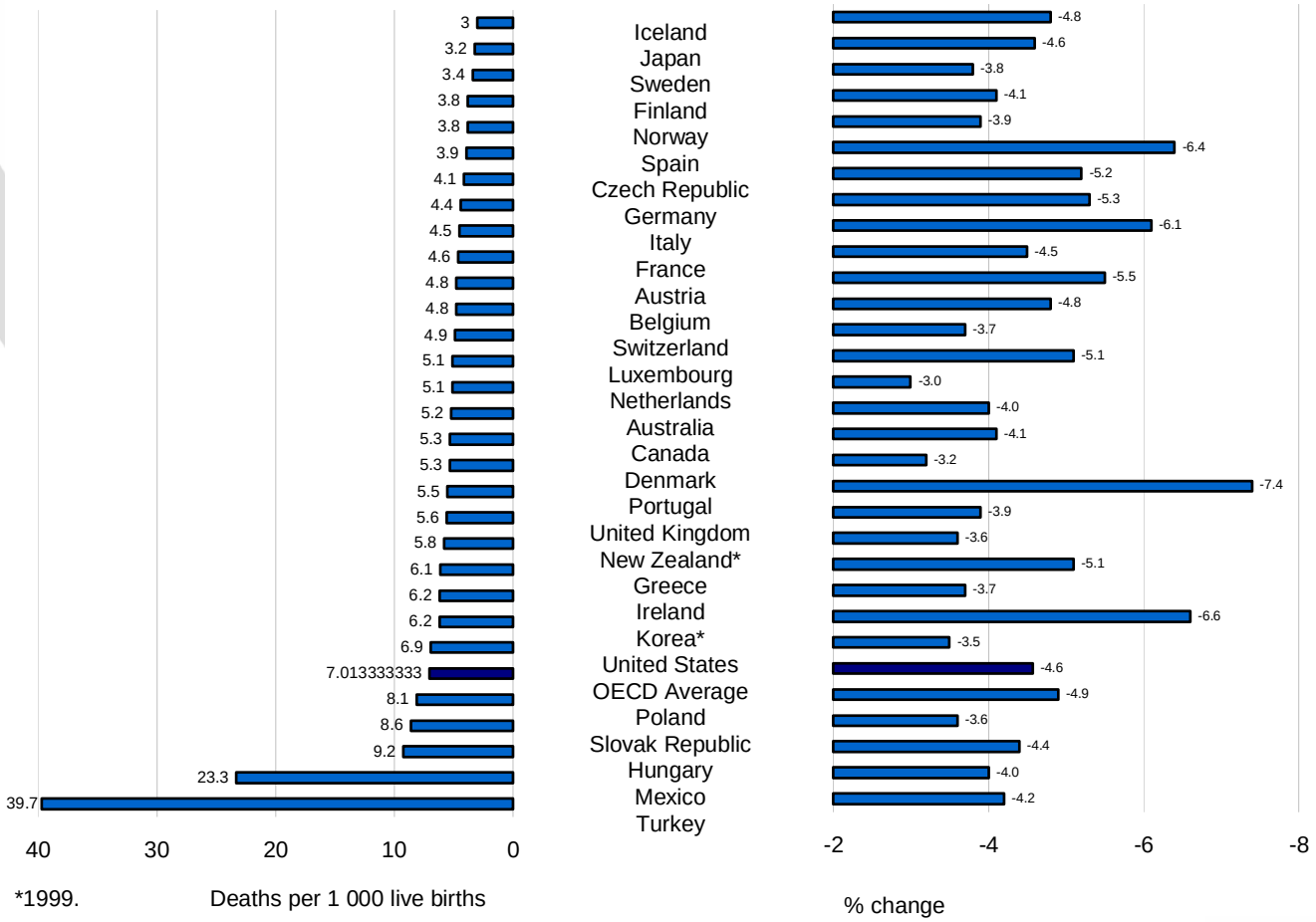
Julio Frenk
Health Minister, Mexico

Gains in life expectancy at birth, total population,1960–2000



Source: OECD Health Data 2003.

Infant mortality, 2000 and average annual declines in infant mortality, 1970-2000



Source: OECD Health Data 2003.

Factors driving health improvements

- Economic expansion and related factors
  - e.g. increased educational attainment
- Improvements in health care and health systems
  - Advances in medicine and technical capability
  - Improvements in access to care and health care systems

The context for reform

Rising health expenditures

+

Growing challenges to financing sustainability

+

Increasing demand to improve performance

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

=

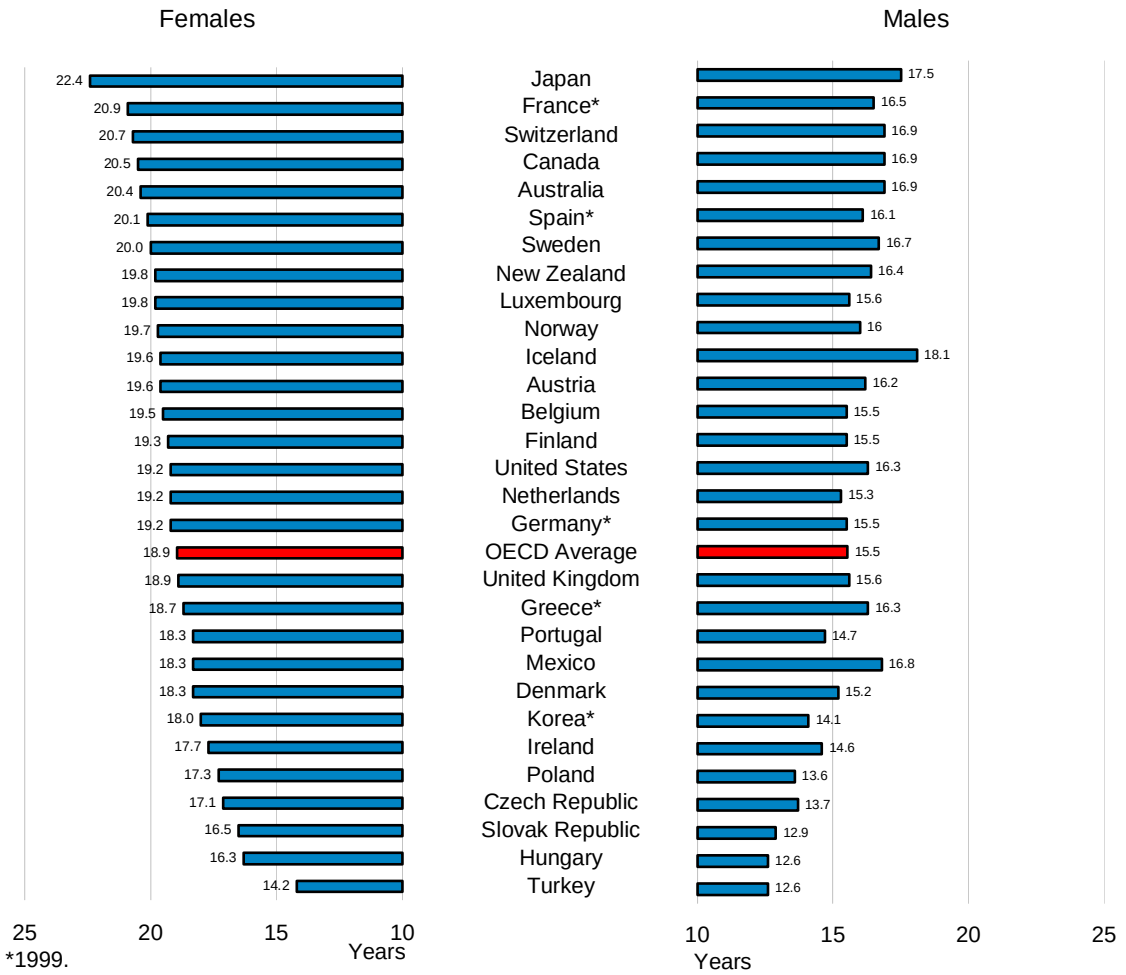
Motive for reform to improve health system efficiency, or “value for money”

Overview of findings

- What can be done to improve health
- What can be done to close disparities in access to care
- What can be done to make systems more responsive to patients and consumers
- What can be done to ensure sustainable costs and financing
- What can be done to improve value for money

Message 1. There are very great opportunities to further improve health.

Further gains are possible
Life expectancy at age 65, 2000



*1999.

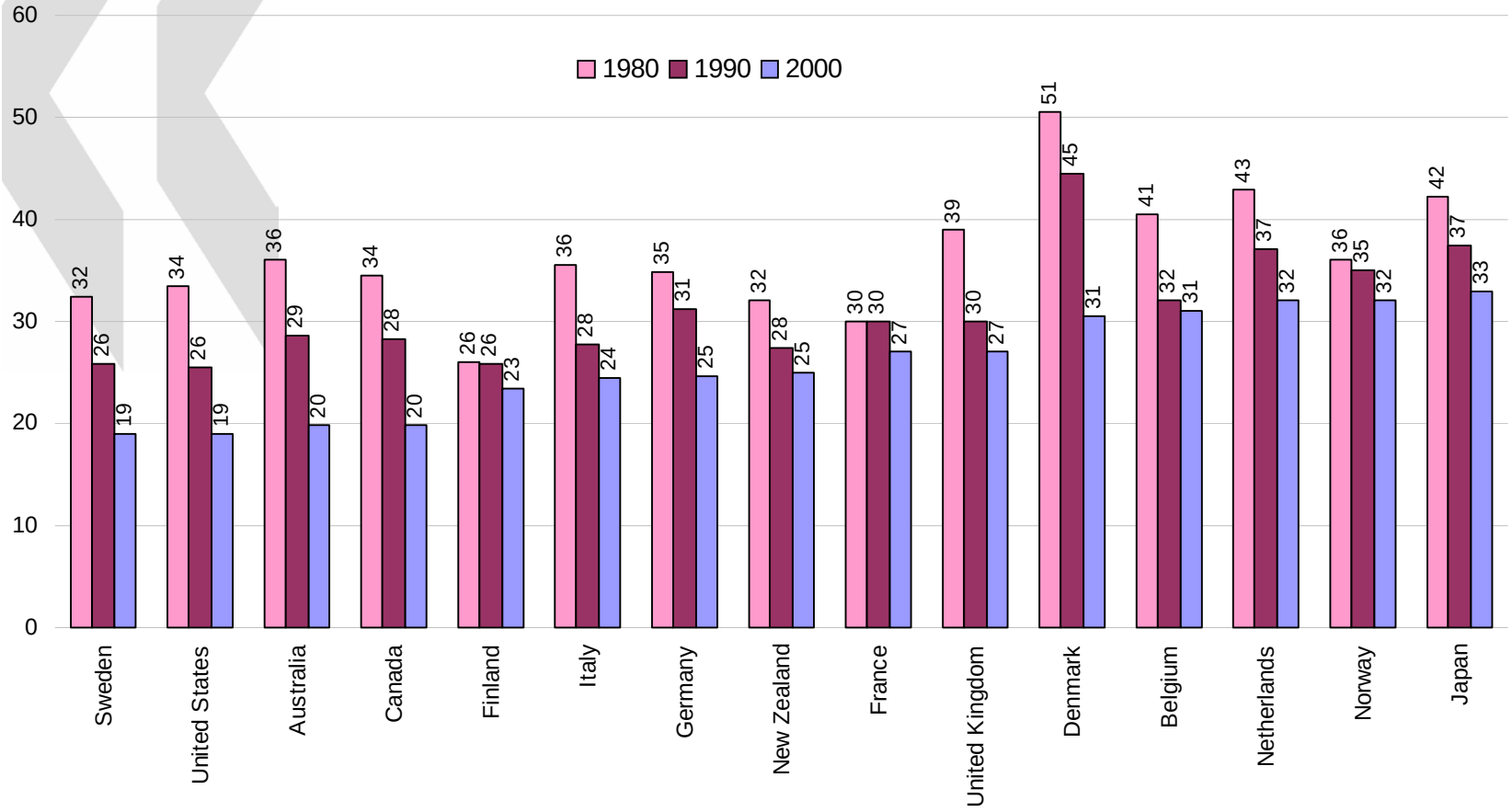
Source: OECD Health Data 2003.

Avenues for improving health

- Promote better health through policy levers that fall outside the traditional purview of health policy makers
  - e.g. address environmental and risk factors such as violence, accident prevention, worker safety

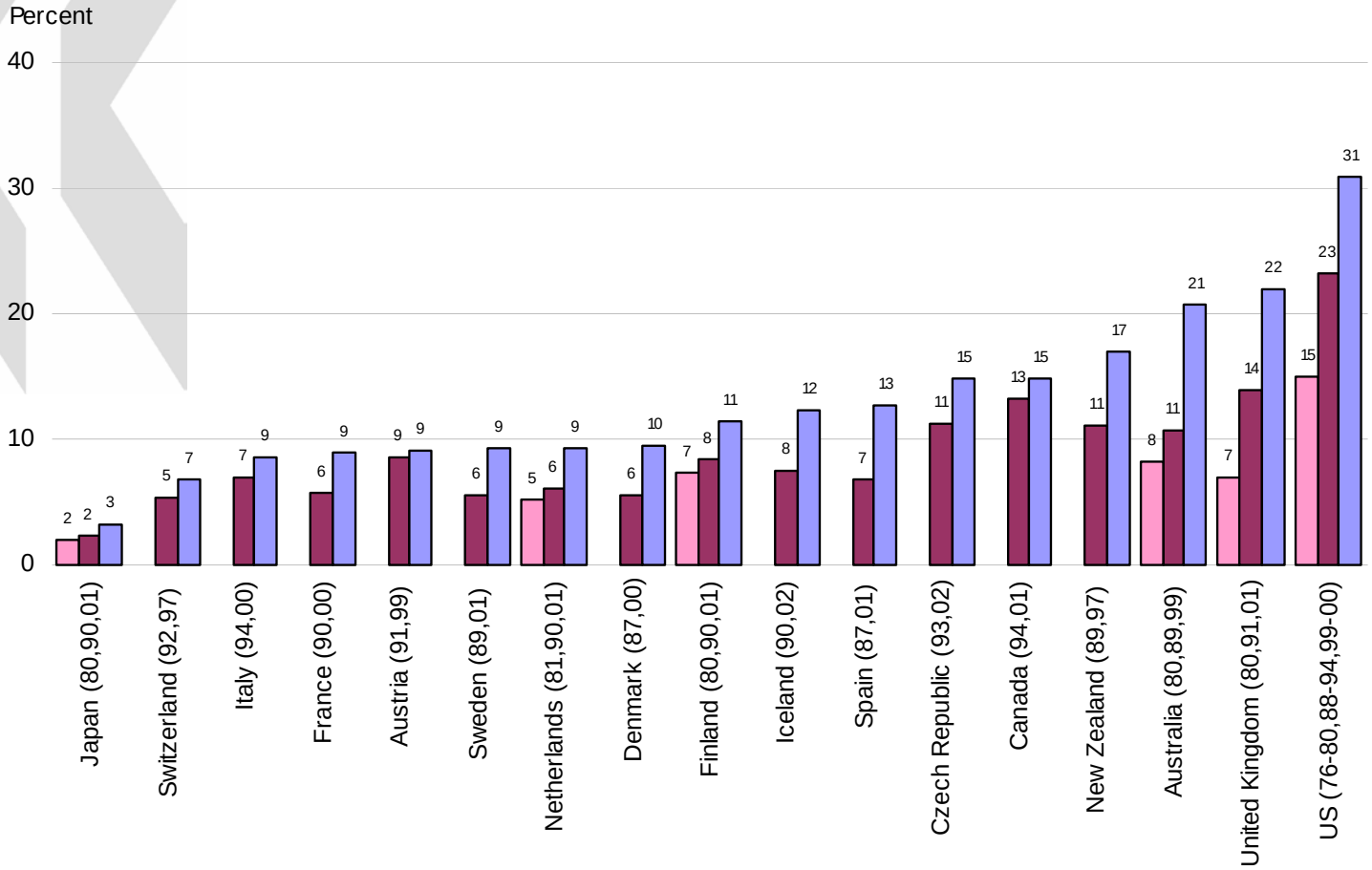
- Pay attention to prevention in health care
  - Invest more on prevention (currently only 5% of THE devoted to health prevention)

Falling smoking rates among the adult population in OECD countries



Source: OECD Health Data 2003.

Increasing obesity rates among the adult population in OECD countries

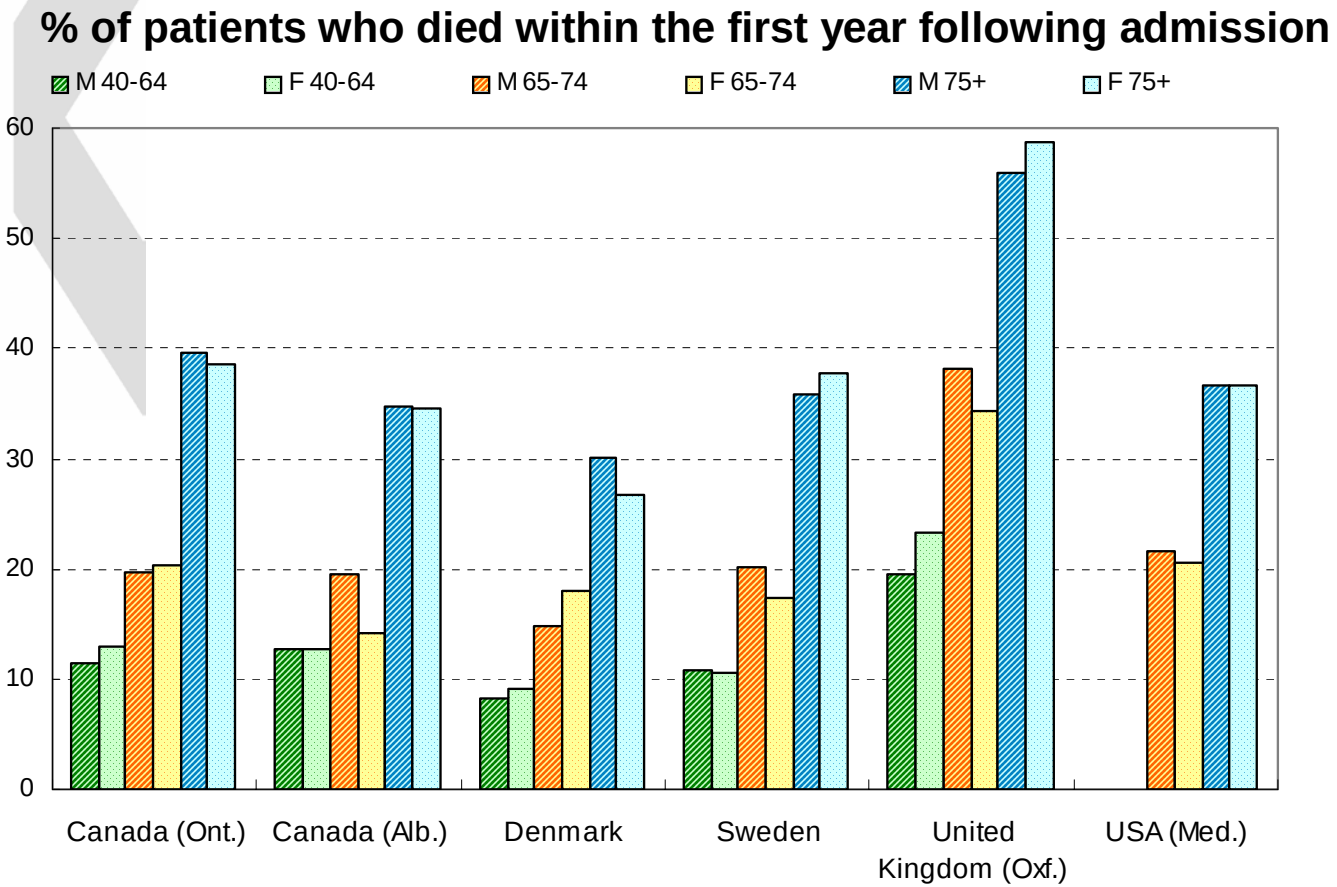


Source: OECD Health Data 2003.

Avenues for improving health (cont'd)

- Address shortfalls in health care quality
  - Provision of inappropriate services
  - Underuse of needed services
  - Errors in health-care delivery

One-year case-fatality rates for ischaemic stroke, 1998



Note: Canadian data are from Alberta and Ontario, United Kingdom data are from the Oxford region, and United States data are from Medicare data only.

Source: OECD (2003), A Disease-Based Comparison of Health Systems.

Improving the quality of care

- Implement quality monitoring systems
  - Standardised indicators, such as those selected as tested in the OECD Health Project
  - Practice guidelines and performance standards
- Invest in automated health data and information systems
- Correct misaligned incentives
  - Economic (e.g. payment) and administrative (e.g. regulatory)
- Give patients and consumers information on quality

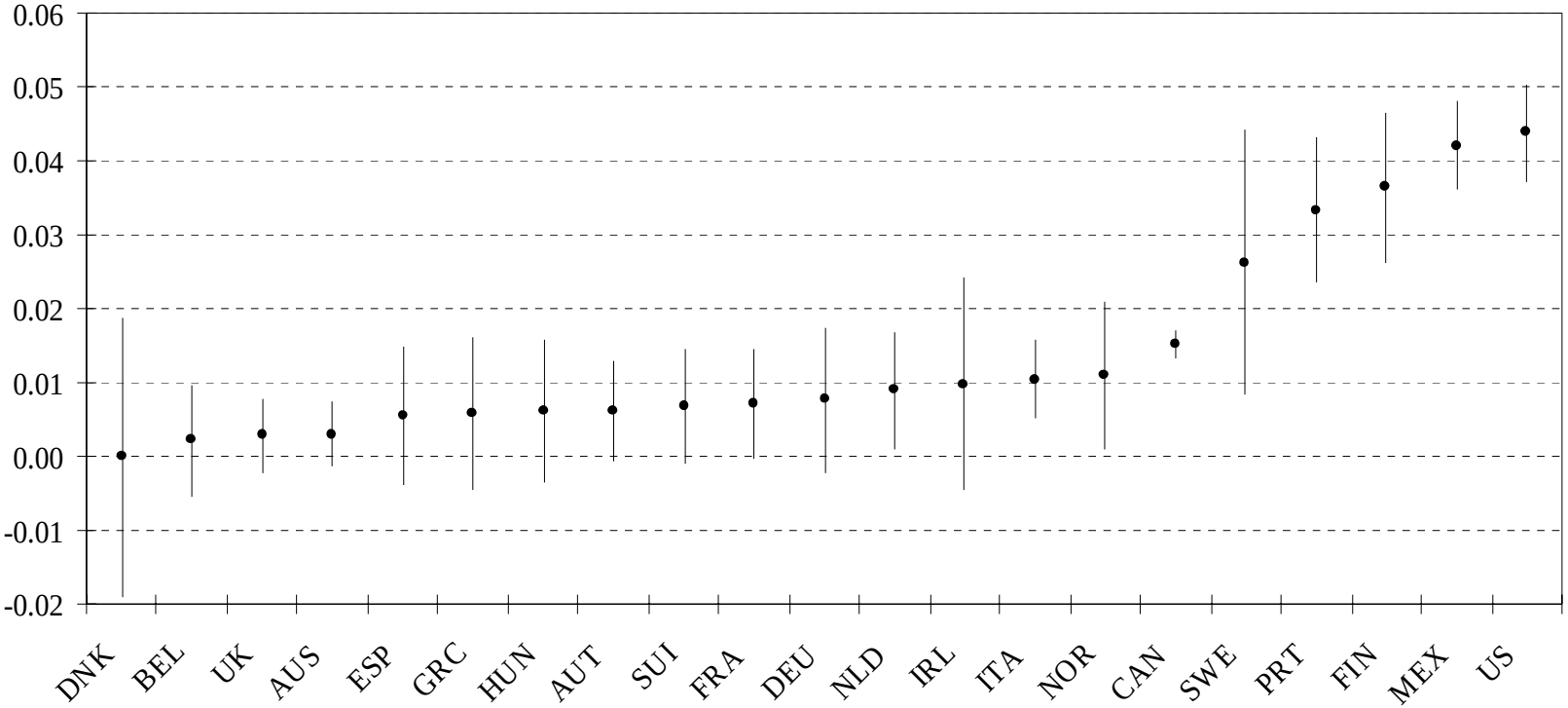
Message 2. There are opportunities to fix disparities in access to needed services and improve access to beneficial new advances in health care.

Universal coverage attained in most OECD countries

- A combination of public schemes and private health insurance

- Recent initiatives to increase coverage, where not universal
  - Mexico “Seguro Popular”
  - US State Children’s Health Insurance Program

Income-related inequities in access to care persist

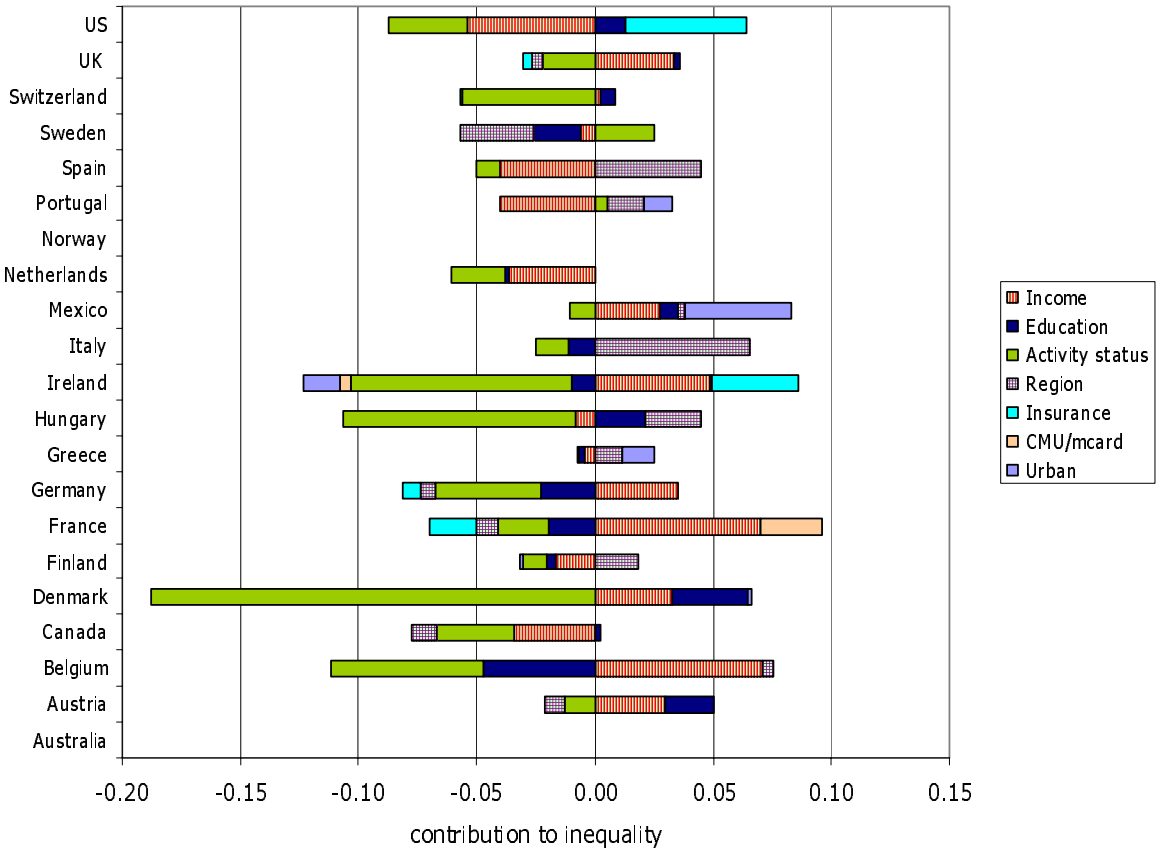


Note: The plotted points are horizontal inequity (HI) indices which summarize the inequality in the probability of at least one doctor visit (per annum) across income quintiles after need differences (variations in self reported health) have been standardised. Positive values of HI indicate inequity favouring the rich.

Source: Van Doorslaer *et al. (2004)*

Inequities have different root causes

Decomposition of *inequity* in number of hospital nights (excluding need contributions)



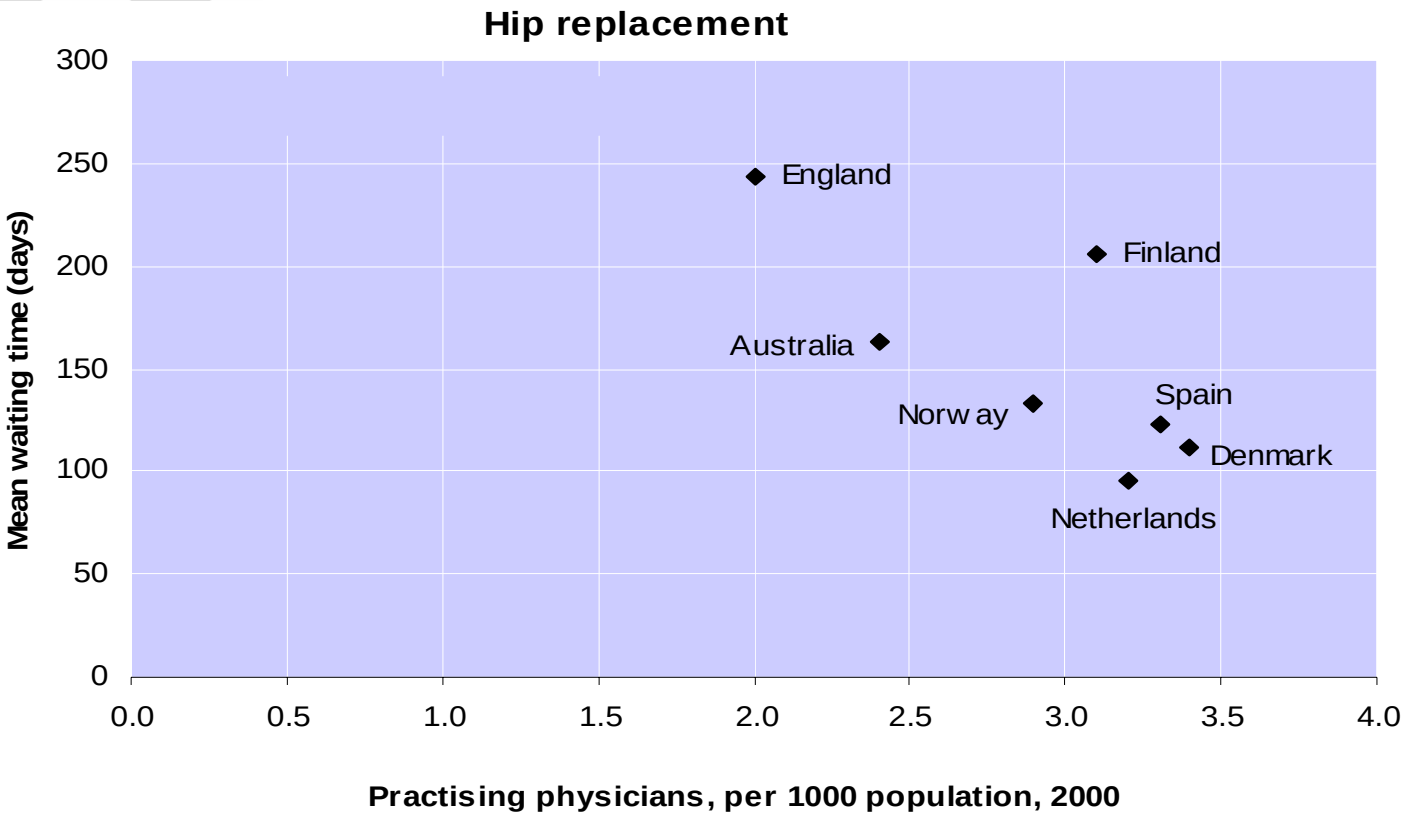
Source: Van Doorslaer *et al. (2004)*

Avenues for improving access

- Eliminate financial barriers to access
  - e.g. CMU reform in France covered cost-sharing for poor
- Address underlying root causes of access problems, where these are a factor
  - e.g., poverty, social exclusion
- Ensure timely access to new treatments
  - e.g., conditional approval of new technologies pending further study is a policy option for coverage in ½ of OECD countries

Ensure an adequate supply of health-care providers

Physician density and waiting times for electives surgery



Source: OECD Waiting Times Project

Message 3. There are opportunities to increase the satisfaction of patients and consumers of health care.

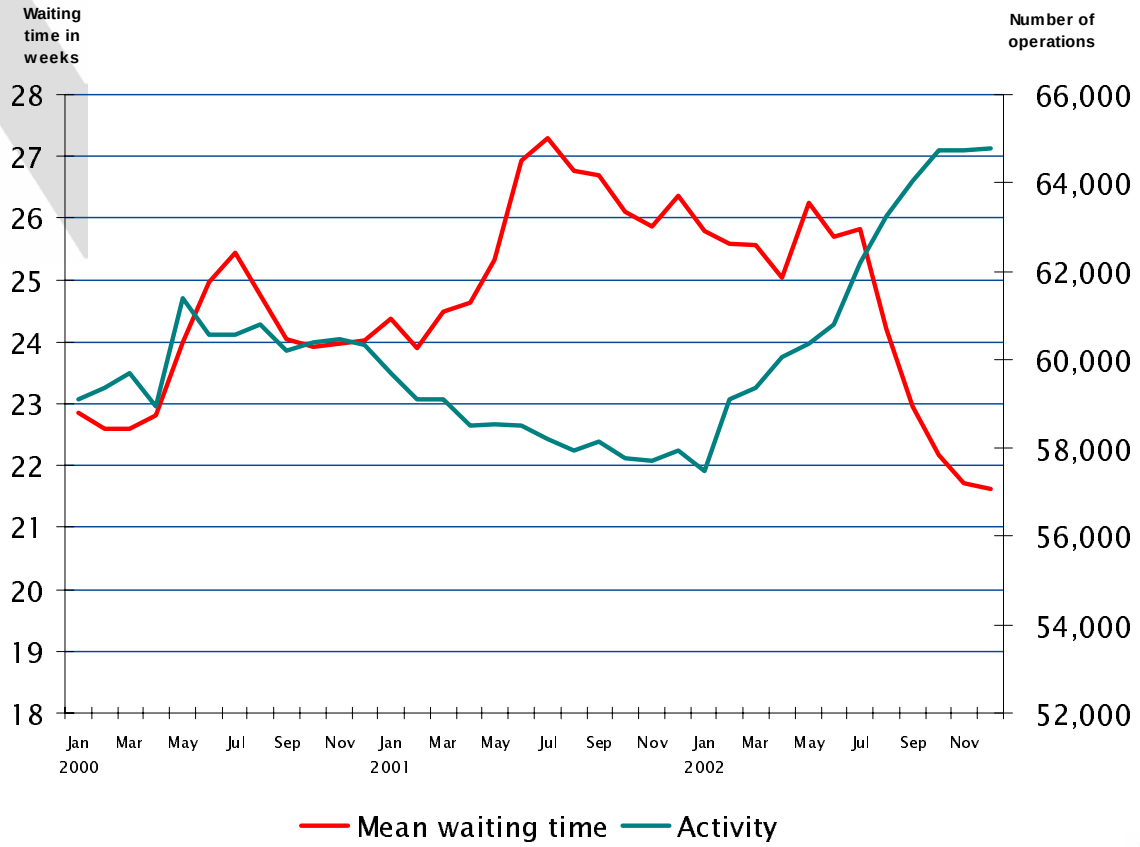
Avenues for increasing responsiveness

Waiting times

- Excessive waiting times for elective surgery are a policy issue in about ½ of OECD countries
- Waiting times can be reduced by increasing surgical capacity or productivity

Waiting times
Increasing productivity: Denmark

Introduction of activity related funding, January, 2002



Source: OECD Waiting Times Project

Increasing responsiveness (cont'd)

Long-term care

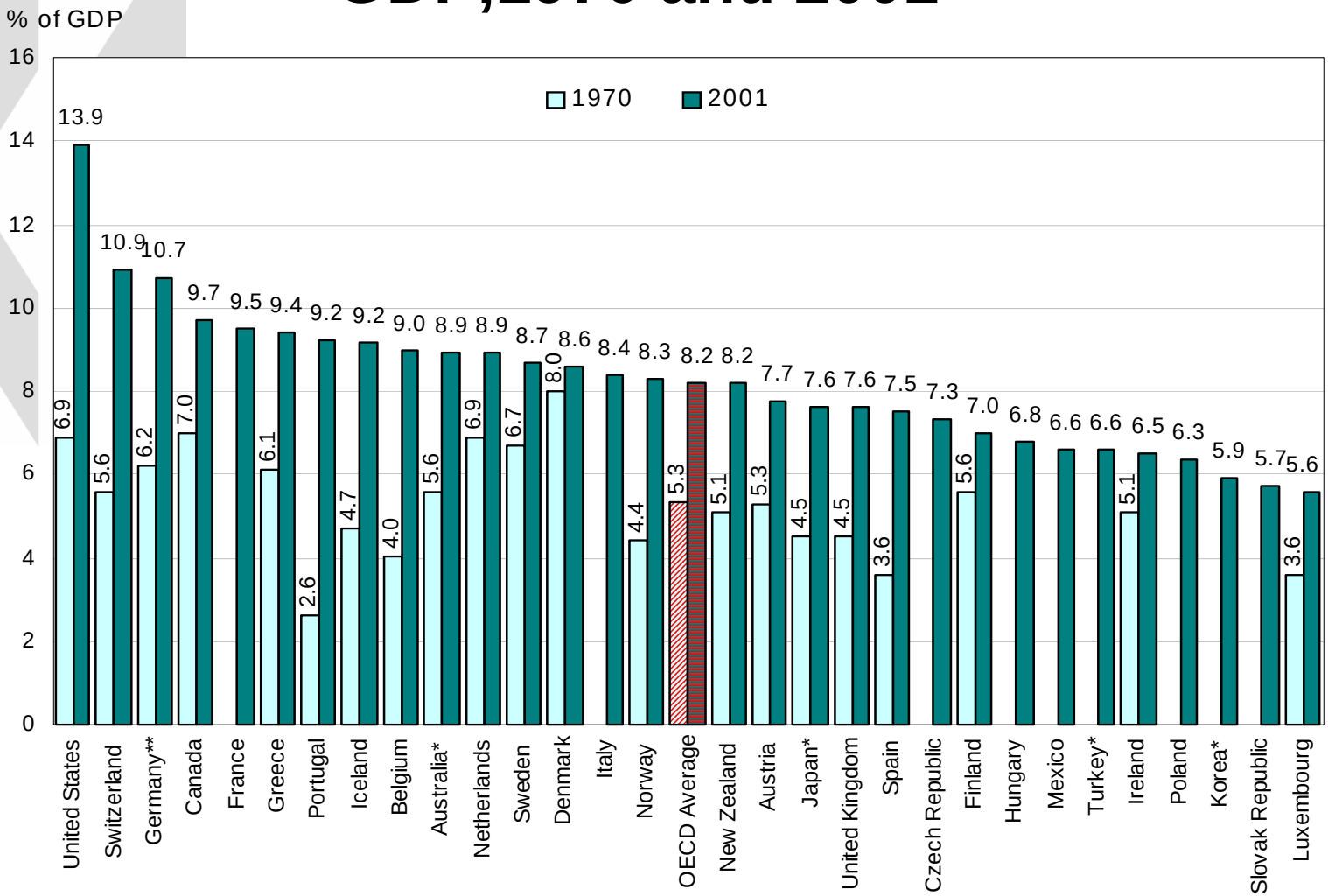
- Give long-term care recipients more control over services and choice of providers
  - e.g. by providing cash benefits for spending on services, as is done in Austria, France and Germany

Overall system responsiveness

- Facilitate informed consumer choice of health coverage

Message 4. Countries should expect continued cost and financing pressure in the health sector.

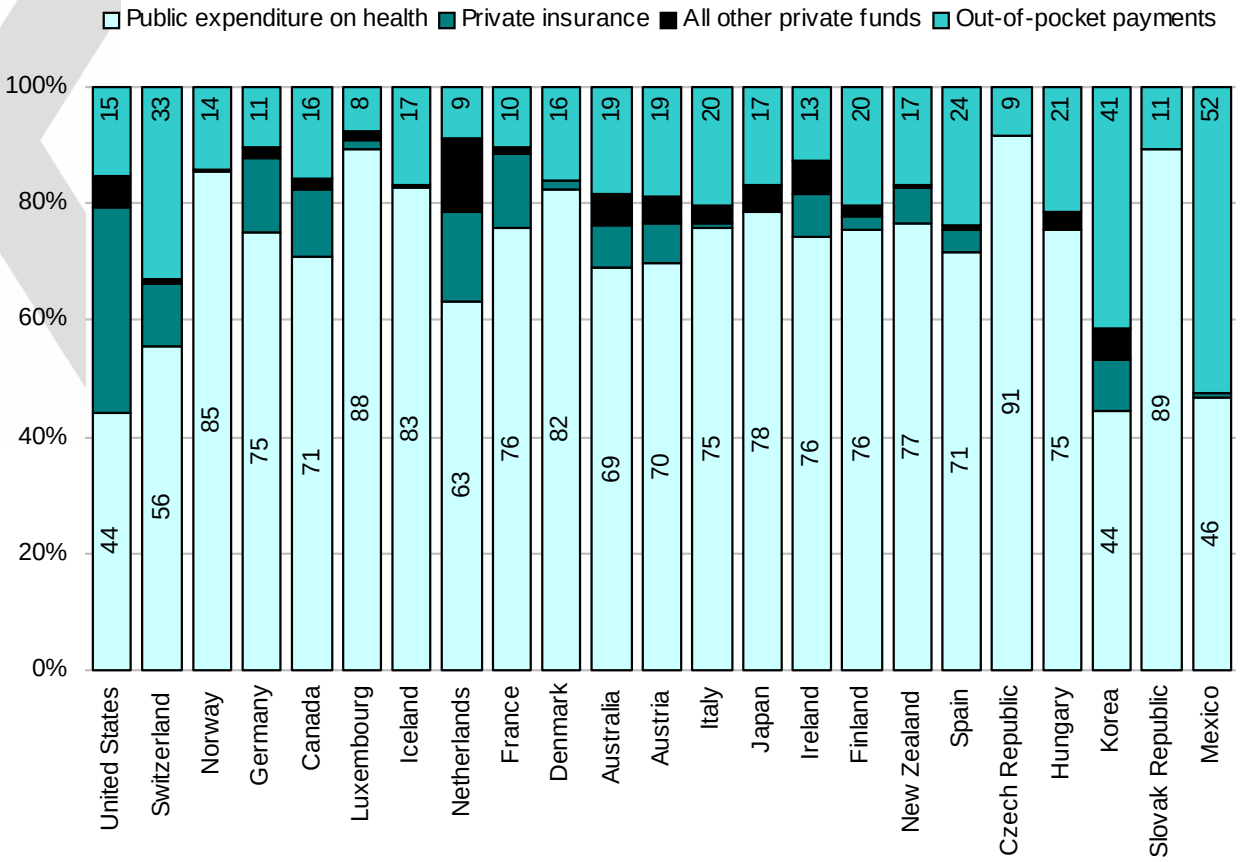
Growing health spending as a share of GDP,1970 and 2001



* 2001 data refer to 2000. ** 1970 data refer to West Germany.

Source: OECD Health Data 2003.

Pressures on public budgets
THE by source of funding, 2000



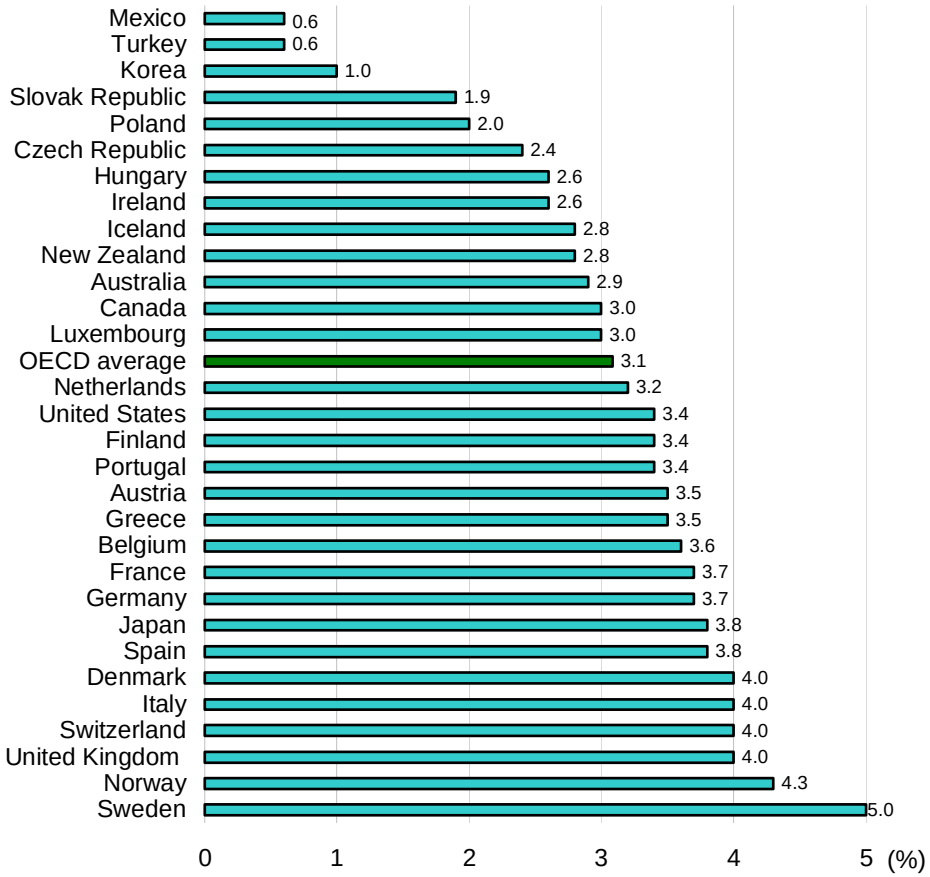
Note: Countries are ranked from left (highest) to right (lowest) according to level of per capita health expenditure.

Source: OECD Health Data 2003.

Cost pressures due to ageing

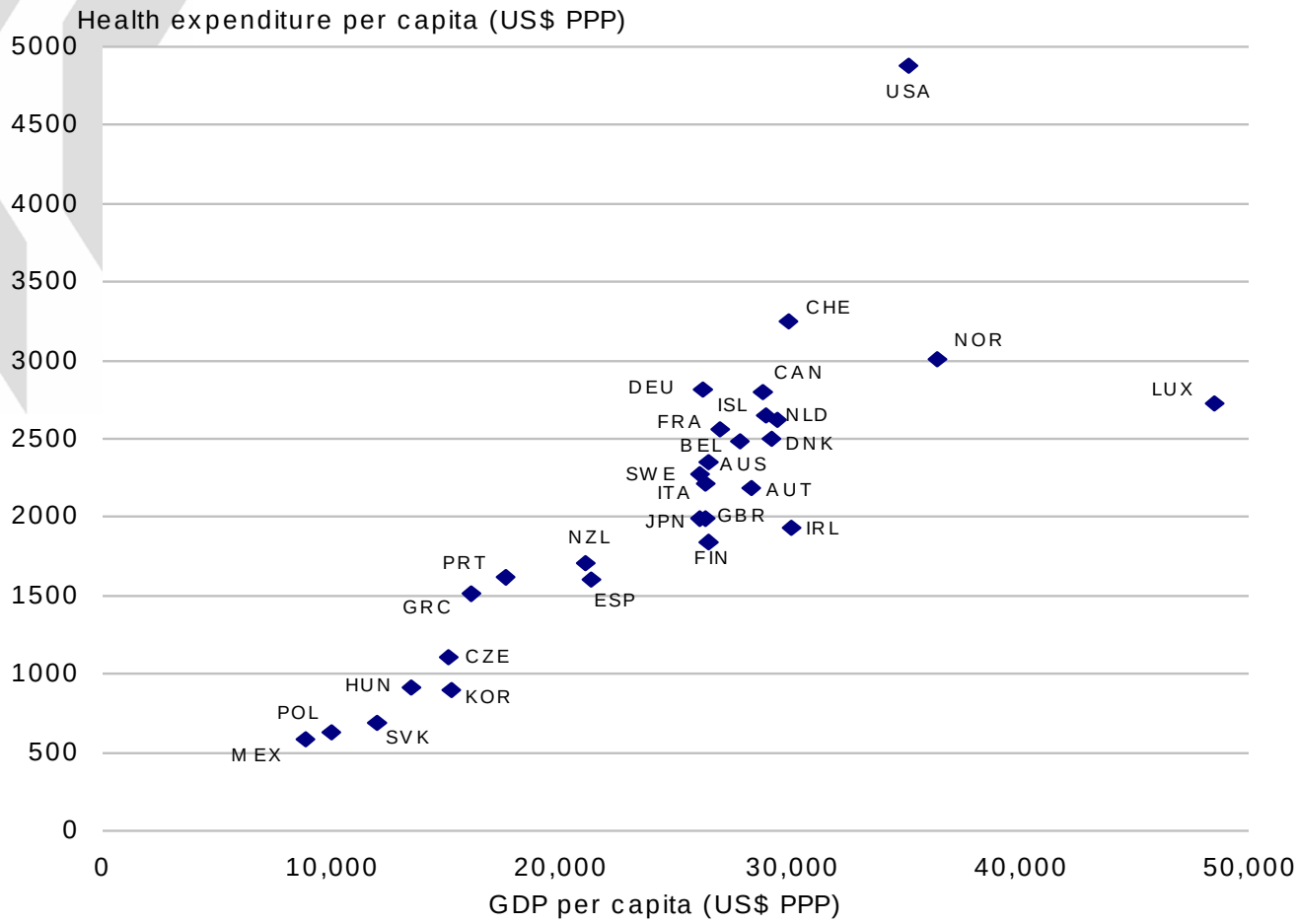
- Growing proportion of over 80
- Ageing populations expected to raise demand for care
- Long-term care costs relatively low but growing

Figure 14. Share of the population aged 80 and over, 2000



Source: OECD Health Data 2003.

Health expenditure correlated with GDP per capita, 2001



Source: OECD Health Data 2003.

Avenues for containing costs and ensuring sustainable financing

- Slow cost growth using a combination of budgetary and administrative controls over payments, prices and supply of services
- Add modest cost-sharing requirements to publicly financed health coverage schemes
  - Complementary private health insurance reduces impact
- Eliminate public coverage for ancillary or luxury services

Message 5. It is possible to save money while improving health-system performance.

Inefficiency in health systems

- Large variation in inputs and outputs suggests that many, if not most OECD countries can improve efficiency in some respects
- Health sector is characterised by market failures and heavy public intervention
  - Excess or misallocated spending can result

Discrepancy between heart disease incidence and treatment rates

Figure 16. Ischaemic heart disease, total population, age standardised mortality rate, 2000

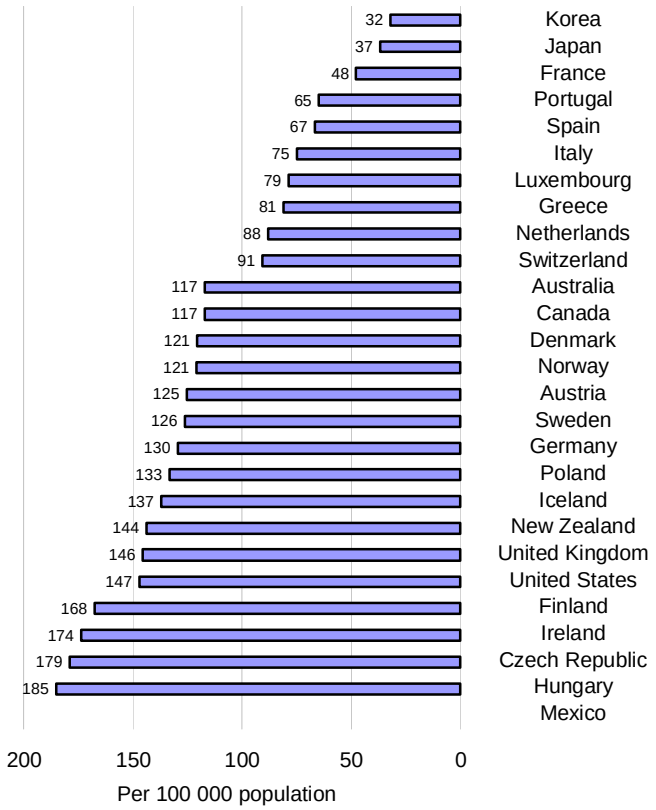
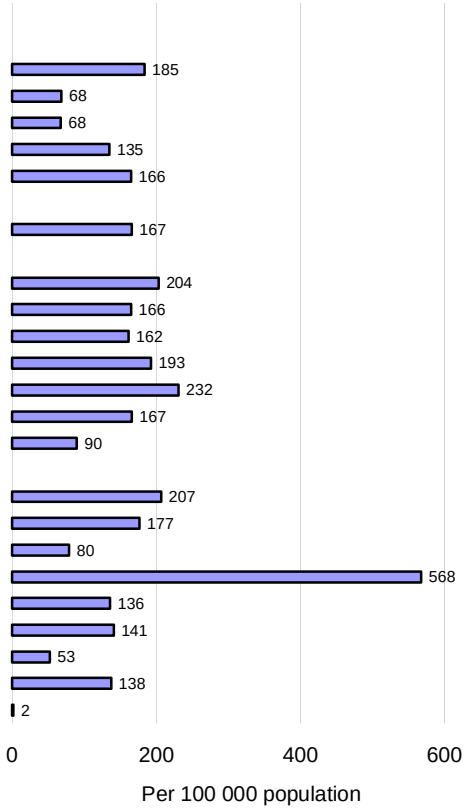


Figure 17. Coronary re-vascularisation procedures*, per 100 000 population, 2000



* Coronary artery bypass grafts (CABG) and Percutaneous coronary interventions (PTCA).

Source: OECD Health Data 2003.

Avenues for increasing efficiency

- Use demand management tools
  - e.g., gatekeepers used to some extent in Australia, Canada, Denmark, US, elsewhere
  - Clinical prioritisation to manage waiting lists
  - Refined cost sharing can help to direct consumption
- Supply-side tools
  - Separation of roles: health-care provision and purchasing
  - Appropriate skill mix of professionals
  - Management change, decentralisation
  - Management of capacity and supply

Increasing efficiency (cont'd)

- Improve provider payment methods
  - Reward productivity and contribution to performance goals such as improved health outcomes (example: US Medicare program experiment with hospital payments)
- Use a value-oriented approach to managing health technologies
  - e.g., value and cost agreements (as in United Kingdom), reference-pricing of pharmaceuticals

Outstanding policy questions raised in the course of the Health Project

- How can competitive market forces be better employed to increase efficiency?
- How can advances in medical technology be promoted and timely access to those be assured while managing public resources?
- Which approaches work best to ensure an adequate future supply of health workers?

Outstanding policy questions raised in the course of the Health Project (cont'd)

- How can the economic incentives of health-care providers be better aligned with goals for cost-effective health-care delivery?
- What should be the balance between prevention and cure to increase value for money?
- Which approaches to medical professional liability can best deter negligence, compensate victims, encourage appropriate services use?

Conclusions

- Even armed with knowledge, improving health-system performance is never easy
- Trade-offs across policy goals are inevitable
- Making real change can be difficult
  - Need to involve stakeholders
  - Reform is an iterative process
- International comparisons provide valuable guidance
  - Monitoring and benchmarking are essential

The Future of OECD's Health Programme

- Future OECD work agenda on health should:
  - Continue to improve annual collection of OECD Health Data
  - Assist national efforts to implement of standard health accounts
  - Develop indicators of health-system performance, including quality indicators
  - Address analytical issues that OECD countries consider important

Source: OECD Health Ministerial Communiqué, 14 May 2004

Future OECD Health Work (cont'd)

- OECD Council to decide size and scope of work programme in course of 2005-2006 biennium budget planning

- Follow-up work in progress or planning
  - Questionnaire to Ad Hoc Group delegates on policy priorities
  - Country-specific dissemination/communications of findings
  - Health system reviews
    - Mexico (in progress)
    - Finland (to begin Fall 2004)
    - Switzerland (under discussion)

More information:

www.oecd.org/health

www.oecd.org/healthmin2004