Main Outcomes of the OECD Health Project

Towards High-Performing Health Systems

Better management of spending is required to ensure better health care in the future.

Key Points	Q & A	Additional Information
1. Demand for health care services will increase while at the same time funding may not. So the money spent on health has to be put to better use.	Q: Is there a risk that cuts or reallocations in spending will result in poor people not getting the care they need? A: OECD countries have made tremendous progress in increasing access to health services and all countries want to preserve this achievement. But increased value for money doesn't have to come at the expense of equity. A number of countries such as France and the United States have taken measures to protect the most vulnerable.	The OECD estimates that ageing alone will result in an increase in health spending of 3 percentage points of GDP by 2050. New advances in technology and pharmaceuticals will also put upward pressure on spending. Three quarters of health spending is publicly financed, putting increasing strain on government budgets.
2. The highest-spending countries do not necessarily obtain the best results in terms of outcomes or performance.	Q: But population health status is not necessarily determined by the level of spending. Education and social backgrounds may be more important factors. A: This is true but improvements in health care also deserve credit for better population health. The recent past has seen major breakthroughs in prevention and treatment for conditions like heart disease, cancer and stroke. And with new drugs and devices, we treat conditions better than before.	Canada, where waiting times can be long, spends the same share of its GDP on health as France where there are no waiting times. Japan has above average breast cancer survival rates although it is a relatively low spender compared with other OECD countries.
3. Countries can learn from each other: the OECD Health Project has highlighted a number of good practices to improve value for money that countries can draw upon and adapt to their own circumstances.		Making sure heart-attack patients get aspirin to reduce risk of a subsequent attack can reduce costs and improve quality of care. Using performance measurement, ICT, and clinical practice guidelines, the US Veterans Administration Health System reduced surgical mortality by 9% over 4 years, increased compliance with practice standards from 34% to 81%, and reduced patient care costs by 25% over 5 years.

Quality of health care: Addressing shortfalls in quality

Improving the quality of health care can save not only lives but money.

Key Points	**Q & A**	**Additional Information**
1. Medical mistakes, provision of services that are inappropriate, and failures to provide the most appropriate services are serious problems that result in inferior health outcomes and wasted resources.	**Q:** Does the OECD think that doctors or other health-care practitioners are at fault for quality problems? **A:** Research suggests that most quality problems in health care are due to **poorly designed systems** that don't support practitioners' doing the best thing at the right time.	The US Institute of Medicine reported that more Americans die annually from health-care errors than from traffic accidents or breast cancer. Similar studies in other countries have found comparable rates of quality problems, *even in countries where the overall utilization rates for procedures are lower*.
2. Quality problems can be addressed by investing in **practice guidelines and other tools** to help promote appropriate care, by creating the **information systems** to facilitate and track progress, and by changing **economic and administrative incentives** to support health-care practitioners in doing the best thing.	**Q:** Wouldn't it cost more to address quality problems than would be saved in doing so? **A:** Quality improvement may require investments, at least in the short term, but can result in savings over the long-term. In addition, some simple quality improvements, such as making sure heart-attack patients take a daily aspirin to reduce risk of a subsequent attack, can even reduce costs in the short run.	Using a strategy that involved performance measurement, information and communication technology, and clinical practice guidelines, the US Veterans Administration Health System reduced surgical mortality by 9% over 4 years , increased compliance with practice standards from 34% to 81%, and reduced patient care costs by 25% over 5 years.
3. Evidence shows there is **more than one way** to improve quality of care successfully --- such as by reforming oversight bodies or by increased professional self-regulation. Different approaches work well, depending on the circumstances. In addition, there is room for experimentation, as most countries are at an early stage in taking steps to improve quality.	**Q:** Which country has the highest quality of care? **A:** We don't yet have sufficient data to compare the quality of care across OECD countries, although the OECD is developing comparable indicators for future use. Several studies, including the one recently released by the Commonwealth Fund of New York, have found differences across countries in health outcomes, such as cancer survival rates, that may reflect differences in the quality of care as well as other factors.	Consumers in a few countries can access information to compare quality across providers. It is hoped that this approach will spur quality-based competition. In the US, information on nursing-home care quality is available on the Internet. Purchasers are beginning to experiment with payments that reward quality. For example, in the US, the Medicare programme is undertaking a 3-year pilot test of a system that will provide higher payments to those hospitals that score well on 35 quality measures.

The sustainability of health-care systems: projections of age-related increases in health and long-term care spending

It is urgent to ensure that we can pay for health care in the future

Key Points	Q & A	Additional Information
Spending is on the rise again and total health care spending now averages over 8 ½ per cent of GDP for the OECD; three quarters of this is financed by the public sector.	**Q.** With new technology and rising expectations, aren't increases in health care spending to be expected? Should health case spending be limited if taxpayers and patients ask for more? **A.** If new types of care and technology lead to improved health outcomes further increases in spending may be desirable. However, in the light of the wide differences in care costs across countries, there is scope for achieving the same health outcomes at lower social and economic cost, leaving more resources available for other social and private needs.	Between 1998 and 2002, health care spending increased by 0.6 percentage points on average across OECD countries after remaining stable between 1994 and 1998.
Public health care costs are likely to increase further as a result of ageing if current patterns of spending remain unchanged**.** Further pressures are expected from new technology, increased expectations of care by patients and rising labour costs. **Public long-term care costs are also likely to increase** as changing demography raises the demand for nursing care and reduces the scope for families of the elderly to provide such care.	**Q.** Will not longer lifetimes, improved health and less disability mean that the rise in age-related health care costs will be less than you project? Are these results very sensitive to assumptions about mortality? **A.** Yes, these results are very sensitive to assumptions and particularly so to lengthening of healthy lifetimes. This suggests that health care that prevents the onset of disease may have a high payoff.	Public health-care spending is projected to increase by just under 2 percentage points of GDP between 2000 and 2050 as a result of ageing alone on average across OECD countries. Public long-term care costs might increase by an additional 1 ¼ percentage points of GDP over the same period.
Increased public spending on health care will need to be financed through higher taxes or contributions unless cost-efficiency can be increased. A larger share of long-term care costs may need to be borne by individuals or their families unless collective insurance-type arrangements are extended to cover the risk of long-term care.	**Q.** Will technology not lead to reduced health care costs in the future? **A.** The impact of technology on costs is complex. Increases in costs now may lead to lower costs at a later stage. However, with new technologies appearing regularly, they tend to put upward pressure on costs, sometimes substantially so.	Increases in public health and long-term care costs come on top of other age-related increases in public spending (mainly pensions). Under current policies, these other spending components could represent an additional 3 percentage points of GDP between 2000 and 2050 on average across OECD countries.

Tackling excessive waiting lists: their causes and possible cures

A mix of policies works best in tackling excessive waiting times for surgery

Key Points	**Q & A**	**Additional Information**
1. Increasing the capacity to deliver surgery is a very effective component in mixed policies to reduce excessive waiting, but it costs big money. That has to be balanced against other priorities. Contrary to popular belief, the optimal waiting time is not zero	**Q**: what is an excessive waiting time? **A**. there is no international agreement on that but many countries have adopted targets of around 3-6 months for maximum waiting. **Q.** which country has the worst waiting times? **A**: it depends on the procedure, but patients in Finland and the UK often had the longest waits in 2000. **Q**: why do around half of OECD countries have no waiting lists? **A:** differences in capacity explain much of the international variation in waiting times. For example, countries without lists have about 70% more acute beds and 25% more specialists, per capita, than countries with lists	**a)** There are waiting time problems in about half of OECD countries. **b)** Some countries (such as Denmark, in the case of coronary re-vascularisation in the 1990s) have brought down waiting times dramatically after significant increases in capacity. **c)** It seems to cost roughly an extra 1% of GDP devoted to health expenditure to go from high waiting to average waiting and another 1% to go from average waiting to low waiting.
2. Increasing surgical productivity significantly can also be an effective component of mixed policies in reducing excessive waiting times - but it may require significant expenditure to secure the necessary clinical and management changes.	**Q**: How can productivity be increased? **A**: (see next box→)	Moving to activity-related funding from fixed budgets seems to bring down waiting times, other things being equal (as in Denmark). Increasing the proportion of surgery carried out as day cases can also help (as in most countries).
3. Managing the demand by adding fewer (low-priority) patients to the waiting list can be very effective in reducing visible waiting and it is cheap to implement. It is the right thing to do if patients are being added to lists inappropriately. Of course, it does not deliver more surgery.	**Q:** Is that not just denying surgery to the needy? Is it not just replacing visible waiting with invisible waiting? **A**: 'watchful waiting' by the general practitioner is often the most appropriate thing to do for mild cases. The trick is to get the prioritisation of patients right.	New Zealand has been able to introduce a booking system for all patients and limit waiting times to under 6 months by introducing a careful prioritisation system and demand management.

Financial sustainability of high-quality long-term care services in the future

Putting the right mix of services in place today is essential to ensure that high-quality-services will be affordable in the future

Key Points	Q & A	Additional Information
Ageing populations and growing expectations for better quality services will continue to exert cost-pressure on long-term care services in the future. OECD countries will have to set aside more for long-term care, through some combination of public and private sources.	**Q:** Does this mean that current long-term care systems will not be financially sustainable in the future? Will larger private cost-sharing be needed? **A:** The OECD estimates that ageing alone will result in an increase in long-term care spending of over one percentage point of GDP by 2050, less than half of what is expected for health care.	Spending on long-term care is currently only around 10 to 20% of health spending. Private cost-sharing and informal care provision have helped contain costs in the past. But in many countries, there are still important quality deficits in the way long-term care services are provided such as the living situation of nursing home residents. The share of single-room beds ranges from 10% to over 90% across OECD countries.
Enabling older persons to stay at home as long as possible can greatly help to improve the situation of many older persons with care needs, and it is what most want. A key factor in achieving this is to have a broad range of support services including respite care in the community together with professional guidance to families.	**Q:** Where will the care workforce come from – given the current shortfall of health workers in general? **A:** A combination of improved working conditions and better pay is needed. **Q:** Are cash schemes for carers at home not just throwing money at informal care that would have been provided anyway? **A: C**ash schemes may need better targeting in the future in some cases.	Staff shortages is the number one quality concern for long-term care services in OECD countries say administrations in response to an OECD questionnaire. It is important to address the issue of staff shortages now to avoid that the situation will soon worsen in many countries.
Population-wide insurance coverage against the risk of expensive care in institutions (for those who cannot receive sufficient care at home) does not need to lead to exploding cost in the future if appropriately combined with private cost-sharing at higher income levels and targeting of benefits to high need.	**Q:** Why have not more countries opted for a social-insurance solution for nursing home care? **A: S**ome countries provide comprehensive services that are tax funded (Scandinavia); others stick to means-tested programmes to contain costs.	Since its introduction in 1995, the German long-term care insurance has managed to keep spending increases under control. The number of countries with social insurance type programmes has been growing (Germany, Japan, and Luxembourg).

Matching the supply with the demand for doctors and nurses in health care

Many countries will have to increase recruitment and retention, especially of nurses, if they are to avoid shortages

Key Points	Q & A	Additional Information
1. Several OECD countries are now experiencing shortages of doctors (such as Australia and England) and of nurses (such as England, Germany and Norway). Projections suggest that the situation could worsen in the next decade in many countries unless countermeasures are taken. The countermeasures include increasing training intakes, improving retention of trained staff by improving conditions of service and/or wages; and recruiting from abroad.	**Q:** Why did governments not wake up to this sooner? **A**: In fact counter-measures have been introduced in countries like Australia, England and Norway but in the case of training, it takes many years to complete the training of new skilled staff.	OECD projections confirm that most countries will see an increase in demand for health care staff because of population ageing in the next decade or two, A good many countries will see a reduction in supply because of workforce ageing – unless countermeasures are taken.
2. Shortages of doctors and nurses can jeopardise the quality and responsiveness of health services.	**Q**: What is the evidence for that? **A**: An OECD study has suggested that increasing doctors per 1000 population by 10% is associated with reducing premature mortality (years of life lost before age 70) for women by almost 4% and for men by about 3%, other things being equal. Another OECD study has suggested that increasing doctor numbers by 0.1 per 1000 is associated with reducing average waiting times for elective surgery by over a week, other things being equal.	There is also evidence from micro studies that low nurse/patient ratios in hospitals can raise treatment errors, complication rates and risk adjusted mortality.
3. International migration of health workers can help to reduce shortages and surpluses. However, if OECD countries recruit from developing countries, they could add to the difficulties of health systems with greater health needs than their own – unless the migration is temporary	**Q: A**re you saying that OECD countries are to blame for people dying from lack of health care in developing countries? **A**: The problems with health systems in developing countries are often a 'push' factor. Skilled people may migrate of their own free will if they see it is to their advantage, whatever governments try to do.	A number of countries are trying to regulate international migration of health care workers under government to government agreements – for example under the Commonwealth's *Code of Practice for International Recruitment of Health Workers*

Striking a better balance between prevention and cure

Governments must find ways to address the growing problem of obesity

Key Points	Q & A	Additional Information
1. Well-targeted prevention strategies can help reduce cost pressures on health care systems (e.g. childhood immunisation and AIDS prevention).	**Q.** Is it really true that prevention results in cost-saving? **A.** There is strong evidence on the cost-effectiveness of interventions to tackle communicable diseases (such as immunisation campaigns). However, there is often a lack of evidence on the cost-effectiveness of measures to prevent non-communicable diseases, partly because of the time lags between interventions and results. More work is needed to guide appropriate policy intervention in this area.	Just 5 cents out of every health care dollar is spent on initiatives to keep people healthy. AIDS prevention has led to a significant reduction in the number of new cases in North America and most European countries over the last decade. This has helped reduce the high costs of HIV/AIDS treatments (e.g. highly active antiretroviral treatment drugs).
2. There have been successes in public health interventions over the past few decades, such as government measures to reduce smoking and drinking (through public awareness campaigns, advertising bans and taxation)	**Q.** But surely, it is only "sin taxes" which work (not public awareness campaigns or advertising bans)? **A**. Increased taxation of tobacco and alcohol has been shown indeed to contribute to reducing consumption, but other interventions (such as health education campaigns, community- and school-based programmes, and government regulations on advertising and sales) have also been shown to be cost-effective, when well-designed.	Adult smoking rates down by 10% over the past two decades on average across OECD countries (26% in 2000, down from 36% in 1980)
3. But all is not rosy. Obesity is a growing health concern in many countries, which requires concerted actions by governments, industry and individuals (or else obesity-related problems will add further cost pressures on health care systems). The World Health Assembly (17-22 May 2004) will discuss a new WHO Global Strategy on Diet, Physical Activity and Health, which includes policy options and recommendations for governments, the food industry and individuals, with a view to promote healthier diets and more physical activity.	**Q**. Is the OECD advocating a "fat tax"? **A**. No, the OECD does not prescribe any specific tax or subsidy. We note that several countries have adopted – or are considering – different measures to increase or decrease the consumption of certain types of food. This can be done through several measures, including tax policies and/or subsidies. There is an urgent need to devote more research to finding cost-effective responses to obesity.	Obesity rates among adults have more than doubled over past 20 years in Australia and US, while it has more than tripled in UK. Also rising in other countries. In the US, in 2003, healthcare costs attributable to obesity were estimated to be US$75 billion (*Obesity Research*, Jan. 2004). This represents about 5% of total health spending in the US. In other countries (e.g. Canada, Australia and NZ), the cost of obesity is estimated to account for 2 to 3% of total health spending, and these costs are rising. In the UK, obesity is estimated to result in 30,000 avoidable deaths per year (National Auditors Office, 2001).

Benchmarking health care performance and efficiency across countries

The OECD is starting to collect health care quality indicators for a large group of countries

Key Points	Q & A	Additional Information
1. Indicators of health care quality are needed to fill a gap in our international health care data base, *OECD Health Data* – which, so far, is better at covering inputs to health care, such as activity, resources and expenditure, than outputs.	**Q**: Who does best? Can we see the results? **A**: The work is in progress. We may have some first results next year. It is quite probable that given the variety of health systems in the OECD area, that, like the data published recently in *Health Affairs* by the Commonwealth Fund of New York, for 5 countries, the new indicators will tell a mixed story.	A number of individual OECD countries are developing indicators of the quality of health care to help them in benchmarking quality across their health care plans or providers. The US, Canada, Australia, France and the UK are examples. There is now a big demand from OECD countries for data that would enable them to make international comparisons of the outcomes and quality of their health care.
2. The aim is to produce a reasonably comprehensive but manageable set of, say, 50-100 health care quality indicators which are scientifically valid and internationally comparable.	**Q:** How do you define quality? **A**: We are guided by the conceptual frameworks for health care quality indicators already developed in a number of OECD countries. They point to measures of the technical quality of medical care including outcomes (such as breast cancer survival) and indicators of good medical practice (such as childhood immunisation rates).	Currently, 21 countries are participating in this project. It is based on two pre-existing international collaborations – that of the Commonwealth Fund and one involving 5 Nordic Countries.
3. So far, we are in the process of collecting data on about 20 indicators for which data are available in about 20 countries. We have also started looking at some priority areas for further indicators.	**Q:** Could you not end up drowning in indicators? **A**: the trick will be to identify a manageable but representative set of key indicators for important areas of health care.	Our 'Initial Indicator List' is based partly on the Commonwealth Fund's list and shares many indicators in common with it. Five expert panels have suggested a further 75 indicators in 5 priority areas: primary care and prevention; cardio-vascular disease; mental illness; diabetes; and patient safety.