

Reforming Health Systems in OECD Countries

Elizabeth Docteur, Principal Health Policy Analyst

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Overview of presentation

- OECD background, the Health Project, Health Data
- Findings from a study of the health system reform experience across the OECD
- Implications for the US health system
- Emerging and future challenges for health systems

The OECD approach: learning from international comparisons

- What is the Organisation for Economic Co-operation and Development?
 - Membership of 30 industrialised countries
 - Goal is to develop better economic and social policies
- How does it work?
 - Member countries identify key, common policy problems
 - Secretariat works with countries to collect standardised data and information on policies, involve experts, carry out analyses and
 - Reports back at meetings of Delegates, sometimes Ministers

Why does OECD work in health?

- Importance of health sector of OECD economies
 - Health expenditure is now 8% of GDP across OECD
 - Health important for continued economic development
- Potential for benefit from better understanding of what works
 - OECD health systems have similar aims and objectives
 - They feature different health care institutions and arrangements
- OECD comparative strengths
 - Work grounded in economic analysis
 - Focus on issues and experience of developed countries



OECD Health Data

- OECD has built up the leading international database on health systems
- More than 1200 indicators, including some time series beginning in 1960
 - Health status
 - Utilisation of services
 - Resources
 - Health expenditure
- Diagrams illustrating health system design



OECD Health Data (cont'd)

- Ongoing efforts to increase comparability, utility
 - Synergy with health policy studies
- Cooperation with WHO and EU
- CD-ROM (database)
- *Health at a Glance* (charts, tables, analysis of key indicators and trends)

The OECD Health Project

- A program of 12 studies on health policy issues
- Began in 2001, continues through mid-year 2004
- Funding from voluntary contributions
- Ad Hoc Health Committee serves as steering group
 - chaired by the heads of the Australian and Dutch Departments of Health
- Ministerial meeting to discuss results, 2004
 - 10-page summary report with recommendations for Ministers
 - 60-page synthesis report for officials
 - Reports on individual component studies for officials and experts

Health Project component studies

- Part A: Measuring and managing performance
 - Quality measurement and improvement
 - Measuring equity of realized access to care
- Part B: Explaining variation in performance
 - Human resources in health care
 - Waiting times for elective surgery
 - Private health insurance
 - The impact of new and emerging health-related technologies



Component studies (cont'd)

- Part C: Essential ameliorative care
 - Core study on long-term care
 - Case study on dementia
- Part D: Overall system assessment
 - Synthesis of past experience with health care reforms
 - Projections of health and long-term care expenditure
 - Development of a framework for reviewing health systems and their performance

Example 1: Equity of access study

- 22 countries included in study examining cross-income group equity of physician, hospital and dental care
 - Extends past research by Prof. Eddy Van Doorslaer
 - Uses mainly household survey data
 - Compares use of services across income groups, adjusting for self-reported health status
 - Analyzes causes of variations in equity

Equity of access study (cont'd)

- Preliminary results
 - Inequity in number of MD visits in 4 countries: Finland, Greece, Portugal, US
 - Inequity in consultations with specialists found in many of the countries for which data were available, offset by pro-poor inequity in GP visits
 - No differences detected thus far in number of hospital admissions or lengths of stay

Example 2: Health care quality indicator project

- Growing concern about safety and quality of care
- Project to collect internationally comparable health care quality indicators
- 20 countries participating, including USA
- Incorporates two existing international collaborations

Quality indicator project (cont'd)

- Agreement (Jan. 2003) to collect data for an initial list of 12 quality indicators
 - Cancer (3 types) survival, mortality following stroke and MI, asthma mortality, child vaccination, infectious disease
- Agreement to work on identifying indicators in 6 additional priority areas
 - Patient safety, primary care, prevention; mental health, diabetes, cardiovascular care.



Example 3: Waiting times for elective surgery

- Excessive waiting times for elective surgery is a major source of public dissatisfaction in about half of OECD countries
- Waiting times exist in some countries but are absent in other countries with common characteristics, spending levels

Waiting times for elective surgery (cont'd)

Waiting times reported by those needing elective surgery in past year, 2001

	AUS	CAN	NZ	UK	US
Less than 1 month	51%	37%	43%	38%	63%
1 to less than 4 months	26	36	31	24	32
4 months or more	23	27	26	38	5

SOURCE: Blendon et al. 2002



Waiting times (cont'd)

- The OECD Study
 - Compares policies to address waiting times in 12 countries in which waiting times are an issue
 - Compares characteristics of countries with and without a problem
 - Resources
 - System design
 - Capacity to provide services
 - Use rates, overall and for key surgeries
 - Develops better data on extent of problems across countries

Lessons from the health system reform experience

- Study objectives
 - Document trends in reforms of health systems in OECD countries
 - Evaluate the effects of reform efforts: What works and under what circumstances?
- Methods
 - Synthesize findings from OECD country-specific studies
 - Review literature: health economics, health policy, health services research
 - Assess new information on reforms and effects supplied by Member countries in response to questionnaire
 - Present findings to two Delegate Groups (Economics, Health)



Policy goals for health systems

- Access to services
- Cost control
- Efficiency
- Effectiveness



Goal: Access to services

- Provide insurance coverage for health care
- Remove barriers to access
- Ensure timely availability of services

Health insurance coverage

- Universal or near-universal coverage achieved in most countries
 - Exceptions: Mexico, Turkey, the United States
- Various mixes of public and private financing arrangements
 - Social insurance
 - National health service
 - Private health insurance
- Mandatory/compulsory element key to universality
- Coverage necessary, but not always sufficient to ensure access



Barriers to access

- Financial barriers (user fees, uncovered services)
 - Concerns about income-related inequities
 - Limiting cost-sharing for vulnerable groups promotes access
- Supply shortages/ maldistribution of supply
 - Problems in some rural and inner-city areas
- Vulnerable populations
 - Efforts to reduce non-financial barriers to access have had mixed success

Timely availability of services

- Waiting times for elective surgeries problematic in many OECD countries
 - Problems more common in countries with constraints on service capacity (acute-care beds, physicians, specialists)
 - Problems more common in countries with relatively low per capita health spending
 - For higher-spending countries, problems appear less common where payment systems reward productivity
- Policies to address waiting times
 - Increasing capacity of health system
 - Increasing productivity of health system
 - Managing or reducing demand
 - Improving management of “waiting lists”



Goal: Cost containment

- Total spending on health represents a sizeable portion of OECD economies
 - 8.3% of GDP, OECD average (2001)
 - 13.1% of GDP, United States (2001)
- Economic importance of health sector has increased
 - 5.3% of GDP, OECD average (1970)
 - 6.9% of GDP, United States (1970)
- Why a policy concern?
 - Strain on public budgets due to high avg. public share in total health expenditure

Public spending on health

- Public share of total spending on health, 2001
 - OECD average 72.2%
 - United States 44.2%
 - Mexico and Korea are the only other countries in which public sector spending represents less than half of total health expenditures
- Per capita public spending on health, 2001
 - OECD average \$1,513 US PPP
 - United States \$2,168 US PPP
 - Only Norway, Luxembourg, and Iceland had levels of per capita public spending on health that exceeded that of the United States in 2001

Growth in health spending

- Great expansions of coverage contributed to rapid growth in health spending in 1970s
 - 6.2% avg. real annual growth, OECD, 1970 – 1979
 - 4.5% avg. real annual growth, US, 1970 - 1979
- Growth slowed through 1980s and 1990s, partly as a result of cost-containment policies
 - 3.1% avg. real annual growth, OECD, 1980 – 1989
 - 5.3% avg. real annual growth, US, 1980 – 1989
 - 3.3% avg. real annual growth, OECD, 1990 – 1999
 - 3.3% avg. real annual growth, US, 1990 - 1999

What works in cost control?

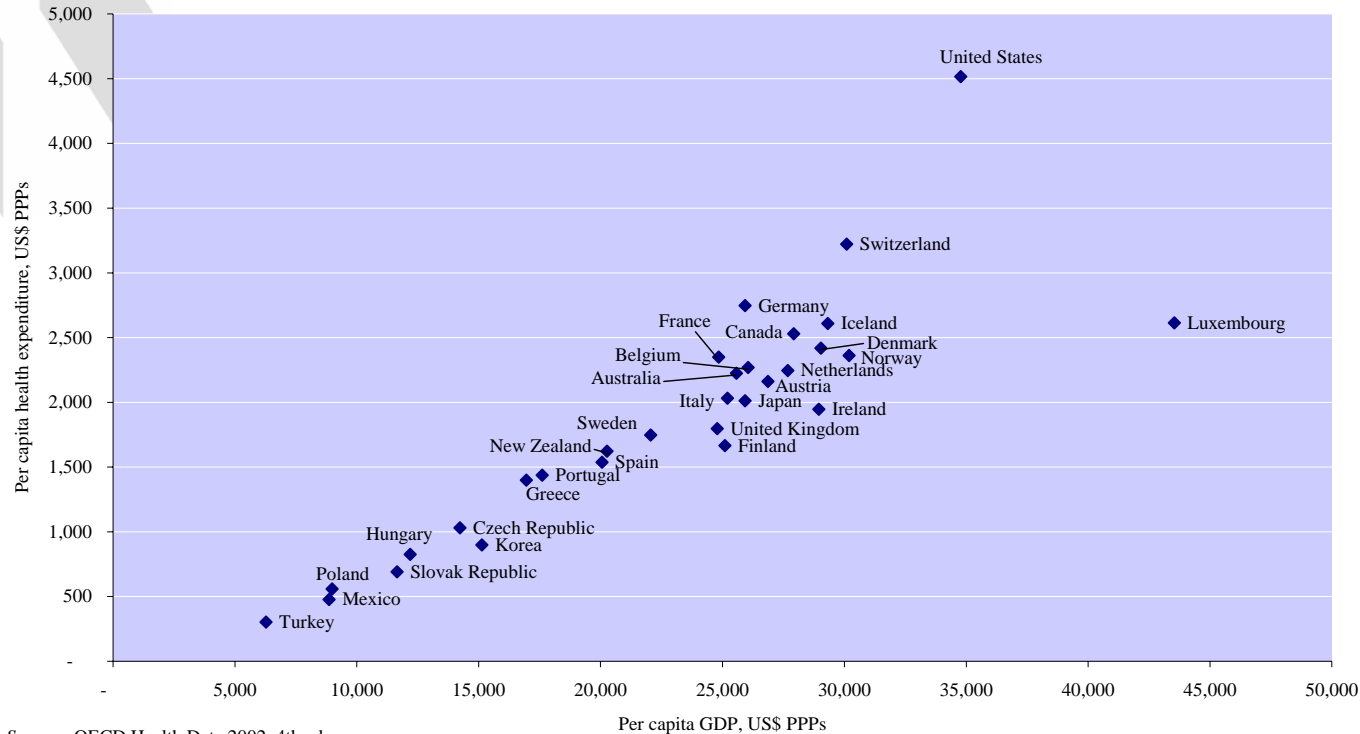
- Structural characteristics of health systems
 - Countries with *single-payer systems* or integrated public financing and delivery (*national health services*) found spending control easier
- Policy tools/reforms
 - Administered pricing
 - Controls on supply
 - Global budgets (overall and sector-specific)
 - Cost shifting

Effects of cost-control reforms

- Budget caps and controls on real resources, mainly in the hospital sector, appear to have been successful
- Wage and price controls also had short-term effects, but are more difficult to sustain over the longer term
- Public spending growth has been limited somewhat by greater patient cost sharing in most OECD countries, although effect on total spending minimal
- Finding appropriate spending level is difficult: some have found restraint has gone too far and are now increasing spending

Today's challenge: finding the "right" level of spending

Figure 1. Per capita GDP and per capita health expenditure, 2000



Source: OECD Health Data 2002, 4th ed.



Goal: Improve efficiency

- Efficiency of health sector very difficult to measure, but opportunities for improvements evident
 - Great variations in capacity and service volumes across and within countries
 - Not necessarily linked to variation in health status or health outcomes
- Improving value for money has been a focus of reforms since 1980s in many OECD countries
 - Increasing the output for a fixed amount of spending
 - Obtaining comparable output at reduced cost



Efficiency-oriented reforms

- Purchaser/provider split occurred in many public integrated systems
- 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 fee-for-service or capitation-based payments for physicians
 - Productivity increases create pressure for health cost growth

Efficiency-oriented reforms (cont'd)

- Decentralisation benefits and challenges
 - Local decisionmaking may improve matching of needs, resources
 - Some functions are best performed centrally
- Efforts to introduce competition in public integrated systems have not proved successful
- Some public-contract systems have tried to introduce competition in insurance markets
 - Developments have not fed through into provider markets
 - Concerns about the long-term sustainability of competition in these markets because of cream skimming

General lessons from efficiency reform experience

- Better cross-national data are needed to support assessment and improvement of health care efficiency
- The most efficient health systems are not necessarily the least costly health systems
- Increasing efficiency may require some additional, targeted investments (for example, in information systems or management improvements)

Policy challenges and reforms in the pharmaceutical sector

- Pharmaceutical sector growing faster than total health spending
 - Real average growth of 50% from 1990 – 2000 across OECD
 - New medicines, increased ability to treat conditions
 - Substitution for hospital care
- Private share in spending is greater in this sector
- Range of policies used to influence spending
 - User fees
 - Price/ industry profits control
 - Encouraging use of generic drugs
 - Pharmacoeconomic assessments
 - Reference pricing

Goal: Increase effectiveness of health systems

- OECD countries want health systems that are effective in
 - Improving health and reducing disability
 - Satisfying health care consumers and patients
- Increasingly, health policies focus on
 - Ensuring safety of health care
 - Improving the technical quality of care
 - Meeting demands for responsiveness, choice, etc....

Improvements in health status

- Life expectancy at birth
 - OECD avg. 77.2 years in 2000, up from 68.5 years in 1960
 - US avg. 76.8 years in 2000, up from 69.9 years in 1960
- Life expectancy at age 65
 - OECD avg. increase, 3.4 yrs (women), 2.8 yrs (men) 1970 - 2000
 - US avg. increase 3.4 years (women), 3.5 yrs (men) 1970 - 2000

Health status improvements (cont'd)

- Infant mortality
 - OECD avg. declined from 36.3 deaths/1000 live births in 1960 to 6.5 deaths/1000 live births in 2000
 - US avg. declined from 26.0 deaths/1000 live births in 1960 to 6.9 deaths/1000 live births in 2000
- Improved access to services and increased capability of medicine to prevent and treat conditions contributed to health status improvements
 - Income growth, standards of living, risk and behavioural factors play a very large role

Opportunities to increase health system effectiveness

- Reduce errors in health care delivery
- Improve clinical outcomes
- Increase technical skills of health care workforce
- Ensure that the “right” services are delivered at the “right” time
- Minimise delivery of unnecessary care
- Improve the continuity of care
- Reduce unwarranted variation in health care practices
- Better meet the expectations of patients and consumers

Reforms to increase effectiveness

- Move to greater involvement by governments, move away from dependence on professional self-regulation
- Investments in performance measures and health information systems to track system performance
- Development of clinical practice guidelines and performance standards, accreditation systems
- Experimentation with changes in organisation and delivery of health care, redesign of payment systems to reward quality
 - US managed care innovations

Emerging and future challenges

- Preparing to address needs of ageing populations
 - More demand for care, less tax and social insurance revenue
 - Improving long-term care financing and delivery
 - Improving the continuum of care, the interface between acute and social care needs
- Promoting efficient use of services and cost-effective application of new medical technology
 - Assessing technology and health care practices
 - Incorporating evidence in policy and practice

Emerging challenges (cont'd)

- Health care performance measurement
 - Developing valid indicators of health care quality
 - Improving health data systems
 - Instituting systems for measuring and reporting on performance
 - Ensuring patient privacy
- Better aligning economic incentives with desired outcomes
 - Experiments with performance-based payments in some OECD countries
 - Experiments with changing demand-side incentives