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**DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE**

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**MINISTERIAL BACKGROUND NOTE:
HEALTH SYSTEM PRIORITIES WHEN MONEY IS TIGHT**

**OECD Conference Centre at 2, rue André Pascal, 75016 Paris
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NOTE BY THE SECRETARIAT

1. This is a revised draft of the document DELSA/HEA(2010)7 which was discussed at the last meeting of the health committee on April 29-30, 2010. This draft incorporates changes suggested by countries at that meeting and subsequently, as well as some boxes containing 'country examples'.
2. Delegates are invited to:
 - **SUGGEST** final drafting changes, and
 - **AGREE** to transmit the document to the OECD Council for agreement that it be included in the Ministerial documentation.

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HEALTH SYSTEM PRIORITIES WHEN MONEY IS TIGHT

1. Health system performance has improved, but we can do even better.

<p><i>Health systems provide important welfare benefits to OECD populations and economies</i></p>	<p>3. OECD countries have achieved major gains in population health over recent decades. Across the OECD area, premature mortality has been cut by more than half since 1970. Life expectancy at birth for the average OECD country has increased by 10 years since 1960, reaching 79 years in 2007. Gains at older-ages have been even more dramatic: today, a woman aged 65 can expect to live a further 20 years, and a man an additional 17 years. Although socio-economic inequalities in health status remain, reductions in child mortality and gains in population health have continued at a steady pace over the past recent decades.</p> <p>4. Economic growth and education are major factors behind this success story, but health systems deserve much credit, too. Indeed, recent OECD estimates suggest that possibly up to 40% of the increase in life expectancy since the early 1990s could be due to more and better health spending. Increased spending and improvements in medical-practice standards have been accompanied by efforts to reduce the provision of inappropriate services and to address shortcomings in the quality of care. For example:</p> <ul style="list-style-type: none"> • A dramatic example over the past decade has been the better survival and lower disability rates after ischemic and hemorrhagic stroke, largely reflecting the impact of dedicated stroke units in hospitals. • Similarly, over the past 5 years, the number of people dying within 30 days after Acute Myocardial Infarction (AMI) has been reduced by a fifth, because of actions such as thrombolysis and early treatment with aspirin and beta-blockers (Figure 1). • Good primary healthcare -- such as being offered influenza immunisation, access to GP consultations, and GP supply – has protected people against premature deaths for chronic obstructive pulmonary disease. <p>5. In other cases, progress in improving health has been in part due to factors outside health care systems, though sometimes these have played a role too:</p> <ul style="list-style-type: none"> • Considerable improvements in median 5-year survival from breast cancers between 1995 and 2000 in 8 OECD countries can be attributed to raising risk awareness, mass screening, and effective treatment and follow-up. • Health care has contributed to reduction in cardiovascular disease, too, although a large share of improvement is directly related to life style modifications.
<p><i>Access to care has improved</i></p>	<p>6. Access to care, too, has continued to improve. Mexico and Turkey have recently introduced reforms to provide coverage for the poor or uninsured. The United States has just passed legislation that will mandate health insurance coverage for almost everyone. OECD countries are closer than ever before to</p>

	<p>achieving universal or near universal coverage for a core set of services. Such reforms have particular importance during recessions, when incomes are lower for some families, making the costs of poor health particularly hard to bear. Finally, the health system contributes to economic performance. It is a major employer; health spending helps stabilise the economy in times of crisis, and it is a contributor to the productive capacity of OECD economies – sick people are far less likely to work than their healthy neighbours, and if they do work, they earn less.</p>
<p><i>We are spending more on health than ever before, and we need to show that we are getting the best possible value for money</i></p>	<p>7. Despite these achievements, there is ample scope for getting better value from money in health systems. We are spending more on health than ever before. Health spending represents 9% of OECD economies (2007). It exceeds 10% in seven OECD countries – the United States, France, Switzerland, Germany, Belgium, Canada and Austria. While the rate of increase slowed in the period 2003-2007, health spending growth has exceeded economic growth in all OECD countries in the past 15 years.</p> <p>8. There is nothing inherently wrong with growing health spending. In fact, further increase of health spending is good – and will be sustainable – as long as it is the result of conscious individual and collective choices, and as long as the benefits of the additional dollar spent on health is worth more than the cost. But there is much evidence that we could – and should -- deliver better health system performance.</p>
<p><i>This is particularly important in the aftermath of economic crises when the public finances are in dire straits</i></p>	<p>9. Showing that health spending delivers good value for money is particularly important when money is tight. The current economic crisis has weakened economies throughout the OECD area. Health spending can act as a buffer against the undesirable social consequences of a recession by stabilising consumption against falls in demand for goods and services elsewhere in the economy. But the economic downturn has also worsened countries' financial and fiscal positions. Given that three-quarters of health spending is funded from public budgets, fiscal constraints in the coming years will heighten pressure on health systems to control costs and improve health-spending efficiency.</p>
<p><i>Thus, getting greater value for money in the longer-run is the biggest challenge facing health systems.</i></p>	<p>10. In the long run, we need to deliver greater value for money by rewarding providers, patients and payers for quality and efficiency. There are many promising new approaches that countries are using – such as pay-for-performance programmes, the more effective use of ICTs in health, or the use of rational decision making tools when allocating health resources. If these and other policies do deliver sustained improvements in quality of care, access to care and confidence in the health care system at reasonable cost, then increases in the resources being devoted to health care will be justified.</p> <p>11. This document addresses these key issues. It offers an overview of policies to improve health-system performance in the aftermath of the economic crisis. It discusses short-term policies to reduce the growth in health outlays before reviewing long-term strategies to achieve value for money.¹</p>

1. The publication *Health System Priorities when Money is Tight* offers a more in-depth analysis of all the health expenditure patterns and policy options to improve value from health spending in the medium and long-term that are discussed in the present note.

2. Health-spending growth puts pressure on government budgets in times of fiscal constraint

<p><i>Health spending has risen faster than GDP, a trend likely to persist...</i></p>	<p>12. Over the past fifteen years, health expenditure has grown at a faster rate than the economy in almost every OECD country (Figure 2), leading to a rise in the average ratio of health spending to GDP from 7.5% in 1992 to 9% in 2007, across the OECD. Factors exerting upward pressure on health spending (technological change, population expectations, increased incomes and, to a lesser extent, population ageing) will continue to drive health spending higher in the future. According to OECD projections, public health spending could increase by between 50% and 90% by 2050, depending on the assumptions made (Figure 3).</p>
<p><i>... and it is absorbing a larger share of government budgets in a context of shrinking government size.</i></p>	<p>13. Health spending falls largely within government budgets. Even in the OECD country with the largest private sector, the United States, public expenditure on health accounts for 7.3% of GDP – a comparable figure to that of the Netherlands and Canada, and above the OECD average of 6.4%.</p> <p>14. Whereas government spending has grown more slowly than the rest of the economy prior to the recent downturn, this has not been the case for public spending on health. Health is therefore taking a larger share of government budgets than before. Whether the result of deliberate policy or of an inability to control cost growth, the share of government expenditure devoted to health increased in most countries from an average of around 12% in 1992 to 16% in 2007. Growth in public health spending has tended to exceed economic growth by a larger margin in low and middle-income countries than in richer economies (between 2 and 3 percentage points, compared with around 1 percentage point).</p> <p>15. There are, however, considerable differences in the pace of growth in public spending on health across countries. Public and private health spending shares are converging: countries with a relatively high public share of health spending in the early 1990s experienced slower growth in the public component compared with private spending, and vice versa.</p>
<p><i>Higher health spending growth can be positive for societies and economies</i></p>	<p>16. All OECD countries have, at different points in time, made deliberate choices to spend more on health in order to strengthen the infrastructure, processes and outputs of health systems. In the past 15 years, several (mainly lower-income) OECD economies, such as Ireland, Korea, the Czech Republic, Greece, Poland and Turkey, experienced rapid growth in health spending. This was necessary to finance the expansion in health coverage and improvements in the delivery of a core set of services (Figure 4).</p> <p>17. Similarly, efforts to improve health-system performance were accompanied by high public health spending relative to economic growth in certain medium and high-income OECD countries. This was the case of the United Kingdom in the early 2000s, for example.</p>
<p><i>Pressure to control cost is stronger during periods of recession.</i></p>	<p>18. Pressure to control costs is less strong during economic expansions because they normally lead to higher government revenues. These additional financial resources provide greater latitude for health-system reforms and investment. But in times of economic retrenchment, governments face the difficult task of financing public sector deficits, while rising health costs strain family</p>

budgets. There may even be pressures to increase public health spending in recessions to protect those vulnerable populations which are particularly hard-hit by recessions, losing jobs which may reduce their medical insurance coverage, and make any out-of-pocket payments harder to bear.

Box 1: How much is too much? Is higher health spending sustainable?

Every time the OECD publishes its *OECD Health at a Glance*, the section that receives most interest and commentary from journalists is that on health spending. Most of these articles either bemoan the fact that their country spends too much on health, or else that they do not spend as much as other countries and that their citizens deserve better. Neither response makes much sense economically. After all, the fact that a country spends more or less than its neighbours on, say, consumer electronics, is treated as entirely irrelevant.

Part of the reason for the interest in health spending is that so much of it comes from the public purse, in most OECD countries, so spending has a direct effect on taxes. But the interest in total spending is high even – perhaps especially – in countries with a high level of private health spending. A useful distinction between two different concepts of health spending sustainability was developed during the Czech Presidency of the European Union:

Economic sustainability is when the value of the health spending exceeds its cost. As long as this is the case, there is no particular reason to worry if health spending goes up.

Fiscal (or financial) sustainability recognises the fact that someone has to pay for health spending, and at times it simply is not possible to raise taxes (or private health contributions) enough, even though the spending would be economically sustainable (i.e. the benefits would exceed the costs). This has been the situation recently in some OECD countries, including Iceland, Ireland, and Hungary.

Ensuring economic sustainability is the long-term challenge that all countries face. Countries need to maximise the benefit-to-cost ratio – to be cost-effective, in other words. This is quite different from being ‘cost-minimising’ – increasing the value of health spending, by delivering more effective, more accessible and higher quality care improves the economic sustainability of health spending just as much as eliminating waste and low-value interventions.

3. Responding to the crisis in the short-term

<p><i>There are tools to reduce cost in times of fiscal restraint</i></p>	<p>19. Policies to control spending can be broadly grouped into two sets:</p> <ul style="list-style-type: none"> • Short-term policies, aimed at expenditure restraints and largely operating through regulatory controls of a top-down nature ; and • Long-term policies, aimed at increasing efficiency mainly by enhancing the incentives facing patients, providers and regulators. <p>20. These policies do not have the same power in restraining health spending. The speed of their impact also varies – the former give quicker results, for example, but also give rise to long-term trade-offs with other policy goals (see Table 1). Not all the policy options included in Table 1 are open to all governments, depending on the way the health system is structured. Also, the starting point from which reforms take place in each country may affect final outcomes.</p>
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<i>Budgetary or regulatory measures can have the largest cost-reducing effects</i>	21. In most OECD countries, governments have considerable control over the supply of health inputs and their prices. Measures that control inputs, set caps to budgets, or freeze prices, can lead to significant cost cuts or strongly moderate the rate of growth in health spending. These tools have been utilised widely, albeit with different intensity over time and across countries. Some are being pushed through in the context of the current economic crisis. They appear to be most successful particularly in single-payer systems or countries with integrated health financing and supply.
<p>Box 2: What matters, where health funds come from, or how they are spent? The case of the Netherlands</p> <p>Integrated health systems relying on budget financing and government-sector providers, such as hospitals, are often contrasted with systems that rely on income from insurance premia. One of the advantages of the integrated system is that it can be easier to control costs – for example, by applying top-down budget caps on spending, without having to renegotiate agreements with different providers or requiring coordination among different insurance bodies. But while it is true that some insurance-based systems are among the highest spenders in the OECD, others spend less than the OECD average. The experience of the Netherlands suggests that it is the way individual providers are paid and the way contractual arrangements with providers are set that plays a far greater role in whether expenditure growth is easy to contain or not, than where the money comes from. The Netherlands had a very effective system of cost-containment during the 1980's and 1990's while having a social security-type health system. In contrast, during the past decade, the Netherlands started paying individual providers fee-for-service (in an attempt to reduce waiting lists), and expenditure increased rapidly. In the United States, integrated delivery systems such as those of Kaiser or that of the Veterans Affairs have provided incentives for coordinated and efficient care among teams of health professionals. Rather than looking for an ideal 'system', it is more important to look at how the money is spent and the incentives facing providers and users if we want to understand what will deliver value for money.</p>	
<i>They include controls over inputs ...</i>	22. Controls over inputs (labour and capital) have been used in almost every OECD country. For example, all OECD countries but Luxembourg and the Czech Republic have quotas on medical student intake, though in many cases these were pared back so sharply in the 1980s and 1990s that shortages have appeared. The average number of acute care beds declined from 4.7 per 1000 population in 1995 to 3.8 in 2007. Only Finland, Greece, Iceland Korea and Poland do not directly regulate the number of hospitals, hospital beds or the availability of high-tech equipment.
<i>... control over prices...</i>	23. Wage controls – typically occurring in the context of broad public-sector pay restrictions – have more commonly been implemented in countries with integrated health systems and those with salary-based remuneration for health professionals (for example, Denmark, United Kingdom and Ireland for hospitals, but also Finland, Spain and Sweden). Even in fee-for-service environments, most OECD governments have maintained oversight over price-setting or set prices administratively (e.g., Japan, Korea before 2000), sometimes in response to a break-down of negotiations with providers (e.g., Australia, Belgium, Canada, France, Luxembourg). Volume-price adjustment mechanisms -- where health fees are automatically adjusted in function of care volumes when a set level of expenditure is reached -- exist in Germany, Austria, Hungary, and Belgium.

<i>... restraints in the pharmaceutical sector...</i>	24. Policymakers have attempted to control pharmaceutical expenditures via a mix of price and volume controls directed at physicians and pharmacies, as well as policies targeting specific products (e.g., through product rebates) or increasing the share of cost borne by users. Recently, reductions in drug prices for reimbursed pharmaceuticals have been announced in Ireland. Other initiatives encouraged greater use of cheaper generic alternatives, including through lower user co-payments, for example in Switzerland.
<i>... budgets constraints ...</i>	25. A further way to control volumes, prices or capacity is by imposing budgets or expenditure targets. All OECD countries – except Austria, Japan, Korea, Mexico and Switzerland – impose budgetary constraints, particularly in the hospital sector. Strict health budgets -- such as those of Canada, Italy, the United Kingdom, New Zealand and some southern and eastern European OECD countries -- tend to be more effective than targets, as the latter are rarely respected.
<i>... and cost-shifting policies.</i>	26. Last, government decisions about the benefit package (what is or is not covered) and about user-cost sharing can have some consequences for public cost. Under fiscal pressure and exploding demand for health care, some US States are currently considering cuts in Medicaid optional benefits, such as dental and optical care, as well as reductions in payments to providers.
<i>However, these measures can only work for a limited period...</i>	27. These types of ‘command and control’ policies can hold expenditures down in the short term. However, they do little or nothing to moderate the underlying pressures which are pushing health spending up over the medium-term. The experience of countries which promptly reduced health expenditure after previous recessions suggests that the reductions in health spending that follow the intensification of such policies are short-lived. It is even possible that measures taken to restrict cost in the short run can increase long-run spending – if necessary investments are delayed and desirable prevention policies are not implemented.
<i>... and may harm other goals of the health system, including access, equity and quality.</i>	28. Even a temporary easing of pressures on health spending may well come at a high price, however. Many of the short-term policies can result in reduced access to care, less equitable provision of services, less responsive care, poorer quality, and delayed access to desirable new technologies. 29. In sum, in the aftermath of the crisis, some countries will find it difficult to raise enough money to maintain health spending. There are ways to reduce spending quickly by rationing care and controlling prices, but such measures cannot be sustainable because they do not address the underlying drivers of health spending. Given the size of the spending increases which are likely, as referred to above, the more important challenges are in fact long-term – how best to ensure that health spending continues to deliver good value for money. In the view of most analysts, the best answers to this challenge is to give better-informed patients the right incentives to steer demand to more appropriate care, and to reward purchasers and providers for giving cost-effective, high-quality care.

4. There are many new promising approaches to deliver value for money in the long-run

<p><i>Changing the incentives that people, payers and providers face will offer a better pay-off in the longer term</i></p>	<p>30. Countries have tried many policies to ensure that health systems deliver the best possible value for money – far too many to cover adequately here. However, many of the most promising new ideas have two things in common. First, they focus in particular on improving the way health systems address the changes in epidemiology and the rise in chronic disease. Second, they seek to reward patients, providers and buyers for quality and efficiency of care. The rest of this paper considers some of these initiatives. But it is important to stress from the start that the evidence on the effects of some of them is incomplete, and close monitoring of the many new initiatives is necessary in order to identify more precisely what is good practice in delivering value for money.</p>
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4.1 Changing individual and patient incentives

<p><i>With an increasingly educated population, there is greater scope for self-care and more informed patient choices...</i></p>	<p>31. Many people with chronic health conditions do not have access to the support services and advice they need to manage their own health, and yet patients who are well-informed about the risks or possible side-effects of treatment may be willing to forego intensive or invasive treatment. For example, a study on Ontario (Canada) shows that the vast majority of patients interviewed regarding their preferences for knee-pain treatment preferred conservative treatment, with only 14% indicating a preference for surgery. According to research on preference-sensitive care in the United States, demand for more invasive surgical options will diminish when patients are involved in treatment decisions. In addition, self-monitoring can contribute to improvements in health outcomes and reductions in emergency-room costs.</p> <p>32. Some caution is needed in extrapolating from these examples. More information does not necessarily lead to more self-reliant patients and potentially dangerous self-diagnosis needs to be avoided. Nevertheless, there does appear to be a case for providing training for self-care and for rewarding shared patient-doctor decision-making. Crucially, involving patients in the care decision-making process brings greater satisfaction to patients and improved quality of life.</p>
<p><i>... better coordinated health systems ...</i></p>	<p>33. Care coordination and disease management show promise in improving quality of care, albeit at a cost. Care coordination is a means to improve transitions from one health-care provider to another, help patients navigate through the system and, in particular, prevent unnecessary – and expensive – hospitalisation and use of specialists. Primary-care coordination via gatekeeping systems has many of the same goals.</p> <p>34. So far, the complexity of financing streams and the difficulty in transferring electronically medical records from one provider to another have proven to be barriers to greater coordination of care. To overcome these barriers, a number of innovative schemes have been tried, including grouping family doctors and hospitals together, rewarding them if they manage to coordinate care more effectively. Results have been mixed, however. Some initiatives have reduced costs somewhat, but a more common finding is an improvement in the <u>quality</u> of care (and hence improving value for money). That said, there may be more grounds for optimism when looking at specific areas of care, such as mental health care,</p>

	<p>particularly for depression and schizophrenia, and palliative care for patients with multiple disorders. The models that work in these areas include multi-axial teams linking primary and specialist care, a care coordinator and greater patient empowerment.</p> <p>35. The failure to achieve cost savings in other areas of care reflects in part the fact that coordination itself is expensive, but also that it is unrealistic to expect cost savings in treating those with extensive co-morbidities. This has led to increasing interest in using ‘predictive modeling’ tools, which have been pioneered in the United States and have been piloted in some Primary Care Trusts in the United Kingdom, to target costly disease-management programmes on those who will be most likely to benefit.</p>
<p>Box 3. Care coordination in Norway</p> <p>The 2008-2009 Care Coordination reform in Norway offered a multi-pronged approach to “provide proper treatment, at the right place and right time”. The reform includes the following steps: i) a clearer role for the patient, through for example the definition of patient pathways and improved patient contact points; ii) a new municipal role, including by re-designing agreements between municipalities and health authorities, emphasising prevention and early intervention; iii) financing incentives, for example by improving the financing framework for specialist health care services to be co-funded by municipalities; iv) strengthening of specialist health care services; v) improved mechanisms for defining health-system priorities; vi) the development of ICT systems, incentives for R&D, measures to develop competent health care professionals and improved planning mechanisms.</p>	
<p><i>... and great emphasis on prevention.</i></p>	<p>36. Imbalances between prevention and cure are evident in all OECD countries. Expenditure data suggest that only one in every 20 dollars spent on health systems is to prevent disease and promote better health. This is probably an underestimate, as it does not take into account the efforts of family doctors to coach patients to adopt healthier behaviour, but still it is clear that prevention does not receive many resources. Yet, there are some measures of proven cost-effectiveness – vaccination against communicable diseases and interventions to reduce tobacco and alcohol consumption. OECD analysis has shown that many interventions to combat obesity have favourable cost-effectiveness ratios.</p>

4.2 *Changing providers’ and purchasers’ incentives*

<p><i>Supply-side measures offer scope for efficiency improvements</i></p>	<p>37. The scope for increasing value for money appears particularly large on the supply-side of the market for health services. There is significant cross-country variation in health-system delivery, which does not appear to lead to outcomes differences. This suggests scope for efficiency improvements by narrowing variation in inputs or utilisation.</p>
<p><i>There are opportunities to improve efficiency in the hospital and ambulatory sectors...</i></p>	<p>38. The scope for efficiency gains appears to be especially important in the hospital sector. Hospitals still account for around 40% of health spending. The sector has undergone significant reforms over the past three decades, with innovations permitting reductions in average lengths of hospital stay. Ambulatory and day surgery has grown in all OECD countries. There has been a trend towards greater specialisation and a focus on patients’ quality and safety. These changes have occurred in a context of tightening budgets and scrutiny over cost, leading to</p>

	<p>enhanced management capacity and cost accountability. Opportunities for further performance improvement remain, for example by improving hospital management or by making less use of acute-care beds for rehabilitation purposes. The growing prevalence of chronic diseases requires care to be shifted out of hospitals and into ambulatory or outpatient settings.</p> <p>39. Achieving more efficient deployment of resources in the ambulatory sector is perhaps more complex, and there is more variation in the organisation of ambulatory care in OECD countries. Still, there is some evidence that doctors acting alone in individual practices are the least well adapted to addressing emerging patterns of morbidity. Health teams or group practices combining both doctors and nurses are a promising direction for change, perhaps particularly when combined with new advanced roles for nurses. “Medical homes” in the United States, or moves towards gatekeeping systems in Germany and France, permit more cost-effective treatment and monitoring of patients with chronic conditions.</p>
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Box 4: Does improving quality also improve efficiency?

Is there a trade-off between improving the quality of care and reducing costs? Or should we, on the contrary, see investing in better quality of care as a way of reducing future use of health services? There are pieces of evidence which suggest that the latter situation is sometimes the case. For example, adverse drug reactions (ADR) cost UK taxpayers £466m a year. Yet most of these ADRs could be avoided if appropriate procedures were followed – the drugs most often involved in ADRs were things like low-dose aspirin, diuretics, warfarin, and non-steroidal anti-inflammatory drugs, where there is a great deal of evidence on appropriate usage. More generally, the WHO estimates that improvements in patient safety could lead to cost savings of between \$6 and \$29 billion per year. Possible areas to target include problems associated with surgical safety, which account for half of the avoidable adverse events, and hospital-acquired infections, which affect up to 1.4m people worldwide. Minimising expensive unplanned hospital admissions for those suffering from chronic diseases could be another area where increased quality of care and greater cost-efficiency could walk hand-in-hand. The opposite scenario can also be the case, however. Many countries have invested in improving patient experience of health care. Those requiring hospital treatments are more likely to have private rooms, and are less likely to be in impersonal 19th Century buildings with paint peeling off the walls. That such changes have made receipt of care a more pleasant, less intimidating and stressful event is for sure. But when money for health care is tighter than in the last few years, is it appropriate to reduce such investments in favour of a focus on maintaining as many medical services as possible?

<p><i>... but separation of purchaser-provider functions has proved difficult to implement effectively.</i></p>	<p>40. The separation between purchaser and provider functions is a third appealing model for furthering health system goals in health delivery. But it has proved difficult to introduce because purchasers often lack the information needed to write and monitor contracts, a process that can be very costly. More effective purchasing requires setting clear targets for purchasers, investment to build the data systems necessary to monitor performance, and continuous evaluation of results.</p>
<p><i>More rational decision-making would allow a better allocation of resources</i></p>	<p>41. New pharmaceuticals and advances in medical technologies have brought large benefits to patients in OECD countries. They are responsible for major lengthening in disability-free life expectancy. They enable new treatments for diseases that represent a heavy burden of morbidity and permit treatments that were previously not possible (e.g., HIV treatment).</p>

42. Yet medical technology is one of the major health-cost drivers. While enabling shorter hospital stays and less invasive procedures, it can increase spending by curing diseases for which no treatment was available earlier. In a resource-constrained health system, policy makers have to ensure that public resources are allocated as efficiently as possible. This may require facing hard decisions, for example, is it better to invest in a costly technology bringing large benefits only to a few people, or to cover a cheaper treatment bringing benefits to a larger group?

43. Many OECD countries have adopted explicit structures or processes to help purchasers make informed decisions on coverage of pharmaceuticals or costly new technologies. Evidence-based medicine and health-technology assessment have already increased the transparency of decision-making and helped ensuring that new investments are worth their cost. For example, to help purchasers prioritise and ensure that patients receive the most cost-effective treatment, the UK's National Institute for Clinical Excellence recently identified 19 recommendations which, if followed, would help free-up resources. These include, for example, encouraging women to use long-acting contraceptives instead of the pill, the prescribing of drugs to control hypertension, and guidelines to reduce health care-associated infections.

44. More however should be done to generate and diffuse evidence about the relative merits of health-care alternatives. According to the American Institute of Medicine, half of health care services are still provided without any evidence about their effectiveness. Evidence of gaps in the quality of care provided to populations is compelling. The Rand Corporation estimated in 2001 that more than half of the care received by American adults for a set of 30 acute and chronic conditions was not consistent with recommendations of evidence-based medicine. Only a few countries produce and actively disseminate clinical guidelines to inform decision-making at the doctors and patient level, moreover uptake or recommendations is as important as the evaluation process. In addition to better information, institutional factors (e.g., procedures, and feedback systems), involvement of key stakeholders in implementation and design, skill training and financial incentives such as pay for performance strategies can encourage adoption of best practices.

Box 5. Evidence-based medicine: the Ottawa Ankle Rules

The Ottawa Ankle Rules (OAR, Canada) offer simple guidelines to help emergency physicians decide when to use radiology for patients with ankle injuries. Prior to the introduction of the rules, patients with ankle injuries were routinely X-rayed, even if only 15% of such X-rays were actually needed. Studies have shown that the Ottawa Ankle Rules could reduce the number of unnecessary X-rays by 30-40%. Some clinical studies have also shown the application of the OAR to children could result in a 25% reduction in x-ray usage in children. Clinical testing of the rules has revealed that the guidelines have been effective at reducing the use of ankle x-rays, waiting for treatment and costs, without under-diagnoses of fractures and without patients' dissatisfaction. In the US, cost savings have been estimated between US\$614, 226 and US\$3,145, 910 per 100, 000 patients depending on the charge for x-rays. In Canada, total savings estimated are CAN\$730,145 per 100,000 patients. The Rules were developed for ankle and foot injuries only, however, similar guidelines have now been developed for other injuries, such as the Ottawa Knee Rule.

<p><i>Reforming payment systems towards performance promises to improve care quality</i></p>	<p>45. Achieving value from health care provision will also require reforms in provider payment mechanisms. Today, most health care providers are still rewarded for activity, or responsibility. Seldom are they rewarded for improving patients' health, or for providing high-quality care. Pay-for-performance (P4P) does this. There has been a proliferation of such schemes in the past few years in the United States (both public and private sector), the United Kingdom (Quality and Outcomes Framework), New Zealand (Performance Based Management), Brazil and Australia (Practice Incentive Programme), to mention a few. Generally, these schemes are used in primary care and encourage greater attention to be given to prevention and to following clinical guidelines, for example for chronic care. Financial rewards (bonuses) are given to providers meeting predefined health-service performance targets, but wide publicity of "league tables" showing which providers give high-quality care has much the same effect. Less frequently, the incentive is related to cost savings.</p> <p>46. Pilot experiences with P4P programmes show improvements in uptake of preventative services and adherence of clinical guidelines for chronic diseases. But identifying the right incentive has been more difficult. Often, incentives are based on reaching targets rather than changes in overall performance. The payments are too frequently small to expect practices to significantly change provider behaviour. There can be professionals' resistance due to loss of clinical autonomy, and consumers' fear about privacy. There are also concerns about the robustness of the targets. If some particular diseases or indicators are targeted with a financial incentive, there is a risk that other activities are neglected. There are important lessons that countries can learn from each other on how to better design these systems and to learn from the successes and mistakes of other countries.</p> <p>47. P4P schemes almost always require upfront investment and significant fine-tuning. In particular, the administrative costs of setting up and running a P4P system can be high. Because health systems often lack the data on clinical quality on which P4P systems depend, providers are usually paid an initial bonus simply for reporting information on clinical quality. Once this reporting system is set up, there is greater scope for using these schemes for achieving quality objectives. Costs can increase because providers will adjust their behaviour to meet the target. This is a sign of success, of course, but illustrates the fact that it is easier to increase value for money by increasing the quality of care, not so easy to achieve it by reducing costs.</p>
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Box 6: P4P: The experience of Australia and Korea

The Australian Government provides financial incentives to both parents and immunisation providers to support child immunisation outcomes. Since the introduction of the General Practice Immunisation Incentives Scheme in 1998, the average practice immunisation coverage has increased from around 76 per cent to around 92 per cent.

The Korean National Health Insurance system developed the so-called HIRA-Value Incentive Program (VIP) in 2007. This pay-for-performance scheme covers 43 tertiary hospitals for improvements in acute myocardial infarction treatment (based on seven indicators including timeliness of reperfusion therapy, case fatality and the administration of aspirin) and reductions in unnecessary caesarean deliveries. High performers and those with improving performance were paid financial incentives from the second year of implementation of the scheme, while penalties for bad performers will begin to apply from the third year.

	<p>To date, the programme has resulted in a 1.5% improvement in the quality measure for myocardial infarction measure and a 0.6% drop in C-section delivery, as well as savings of 1.8 billion won.</p>
<p><i>Pharmaceutical pricing and reimbursement policies should be based on their value</i></p>	<p>48. Much decision-making in the health sector is still made on a relatively ad hoc basis. More rational and explicit decision-making in areas such as coverage and pricing could achieve efficiency gains from pharmaceutical spending. This is an area of some importance: expenditure for out-patient pharmaceuticals has increased at a faster pace than total health spending in OECD countries on average, and now accounts for more than a quarter of total health spending in the Czech Republic, Korea, Poland, Hungary and the Slovak Republic.</p> <p>49. Current pharmaceutical pricing and reimbursement policies do not always deliver good value-for-money. In over 80% of OECD countries, prices used in a group of reference countries are used as benchmarks to define the price of new and innovative medicines. This approach is open to manipulation, with new drugs being launched in high-price markets first, and does not guarantee best value for money.</p> <p>50. Innovative payment methods based on agreements to share the risks of developing new products with purchasers are promising, but should be subject to rigorous and public evaluation. Last, many countries could achieve rapid efficiency gains by promoting greater use of generic drugs. In 2006, the share of generics in pharmaceutical markets ranged from a low of 1% in Ireland to a high of 60% in Poland.</p>
<p><i>There is ample evidence that greater use of ICT can increase quality of care, prevent medical errors, and possibly even cut cost.</i></p>	<p>51. The adoption of information technology and computerisation of providers' minimises duplication of medical tests and reduces the administrative cost of billing, patient scheduling, and paper forms. For example, claims that previously cost \$5 per paper transaction are now being processed electronically at 25 cents in New England (United States), thanks to the Healthcare Electronic Data Interchange Network, a consortium of providers and payers. Use of electronic prescriptions in Sweden saved doctors and pharmacists an average of 30 minutes per day. Telemedicine makes possible treatments from remote areas, while enhanced information systems help monitoring care quality. Establishing digital networks to facilitate the transmission, processing and storing of medical information makes health system more responsive to users' needs, too.</p>
<p><i>... but problems in implementation need to be overcome...</i></p>	<p>52. All of this is good news. Why is it then that health systems are so much lagging behind other parts of the economy in exploiting the productivity benefits of ICT? One problem is that those who benefit most from greater use of electronic health records, for example, are often not those who have to do much of the work in order to make them effective. General practitioners have to input much of the data needed for electronic health records, but it is those who pay for health care who will benefit most from them in reduced costs.</p>
<p><i>... and privacy concerns addressed.</i></p>	<p>53. Furthermore, privacy concerns have to be respected, and a balance found between ensuring that only those who really need to can access health records with the need to extract information to monitor performance. Inter-operability issues between different IT systems remain problematic, and overall governance of large-scale health ICT systems has often been poor. Overcoming these difficulties require government stewardship: market forces alone are not enough to realise the potential of health ICTs. The United States is offering subsidies of \$15-40,000 to</p>

	family doctors to persuade them to set up Electronic Health Records, and will reduce Medicaid payments to those who do not use them. In Denmark, a mandate for primary care doctors to use health IT in 2004, combined with technical assistance for physicians and national standards to ensure interoperability, resulted in 100 percent of primary care doctors using electronic medical records by 2010.
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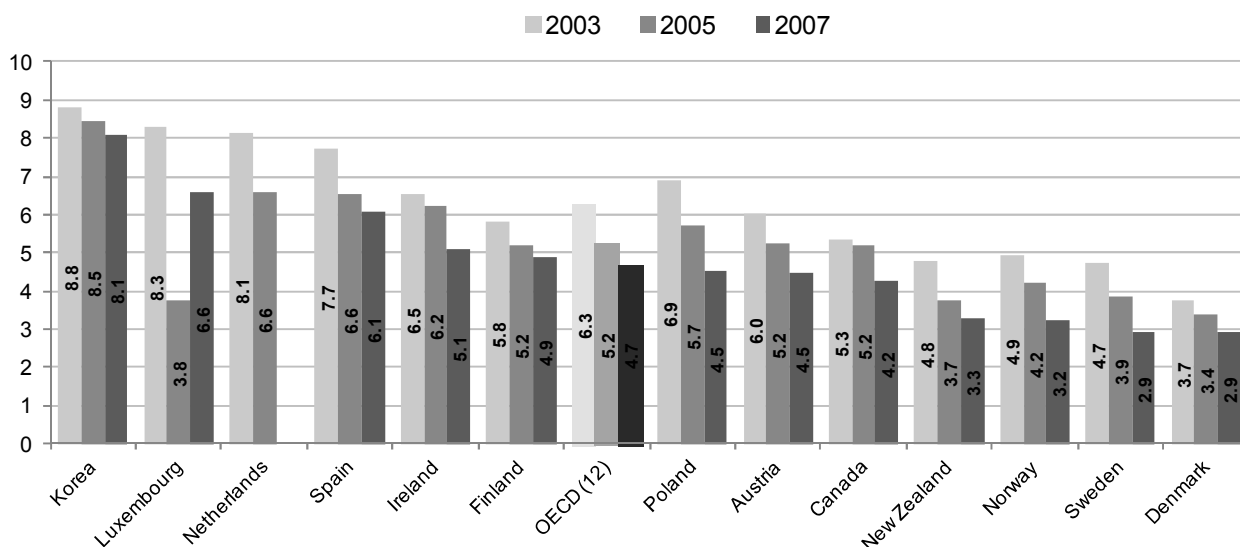
5. Reconciling the short and the long-term

<i>There are inevitable trade-offs to address in a resource-constrained environment</i>	54. Short-run pressures to limit health-spending growth are sometimes not easily reconciled with long-term goals of high-performing health systems. Investing in health ICTs, paying providers to improve their performance, rewarding coordinated care provision, and even investing in prevention and health promotion all offer the prospect of better health care, and indeed better health. Evidence that they can reduce costs as well is thin on the ground. Furthermore, to make these sorts of initiatives work, new resources often have to be found.
<i>Significant upfront investment in these initiatives may be necessary to achieve long-term value from money</i>	55. The growth of health spending will continue to out-pace the growth of national income in the foreseeable future, as it has in the past, reflecting the value it brings to societies and consumers. It will deliver jobs, better health outcomes, growth and well-being. But this does not mean that we can be indifferent as to how we spend our health money. 56. Some of the exciting new initiatives discussed in this report promise to achieve efficiency improvements. Many of them are interlinked: we need good information flows to make care-coordination practicable; P4P requires a lot of information: in both cases, a well-functioning system of electronic health records vastly increases the possibility of successful implementation. Widespread acceptance of evidence-based medicine and clinical guidelines is a necessary condition of setting P4P targets and getting a sensible pricing structure for pharmaceuticals. Changing the incentives facing consumers, providers and purchasers is a complex undertaking but there is no alternative to ceaselessly searching for ways to deliver good value from health spending.

Table 1. Policies for limiting spending in a period of budget restraint

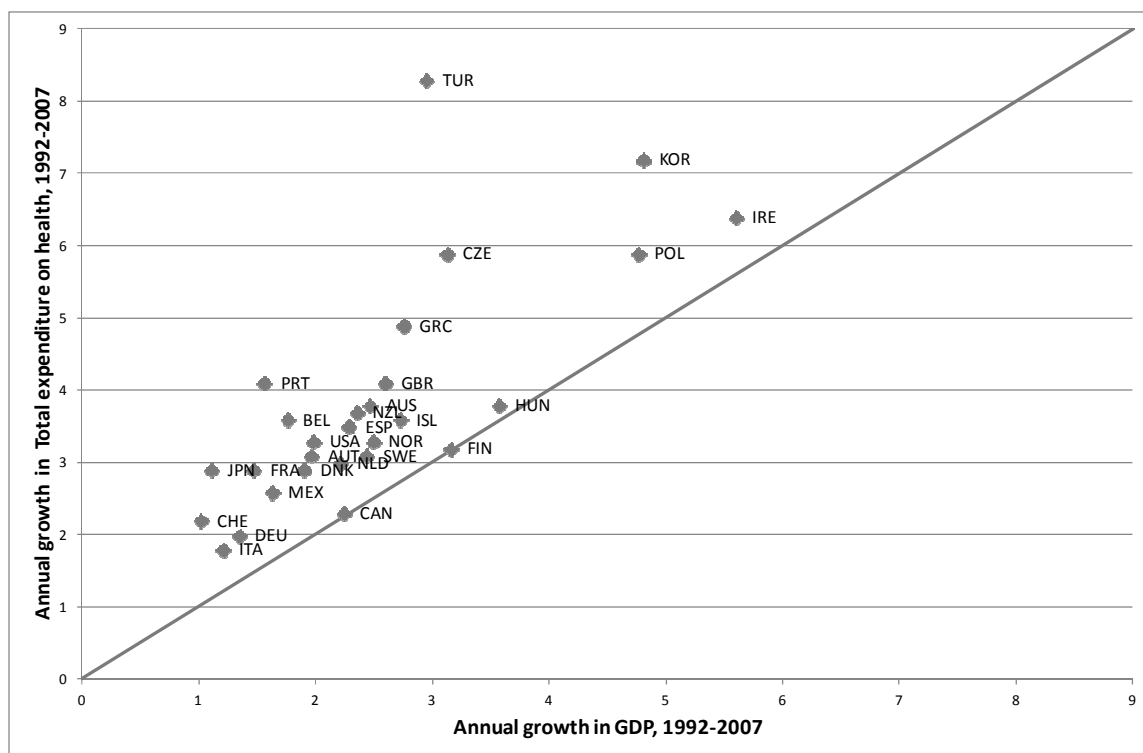
Characteristics, impacts and tradeoffs	Impact on expenditure		Financial protection and access to care	Objectives and tradeoffs		
	Strength	Impact lag		Quality of care	Responsiveness	Cost efficiency
A. Macroeconomic policies aimed at expenditure restraint						
<i>A.1 Wage and price controls (labour)</i>	HIGH	SHORT	NONE	NONE/ NEGATIVE	NEGATIVE	POSITIVE
<i>A.2 Wage and price controls (medical materials)</i>	HIGH	SHORT	NONE	NEGATIVE	NEGATIVE	POSITIVE
<i>A.3. Controls on volume of inputs (labour)</i>	HIGH	MODERATE	NONE/ NEGATIVE	NEGATIVE	NEGATIVE	POSITIVE
<i>(capital investment)</i>	HIGH	SHORT	NONE/ NEGATIVE	NEGATIVE	NEGATIVE	POSITIVE
<i>A.4 Controls on volume of other inputs (high tech)</i>	MODERATE	SHORT	NEGATIVE	NEGATIVE	NEGATIVE	POSITIVE/ NEGATIVE
<i>A.5 Budget caps (sector and global)</i>	HIGH	SHORT	NEGATIVE	NEGATIVE	NEGATIVE	POSITIVE
<i>A.6 Shifting costs to private sector (increased financing of cost of system by users)</i>	MODERATE	MODERATE	NEGATIVE	POSITIVE/ NEGATIVE	POSITIVE/ NEGATIVE	POSITIVE
B. Micro policies aimed at increasing efficiency						
B.1 Demand side						
<i>B.1 Disease prevention and health promotion</i>	LOW/MOD	LONG	POSITIVE	POSITIVE	NONE	POSITIVE
<i>B.2 Gate-keeping/triaging</i>	LOW	LONG	POSITIVE	POSITIVE	NEGATIVE	POSITIVE
<i>B.3 Care coordination integrated care/self care</i>	MODERATE	LONG	POSITIVE	POSITIVE	POSITIVE	POSITIVE/ NEGATIVE
<i>B.4 Better patient/doctor contact</i>	LOW	MODERATE	NONE/ POSITIVE	POSITIVE	NONE/ POSITIVE	POSITIVE/ NEGATIVE
<i>B.5 Access to a PC doctor out-of-office hours (to take the pressure off hospital emergency services)</i>	MODERATE	LONG	POSITIVE	POSITIVE	POSITIVE	POSITIVE
B.2 Supply side						
<i>B.6. further reducing inpatient care supply</i>	MODERATE HIGH	LONG	NEGATIVE	POSITIVE/ NEGATIVE	NEGATIVE	POSITIVE
<i>B.7 Enhancing the role of health-care purchasers</i>	MODERATE	LONG	POSITIVE/ NEGATIVE	POSITIVE	POSITIVE/ NEGATIVE	POSITIVE
<i>B.8.Improving hospital contracting/purchasing and payment systems</i>	MODERATE	LONG	NONE	POSITIVE/ NEGATIVE	UNKNOWN	POSITIVE
<i>B.9 Increasing managerial independence</i>	LOW	LONG	UNKNOWN	POSITIVE	UNKNOWN	POSITIVE
<i>B.10 Improving payment methods /incentives for hospitals</i>	MODERATE	LONG	POSITIVE	POSITIVE	UNKNOWN	POSITIVE
<i>B.11 Overseeing technological change and the pricing of medical goods</i>	MOD/LOW	LONG	POSITIVE/ NEGATIVE	POSITIVE/ NEGATIVE	POSITIVE/ NEGATIVE	POSITIVE
<i>B.12 Increased use of ICT for information transmission</i>	MOD/LOW	LONG	POSITIVE/ NEGATIVE	POSITIVE/ NEGATIVE	POSITIVE/ NEGATIVE	POSITIVE/ NEGATIVE

Figure 1. Reduction in in-hospital case-fatality rates within 30 days after admission for AMI, 2003-2007 (or nearest year available)



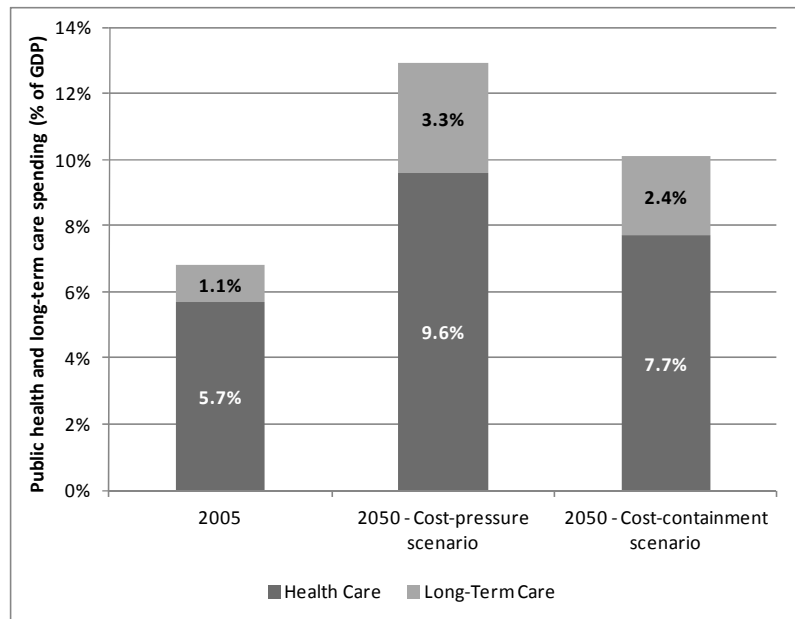
Source: OECD Health Care Quality Indicators Data 2009. Rates age-sex standardised to 2005 OECD population (45+).

Figure 2. Annual growth in health expenditure and GDP, 1992-2007



Source OECD Health Data 2009.

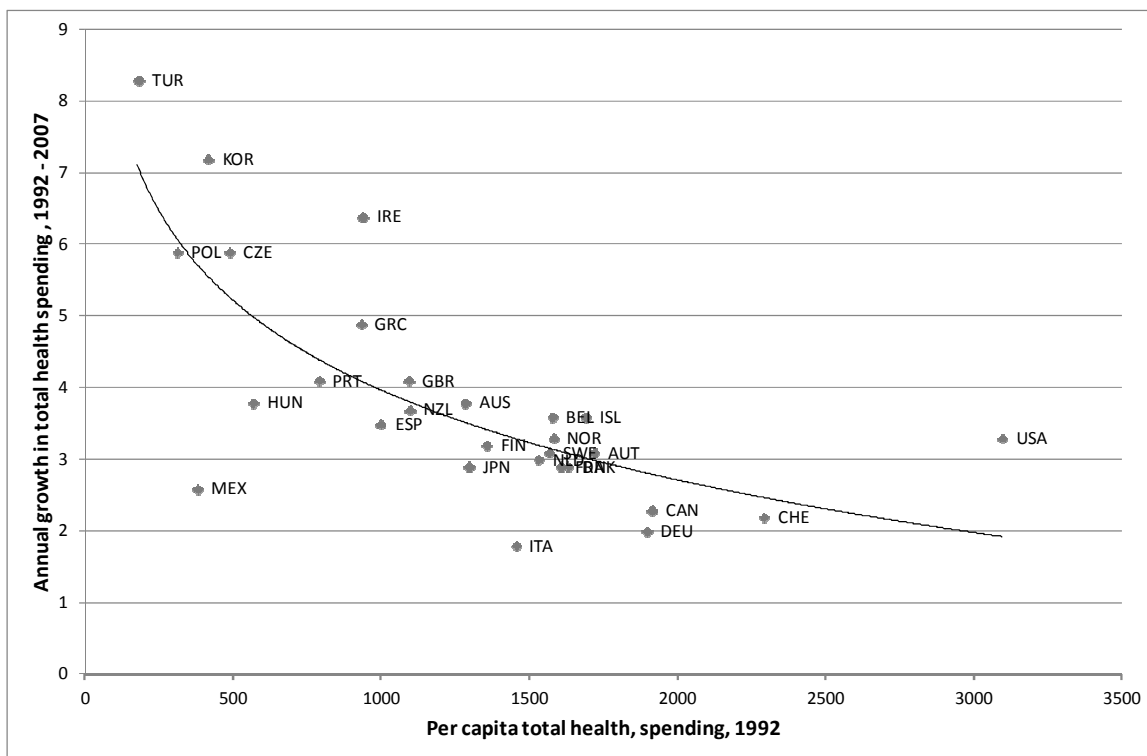
Figure 3. Projections of public health and long-term spending 2005 - 2050



Note: Under the “cost pressures” scenario, it is assumed that, for given demography, expenditures grow 1% per annum faster than income. Under the “cost-containment” scenario, policy action is assumed to curb “extra” expenditure growth by 2050.

Source: OECD Economics Department Working Paper No. 477.

Figure 4. Per capita total spending on health in 1992 and annual growth in spending between 1992 and 2007



Source OECD Health Data 2009.