

The OECD Health Project

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TOWARDS HIGH-PERFORMING HEALTH SYSTEMS

Summary Report



ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

Pursuant to Article 1 of the Convention signed in Paris on 14th December 1960, and which came into force on 30th September 1961, the Organisation for Economic Co-operation and Development (OECD) shall promote policies designed:

- to achieve the highest sustainable economic growth and employment and a rising standard of living in member countries, while maintaining financial stability, and thus to contribute to the development of the world economy;
- to contribute to sound economic expansion in member as well as non-member countries in the process of economic development; and
- to contribute to the expansion of world trade on a multilateral, non-discriminatory basis in accordance with international obligations.

The original member countries of the OECD are Austria, Belgium, Canada, Denmark, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The following countries became members subsequently through accession at the dates indicated hereafter: Japan (28th April 1964), Finland (28th January 1969), Australia (7th June 1971), New Zealand (29th May 1973), Mexico (18th May 1994), the Czech Republic (21st December 1995), Hungary (7th May 1996), Poland (22nd November 1996), Korea (12th December 1996) and the Slovak Republic (14th December 2000). The Commission of the European Communities takes part in the work of the OECD (Article 13 of the OECD Convention).

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VERS DES SYSTÈMES DE SANTÉ PLUS PERFORMANTS

Résumé

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FOREWORD

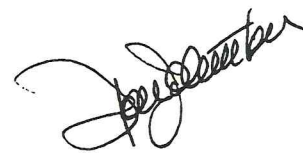
The OECD initiated the Health Project in 2001 to address some of the key challenges policy makers face in improving the performance of their countries' health systems. A desire for real progress and a recognition of important gaps in the information needed to undertake change led to political commitment and support across countries for a focused cross-national effort. The three-year initiative provided member countries with multiple opportunities to participate in and learn from component studies focused on pressing health policy issues. Countries also benefited from the information and exchanges that occurred, first at the kick-off conference in Ottawa, Canada in November 2001, and at no fewer than 20 subsequent meetings of officials and experts in venues ranging from Paris to The Hague to New York.

Performance improvement requires grappling with difficult questions. What can be done to ensure that spending on health is affordable today and sustainable tomorrow? What is needed to improve the quality and safety of health care, and to ensure that health systems are responsive to the needs of patients and other stakeholders? How should equitable and timely access to necessary care be supported? And perhaps the most challenging question of all: what can be done to increase value for money?

The Health Project offered a means for officials in member countries to learn from each others' experiences in tackling these questions, to draw upon the best expertise available across OECD member countries and within the OECD Secretariat, and to break new ground to support health-system performance improvement in the future. It encompassed nearly a dozen studies addressing key policy issues pertaining to human resources in health care, new and emerging health technologies, long-term care, private health insurance, health-care cost control, equity of access across income groups, waiting times for elective surgery, and other topics that are central to the policy concerns of OECD member countries. It was not possible to address every issue important to Health Ministries in the course of the project, but the issues that were chosen were ones considered to be of the most pressing importance.

The Health Project built on the foundation of the OECD's work in health statistics and health policy that has been carried out under the purview of various committees and working parties across the OECD. An important contributor to the success of the Health Project was its horizontal approach. Work in progress was discussed by experts and Delegate groups with a variety of important perspectives on health policy issues. The project benefited from the guidance and support of an Ad Hoc Group on Health, made up of Delegates from member countries, and the specialised expertise of various OECD directorates was employed in tackling issues. The Directorate for Employment, Labour and Social Affairs took the lead in coordinating the work conducted in horizontal co-operation with the Economics Department, the Directorate for Science, Technology and Industry, and the Directorate for Financial and Enterprise Affairs.

From my own political experience, I know how significant the results of this project will be for policy makers at the most senior levels of government. There are no governments within the OECD or beyond which will not derive important benefits from this work as they all struggle to meet varying challenges in the field of health care. It is apparent that there are few one-off solutions or quick fixes. But this project has demonstrated that benchmarking within and across countries, and sharing information can bring new ideas together and help policy makers meet those challenges.



Donald J. Johnston
Secretary-General of the OECD

PREFACE

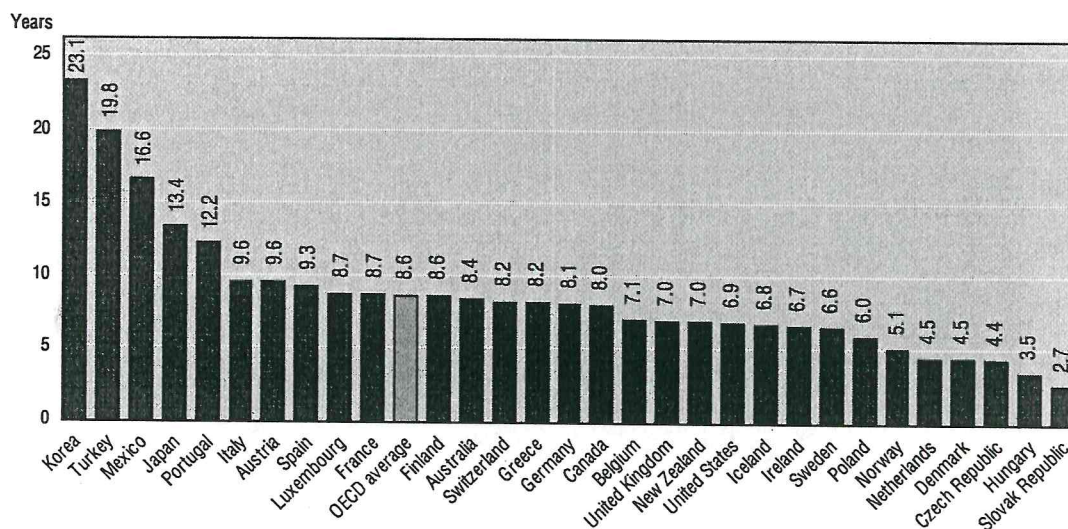
This report serves as an executive summary of the final report on the OECD Health Project, *Towards High-Performing Health Systems*. It presents the main policy conclusions drawn in the final report, which synthesized key findings from studies conducted as part of the three-year Project and other recent work on health at the OECD. The summary report follows the general framework of the final report, corresponding to the main health policy goals shared by OECD countries: health care that is accessible and of high quality, and health systems that are responsive, affordable, and good value for money. It offers lessons on the effects of various policies intended to manage the adoption and diffusion of health-related technology, address shortages of nurses and other health-care workers, increase the productivity of hospitals and physicians, manage the demand for health services, reduce waiting times for elective surgery and foster the availability of affordable private health insurance coverage. In addition, it sheds new light on problems policy makers face, such as judging the appropriate level of health spending, assessing the appropriate role for private financing in health and long-term care systems, and evaluating the implications for health system performance of waiting times for elective surgery.

TOWARDS HIGH-PERFORMING HEALTH SYSTEMS

OECD countries have good reason to feel proud of their accomplishments in improving health. A child born in an OECD country in 2000 can expect to live nine years longer, on average, than someone born in 1960 (see Figure 1). Infant mortality is five times lower today than it was then. In the past four decades, the level of premature death – as measured by years of life lost before age 70 – has been cut by half.

Health has improved dramatically...

Figure 1. Gains in life expectancy at birth, total population, 1960-2000



Note: Differences across countries in method used to calculate life expectancy can affect the comparability of reported life expectancy estimates, as different methods can change a country's estimates by a fraction of a year. Life expectancy at birth for the total population is estimated by the OECD Secretariat for all countries, using the unweighted average of male and female life expectancy.

Source: OECD Health Data 2003.

Economic expansion and rising educational attainment have laid the foundation for better population health, but improvements in health care also deserve some credit. The recent past has seen major breakthroughs in prevention and treatment for conditions like heart disease, cancer, stroke and premature birth, to name but a few. And with new drugs, devices and procedures, we can treat conditions better than before. For example, minimally invasive new surgical techniques result in quicker and less painful recovery for patients, and some who were not formerly candidates for surgery can now be treated successfully.

... thanks partly to advances in medicine...

In most countries, universal health-care coverage – whether public or privately financed – not only provides financial security against the costs of serious illness, but also promotes access to up-to-date treatments and

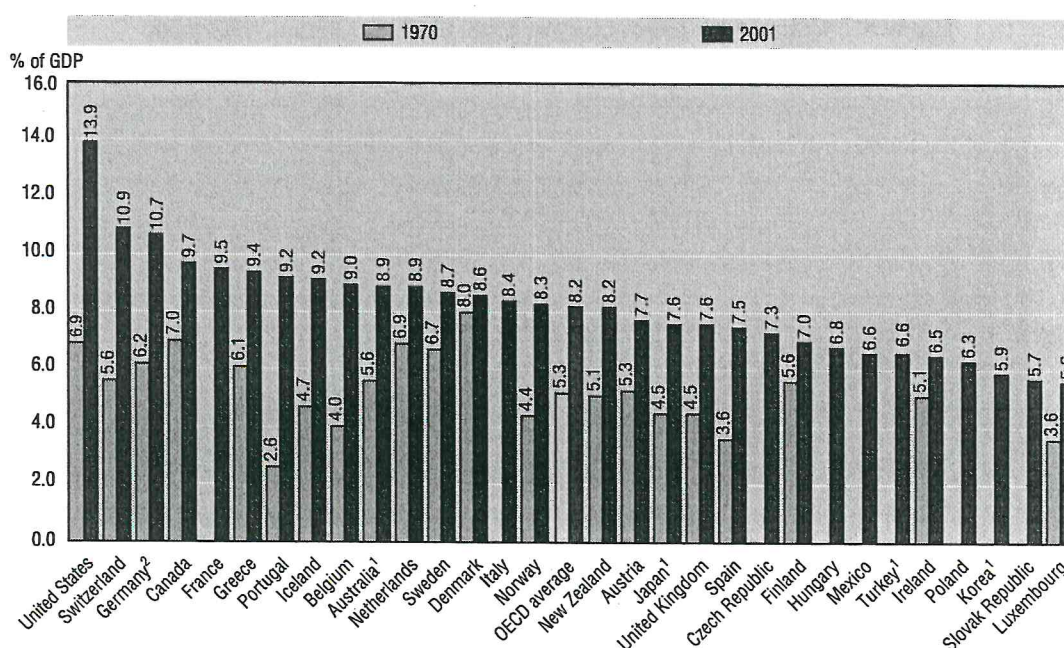
... and expansions in access to services.

preventive services. By 2001, more than two-thirds of OECD countries had achieved rates greater than 90% for childhood immunisation against measles, compared with only a third of countries ten years earlier. As a direct result of such improvements in health systems and health care, people are living longer and healthier lives.

But these benefits have to be paid for...

Naturally, these gains do not come cheap. The most recent data show health-related spending to be more than 8% of GDP on average for the OECD area, and exceeding 10% in the United States, Switzerland and Germany (see Figure 2). Compare this with 1970, when health care spending represented an average of just 5% of GDP in OECD countries. Much of this increase can be attributed to progress in medicine and the concurrent rise in expectations for health care. Simply put, advances in technology mean that we can do much more and so we expect more, but we must pay more, too.

Figure 2. Health spending as a share of GDP, 1970 and 2001



Note: The OECD average is unweighted. For 1970, the OECD average includes only the 21 countries for which data are available.

1. 2001 data refer to 2000.

2. 1970 data refer to West Germany.

Source: OECD Health Data 2003. Data for Turkey are from Turkish National Health Accounts.

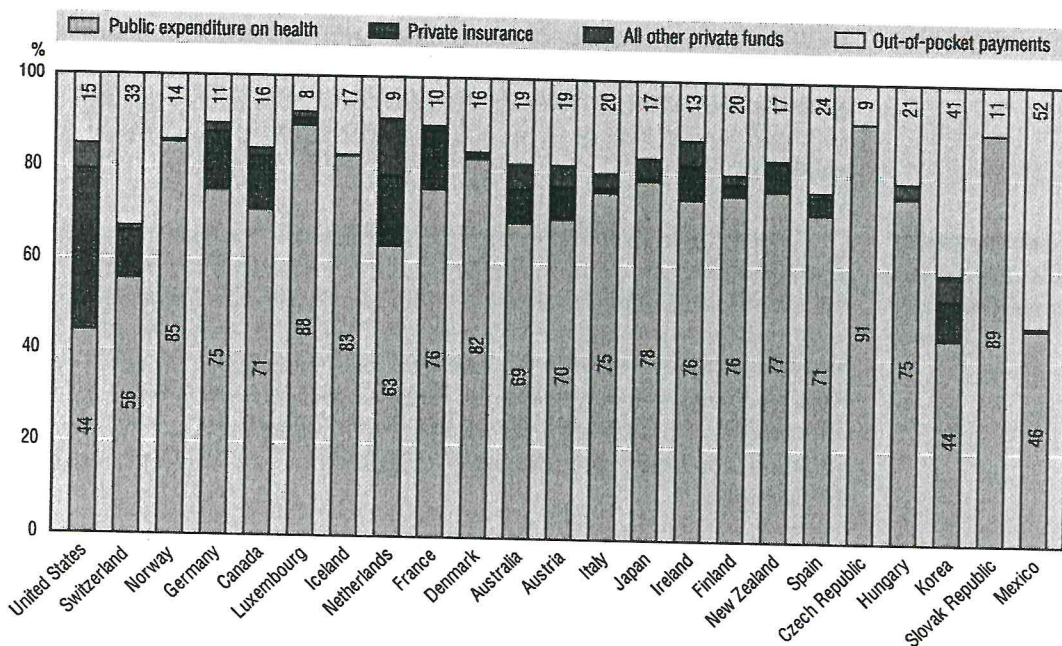
... and public budgets are bearing the brunt.

Spending more is not necessarily a problem, particularly if the added benefits exceed the extra costs. But since three-quarters of OECD health spending comes from the public purse, government budgets are feeling the pinch (see Figure 3). Even in the United States, where the private sector plays an unusually large role in financing, public expenditure on health represents 6% of GDP, comparable to what the average OECD country spends publicly on health.

Tomorrow's health systems are likely to be even more costly.

The trouble is that upward pressures on health spending are unrelenting, reflecting continued advances in health care and increased demand from ageing populations. At the same time, the share of the population in its working years will decrease, straining public finances still further.

Figure 3. Health expenditure by source of funding, 2000

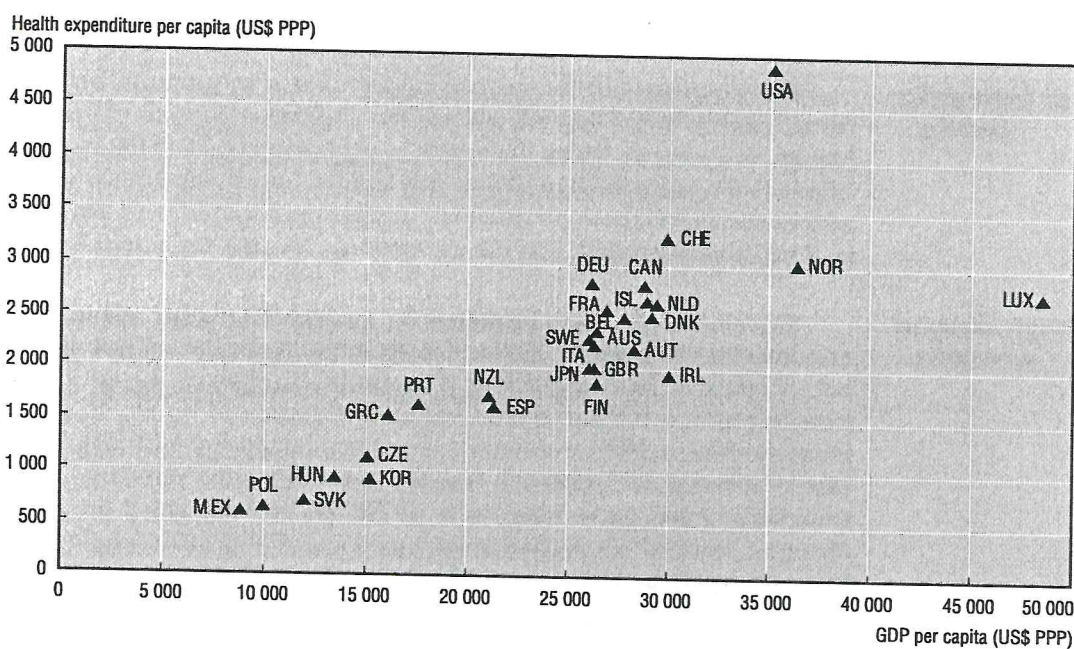


Note: Countries are ranked, from left (highest) to right (lowest), according to level of per capita health expenditure.
Source: OECD Health Data 2003.

While richer countries tend to spend more on health (see Figure 4), there is great variation in spending among countries with comparable incomes. Even more importantly, the highest spending systems are not necessarily the ones that do best in meeting performance goals.

There is no single, most appropriate level of health spending.

Figure 4. Health expenditure and GDP per capita, 2001



Source: OECD Health Data 2003.

Policy makers are under pressure to improve performance.

Cost and financing challenges aside, the public is increasingly aware that opportunities abound to improve the performance of health systems still further. Policy makers in OECD countries are faced with a large and growing demand to make health systems more responsive to the consumers and patients they serve, to improve the quality of care, and to address disparities in health and access to care. Is it possible to do better without raising cost pressure?

Cross-country studies can help in the quest to increase value for money.

Health systems differ in their design, in the amounts and types of resources they use, and in the health outcomes and other results they attain. But health policy makers share common goals and can learn from each other's experiences as to what works – and what does not – when making changes to health systems intended to improve performance. The three-year OECD Health Project has sought to add to the evidence base and provide information on past experience that policy makers can adapt to their own national circumstances for use in their efforts to improve health-system performance.

High-quality health care and prevention

There are opportunities to further improve health...

Big differences across countries in life expectancy and other indicators of health suggest that for many countries, if not all, further gains are possible. The extent of variation raises questions, together with expectations. For instance, why, in 1999, did Sweden and Japan have infant mortality rates of just 3.4 per 1 000 live births, while New Zealand and the United States reported rates over twice as high (7.2 and 7.7, respectively)? Why did 65 year-old women living in Ireland or Poland have an average life expectancy of less than 18 years in 2000, while women in Japan, Switzerland and France could expect to live three or more years longer than that (see Figure 5)?

... and to reduce disparities in health...

Large differences in health status also exist between population groups within countries. These may be partly caused by barriers in access to needed services that affect disadvantaged populations disproportionately.

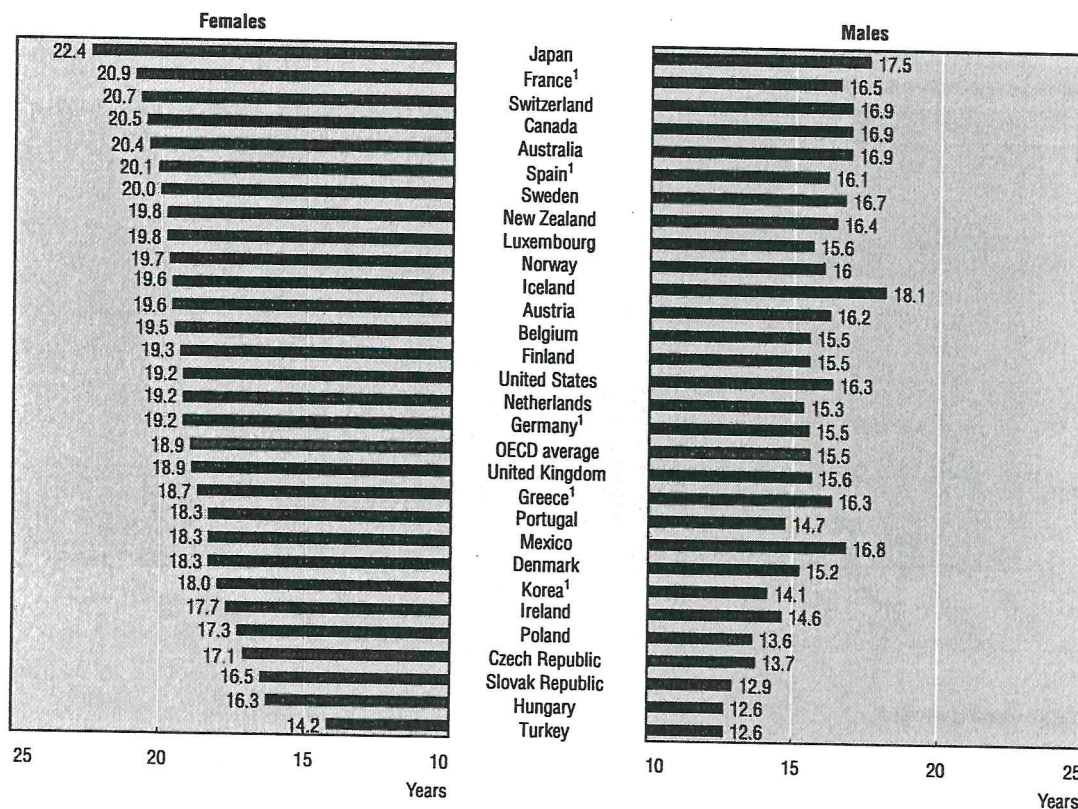
... through better policy making...

It is important not to overlook opportunities to promote better health through policy levers that fall outside the traditional purview of health policy makers. For instance, given the health impact of injuries and illnesses that are influenced by environmental and risk factors, improving health also means addressing factors such as violence, accident prevention and worker safety, road traffic enforcement, and the use of drugs, alcohol and tobacco.

... through enhanced prevention...

Moreover, systems focused on curing illnesses today can miss opportunities to prevent illness and disability tomorrow. In fact, just 5 cents out of every health care dollar is spent on initiatives designed to keep people healthy. Yet population health has improved thanks to preventive measures like public awareness campaigns, regulation and taxation (in the case of tobacco, for example). Notable is the dramatic reduction in rates of smoking that has taken place in most OECD countries since the 1960s (see Figure 6), leading to a decline in the incidence of lung cancer. But new threats have emerged, with the recent dramatic rise in obesity being a particular concern (see Figure 7). Obesity raises the risk for chronic conditions ranging from diabetes to dementia, so the rapid growth in the prevalence of obesity foretells health problems in years to come. Stepped-up attention to

Figure 5. Life expectancy at age 65, 2000



Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

1. 1999.

Source: OECD Health Data 2003.

prevention strategies is highly desirable in light of the difficulty in treating obesity.

One of the most important developments in health care over the past decade has been a popular awakening to problems of quality. In fact, across OECD countries, there is a large and expanding bank of evidence of serious shortcomings in quality that result in unnecessary deaths, disability, and poor health, and that add to costs. The problems are of three types:

First, some services are provided when, according to medical practice standards, they should not be. Studies of elective surgeries like coronary artery bypass grafts show that a significant minority of certain procedures occur when the patient is not an appropriate candidate. This leads to an unnecessary exposure to health risks as well as wasted resources.

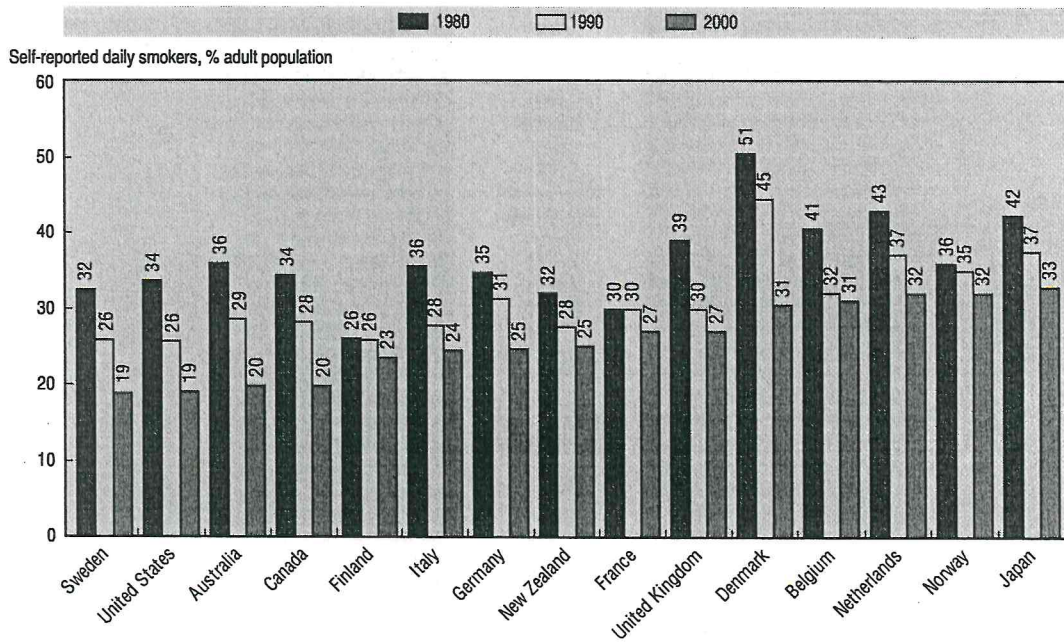
A second type of quality problem is that patients who could benefit from certain basic services do not always get them. For example, medicines to control hypertension are often not prescribed when they should be, leading to inferior outcomes and higher costs later on. And aspirin is not prescribed

... and by addressing shortfalls in health-care quality...

... such as provision of inappropriate services...

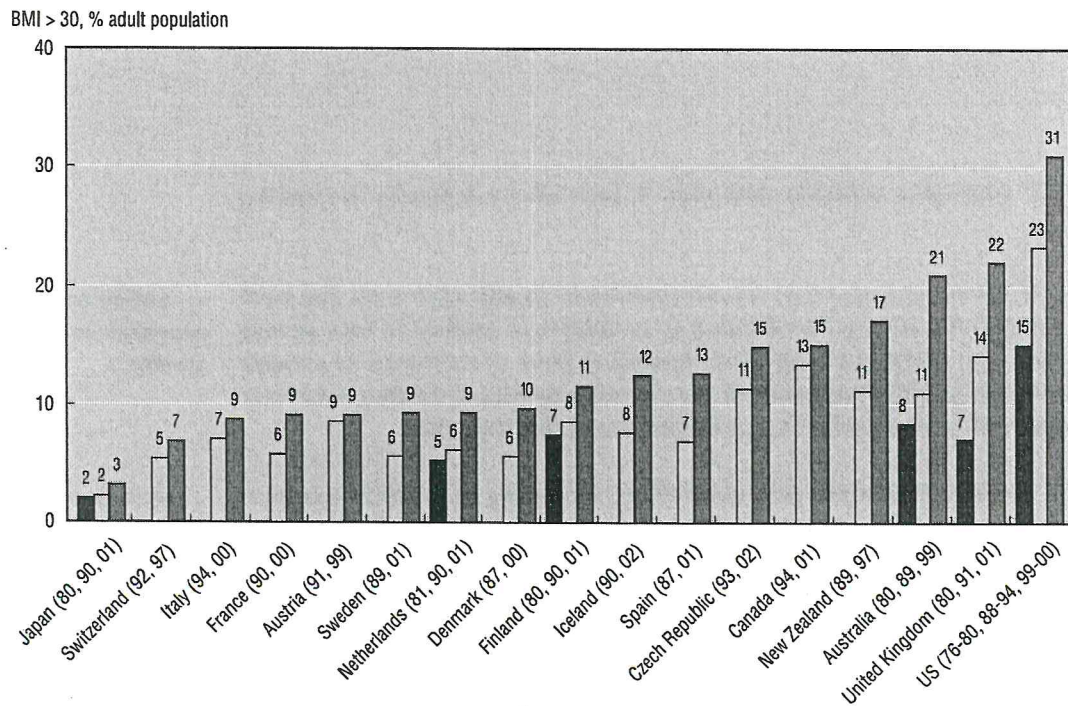
... failures to administer appropriate care...

Figure 6. Falling smoking rates among the adult population in OECD countries



Source: OECD Health Data 2003.

Figure 7. Increasing obesity rates among the adult population in OECD countries



Note: BMI: Body Mass Index. For Australia, UK and US, estimates are based on health examination surveys, rather than health interview surveys.
Source: OECD Health Data 2003.

to heart-attack patients often enough, even though it is a low-cost and effective way to reduce the risk of another heart attack.

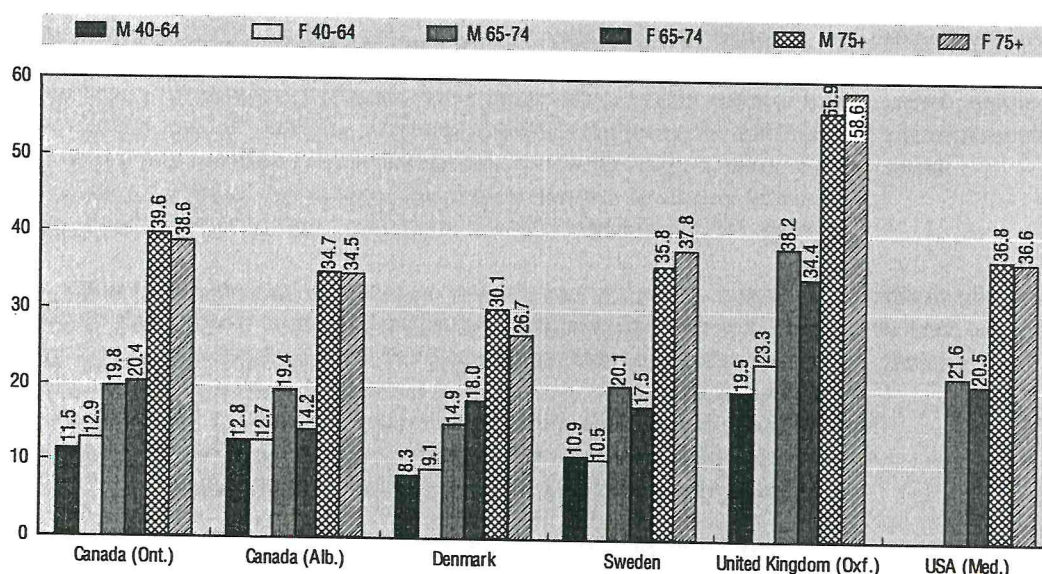
Yet a third type of quality problem arises from care delivered in a technically poor or erroneous manner. Examples here include wrong-site surgeries, mistakes in administering medicine and so on.

... and errors in health-care delivery.

Differences across countries in outcomes for conditions like stroke (see Figure 8), heart attack and breast cancer might be explained by the intensity of treatments, the technical quality of care, the organisation and co-ordination of care, and influences outside the health system. More data on potential explanatory factors, such as prevention and screening, are needed to explore these possibilities.

More data are needed to explain cross-country variation in outcomes of care.

Figure 8. **One-year case fatality rates for ischaemic stroke, 1998**
Percentage of patients who died within the first year following admission



Note: Canadian data are from Alberta and Ontario, United Kingdom data are from the Oxford region, and United States data are from Medicare, which covers persons aged 65 and older, as well as disabled persons under the age of 65.

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

Many OECD countries have started to monitor indicators of health-care quality, often for benchmarking purposes as part of broader efforts to track and improve health-system performance. In most countries, attention has first focused on the quality of hospital care, but initiatives to evaluate other health and long-term care settings are also under way. Such efforts can be strengthened by developing tools like clinical practice guidelines and performance standards that promote the practice of evidence-based medicine.

Quality measurement is essential to improvement.

Better systems for recording and tracking data on patients, health and health care are essential for big leaps in quality improvement to be made. Paper medical records, prescriptions, and test reports do not support accuracy, access or sharing of information. Where they have been implemented, automated health information systems have had a positive

Use of automated records on patients' health and health care would help.

impact on both health-care quality and cost. For example, hospitals in Australia and the United States that have adopted automated systems for placing medication orders in hospitals have achieved marked reductions in the rate of medication errors and related patient injuries, resulting in measurable improvements in quality and shorter lengths of stay.

Economic and administrative incentives should encourage provision of high-quality health care.

Physicians and hospitals need to be given incentives to take on the cost of investing in automated data systems and the other steps needed to improve health-care quality. The economic and administrative incentives that are now in place sometimes actually discourage providers from doing the best thing. For example, in some countries, many unnecessary and inappropriate tests are prescribed because of the incentives set up by medical malpractice liability systems. Correcting such inappropriate incentives – and replacing them with ones that reward practice of evidence-based medicine – is essential to foster high-quality care.

Accessible health care

Shortages of health-care practitioners could pose a problem, unless countermeasures are taken.

Concerns have been voiced in a number of OECD countries that a gap may be looming between demand for and supply of the services of physicians and nurses. Indeed, shortages have already appeared in a number of OECD countries. Despite increasing demand for services, supply is projected to fall, or at best to grow slowly (in the absence of countermeasures) as a result of societal trends to reduce work hours and retire early, physician workforce ageing, and diminished interest in nursing, relative to other professions.

Increasing the health workforce has proved difficult.

Some countries are already seeking to increase the number and the productivity of physicians and nurses in their workforces. Strategies for training, retention, and recruitment from abroad have been used with varying degrees of success to increase the number of doctors. Increasing the nursing workforce has proved difficult, but there is room for more experimentation with approaches such as increasing nurse pay, improving working conditions and improving nurse education and training programmes.

Inadequate access to services can impact health.

Although ensuring comprehensive coverage of core services and minimising financial and other barriers to access have proven effective in promoting equitable use of health services, inequities in service use persist in some countries. These reflect factors such as the impact of user fees on lower-income groups, differences in insurance coverage across the population, and so on. The outcome can be poorer health, which further fuels economic isolation and social exclusion. Other types of inequities, such as disparities in the timeliness of service provision, can be the by-product of policies intended to foster a high degree of consumer choice.

Health policy interventions can address inequities in access to care, but can also be costly.

Health policy changes alone may be insufficient to close gaps in health status for some disadvantaged groups, to the extent such disparities are symptoms of problems like poverty and social exclusion. However, experience shows that policy interventions can mitigate income-related inequities in access to care, where they exist, although this can be costly. In France, for example, the introduction of publicly financed coverage of cost-sharing for the poor has considerably reduced the pro-rich bias in the use of specialist services.

Medical advances offer chances to improve patient care and health outcomes, but they can increase aggregate costs as well. Uncertainty regarding costs and benefits, which is often the case, creates a dilemma for decision makers. Countries differ greatly in how decisions to adopt and pay for new health-related technology are made, and these in turn affect diffusion. Some emerging technologies, such as gene therapies, pose ethical challenges that can make decision-making even more difficult. The conditional approval of promising technologies, pending further study; rigorous technology assessment practices; and use of transparent processes for decision-making, can all help in coping with uncertainty.

Ensuring timely access to the latest medical technologies requires strategies for coping with uncertainty.

Responsive systems that satisfy health-care patients and consumers

Health systems can do more to meet the expectations and preferences of patients and consumers of health care. OECD work has identified policies that reduce waiting times for elective surgery and improve long-term care, two major sources of dissatisfaction in OECD countries. Also, offering choice in health coverage can result in a more responsive health system.

Opportunities exist to increase the satisfaction of patients and consumers.

In at least a dozen countries, waiting times for elective surgery are viewed as excessive. Moderate waiting times do not appear to have negative effects on health outcomes, but they do affect quality of life; also, those waiting in discomfort are less likely to be fully productive in their work.

Waiting times for elective surgery are a problem in many OECD countries.

Countries wishing to reduce waiting times generally need to increase either the capacity or the productivity of their health-care systems. Costs will probably increase, though, since countries with long waiting times tend to have lower spending on health and fewer acute-care hospital beds. They also tend not to use fee-for-service payments for doctors and discharge-based payments for hospitals, which encourage productivity. And waiting times tend to be longest in those countries with fewer doctors per head (see Figure 9). Nevertheless, if the supply of surgery is judged to be adequate, waiting times can also be reduced by ensuring that patients are not added to waiting lists unless (or until) their need exceeds a threshold level, while those with greatest need are assured of timely services.

Increasing productivity or surgical capacity can help, but this will usually increase costs.

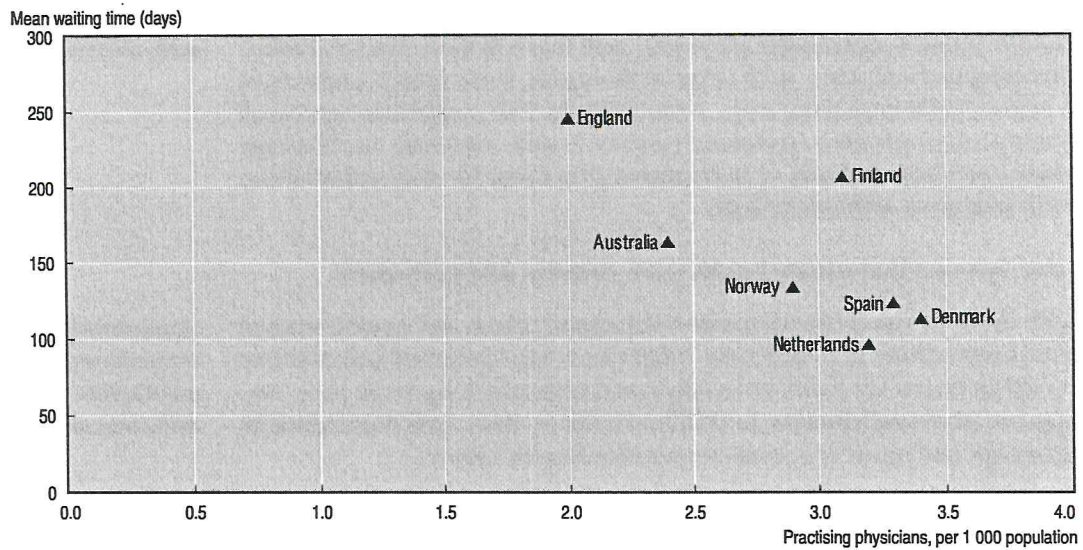
A number of countries are experimenting with policies to provide consumers with more choice in long-term care services and to help patients get care at home, rather than in an institution, when feasible. Some countries provide funds to be spent upon such care, rather than payment for covered services, and such funds may be used to support family caregiving in most cases. This yields increased flexibility and control over services received, and reduced feelings of dependency. However, consumer-directed spending policies are likely to be more expensive than traditional approaches.

Increasing consumer choice in long-term care can also be costly.

The availability of publicly or privately financed options for health coverage, in and of itself, can create more consumer choice. Furthermore, a health system in which multiple insurers are free to innovate can evolve in line with consumer preferences. But as with other benefits, choice has a cost. Compared with systems that feature just a single payer for health services or an integrated system of financing and delivery of care, multi-payer systems

Choice of cover can increase health-system responsiveness at increased cost.

Figure 9. Physician density and waiting times for elective surgery, 2000
Hip replacement



Note: Finland and the Netherlands provide the number of physicians entitled to practise rather than actively practising physicians.
Source: OECD Health Data 2003 and country responses to the OECD Waiting Times Study Data Questionnaire.

can raise spending pressure and make it difficult to maintain equity in access and financing.

Sustainable costs and financing

Financing is critical to sustainability.

Systems that rely on contributions by working people for their financing will come under particular pressure as populations age and the share of the population participating in the workforce drops. Using general taxation revenues to finance expansion of health-care provision increases the burden on taxpayers or detracts from other publicly financed services and programmes. In order to relieve future public-financing pressure, individuals may be called upon to play a larger role in financing their own health care.

Modest co-payments can relieve public financing systems, but are no magic bullet.

Cost-sharing requirements for users of health services can reduce the burden on public financing systems. But major savings from user fees are unlikely, particularly as vulnerable populations must be exempted to avoid restrictions on access that could be costly in the long run. Such exemptions impose administrative costs. Apart from this, consumers are likely to skimp on preventive care and appropriate treatments unless they are given incentives to do otherwise. Complementary private health insurance can help to ensure access to care where cost-sharing requirements are large. But it can drive up consumer demand and overall costs at the same time.

Private health insurance can offset some of the costs that would otherwise be borne publicly. However, subsidies are sometimes needed to encourage purchase of insurance and other interventions may be needed to promote the use of privately financed services by those with publicly financed coverage who are also privately insured. Even in countries where a sizeable share of the population is privately insured, private health insurance has tended to represent a relatively low share of total health spending, as it often concentrates on minor risks, rather than more costly cases and treatments.

Private health insurance has not led to significant reductions in public spending on health...

Private health insurance premiums are a regressive source of financing compared with income-based taxes or social insurance contributions. When premiums reflect health-status factors, they may be as regressive as direct out-of-pocket payments, but they do nonetheless provide individuals with a means of pooling health-care risks and avoiding catastrophic expenditures. Government efforts to promote access to private health insurance through restrictions on risk selection or targeted subsidies can improve the equity of private health insurance markets, in terms of both financing and access to care, but at a cost.

... and entails trade-offs with equity that are costly to offset.

Where private health insurance markets play a role in health financing, policy makers should carefully craft regulations and/or fiscal incentives to ensure that policy goals are met. Absent such interventions, private health insurance markets will fail to promote access to coverage for people with chronic conditions and other high-risk persons – as well as those with lower incomes. Additional interventions, such as standardisation of insurance products or other steps to help consumers understand the costs and benefits of insurance, can increase the potential of private insurance markets to make a positive contribution to health-system performance.

Well-designed government interventions are critical to the success of a private health insurance market.

People need protection against the risk of incurring large expenses for long-term care, as for acute health-care and disability. Different approaches can work, such as mandatory public insurance (as in Luxembourg, Netherlands and Japan), a mix of public and mandatory private insurance (as in Germany), tax-funded care allowances (as in Austria) and tax-funded in-kind services (as in Sweden and Norway). The market for private long-term care insurance is small, but could increase with the right policy support.

There is a strong case for protecting individuals against the risk of incurring long-term care costs.

Countries have slowed cost growth using a combination of budgetary and administrative controls over payments, prices and supply of services. Although sophisticated payment systems can be technically difficult to employ, there are numerous examples of successful systems – such as discharge-based payment systems for hospitals – that can promote productivity without harming outcomes. On the other hand, systems that keep health-sector wages and prices artificially low are likely to run into problems eventually, such as quality that has been bid down, difficulty with recruitment and retention of health-care practitioners, or shortfalls in the supply of services and innovative medical products.

Cost-containment tools can work, but have negative side-effects.

Value for money in health systems

It is possible to save money while improving performance.

Ultimately, increasing efficiency may be the only way of reconciling rising demands for health care with public financing constraints. Cross-country data suggest that there is scope for improvement in the cost-effectiveness of health-care systems. This is because the health sector is typically characterised by market failures and heavy public intervention, both of which can generate excess or misallocated spending. The result is wasted resources and missed opportunities to improve health. In other words, changing how health funding is spent, rather than mere cost-cutting, is key to achieving better value.

Better methods of paying providers and purchasing care can pay off in terms of value.

Across the OECD, payment methods for hospitals, physicians, and other providers have moved away from cost-reimbursement, which encourages inefficiency, towards activity-based payments that reward productivity. But these systems also introduce risks, such as that of promoting service volume that is too high in some areas, and of low marginal benefit. They can under-value preventive services and treatments that reduce the need for expensive interventions later on. Far better would be payment methods that provide incentives to provide the right services at the right time, and that reward providers or organisations that contribute to realising performance goals, such as improved health outcomes. But this is technically difficult. Some public and private payers are taking initial steps to improve payment incentives by offering bonus payments to health-care providers who meet certain quality standards, for example.

Structural reform to health systems and the organisation of delivery and management systems also holds promise.

In systems where both financing and delivery of care is a public responsibility, efforts to distinguish the roles of health-care payers and providers, so as to allow markets to function and generate efficiencies from competition, have proved generally effective. In systems of any type, shifts in responsibility in health-care management or administration can also reduce waste and increase productivity. For instance, certain qualified nurse practitioners might undertake certain duties that are also performed by physicians, where safe and appropriate.

Demand management can also help.

Nurses or general-practice physicians can serve as gatekeepers, assessing need for treatment and directing patients to the most appropriate care provider. With the Internet, patients can be better informed about the costs, risks and expected outcomes for treatments. This could either temper or increase their demand. To promote value, patient cost-sharing requirements might be employed in a more discriminating manner, letting patients benefit financially from making cost-effective treatment choices.

Value-based competition among insurers has been hard to achieve.

In theory, systems featuring competing insurers (whether private or social) should promote a more efficient health system. In practice, it has proven difficult to establish value-based competition among insurers, as there is a tendency for competitors to try to attract healthier populations, who are less costly to insure. Policy measures such as banning discrimination in enrolment and implementing an experience-based system of risk compensation between insurers can counter this, but these same measures reduce incentives for insurers to manage costs and also require complex regulatory interventions.

A value-oriented approach to health technology can result in better outcomes at lower cost.

Blunt cost-containment instruments can focus on short-term cost effects, failing to take into account possibilities to increase value over the longer-term through investment in new health-related technologies. Value-oriented management of technology can mean using technology assessment programmes and employing mechanisms "like value and cost agreements"

between purchasers and manufacturers that take into account the effects of a new technology on patient outcomes and costs.

On track towards improved health-system performance

Health policy makers in OECD countries now know quite a bit about which tools and approaches can be used to accomplish many key policy objectives, such as controlling the rate of public spending growth, ensuring equitable access to care, improving health and preventing disease, and establishing equitable and sustainable financing for health and long-term care services. These tools and approaches have been used, with varying degrees of success, in reform efforts employed over the past several decades, providing a wealth of experience in both successes and failures from which to draw. In moving ahead, it is important to learn from past efforts to improve and to anticipate the many significant obstacles to successful change.

We must build on experience, learning from both successes and failures.

Health policy-making involves a careful balance of trade-offs, reflecting the weights assigned to a range of important goals and a great deal of uncertainty. The ultimate goal, certainly, is robust population health, but promoting health is not the only consideration. Health policy decisions also have considerable economic consequences, since the health sector is a strong and important component of the economies of OECD countries that provides extensive employment and profitable industry. Even when the tough choices are made, changing systems so as to improve performance is never easy, as the success of making change can be affected by the willingness of various stakeholders to embrace the proposed reforms. Given the speed of developments in medicine and evolution of health-care goals, reform of health systems is necessarily an ongoing, iterative process; there are few one-off solutions or quick fixes.

Even when we know how to improve health-system performance, this is never easy.

Recent work at the OECD has filled a number of knowledge gaps (see Box). But numerous important policy questions remain unanswered. Among the most urgent ones are: How can continued advances in medical technology be promoted and timely access be assured while managing public resources responsibly? How can innovation to match health needs and priorities best be fostered? What is the best way to ensure an adequate future supply of health workers? How can the economic motives of health-care providers be better aligned with goals for cost-effective health-care delivery? How can competitive market forces be better employed to increase the efficiency of health systems? Which approaches to medical professional liability can best deter negligence, compensate victims and encourage appropriate use of services?

We have learned much, but still have much to learn about improving health systems.

Value for money is a moving target. Increasing value requires experimentation and conscientious performance measurement using actionable and specific indicators. Benchmarking within and across countries, and sharing information can help. Mutual observation is key to uncovering effective practices and the circumstance in which they work. Further work at the international level will, by bringing experience, evidence and new ideas together, help policy makers meet the challenges they face.

Experimentation, performance measurement and information sharing are fundamental.

Promising directions for health policy

Findings from the OECD Health Project point to a number of useful practices or approaches that can be employed in efforts to improve health-system performance. As these typically imply trade-offs with competing policy goals, policy makers must determine whether the expected benefits from these practices are likely to outweigh the costs in a particular situation. In addition, a country's unique circumstances must be taken into account when determining appropriate policy. There is no one-size-fits-all approach to performance improvement.

Possible lines of action for improving population health status and health outcomes

- Employ well-designed strategies to prevent illness and disability, which may entail reallocations of health-system resources from care to prevention, or changes in the way resources are spent. Evaluate the potential to improve health through changes in policy (including taxation) relating to nutrition, violence, traffic, alcohol or tobacco use, or other areas that may fall outside the strict purview of health policy-making.
- Address inequities in health through initiatives targeted at tackling root causes, such as poverty and social exclusion, in addition to ones targeted at improving health care for vulnerable populations.
- Support efforts to increase the extent to which medical practice is consistent with evidence – including development and implementation of evidence-based practice guidelines and performance standards, and alignment of economic and administrative incentives with use of appropriate care and attainment of desired health outcomes.
- Ensure that systems for monitoring the quality of health and long-term care are sufficient to assist in meeting improvement goals. Development and standardisation of valid quality indicators, including measures of health outcomes, are essential steps.

Possible lines of action for fostering adequate and equitable access to care

- Eliminate financial barriers to access by providing or subsidising health coverage for the poor, exempting poor persons from patient cost-sharing requirements, and allowing complementary private health insurance to cover a portion of user fees in cases where these are high enough to create access barriers.
- Foster access to affordable private health insurance by high-risk persons (*e.g.* the elderly and those with costly medical conditions), where such coverage is needed to assure access to care, through interventions such as targeted regulations, subsidies or fiscal incentives.
- Avoid unintended inequities in access by persons with different sources of health coverage through policy interventions such as universally applicable provider reimbursement limits or employment of common waiting lists.

Possible lines of action for increasing health-system responsiveness

- Reduce waiting times for elective surgery, where they are judged to be excessive, by increasing surgical capacity or productivity (through a change in provider payment methods, for example).
- Improve recipient satisfaction with long-term care by supporting family caregivers and/or – so as to increase care recipients' control over services and choice of providers – offering cash payments for spending on services directly to those eligible for benefits.
- Facilitate informed consumer choice of health insurance coverage, whether publicly or privately financed.

Possible lines of action for ensuring sustainable costs and financing

- Moderate the rate of growth in public spending on health through a combination of budgetary and administrative controls over payments, prices or supply of services. Monitor carefully the effects of such interventions on health-system performance.
- Add modest cost-sharing requirements to publicly financed health coverage schemes and bar complementary health insurance from covering, in full, the amount to be paid by the patient.
- Eliminate public coverage for ancillary or luxury services, allowing for rationing by price and optional risk-pooling through privately financed supplementary coverage.

Promising directions for health policy (cont.)

Possible lines of action for increasing the efficiency of health systems

- Manage demand for elective surgery and other discretionary care through gatekeepers, clinical prioritisation, or consumer and patient information schemes, particularly in systems where low patient cost-sharing and excess supply of health-care providers combine to promote high levels of service use.
- Employ pharmaceutical pricing systems and other policies that reward cost-effective choices among similar medications and encourage truly novel innovation in the pharmaceutical sector.
- Use technology assessment to promote informed decision-making, and use technology-management approaches that take health outcomes into account and promote cost-effective health-care delivery.
- Develop, test and employ payment systems for health-care services that reward productivity and quality.

Possible lines of action for improving overall health-system performance

- Invest in automated health-data systems needed to improve the organisation and delivery of health care.
- Monitor health-system performance regularly, using valid indicators and reliable data, and benchmark against established goals or the performance of peers (through international comparisons).

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