ISSUES FOR DISCUSSION

OECD HEALTH MINISTERIAL MEETING

Health System Priorities in the Aftermath of the Crisis

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Paris, 7-8 October 2010

Issues for Discussion

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Health System Priorities in the Aftermath of the Crisis

Population health has been improving steadily in OECD countries. Life expectancy at birth has increased by ten years since 1960, exceeding 79 years in 2008. Gains in older age are even more striking: today a woman aged 65 can expect to live an additional 20 years, and those over 85 are the fastest growing part of the population. Better medical care increases survival rates for people with heart attacks and ischemic and hemorrhagic strokes, while good primary healthcare protects people against premature deaths for chronic obstructive pulmonary disease. Mass screening and effective treatment contributes to considerable improvements in survival from breast cancers. These improvements are not due only to the performance of the health system: increased wealth and lifestyle changes have been important. But health care has played its part too: recent OECD research suggests that up to 40% of gains in life expectancy are attributable to increased spending. And health care is available to more people than ever before – health insurance coverage has expanded in Turkey, Mexico and most recently the United States.

In the past ten years, average health expenditure in the OECD area has increased by 50% in real terms, from around USD 2 000 per capita to nearly USD 3 000 per capita. Health spending now accounts for more than 10% of the economy in seven OECD countries, and, given its size, plays an increasingly important role in the economy. In addition to delivering improvements in health, the industries that serve it play a major role in innovation and economic growth.

However, in the aftermath of the crisis, some countries face the difficult task of choosing where to cut public spending, and sometimes this will affect health budgets. Even where this is not immediately necessary, policymakers need to ensure that health spending achieves the best possible value for money. There *is* evidence that health spending is becoming more efficient: the length of hospital stays has declined nearly everywhere, helping to reduce unit costs for hospital treatments in many cases, as just one example. But there is plenty of room for improvement. Better coordination of care, the use of evidence-based medicine and assessment of new technologies, and paying providers according to the quality of service they provide could all help to make healthcare systems not only more clinically effective, but also more cost-effective.

Not getting sick in the first place is better than even the best care. Many diseases such as cardiovascular conditions or diabetes are linked to lifestyle and are therefore amenable to policies which encourage changes in behaviour. However, the benefits of prevention may take years to appear (through a healthier elderly population for instance) while the costs are immediate. Spending on prevention is often one of the first casualties when finances are squeezed, even though it can be highly cost-effective.

In reforming health systems, an ever greater priority is being given to improving the quality of care. Fragmented care delivery systems make it more difficult to ensure high quality health care. Poor quality of care is bad for everyone – patients, providers and even payers, who must bear the costs of treating avoidable diseases and unnecessary hospital admissions and readmissions. Improving quality of care requires measuring it, and this is not easy. However, the effort must be made: evidence shows many health services being overused, misused, and underused, and there is wide scope for improvements in the quality of care that deliver increased value for money.

FORUM. Using information on Quality to Improve Health Care

Thursday 7 October 2010

Quality of care cannot be taken for granted. Despite major developments in medical innovation, professional competencies and investments, today's health systems are failing to deliver the quality of care patients might expect. For example, an English study showed that 40% of 1.7 million emergency admissions were preventable with better quality of care. An Institute of Medicine report in the United States highlighted that more people die of medical errors than traffic accidents. Nordic data show that over 12% of hospitalised patients had an adverse event and most of these are preventable. Poor quality of care not only leads to patient suffering, but increases health care costs through increased hospital readmissions, longer lengths of stay, and returns to the operating theatre. No wonder that improving quality of care has become a key objective in so many health policy innovations, including patient-centred care, health-technology assessment and clinical evaluation, patient safety, coordination of care and pay-for-performance.

In order to improve quality of care, we need to measure it. In the 20th century, measurement of quality was usually restricted to mortality by specific (avoidable) causes and life expectancy. However, medical care has shifted focus to improving the health of those with chronic conditions, so new measures of quality are needed. For example, hip replacement for someone with arthritis may not increase life expectancy, but it dramatically improves quality of life. Since 2002, the OECD's Health Care Quality Indicator project has developed measures of quality in cancer care, acute care for stroke and myocardial infarction, treatment of chronic diseases in primary care such as diabetes or asthma, and mental health care. The data reveal dramatic differences in, for example, survival rates for different cancers among OECD countries, and raise questions about causes and effective treatments that should be the basis for debates in these countries.

Despite the progress made, there are still major limitations in the indicators of health care quality. Progress is hampered by limited information: cancer registries that do not collect data on the stage of disease; incomplete administrative databases; little use of electronic health records; limited information on patient experience from patient surveys. Meeting legitimate concerns about patient privacy and data-protection is a major challenge in developing better indicators of quality of care.

Improving quality requires that it is put at the centre of health care decision-making. Quality-led governance involves key actors all recognising, and being held to account for, the quality of care that patients receive. High-performing health systems must deliver quality in system inputs, design, monitoring and improvement. Policies to ensure quality *inputs* have to ensure that professionals, organisations and technologies meet demanding standards (*e.g.* in licensing, accreditation, certification). *Systems* must allocate responsibilities to stakeholders in ways that promote quality and public accountability. *Monitoring* of standards and information is needed. Incentives (both monetary and non-monetary) and targeted programmes on areas like patient safety can promote a culture of continual quality *improvement*. All four types of policies are needed if quality is to be found in all parts of the health system, at all times.

QUESTIONS FOR DISCUSSION

1. How can countries strengthen their information infrastructure for measuring quality of care?
2. What policies work best in ensuring high quality throughout the health system?

Session 1. Health System Priorities When Money is Tight

Friday 8 October 2010

In the aftermath of the financial and economic crisis, many countries face budget deficits and the need to constrain public spending to achieve broader macro-economic stability. As health is one of the largest components of public sector spending, improving the value from health spending will be a political priority. In all OECD countries, health spending has been rising more rapidly than GDP over the past decades, a trend expected to continue. Even in those countries not facing a fiscal crisis, governments are searching for ways to achieve better outcomes from each dollar spent on health or to engineer a long-lasting reduction in the growth rate of health care spending while maintaining and indeed improving on the gains achieved by health care systems in recent years: increased quality of care; reduced waiting times; greater patient responsiveness; increased access to care; and greater efficiency in the production of health.

In previous economic downturns, many countries used policy tools such as tighter budget constraints for purchasers or providers, to decrease health spending. Controls over inputs (labour and capital) were used in almost every OECD country, while wage controls and oversight of price-setting were commonplace. Some countries, such as Canada and Finland, used a combination of decentralisation linked with hard budget constraints to lower health spending during the previous downturn. Policymakers also attempted to restrain pharmaceutical expenditures via a mix of price and volume controls directed at physicians and pharmacists

However, often, short-term policy responses to crises have had long-term consequences for future health spending. For example, cutting health spending on prevention is likely to lead to higher health costs later. Postponing spending on needed health infrastructure only pushes the financial burden into the future. Cuts in one area, like hospitals, lead to faster growth in other areas such as ambulatory care. Governments need to ensure that the policy instruments they use to control public spending in the short-term do not damage their long-term goals of having more equitable, responsive, effective and efficient health systems.

All countries are looking for ways to increase the efficiency of health systems in the long-run. There are many potentially useful tools for improving value from money such as improved care coordination, better information technology, greater use of health technology assessment and improved pharmaceutical policies. Paying providers according to their success in meeting quality objectives – including greater use of evidence-based medicine and guidelines - appears to be effective. But it is important not to oversell these measures as a means to save money: in general, there is limited evidence that they control costs and often they require significant upfront investment. Their greatest achievement in the long run is likely to be delivering more health for roughly the same amount of money, a worthwhile success in itself.

QUESTIONS FOR DISCUSSION

1. In times of budgetary restraint, how can governments continue to improve health outcomes and access to high quality of care?
2. What are the most promising directions for achieving improved health outcomes at lowest cost?

Session 2. Healthy Choices

Friday 8 October 2010

Over the course of the past century life expectancy has increased on average by as much as 25-30 years, major infectious diseases have been eradicated, and infant mortality rates have been dramatically reduced. Economic growth has played an important role in these achievements, as have public policies in education, sanitation, public health, and the development of welfare systems. However, increased prosperity has been accompanied by increases in the incidence of chronic diseases. Morbidity for virtually all chronic diseases has expanded due to large improvements in managing such diseases. Far from removing the need for prevention, medical advances have increased the opportunity cost of neglecting it.

Much of the burden of chronic diseases is linked to lifestyles. In high-income countries, smoking is estimated to be responsible for 22% of cardiovascular diseases. Alcohol abuse is deemed to be the source of 8% to 18% of the total burden of disease in men. Overweight and obesity account for an estimated 8% to 15% of the burden of disease, while high cholesterol accounts for 5% to 12%. Social and environmental conditions often drive lifestyle choices, and the most disadvantaged social groups bear a disproportionate burden of lifestyle-related diseases. Governments have great expectations of prevention, hoping it will cut health expenditures and redress health inequalities in addition to improving population health. But governments spend a small fraction of their health budgets on public health and prevention (3% of total health spending on average) and policies having undesirable impacts on population health (*e.g.* in agriculture, transport, or urban planning) may be adopted without coordination with health ministries.

Many prevention programmes are highly cost-effective in improving health and longevity. However, expectations about the benefits of prevention must be realistic. Overall demand for medical care will be reduced in some age groups and increased in others. As a result, few prevention programmes have the potential to reduce health expenditures – a recent review of 600 studies found only one in five showing cost savings. Furthermore, many prevention policies will take several decades to show their full effectiveness, while their costs are borne upfront. On the other hand, in addition to achieving their primary objective of lengthening healthy life, prevention may generate substantial gains in labour productivity.

Financial and non-financial incentives may be used, especially at the primary care level, to shift the balance of care towards prevention. However, triggering changes in social norms will require policies which go far beyond the boundaries of health systems. Governments tend first to tackle lifestyle-related risk factors through less intrusive measures, such as appealing to individual responsibility, expanding choice, and informing people about the health effects of lifestyles. More intrusive measures such as banning certain behaviours or using taxes to make them more expensive are not always more effective than less intrusive measures in changing behaviours, but they are generally less expensive in the short-term.

A multi-stakeholder approach to prevention could lead to a smoother implementation of cost-effective policies. Governments retain overall control of initiatives for the prevention of chronic diseases, while encouraging private sector commitment and contributions. However, the difficulties involved in getting multiple partners with potentially conflicting objectives to work together should not be underestimated.

QUESTIONS FOR DISCUSSION

1. Should governments be spending more on prevention than they currently do? What degree of interference with people's lifestyle choices is appropriate, given the health benefits of prevention?
2. Healthy lifestyles can be promoted by policies not traditionally considered the responsibility of health Ministers. Are there good ways of ensuring that health concerns are taken into account when policy is made elsewhere?