OECD

Health Update

Internal Co-ordination Group for Health (ICGH)

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Introduction

This newsletter provides up-to-date information on the OECD's work on health. Although it is mainly intended for delegates to OECD meetings who are familiar with the Organisation and aspects of its work, it is hoped that the newsletter will also provide information of interest to a broader community of stakeholders interested in health matters and the OECD's work in this area.

Contact points named are members of the OECD Secretariat, who can be contacted via e-mail using the form firstname.lastname@oecd.org.

This inaugural issue of *OECD Health Update* was inspired by – and modelled after – the *OECD Biotechnology Update*, a periodic newsletter produced by the OECD's Internal Co-ordination Group for Biotechnology.

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HEALTH ONLINE

The OECD's website includes much information on health-related topics and issues, and allows individual users to tailor the site to their needs. By selecting the themes that interest them, visitors can personalise their homepages at ***MyOECD*** to obtain the news, events and documentation related to their chosen themes.

- OECD's portal is http://www.oecd.org
- OECD's health portal, presenting health-related work administered throughout the organisation, is http://www.oecd.org/health
- The portal of the OECD Health Division is http://www.oecd.org/els/health
- The portal of the OECD Biotechnology Division is http://www.oecd.org/biotechnology

Information about health-related work administered by other Divisions within the OECD Secretariat can be found at either or both the general OECD health portal or at the Division's portal, accessible from the main OECD portal.

OECD WORK ON HEALTH INCREASES IN PRIORITY, PROMINENCE

Beginning with the inauguration of the three-year OECD Health Project in 2001, health has been an increasingly significant and prominent part of the Organisation's work programme. Over time, the OECD has become more and more widely recognised as an important contributor to the field of health data development and policy analysis.

The OECD initiated the Health Project to address some of the key challenges policy makers face in improving the performance of their countries' health systems. It encompassed nearly a dozen studies addressing key policy issues pertaining to issues such as human resources in health care, new and emerging health-related 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 central to the concerns of OECD member countries. The work benefited from the guidance and support of an Ad Hoc Group on Health, made up of Delegates representing member countries.

The Health Project built on the foundation of the OECD's work in health statistics and health policy that had been carried out under the purview of various committees and working parties across the OECD. Indeed, an important contributor to the success of the Health Project was its horizontal approach: Work on the Health Project involved a number of OECD directorates, notably the Economics Department, the Directorate for Science, Technology and Industry, and the Directorate for Financial and Enterprise Affairs, with the Directorate for Employment, Labour and Social Affairs playing a role in overall coordination as well as implementation of many component studies.

The Health Project concluded in May 2004 with a first-ever OECD meeting of Health Ministers, where key findings and policy implications were discussed. One important output from the meeting was a mandate from Ministers for continued OECD work on health data development, health accounting, development of health-system performance indicators and analysis of key health issues, as determined by member country priorities.

The ministerial mandate was acknowledged by OECD member countries in developing the Organisation's Programme of Work and Budget for 2005-2006. Work on health received an increased contribution from the main budget of the Organisation, while short-term financing was also increased through a contribution from the Secretary-General's Central Priorities Fund. This funding has been nearly matched by additional voluntary contributions received from member countries.

At the same time, the OECD Group on Health was created to oversee an ambitious new programme of work on health data, indicators and policy analysis. New studies include research and analysis on efficiency of health-care service delivery, trends in disability among the elderly, technological innovation in the health sector and pharmaceutical pricing policies.

In the Directorate for Employment, Labour and Social Affairs, a new Health Division was established to administer the work programme of the Group on Health, in close collaboration with other Directorates responsible for or contributing to particular studies. In addition to the work programme of the Group on Health, health-related work continues to be an important component of the work programmes of a number of other bodies within the organisation. Given this, an Intra-Directorate Coordination Group for Health,

modelled after a long-standing group focused on biotechnology issues, was established by Deputy Secretary-General Berglind Ásgeirsdóttir to ensure strong internal communication within the Secretariat on health-related matters.

In recent weeks, the Organisation has begun to review the results of its annual survey of member countries to assess the quality and impact of its work. Four health-related publications were listed in the top 46 outputs of the Organisation in 2004, including *OECD Health Data 2004* and *Towards High-Performing Health Systems*, the final report to Ministers on the OECD Health Project. This outcome demonstrates that member countries place a high value on the OECD's recent work on health.

RELEASE OF *OECD HEALTH DATA 2005*

OECD Health Data offers the most comprehensive source of comparable statistics on health and health systems across OECD countries. The 2005 edition of the database, released on 8 June 2005, provides evidence of striking variations across the 30 OECD member countries in many aspects of their health systems (including health expenditure and financing), as well as population health status and health risks. *OECD Health Data 2005* includes more than 1200 statistical series and indicators, with some time series going back to 1960. It comes with an extensive documentation of definitions, national sources and estimation methods per country.

The main achievements of the 2005 release of *OECD Health Data* include:

- improving the comparability of data, particularly for the "core" group of indicators which will be highlighted in the associated publication *Health at a Glance – OECD Indicators 2005*, to be released in October 2005.

- increasing the number of countries that are reporting their health expenditure and financing data according to the *System of Health Accounts* (SHA), thereby enhancing the completeness and comparability of these data.

- including expenditure indicators to cover the enlarged European Union. Using data from the World Health Organization (WHO) for those EU countries which are not currently members of the OECD, average total and public expenditures for the EU-25, as well as for the individual countries are presented under the "Get more data" section of *OECD Health Data*.

- reporting new data on the remuneration of certain categories of health professionals along with appropriate metadata information to signal comparability limitations (also in the "Get more data" section).

OECD Health Data 2005 is available on CD-ROM in a multilingual version (English, French, German, Italian, Spanish and Russian). An online version is also available to subscribers of SourceOECD (the main OECD Publications dissemination system), to all OECD Health Data national correspondents, and to officials in national governments and other international organisations requesting access to it. The release of *OECD Health Data* would not be possible without the contribution of national data correspondents in the 30 OECD countries, who provided most of the statistics and qualitative information contained in the database.

More information on *OECD Health Data 2005* can be found online at the website mentioned below. Available items include press releases and country-specific notes presenting new data, frequently-asked questions, lists of variables and a trial version for download.

The next annual meeting of OECD Health Data national correspondents will be held in September 2005, in conjunction with the annual meeting of Health Accounts experts and correspondents for health expenditure data. A key item for discussion will be the need to improve further the comparability of hospital statistics and other indicators related to health care resources and activities, working in close collaboration with WHO and Eurostat.

Future events:

- Meeting of OECD Health Data National Correspondents, 28-29 September 2005, Paris, France.

Recent publications:

- *OECD Health Data 2005*

Future publications:

📖 *Health at a Glance – OECD Indicators 2005*

Website: http://www.oecd.org/health/healthdata

Contact: Gaetan Lafortune
Marie-Clémence Canaud

IMPLEMENTING THE SYSTEM OF HEALTH ACCOUNTS IN OECD COUNTRIES

In response to the pressing need to improve comparability of data on health financing and expenditures, the OECD, in co-operation with experts from OECD member countries, developed the manual, *A System of Health Accounts* (SHA), releasing the initial 1.0 version in 2000. As a key component of the SHA, the International Classification of Health Accounts (ICHA) was developed. The SHA proposes a comprehensive framework, basic accounting rules and a set of standard tables for reporting health expenditure data. It provides a consistent functional approach in order to define the boundaries of the health system.

Nearly all OECD countries have, by now, commenced or completed a pilot implementation of the SHA framework, with the exception of Italy and New Zealand. SHA-based health accounts have become the basis for regular international data reporting in eleven OECD member countries. The collection of data based on the SHA classification system is not only resulting in more comparable aggregate data on health expenditure, it is also opening up new opportunities to do more in-depth analyses of how much is spent on different types of health services (in-patient care, out-patient care, pharmaceuticals) and how these health services are paid for by different sources (public funding, private health insurance or out-of-pocket spending).

Beginning in autumn 2005, OECD, Eurostat and the World Health Organization will commence a regular, joint SHA data collection. This initiative aims to achieve steady progress in the use of common international standards and definitions, while at the same time reducing the data collection burden on national correspondents.

Further methodological work constitutes another important component of the OECD's work on SHA, including preparation of addendums (complements) to the SHA manual in relation to issues requiring more detailed description and guidance. Some of the most important developmental projects being administered over 2005-2006 are as follows:

- Refinements and addendums to current expenditure classifications;
- Improvement of statistical guidelines and routine estimates of long-term care expenditures and service recipients;
- Development of indicators connecting health expenditure and non-monetary measures of health-systems inputs and outputs; and
- International and inter-temporal comparisons of volumes and prices in health care.

Future events:

➢ 7th Meeting of Health Accounts Experts and Correspondents for Health Expenditure Data, Paris, 29 - 30 September 2005

➢ Workshop on Out-of-pocket Spending and Private Cost-sharing, 30 September 2005

Working and technical papers:

📖 The first results from the implementation of the SHA were released last year in *OECD Health Working Paper* No.16, "SHA-based National Health Accounts in Thirteen OECD *Countries*: A Comparative Analysis," available at: http://www.oecd.org/els/health/workingpapers and a series of *OECD Health Technical Papers* (Nos. 1 to 13) presenting the related country studies, available at: http://www.oecd.org/els/health/technicalpapers

Website: http://www.oecd.org/health/sha

Contact: Eva Orosz
David Morgan

TRACKING HEALTH CARE QUALITY

The long-term objective of the OECD Health Care Quality Indicator (HCQI) Project, which commenced in 2001, is to develop a set of indicators that reflect a robust picture of health care quality that can be reliably reported across countries using comparable data. The HCQI Project will eventually represent the largest effort, in terms of

number of quality indicators and number of countries, to track international health care quality that has ever been undertaken. The HCQI project has built on two pre-existing international collaborations organised by the Commonwealth Fund of New York (five countries) and the Nordic Group of countries (also five countries). It now involves 21 countries.

The project has been divided into two phases. In Phase I, pilot work was carried out on an initial set of 17 indicators to explore the technical issues associated with reporting health care quality internationally. In the current, second phase, the project will finalise an overall conceptual framework and report on a broader set of indicators across a range of clinical conditions. The hope is that this second phase will lay the groundwork for the eventual selection of a set of quality indicators to be included among those statistics and indicators reported and published annually in *OECD Health Data*. The conditions and care areas for the two phases are presented below.

OECD HCQI Conditions and Care Areas

Phase 1

- Cancer screening rates and survival
- Vaccination rates for children and elderly
- Mortality rates for asthma, heart attack and stroke
- Waiting times for surgery (hip fracture)
- Diabetes control and adverse outcome rates
- Smoking rates

Phase 2 (currently proposed)

Phase 1 indicators, plus additional indicators on:

- Promotion, prevention and primary care
- Mental health care
- Patient safety
- Cardiac care (additional indicators)
- Diabetes care (additional indicators)

The project has been guided by an expert group from the participating countries, which has reviewed data and discussed technical measurement issues in five separate meetings. In December 2004, the OECD hosted the most recent meeting of the expert group in Paris to address progress and plans for future work.

Future events:

- Meeting of the HCQI Expert Group, November 17-18, 2005

Recent technical papers:

- *OECD Health Technical Paper* No. 18, "Selecting Indicators for Patient Safety at the Health Systems Level in OECD Countries", by John Millar, Soeren Mattke and the Members of the OECD Patient Safety Panel.
- *OECD Health Technical Paper* No. 17, "Selecting Indicators for the Quality of Mental Health Care at the Health Systems Level in OECD Countries", by Richard Hermann, Soeren Mattke and the Members of the OECD Mental Health Care Panel.
- *OECD Health Technical Paper* No. 16, "Selecting Indicators for the Quality of Health Promotion, Prevention and Primary Care at the Health Systems Level in OECD Countries", by Martin Marshall, Sheila Leatherman, Soeren Mattke and the Members of the OECD Health Promotion, Prevention and Primary Care Panel.
- *OECD Health Technical Paper* No. 15, "Selecting Indicators for the Quality of Diabetes Care at the Health Systems Level in OECD Countries", by Sheldon Greenfield, Antonio Nicolucci and Soeren Mattke.
- *OECD Health Technical Paper* No. 14, "Selecting Indicators for the Quality of Cardiac Care at the Health Systems Level in OECD Countries", by Laura Lambie, Soeren Mattke and the Members of the OECD Cardiac Care Panel.

Website: http://www.oecd.org/health (Information found under the theme: health care quality)

Contact: Edward Kelley

PHARMACEUTICAL PRICING POLICIES AND INNOVATION

Pharmaceutical pricing decisions raise important international considerations that complicate national decision-making. How do national pharmaceutical pricing policy decisions affect innovation in the pharmaceutical sector? How do such decisions impact pharmaceutical costs elsewhere? Are policy changes needed to safeguard continued pharmaceutical innovation and to promote innovation that matches national health priorities?

Are policy changes needed to ensure that the benefits of innovation are widely available and affordable on a world-wide basis?

The international considerations involved, the strong economic aspects of the policy questions, and the potential value of assessing these questions from multiple perspectives – including health, industrial and trade policy – point to a clear rationale for OECD work in this area. As noted by participants in the May 2004 meeting of OECD Health Ministers, such work could lead to more informed policy making as well as further clarification of the international co-operation needed to achieve cross-national policy goals.

The OECD Project on Pharmaceutical Pricing Policies and Innovation has two main objectives, both of which are encompassed by the general goal of improving the grounds for informed policy making in OECD countries:

- To add to the base of information about pharmaceutical pricing policy in OECD countries and develop a taxonomy and framework for making international comparisons of policies.

- To analyse cross-national impacts and implications of policies, particularly with respect to the impacts on pharmaceutical prices paid in other countries and on pharmaceutical R&D.

Given that the issues to be addressed cut across a number of disciplines and portfolios within governments, the work is being administered by the Health Division in the Directorate for Employment, Labour and Social Affairs in close consultation with other Directorates, notably the Directorate for Science, Technology and Industry (particularly the Biotechnology Division). Coordination with relevant work undertaken elsewhere in the Organisation and by other international organisations is viewed by the Secretariat as critical to this project's success.

A network of invited experts on pharmaceutical pricing policy and national representatives from member countries choosing to participate in the project will provide technical input.

A policy-oriented symposium is tentatively planned to be held in the fourth quarter of 2006. The agenda will include presentations and discussion of key issues (policy and technical), options for ensuring that pharmaceutical pricing policies meet health and economic policy goals, and avenues for furthering dialogue among policymakers on these topics.

Future Event:

- Meeting of Experts on Pharmaceutical Pricing Policy, Paris, France, 1-2 December 2005.

Contact: Elizabeth Docteur

BIOTECHNOLOGY, INNOVATION AND HEALTH

The links between innovation, productivity, health and wealth are recognised by OECD countries. Investing in and encouraging innovation is a priority for many jurisdictions as is the affordability, quality and sustainability of health-care systems. The apparent tension between these two goals can be mitigated, however. The challenge for policymakers is to encourage innovation that addresses health needs and priorities; maximises access to the benefits; and manages risks in a way that is beneficial both to innovators and health systems.

A workshop on "Biomedicine and Innovation in Healthcare: Examining the Links Between Policy Makers and Innovators" was held in Berlin, Germany, on 15-16 November 2004 in Berlin to explore two questions: (1) How can OECD countries deliver greater convergence between healthcare priorities and the direction of innovation?; and (2) What tools need to be developed to ensure that decisions taken in OECD countries capture the benefits of, and contribute to fostering, innovations in human health-related biotechnologies?

The medical biotechnology sector has developed over the last decades at an unprecedented speed and is already influencing the provision of medical care. New and emerging biotechnologies offer many opportunities that are likely to change the way society understands and treats disease. While there is wide recognition that the contribution of innovation needs to be fostered, many also believe that the situation for how biotechnological innovations are used within health systems is for the moment sub-optimal. Policy makers and health system managers in all countries face many challenges in making decisions regarding the uptake of efficient and effective technologies into health

systems. The limitations of current approaches to health technology assessment are identified and analysed in the forthcoming OECD report, *Health Technologies and Decision Making*.

As countries make major investments in biotechnology-related innovation there is a need to develop accompanying policy tools to ensure that the benefits of research and development can be appropriately used to improve the health of citizens. To respond to this challenge, several projects have been launched in 2005 which, when taken together, seek to identify different ways of building partnerships that link researchers, industry, governments, policy makers, and health system managers so that the fruits of innovation are quickly and appropriately taken into health systems and reach those that need them. The projects include:

- A survey of health and innovation policies which will: (1) explore the policies in place to create an innovation-friendly atmosphere for health-related technologies, (2) explore conditions across the whole innovation cycle that affect biomedicine; (3) gather information on different tools and approaches to evaluate such biomedicines; and (4) collect information on a number of case study biomedicines.

- Case studies identifying and analysing incentives and barriers to the uptake and diffusion of specific health related biotechnologies.

- A workshop and an analytic report on new biotechnology research and innovation models for health which will explore the conditions and factors common among these models that move discovery more quickly, efficiently, and appropriately and achieve better health outcomes.

- A scoping of possible indicators for biotechnology, innovation and health.

Forthcoming publication:

📖 *Health Technologies and Decision Making*

Website: http://www.oecd.org/sti/biotechnology

Contact: Bénédicte Callan

UNDERSTANDING DISABILITY TRENDS AMONG THE ELDERLY AND THEIR IMPLICATIONS FOR COSTS OF CARE

The OECD study on disability trends among the elderly and their implications for costs of care has four main objectives:

1. to monitor the most recent trends in elderly disability rates in a dozen OECD countries;

2. to review emerging information on factors (both medical and non-medical) that might be driving changes in elderly disability rates over time;

3. to measure the links between disability and costs of care; and

4. to project future rates of disability among elderly populations and, by combining it with demographic and other variables, project future health and long-term care spending related to these demographic and non-demographic variables (based on different scenarios/assumptions).

The last objective (the cost projections) will be carried out in co-operation with the OECD Economics Department and the Ageing Working Group of the European Commission.

The first experts meeting in relation to this OECD study was held on 20 February 2005. Experts from the 12 countries participating in the study were convened to exchange ideas and discuss plans for conducting the study. Immediately following the experts meeting was a workshop, jointly hosted by the European Commission and the OECD, on *'Understanding trends in disability among elderly populations and the implications of demographic and non-demographic factors for future health and long-term care costs,'* which took place on 21-22 February in Brussels. (Presentations from this workshop are available online at: http://europa.eu.int/comm/economy_finance/events/2005/events_brussels_0205_en.htm).

The OECD study will be conducted over the next 18 months. Work to meet the first two objectives of the study is expected to be completed before the end of 2005. A second meeting of the expert group to discuss and agree on the best method to carry out work to accomplish the third, and possibly the

fourth, objectives of this study is tentatively scheduled for early 2006 in Paris.

Contact: Gaetan Lafortune

HEALTH ISSUES IN OECD'S ECONOMIC SURVEYS

Health is an issue that is taken up in nearly all OECD *Economic Surveys.* This is not only because it is a major item of expenditure in its own right, but also because of its important contribution to economic performance and living standards. It is also a growing element of public expenditure, hence important in any fiscal analysis, and with ageing populations it is likely to be a growing pressure point in economic policy. In looking at the issue of fiscal sustainability over the medium and longer term it is health and elderly care, as well as pensions, which loom large in the calculations. The health issue is therefore treated in any discussion of long-term trends in public expenditure and in reviewing public sector efficiency. In addition, there are clear links to the labour market through sickness and disability, which has been a growing and worrying problem in many OECD countries; indeed, in quite a few countries it is more important than unemployment in reducing the effective input of labour into the economy.

Because of its inherent importance in the economy, the OECD Economics Department has long worked on health issues. Healthcare and its implication for the economy has been the subject of special chapters (among a number of other "structural" topics) since the 1990s. Since then, there have, at one time or another, been health chapters in well over half of the economic surveys of the 30 OECD countries, and occasional second visits. A lot of the material in these special chapters was used and synthesised in a paper on "Health-care systems: lessons from the reform experience" by Elizabeth Docteur and Howard Oxley in December 2003 (see Economics Department Working Paper No. 374). Since then, health has appeared as an issue in a variety of special chapters on public expenditure, ageing, the environment, fiscal federalism and sickness and disability; and special chapters devoted solely to health have been rather less frequent although still being regarded as an important element in overall economic performance and welfare. In some respects health has been mainstreamed, popping up in a variety of places in the economic surveys rather than necessarily being focused on as a self-contained subject in its own right.

As regards the more intensive coverage of health in special chapters in the Surveys, most of the major economies have now been covered, including several of the top spenders (in terms of the ratio of health expenditure to GDP): the United States (2002), Germany (1997) and France (2000). The issue of health care in the United States will probably be revisited in the next few years, while the situation in France and Germany will soon be worth revisiting to gauge the effect of recent reforms. Special chapters on health in Hungary and in Norway were considered by the review body, the Economic and Development Review Committee, in June. Both surveys will be published in summer 2005.

The two most recently published special chapters on health are those for Portugal (September 2004) and Sweden (June 2005), with the main conclusions being as follows:

In *Portugal*, an ambitious reform to increase the efficiency of the health care system was launched in 2002. In contrast to previous attempts at gradual reforms, which were never fully implemented, the strategy was to create a big bang in the health sector, making changes essentially irreversible. The reform had two main aims: to deliver better-quality public health services than at present but at no higher cost; and to reduce the underlying growth rate of public health-care spending over the medium term. New legislation approved included the separation of the functions of regulation, financing and provision of health care services; setting up new models of financing for providers, which impose harder budget constraints; the introduction of incentives towards productivity, management and quality improvements; the possibility for the private sector to play a larger role in service provision; and the promotion of generic drugs. The OECD report describes in detail the on-going reform programme, assessing to what extent it addresses the weaknesses of the health care system and can increase its performance. The report concludes that the effective implementation of the whole reform programme will be key to achieving durable results and that, nevertheless, additional measures will be needed to further raise efficiency, reduce current cost pressures and improve health status.

Health-care expenditure has also risen rapidly in *Sweden*, prompting a report in the most recent

Economic Survey that reviewed the strengths and weaknesses of the country's health-care system and the challenges that it will face in the future. It discusses ways to improve access to primary care, including different methods for paying GPs, whether access is less equitable than in other countries and the role of patient fees. The maximum waiting time guarantee for elective surgery is reviewed, along with ways of reducing regional variations in quality. The extent of decentralisation is questioned, as that may be affecting the quality of care and value for money in some areas, including elderly and psychiatric care. Mechanisms for improving the hospital sector are also examined including activity-based payment mechanisms and whether for-profit hospitals would help. Finally, it considers ways to make financing more stable and sustainable. The *Survey* also has a special chapter on sickness and disability.

Future issues of *Health Update* will include the conclusions of the special chapters on health in the forthcoming surveys of Hungary and Norway, and ones beyond. While the health chapters in the *Economic Surveys* are effectively the product of the Economics Department, colleagues in the Directorate for Employment, Labour and Social Affairs have been very supportive in making sure that the analysis and recommendations have been to the mark, relevant in the country covered and consistent across countries.

Website:
http://www.oecd.org/eco/structural_issues/health

Contact: Andrew Dean

OECD REVIEWS OF HEALTH-SYSTEM PERFORMANCE

In the course of the Health Project, the OECD Secretariat received requests to undertake reviews and performance assessments of the health systems of certain member countries. The first such review, an assessment of the Korean health system, was completed during the Health Project. This activity continues as part of the current programme of work.

OECD reviews of health systems are in-depth, country-specific studies initiated at the request of individual member countries. The reviews assess the performance of health systems in a comparative context. A framework for conducting the reviews was developed in the course of the Health Project. It provides a structure underpinning the assessment of the strengths and weaknesses of health systems, and suggestions for ways forward to address policy and performance challenges. In addition, each country identifies specific areas of policy interest, which, within the context of the broader framework, serve as areas of particular focus for the review. A draft of the review is presented and discussed at a review meeting, which takes place either in Paris or, at country request, in the country under review. After the meeting, the review is finalised and published within the series *OECD Reviews of Health Systems*.

Several country reviews have recently concluded or are now underway. A review of the Mexican health system was completed this year and a review the Finnish health system is in progress, with a final report expected by year-end. A review of the Swiss health system, undertaken jointly in collaboration with the World Health Organization, has recently commenced. A draft report is to be discussed at a review meeting envisaged for spring 2006, and the final report published in summer 2006.

The OECD's review of the Mexican health system revealed that the population is marked by significant inequality in health status and in access to health-care services, mainly among the poor and in rural areas. This has been reflected in poor population health status when compared with other OECD countries, despite considerable emphasis on preventive care. Financing arrangements have resulted in low levels of per capita health-care spending, particularly among those who do not belong to the social security system.

Increasing access to coverage and quality care among disfavoured groups is, therefore, a critical challenge. Recent reforms – particularly the System of Social Protection in Health (SPSS) and the Seguro Popular – aimed at increasing resources for health care and reallocating them towards underserved areas will go a considerable way to meeting these challenges. However, because of the decentralisation of the supply of services to those not covered by social security to the states, the segmentation of the supply system more generally and low provider efficiency, there are important implementation problems to be overcome. The availability of resources to finance the new programme remains conditional on the fiscal situation. Currently, measures to encourage greater efficiency in the State Health Services have not been put in place and this policy area requires urgent attention to ensure that new resources under

the System of Social Protection in Health are used to best advantage. Establishing a purchaser-provider split to break the link between financing and provision is an important first step. Over the longer term, the authorities should attempt to unify the existing health care system by establishing a single package of care services that is covered by all public insurers in the health-care system.

Forthcoming publication:

- *OECD Reviews of Health Systems: Mexico*

Previous publication:

- *OECD Reviews of Health-Care Systems: Korea*

Contact:

Peter Scherer
Francesca Colombo (Switzerland, Mexico, Korea)
Jeremy Hurst (Finland, Korea)
Howard Oxley (Mexico, Switzerland)

HEALTH CARE FINANCING IN DEVELOPING COUNTRIES

Health care financing continues to be a key challenge in the developing world. Despite efforts to improve the provision of health services, many low- and middle-income countries are still far from achieving universal health coverage An estimated 1.3 billion people do not have access to effective and affordable health care, including drugs, surgeries, and other medical interventions. According to the World Health Organisation, developing countries bear 93 % of the world's disease burden, yet merely account for 18 % of world income and 11 % of global health spending. As these countries rarely have the institutional capacity to offer state-based health insurance and/or tax-financed health care, a large amount of health costs are directly borne by patients. These so-called "out-of-pocket payments" account for one-third of total health expenditure in two-thirds of all low-income countries. Catastrophic health costs (i.e. payments exceeding 40 % of a household's capacity to pay) are a common phenomenon in the developing world and drastically increase the risk of impoverishment; especially considering the loss of productive capital associated with illness. In order to achieve greater health coverage, it thus seems indispensable to pool resources by bundling available funds and spreading the risk of illness and heath care costs.

The OECD Development Centre looks at health care financing options for developing countries, focusing on the role of innovative health insurance schemes that aim to increase access to health care, reduce out-of-pocket payments, and increase utilisation rates.

A recent publication of the OECD Development Centre analyses characteristics of private health insurance (PHI) in low- and middle-income countries and evaluates its significance for national health systems. It yields three major results. First, PHI involving pre-payment and risk sharing currently only plays a marginal role in the developing world. Coverage rates are generally below 10 % of the population while private risk sharing programs only have wider significance in a small number of countries (e.g., South Africa, Uruguay, and Lebanon). Second, the importance of PHI to finance health care is on a rise in many countries. Various factors contribute to this development: growing dissatisfaction with public health care, liberalisation of markets and increased international trade in the insurance industry, as well as overall economic growth allowing higher and more diversified consumer demand. This last aspect in particular is expected to put pressure on the supply side of the system to increase choices and improve the quality of health care coverage. Third, the development of PHI presents both opportunities and threats to the health care system of developing countries. If PHI is carefully managed and adapted to local needs and preferences, it can be a valuable tool to complement existing health financing options.

Statutory health insurance schemes cover only a marginal proportion of the population in low-income countries. Due to economic constraints, lack of good governance and institutional weaknesses, formal social protection for the vulnerable segments of the population is widely absent. In this context, the Development Centre analyses the emerging movement of community-based health insurance (CBHI) schemes in the developing world, as a potential promising tool to existing forms of health care financing. CBHI insurance schemes are generally based on local initiatives of rather small size with voluntary membership. Programs have either been initiated by health care providers (e.g., hospitals), Non-Governmental-Organisations, or local associations. Schemes are generally limited to a specific region or community and thus only reach a small number of people. Moreover, insurance packages are not comprehensive, but only offer supplementary coverage for certain medical

treatments. Despite these limitations, the schemes often offer important advantages for their members, including better access to health care when needed, improved financial protection and reduced reliance on welfare-threatening ways of health-care financing, such as selling assets and borrowing money. These results confirm the importance of political strategies setting priorities in extending coverage of social protection schemes to the poor and investing in social health protection development.

Recent reports and publications:

- Drechsler, D. and Jütting, J. (2005): "Private Health Insurance in Low- and Middle-Income Countries – Scope, Limitations, and Policy Responses". Study commissioned by the World Bank and prepared for the Wharton Impact Conference 2005. (http://hc.wharton.upenn.edu/impactconference/drechsler_031005.pdf)

- Jütting, J. (2005): Health Insurance for the Poor in Developing Countries. Ashgate, Aldershot.

Contact: Johannes Jütting
Denis Drechsler

IMPACT OF DECENTRALISATION OF HEALTH SECTORS IN LOW- AND MIDDLE-INCOME COUNTRIES

Achieving the Millennium Development Goals will require substantial improvements in the health outcomes of the developing world. Many low- and middle-income countries are currently undertaking considerable reforms in order to raise the efficiency and quality of health care provision. In this context, the transfer of public functions from higher to lower tiers of government can have a positive impact on the health system by changing its regulatory structures.

Theory suggests that decentralisation should have a positive impact on access to, and quality of, public services such as health care. The process is expected to improve information flows (incorporating local information in decision making), alter patterns of authority and accountability (holding officials and health workers accountable for performance), and strengthen linkages between local health officials, service providers, clients, and other beneficiaries. These changes are intended to improve efficiency, equity, accessibility, and responsiveness in the health sector.

Empirical findings indicate, however, that positive outcomes crucially depend on key factors in the political, administrative, fiscal and local governance arenas. The OECD Development Centre is engaged in current research activities that aim to identify determinants of successful decentralisation in the health sector. Through a comparison of experiences in China and India, it is envisaged to derive policy conclusions on how to make decentralisation processes more pro-poor.

Contact: Johannes Jütting

MEASURING THE SOCIAL OUTCOMES OF LEARNING

Over the last 50 years, a large body of research has contributed to our understanding of the economic advantages that education can provide for individuals and society. By comparison, social outcomes of learning (SOL) do not feature as prominently. While it is widely acknowledged that governments and individuals invest in learning for social reasons, the theoretical and conceptual setting for SOL is comparatively less rigorous and empirical analysis less developed.

The OECD Social Outcomes of Learning project is an international effort to improve our understanding of the effects of learning (formal and informal) on social domains. The project is designed to inform economic and social policy that relates to education and lifelong learning. The aims are to:

- Develop coherent models and indicators for understanding better the complex links between learning and social outcomes and their implications for policy;
- Add to the empirical knowledge base of SOL;
- Draw relevant policy implications.

The SOL project will initially focus its efforts on two domain areas:

- *Health (physical and mental) outcomes.*
- *Civic and social engagement outcomes.*

Under the sub-domain of physical health, the project is likely to focus on lifestyle and nutritional outcomes, and on depression within the sub-domain of mental health.

Additionally, two cross-cutting themes will be considered in the first phase:

- *Intergenerational effects of learning* via the family and home environment
- *Distributional effects of learning*: how different social groups benefit from education

The project is based in the Directorate for Education and is led by the Centre for Educational Research and Innovation (CERI), in co-operation with the Indicators of Education Systems (INES) Network B and the Social Policy Division of the OECD Directorate for Employment, Labour and Social Affairs.

Sponsoring countries within the OECD include: Austria, Belgium (Flemish community), Canada, Luxembourg, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom (England and Scotland) and the United States.

Policy researchers in the health field who have related interests are invited to contact the OECD Secretariat.

Contact: Tom Schuller

INTERNATIONAL MIGRATION OF HEALTH AND OTHER PROFESSIONALS

To address the problems of scarcity and lack of comparability of statistics on international migration stocks – problems which are particularly acute for the highly skilled – the OECD launched in 2003 an initiative with national statistical offices aiming at collecting census and population-register data on the stock of foreign-born persons in OECD countries by educational attainment. The first phase of the project has been completed and the data have been publicly released, along with information on expatriation rates by level of qualification and country of origin. These are accessible via the OECD's Migration Policy web page (see address below).

A second phase of the project, now underway, aims to focus on demographic and labour market variables such as gender, age, duration of residence, employment status, occupation, sector of activity or field of study. Given the level of detail in the data collected and the necessity to harmonise occupational and sectoral classifications, it is expected that this phase of the project will be labour-intensive and require significant resources in order to ensure a timely release of the data.

One of the areas of particular interest concerns health professionals (nurses and doctors). Among the outputs envisaged are statistics on the number and prevalence of foreign-born doctors and nurses and the main countries of origin of foreign-born health professionals currently working in OECD countries. For some countries it may also be possible to identify persons trained as health professionals who are out of the labour force.

Website: http://www.oecd.org/els/migration
Data from first phase of project found under "Don't Miss"

Contact: Jean-Christophe Dumont

COMPETITION IN THE HEALTH PROFESSIONS

In a recent meeting, the OECD Working Party on Competition and Regulation focused on methods for enhancing beneficial competition in the health professions. Health professions are overseen by an array of rules and regulations that are justified by the need to protect consumers from unqualified practitioners. The most common method of ensuring practitioner quality is professional licensure. Because health care expertise is necessary to establish the appropriate program of study, training, and examination for new professionals, a licensed profession often directly or indirectly controls its own licensure rules. In this process of self-regulation, a profession exercises its legitimate interest in maintaining the quality of its members. But a self-regulating profession also has the potential to abuse its control over who can practice in order to enhance member income. Examples of such abuse can include:

- limiting the number of practitioners,

- limiting competition between its own members, and

- hindering other potentially competing professions from practice.

The meeting suggested that a policy of evaluating professional restrictions and eliminating those which are harmful could yield substantial gains to consumers and payers, and could potentially help to reduce health care spending without substantially reducing quality of care.

A key distinction was drawn at the meeting between insured professional services (such as medical care delivered by physicians) and uninsured services (frequently eye exams, dental care, and psychotherapy are uninsured, among other professions.) Professional restrictions are especially problematic for uninsured services and can result in significantly increased prices for consumers. In contrast, restrictions on quantity may be necessary to some extent for insured services in order to reduce over-consumption. Nonetheless, restrictions on efficient forms of service delivery (e.g. by para-professionals) also exist for insured services.

Structural limits common to health professions include:

- Entry limits, such as restrictions on the number of practitioners or training places and geographic training limits;
- Exclusive rights that limit the practice of para-professionals and alternative professionals; limit access to health-related products; or deny access to medical facilities and records to potential competitors; and
- Limits on organisational structures, such as the abilities of corporations to act or of practitioners to affiliate with other kinds of practitioners.

Behavioural limits common in health professions include

- Advertising restrictions;
- Constraints on fee-setting; and
- No-discount rules.

A number of studies have shown that restrictive practices raise costs, with results suggesting that limits on professional activity will often merit careful review by knowledgeable experts, particularly experts who are not currently practising members of the professions. Even if policy actions to reduce multiple barriers do not have the dramatic effects these estimates would suggest, given the high percentage of health care expenses that result from professional services, even a very small 0.1% reduction in total health care expenses as a result of better professional regulation would yield dramatic results for OECD members and could reduce health spending by USD 2.8 billion per year. Health ministries, competition agencies and finance ministries can serve as the best advocates for change.

A number of ways to enhance efficiency in health professions stand out:

- Increased roles are merited for para-professions;
- Increased mutual recognition of qualifications across borders could significantly reduce professional shortages in some countries;
- Increased consumer choice over the quality of the service receive is critical for reducing the cost and intensity of privately purchased services and products; and
- Reduced professional regulation over advertising, discounting and ownership can frequently have beneficial impacts for non-insured services.

In light of the success of the roundtable on competition in the health professions, another roundtable on competition in the health sector is planned for October 2005, focusing on competition in the delivery of hospital services.

Future event:

➢ OECD Working Party on Competition and Regulation, Competition Committee Roundtable Meeting on Competition in the Delivery of Hospital Services, Paris, France, 17 October 2005

Forthcoming report:

🕮 OECD Competition Committee Roundtable, "Enhancing Beneficial Competition in the Health Professions"

Contact: Sean Ennis

ACHIEVING HIGH-QUALITY REGULATION IN HEALTH CARE

The OECD has developed a multidisciplinary framework to address regulatory issues from a broad range of perspectives. The horizontal programme on regulatory reform involves contributions from the regulatory management, trade policy, and competition policy perspectives. In recent years, work has focused on network utilities such as energy or telecommunications. Health and education, significant sectors covering large policy areas with important public intervention, have not yet been covered. Analytical work to fill this gap includes specific substantive research on how to achieve high-quality regulation in health care.

The study will set out key strategic issues pertaining to regulation of health-care systems in OECD countries. The study would essentially concern the processes that lead to preparing regulation -- such as administrative simplification, transparency, consultation and accessibility -- and the proper setting up of efficient regulatory frameworks, tools and institutions to enforce them. The analysis should consider, in particular, the implications for the regulatory process of the diversity across health systems, including how to ensure a level playing field across a wide range of providers. The goal is to consider the applicability of high-quality regulation principles to the health sector.

Specific regulatory issues to be addressed include:

- the adequacy of transparency, consultation and evaluation when preparing new regulations;
- the effect of licensure and certification requirements on market entry, for example, for physicians, hospitals, and other health care providers;
- the extent and impact of regulatory burdens imposed on health care providers (institutions and individuals);
- the effectiveness of governance by regulatory institutions operating in the health-care sector, and the impact of the independence and accountability of these institutions on effective governance; and
- the efficiency and effectiveness of coordination between levels of governments in developing and administering regulation of the health-care sector.

This study will be developed in 2005-06. It will be shared for comments with relevant expert communities as soon as it is finalised. It could then be offered for discussion to the regulatory and health policy communities.

Contact: Josef Konvitz
Stéphane Jacobzone

THE IMPACT OF PHARMACOGENOMICS ON HEALTH SYSTEMS

In 2004, the OECD Working Party on Biotechnology (WPB) announced it will review what could best be done to advance the efficiency, utility and use of genomic knowledge for the delivery of safer medicinal products and better health. The announcement followed statements made by OECD Science and Health Ministers at their meetings in January and May 2004 that the challenge from increased understanding and use of human genetics had to be met in order to achieve the dual goals of economic growth and better public health.

One of the areas to be addressed in 2005 is pharmacogenetics. Pharmacogenetics is the study of the impact of heritable traits on pharmacology (pharmacokinetics and pharmacodynamics) and toxicology. An extension of pharmacogenetics is pharmacogenomics, which is based on the discovery that genetic polymorphisms have the potential to affect a drug's mechanism, including its efficacy. The commitment is to deliver by 2006 a policy report addressing challenges and opportunities to health systems from pharmacogenetics

The policy report will draw on discussion at a workshop on Pharmacogenetics set to take place in Rome, 17-20 October, 2005. The workshop hopes to accomplish three main goals:

- Communicate the status of pharmacogenetics internationally, analyse and raise awareness on the anticipated impacts on innovation, health delivery and health care systems.

- Review and address regulatory issues and challenges that may arise in translating pharmacogenetics into useful products for targeted therapies and diagnostics.

- Identify and explore initiatives and strategies relevant for pharmacogenetics development and implementation to improve public health across OECD countries.

Future events:

➢ An international perspective on pharmacogenetics: The intersection between innovation, regulation and health delivery, Rome, Italy, 17-19 October, 2005.

Contact: Elettra Ronchi

DRAFT GUIDELINES FOR THE LICENSING OF GENETIC INVENTIONS

Biotechnology and genetics research have been subjects of extensive investment by both the public and private sectors, with the products and processes emerging from these efforts making a significant and increasing contribution to human health and health care. Moreover, biotechnological, including genetic, innovations have been the subject of intellectual property rights for decades. Over the last decade, as the number of such innovations has increased, their use in and importance for the human health care field has also grown.

In this light, the OECD has undertaken work in the field of licensing and biotechnological inventions, with a particular focus on development of draft guidelines for the licensing of genetic inventions. The need for these was highlighted during an expert workshop examining issues related to intellectual property, licensing practices and genetic inventions. OECD work to develop draft guidelines was subsequently endorsed by the OECD Committee on Scientific and Technological Policy meeting at Ministerial level in January 2004 and by OECD Health Ministers at their meeting in May 2004.

The draft guidelines offer principles and best practices for the licensing of intellectual property rights that relate to genetic inventions used for the purpose of human health care. They are targeted at those involved with innovation and the provision of services in health, and particularly at those involved in the licensing of such inventions. Overall, the draft guidelines seek to foster the objectives of stimulating genetic research and innovation while maintaining appropriate access to health products and services.

The OECD Secretariat is revising the draft guidelines in light of the comments received from consultations held in February and March 2005. Information concerning this project may be obtained on our website.

Website:
http://www.oecd.org/sti/biotechnology/licensing (in English)
http://www.oecd.org/sti/biotechnologie/licences (in French)

Contact: Christina Sampogna

GUIDELINES ON BEST PRACTICES IN MOLECULAR GENETIC TESTING LABORATORIES

On the basis of a comprehensive analysis of quality assurance practices in molecular genetic testing in 18 OECD countries, member countries reached agreement in 2004 to develop international best practice guidelines. The decision comes at a time of international convergence of opinion on the need for a broad international framework that will foster best practice and good governance in molecular genetic testing laboratories. For example, the European Parliament called, also in 2004, for an opinion on the need for legislation in the area.

The approach agreed by OECD member country experts – and by the Organisation's governing body – is to develop broad guidelines for action, within the scope of which national or regional initiatives – including, if deemed appropriate, national legislation – might subsequently be developed.

These guidelines will offer short and succinct principles and best practices that relate to quality assurance systems, result reporting, education and training, and insofar as possible, clinical validity and utility. The guidelines should facilitate application of best practice in relation to human genetic and genomic testing, guarantee an international approach to exchange of clinical

samples and data facilitating access to rare disease testing, and help meet the general objectives of OECD member countries in relation to best practices in health care.

The summary report of results from the OECD survey can be downloaded from our website.

Website: http://www.oecd.org/sti/biotechnology

Contact: Elettra Ronchi

BEST PRACTICE IN GOVERNANCE AND MANAGEMENT OF HUMAN GENETIC RESEARCH DATABASES

The OECD held a workshop on "Human Genetic Research Databases (HGRDs) – Issues of Privacy and Security" in 2004. With the participation of over sixty experts, the main goals of the workshop were to:

- Gain an understanding of current practices internationally for the acquisition and maintenance of human genetic and genomic data and information;
- Identify any challenges in the management of genetic databases (including issues about their storage, use, transfer, disposal and abolition) that need to be resolved; and
- Identify good management practices for human genetic research database management, where such good practices exist.

The workshop concluded that:

- Human Genetic Research Databases (HGRDs) are an invaluable tool for research into the genetic basis of disease.
- There remains no expert consensus on whether genetic information should be treated as distinct from other medical information, though the perception of many that it has led to an increasing impact of that perception on policy making. Further efforts are required to avoid inappropriate consequences arising from such perceptions.
- Public – and more particularly, patient – trust in the development, management and governance of HGRDs remains an essential element of the enabling environment for health research and innovation in this field. (The workshop considered a number of practical approaches to assure public engagement and trust.)
- Clear procedures must be in place for informing patients about the way that data based on their genetics might be used in HGRDs. Participants questioned whether current approaches to informed consent were sufficient to assure patient privacy and achieve an appropriate balance with research access. Whether or not such a balance is achieved in public policy will affect how successful genetic science is as a driver for innovative products and processes and delivery of better health.
- The OECD should develop principles of best practice for the management and governance of Human Genetic Research Databases.

The full report of the Tokyo Workshop is expected to be published shortly. The OECD governing body has agreed that best practices guidelines for management and governance of Human Genetic Research Databases should be developed based on the work of the carried out at the Tokyo workshop. A steering group met in May 2005 to discuss and recommend the way forward for the work on best practices for HGRDs.

Forthcoming Publication:

📖 *Report of Tokyo Workshop on Human Genetics Research Database*

Website: http://www.oecd.org/sti/biotechnology

Contact: Christina Sampogna

THE ECONOMIC VALUATION OF CHILDREN'S HEALTH

The relationship between the environment and children's health has been the subject of increasing interest over the last ten years. The results of studies evaluating the adverse health effects of environmental degradation and the benefits associated with their reduction have brought the social importance of these issues more clearly into focus.

In this context, the OECD Environment Directorate has launched a project on the economic valuation of environmental health risks to children. The goal of the work is to help policymakers identify health and safety risks that largely affect children, and to develop guidelines for the valuation of children's health environmental risk. This work includes a methodological and an applied phase. The first phase consisted of the organisation of a technical workshop – held at the OECD in September 2003 – to take stock of the methodological advances and issues. Findings and discussions from the workshop will lead to a major publication on this issue by the end of 2005. The second phase will consist in carrying out a series of pilot valuation studies in – at least – three OECD countries (United Kingdom, Italy and the Czech Republic). The work undertaken in the second phase of this project is anticipated to have the following outcomes:

- Estimation of values differentiated across factors such as age, latency and risk factor;
- Estimation of values which are specific for children;
- Elaboration of an appropriate methodology for addressing such factors and populations; and
- Application of the reliability of international benefits transfer.

Further work would include the preparation of a reference manual of practical use by the end of 2007. It would consist in a more policy-oriented and user-friendly handbook on the valuation of children's health, based on the findings from the empirical case studies. This handbook would be designed to provide practical guidelines and recommendations to economists as well as policymakers interested in children's health valuation.

Website:
http://www.oecd.org/department/0,2688,en_2649_32495306_1_1_1_1_1,00.html

Contact: Pascale Scapecchi
Nick Johnstone

CO-ORDINATION OF ENVIRONMENT AND HEALTH POLICIES

Given that the linkages between health and environment are a growing concern in most OECD countries, the OECD Environment Directorate has commenced a project on how to improve policy co-ordination between the environmental and the health spheres. Health and environmental policies are not well co-ordinated and there is a lack of harmonisation in the policy evaluation and design process between the two spheres. In particular, the lack of co-ordination may be associated with differences in terms of valuation frameworks used in the two fields (cost-effectiveness analysis in health economics and cost-benefit analysis in environmental economics) and could lead to an imbalanced allocation of resources – with perhaps too much focus on addressing the health concerns generated by environmental problems, rather than on preventing the environmental problems in the first place.

Through the comparison of the means by which environment-related health impacts are assessed in the environmental and health spheres and the assessment of their incorporation in policy making, this project will make a contribution toward improved policy coordination and inter-departmental resource allocation.

Contact: Pascale Scapecchi
Nick Johnstone

OECD'S WORK ON HUMAN HEALTH IN THE FRAMEWORK OF MUTUAL ACCEPTANCE OF DATA

A large part of the work undertaken in OECD's Chemicals Programmes is directly related to protection of human health from risks posed by chemicals and chemical products (including pesticides, cosmetics, medical products, etc.). Although the various groups of chemicals and products are regulated under specific regimes in member countries (*e.g.* environment, health and/or industry agencies and ministries for new industrial chemicals; health agencies and ministries for pharmaceuticals; agriculture, health and/or environment agencies and ministries for pesticides), they are all subject to similar testing requirements for the evaluation of their effects on health prior to decisions on their use by consumers. In order for

industry to meet these requirements and governments to implement them in the most efficient and effective way possible, harmonised testing methods and data quality standards are agreed in the framework of the OECD Council Acts related to the Mutual Acceptance of Data in the Assessment of Chemicals.

A great many of these methods (Test Guidelines) are used to determine the toxicity of substances to animals or non-animal equivalents at various exposure levels and to extrapolate any information on potential risks to humans so they can be appropriately managed. The OECD Test Guidelines, which are revised and updated as necessary to meet evolving scientific and regulatory needs, constitute the body of international standards for methods for pre-clinical safety testing of chemicals and chemical products. In addition, OECD, by following closely scientific developments which impact on filling regulatory requirements related to physical and toxicological properties of substances, is working towards agreement on application of new approaches in assessment frameworks – for example, by using relationships between the structural qualities of a chemical and its known toxic effects and extrapolating this to other related chemicals, or by applying the knowledge generated in research in toxico-genomics.

The OECD Principles of Good Laboratory Practice are the companion international standard for data quality in pre-clinical safety testing. Work continues at OECD to develop guidance for the application and interpretation of the principles and to harmonise government monitoring of compliance with them. Chemical testing laboratories submit safety data to regulatory authorities using these standards and do not need to carry out duplicative testing in order to notify or register a substance in several countries at the same time; governments in member countries verify the scientific reliability and quality of the data submitted using these standards and the compliance monitoring procedures developed by OECD. Non-tariff trade barriers are avoided; expensive and animal-intense duplicative testing is reduced; and a high level of safety to occupational and consumer health is guaranteed.

For further information, including participation of non-members in the MAD system, see the website.

Website: http://www.oecd.org/ehs

Contact: Dian Turnheim
Drew Wagner

OECD'S WORK ON HUMAN HEALTH IN THE FRAMEWORK OF THE CHEMICAL ACCIDENTS PROGRAMME

The work on chemical accidents undertaken as part of the OECD Environment, Health and Safety Programme helps member countries prevent chemical accidents and respond appropriately if one occurs. This work has an important occupational and public health component.

One of the most important products of this work programme is the *Guiding Principles for Chemical Accident Prevention, Preparedness and Response*. First published in 1992, an updated, second edition was published in 2003. The new edition includes new guidance on anticipating and responding to health hazards from chemical accidents, based largely on the outcome of a workshop on *Health Aspects of Chemical Accidents* and a guidance document on *Chemical Accident Awareness, Preparedness and Response for Health Professionals and Emergency Responders*. The latter focuses on the health aspects of chemical accidents and is directed to officials in the health field including, for example, those in ministries of health, labour and industry; regional and local health authorities; hospitals; poison information centres; and occupational health centres.

The OECD Chemical Accidents Programme has recently taken a more active interest in the management systems standards for occupational health and safety, environment and quality, with focus on identifying their similarities and differences, and investigating benefits achievable from integrated management systems (IMS) for safety, health, environment and quality (SHE&Q).

With respect to occupational health and safety systems, it is important to note that although "health" and "safety" are almost always treated together, most national and international workplace legislation and standards in fact concentrate much more on safety hazards (prevention of injury) than on health hazards (prevention of illness). However, the integrated management of SHE&Q in the chemical industry is gaining more and more acceptance. The development and use of tools that allow enterprises to effectively address risks in an integrated way lead to a number of benefits. A workshop on *Integrated Management of Safety, Health, Environment and Quality* (2001) pointed to

the value of developing, implementing and operating IMS for SHE&Q programmes within enterprises and public authorities. As a result, OECD work on development of guidance for the implementation of integrated management of SHE&Q began in 2004; the report will be based on case studies and shared experience. A pilot programme is planned for 2006–2007 to 'test' the draft SHE&Q guidance and get feedback from users so that it can be revised to make it as practical as possible.

Website: http://www.oecd.org/env/accidents

Contact: Marie Chantal Huet

OECD'S WORK ON SAFETY OF NOVEL FOODS AND FEEDS

The OECD's Task Force for the Safety of Novel Foods and Feeds was established in 1999 to promote international harmonisation in the health safety assessment of novel foods and feeds, especially products of modern biotechnology. Delegates to the Task Force are from those ministries and agencies which have responsibility for the safety of transgenic products from a human food and animal feed safety perspective. In addition to the OECD member countries, the Task Force also includes a number of observer delegations from non-member countries.

The main output of the Task Force is its food and feed safety consensus documents. These documents provide information that is important in the health risk assessment of transgenic foods/ feeds. To this end, the documents compile information on the major nutrients, toxicants, anti-nutrients and allergens of specific food crops. During 2004, the Task Force completed its 10th consensus document, which was on barley.

The other major item of the work of the Task Force is a project on the molecular characterisation of genetic sequences inserted into crop plants. The purpose of this project is to explain the scientific basis underlying the application of molecular characterisation to the food, feed and environmental safety assessment of transgenic plants. This project is being carried out in coordination with the Working Group on Harmonisation of Regulatory Oversight in Biotechnology, whose main goal is the environmental biosafety of transgenic organisms.

On 20-22 June 2005, the 10th meeting of the Task Force will be held in Paris. One of the main objects of this meeting will be the discussion on a text of an *Introduction to the Consensus Documents* and a draft *Template for Consensus Documents*. Together, these two texts will explain the uses of the consensus documents as well as the process by which they are developed.

For further information, see *BioTrack Online*: http://www.oecd.org/biotrack.

Contact: Peter Kearns

WORKING AND TECHNICAL PAPERS AVAILABLE AT NO CHARGE

The *OECD Health Working Papers* series is designed to make available to a wide readership health studies prepared for use within the OECD. The series, inaugurated in February 2003, now comprises 20 papers on a wide variety of topics such as health systems reforms, waiting times for elective surgery, private health insurance, health workforce, equity in use of health-care services, consumer choice in long-term care, dementia and pharmacoeconomic assessment.

The *OECD Health Technical Papers* series is designed to disseminate technical studies and statistical analysis presenting new data sources, empirical results and developments in methodology. Although this series was inaugurated only late last year, it already includes 13 country-specific studies on the implementation of the System of Health Accounts, and 5 reports on the development of indicators of health-care quality.

Releases in both series are available for download at no charge at the websites below.

- *OECD Health Working Papers* are available at http://www.oecd.org/els/health/workingpapers
- OECD Health Technical Papers are available at http://www.oecd.org/els/health/technicalpapers

WHO'S WHO IN HEALTH AT THE OECD

Bénédicte CALLAN (STI/BIO)
Biotechnology, Innovation and Health

Marie-Clémence CANAUD (ELS/HD)
OECD Health Data

Pat CHARDOME (ELS)
Secretary to the OECD Group on Health

Francesca COLOMBO (ELS/HD)
Mexican and Swiss health-system reviews

Andrew DEAN (ECO/CS)
Deputy Director, Country Studies Branch, Economics Department
Health issues in *OECD Economic Surveys*

Elizabeth DOCTEUR (ELS/HD)
Deputy Head of Health Division
Pharmaceutical pricing policy

Denis DRECHSLER (DEV/RECH)
Private health insurance in developing countries

Jean-Christophe DUMONT (ELS/NEIM)
International migration

Sean ENNIS (DAF/COMP)
Competition in the health professions
Competition among hospitals

Helen FISHER (PAC/COM)
Media enquiries

Iain GILLESPIE (STI/BIO)
Head of Biotechnology Division

Marie-Chantal HUET (ENV/EHS)
Chemical accidents programme

Jeremy HURST (ELS/HD)
Finnish health-system review

Stéphane JACOBZONE (GOV/REG)
Regulation in the health sector

Johannes JÜTTING (DEV/RECH)
Health and development

Peter KEARNS (ENV/EHS)
Novel foods and feeds

Edward KELLEY (ELS/HD)
Health care quality indicators

Josef KONVITZ (GOV/REG)
Head of Regulation Division
Regulation in the health sector

Gaetan LAFORTUNE (ELS/HD)
OECD Health Data
Disability trends among ageing populations

David MORGAN (ELS/HD)
Health accounts and expenditure data

Eva OROSZ (ELS/HD)
Health accounts and expenditure data

Howard OXLEY (ELS/HD)
Mexican and Swiss health-system reviews

Elettra RONCHI (STI/BIO)
Quality assurance of genetic testing
Pharmacogenomics

Christina SAMPOGNA (STI/BIO)
Intellectual property rights
Patent pools
Human genetic research databases

Pascale SCAPECCHI (ENV/NP)
Economic valuation of children's health
Co-ordination of environment and health policies

Peter SCHERER (ELS/HD)
Head of Health Division
OECD Reviews of Health Systems

Tom SCHULLER (EDU/CERI)
Head of Centre for Educational Research and Innovation
Social outcomes of learning

Kenji TAKEZAWA (STI/BIO)
Human genetic research databases
Biotechnology, innovation and health

Dian TURNHEIM (ENV/EHS)
Mutual acceptance of data in the assessment of chemicals
Principles of good laboratory practice

Drew WAGNER (ENV/EHS)
Test guidelines on toxicity

FUTURE EVENTS ON HEALTH-RELATED TOPICS OR ISSUES

- Expert meeting on Principles for Licensing Genetic Inventions, Berlin, Germany, 27-29 June 2005 (Contact: Christina Sampogna).
- Expert meeting on Principles for Licensing Genetic Inventions, Paris, France, 12-13 September 2005 (Contact: Christina Sampogna).
- The 18th Session of the Working Party on Biotechnology, Paris, France, 26-27 September, 2005.
- The 19th meeting of the Working Group on Human Health-Related Biotechnologies (WG-HHRB), Paris, France, 27-28 September 2005.
- Meeting of OECD Health Data National Correspondents, Paris, France, 28-29 September 2005 (Contact: Gaetan Lafortune).
- The 7th Meeting of Health Accounts Experts and Correspondents for Health Expenditure Data, Paris, France, 29-30 September 2005 (Contact: Eva Orosz).
- Workshop on Out-of-pocket Spending and Private Cost-sharing, 30 September 2005 (Contact: Manfred Huber).
- Roundtable on Competition in Hospital Services, Paris, France, 17 October 2005 (Contact: Sean Ennis).
- Meeting of Experts in the Efficiency of Delivery of Health-Care Services, Paris, France, 17-18 October 2005 (Contact: Howard Oxley).
- Workshop on Pharmacogenomics, Rome, Italy, 17-19 October 2005 (Contact: Elettra Ronchi).
- Expert Meeting on Quality Assurance Molecular Genetic Testing, Rome, Italy, 20 October 2005 (Contact: Elettra Ronchi).
- Meeting of the Health Care Quality Indicators Experts, Paris, France 17-18 November 2005 (Contact: Edward Kelley).
- Meeting of Pharmaceutical Pricing Policy Experts, Paris, France, 1-2 December 2005 (Contact: Elizabeth Docteur).
- The 1st Meeting of the OECD Group on Health, Paris, France, 30-31 January 2006 (Contact: Pat Chardome).

CONTACT

- Elizabeth Docteur
  Editor, *OECD Health Update*
  2 rue André-Pascal
  75775 PARIS Cedex 16
  France
  Tel: (33-1) 45 24 76 03
  Fax: (33-1) 45 24 90 98

  E-mail: Elizabeth.Docteur@oecd.org

MEDIA ENQUIRIES

- Helen Fisher
  OECD, Communications
  2 rue André-Pascal
  75775 PARIS Cedex 16
  France
  Tel: (33-1) 45 24 80 97
  Fax: (33-1) 45 24 94 37

  E-mail: Helen.Fisher@oecd.org

ENDNOTE: A BRIEF GUIDE TO THE OECD

The Organisation for Economic Co-operation and Development (OECD) is an intergovernmental organisation with 30 member countries. Its principal aim is to promote policies for sustainable economic growth and employment, a rising standard of living, and trade liberalisation. By sustainable economic growth the OECD means growth that balances economic, social and environmental considerations.

The OECD is an institution that enables its member countries to discuss and develop both domestic and international policies. It analyses issues, recommends actions, and provides a forum in which countries can compare their experiences, seek answers to common problems, and work to co-ordinate policies.

The Council of OECD is the highest decision-making body of the Organisation. Its members are the Ambassadors of the member countries to OECD. It is chaired by OECD's Secretary-General. Once a year, it meets at the level of Ministers from member countries. Amongst other things, the Council decides on the annual budget of Organisation as well as the content of the programme of work.

In addition to the Council, there are around 200 specialised Committees and other bodies (including Working Parties, Working Groups, and Task Forces), which undertake the Organisation's programme of work. The governments of the member countries nominate the participants to all these groups.

The list below shows the main OECD bodies that have activities related to health:

OECD Council

Committee for Scientific and Technological Policy (CSTP)

- Working Party on Biotechnology
- Working Group on Human-Health-Related Biotechnologies

Economic and Development Review Committee (EDRC)

Economic Policy Committee

- Working Party 1

Environment Policy Committee (EPOC)

- Working Group on Economic Aspects of Biodiversity

Group on Health

- Health Care Quality Indicators Experts
- Health Data National Correspondents
- Health Accounts Experts and Correspondents for Health Expenditure Data

Joint Meeting of the Chemicals Committee and the Working Party on Chemicals, Pesticides and Biotechnology (Joint Meeting)

- Working Group for the Harmonisation of Regulatory Oversight in Biotechnology
- Task Force for the Safety of Novel Foods and Feeds