Health Update

Internal Co-ordination Group for Health (ICGH)

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THE OECD ENLARGEMENT PROCESS AND IMPLICATIONS FOR HEALTH ACTIVITIES

At the OECD Ministerial Meeting in May 2007, the OECD formally launched the process of Enlargement and Enhanced Engagement of OECD. This process reflects the Organisation's intention to strengthen and expand its involvement with emerging new players in the global economy. It also underpins OECD's role as a hub for dialogue on global issues. On Friday 30 November 2007, the OECD Council adopted a road map for the accession of five prospective OECD member countries: Chile, Estonia, Israel, Russia and Slovenia. Five additional countries—Brazil, China, India, Indonesia and South Africa—with significant positions in the world economy have also been identified for enhanced engagement with the OECD. Different OECD bodies have been called upon to examine the positions of each candidate countries and to provide a formal opinion to Council on accession, based on the country's willingness and ability to assume the obligations of membership in their respective field. With regard to health-related activities of prospective members, the OECD Health Committee has been invited to consider the Russian Federation's health system and policies. Accession countries have been invited as *ad hoc* observers to the Health Committee. All candidate countries will also be assessed in their commitment to harmonising their chemical safety policies to protect human health by the Chemicals Committee. In the biotechnology field, the policies and practices of accession countries will be assessed against OECD guidelines and widely accepted best practices by the Working Party on Biotechnologies. Social policies intended to promote social integration and cohesion in candidate countries will also be reviewed by the Employment, Labour and Social Affairs Committee.

INTRODUCTION 2

RELEASE OF OECD HEALTH DATA 2008 2

THE OECD PROJECT ON QUALITY OF CARE CONTINUES TO BREAK NEW GROUND 2

SYSTEM OF HEALTH ACCOUNTS REVISION: IMPROVING THE LINK WITH THE SYSTEM OF NATIONAL ACCOUNTS 3

HOW TO IDENTIFY, MEASURE AND VALUE HOSPITAL PRODUCTS WITHIN A PURCHASING POWER PARITIES FRAMEWORK 3

THE REMUNERATION OF GENERAL PRACTITIONERS AND SPECIALISTS IN 14 OECD COUNTRIES 4

HEALTH PROFESSIONALS' MIGRATION IN NEW ZEALAND 4

PHARMACEUTICAL PRICING POLICIES AND REIMBURSEMENT POLICIES PROJECT – FINAL REPORT 5

RETAIL PHARMACEUTICAL PRICES SURVEY 6

OECD ECONOMIC REVIEWS EXAMINE THE HEALTH SYSTEMS OF DENMARK, GERMANY AND ICELAND 6

HEALTH-SYSTEM EFFICIENCY THROUGH USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES (ICTs) 8

OECD-EC CONFERENCE: IMPROVING HEALTH SYSTEM SUSTAINABILITY THROUGH BETTER VALUE FOR MONEY 8

THE PREVENTION OF LIFESTYLE-RELATED CHRONIC DISEASES 9

MEASURING AND ADDRESSING PRESSURES ON LONG-TERM CARE SYSTEMS 9

SICKNESS AND DISABILITY REVIEWS – AUSTRALIA, LUXEMBOURG, SPAIN AND THE UNITED KINGDOM 10

TASK FORCE ON BIOMEDICINE AND HEALTH INNOVATION 11

KNOWLEDGE MARKETS IN LIFE SCIENCES – APPLICATION TO HEALTH INNOVATION 11

TARGETED THERAPIES AND PERSONALISED MEDICINES—BIOMARKERS AND PHARMACOGENOMICS 12

NANOTECHNOLOGIES AT OECD 12

THE BIOECONOMY TO 2030: DESIGNING A POLICY AGENDA 13

ACCRA HIGH-LEVEL FORUM ON AID EFFECTIVENESS AND HEALTH AS A TRACER SECTOR TO MONITOR PROGRESS 13

FISCAL DECENTRALISATION CHINESE STYLE: GOOD FOR HEALTH OUTCOMES? 14

NEWS ON OTHER ONGOING HEALTH-RELATED PROJECTS 15

ENDNOTE: A BRIEF GUIDE TO THE OECD 17

HEALTH-RELATED OECD PUBLICATIONS 17

OECD HEALTH ONLINE 18

HOW TO SUBSCRIBE TO HEALTH UPDATE 18

WHO'S WHO IN HEALTH AT THE OECD 18

FUTURE EVENTS ON HEALTH ISSUES 20

INTRODUCTION

This newsletter offers up-to-date information on OECD health-related activities. It is mainly intended for OECD delegates who are already familiar with OECD work. We hope that it is also informative for the wider health community.

RELEASE OF OECD HEALTH DATA 2008

The 2008 edition of *OECD Health Data*, the most comprehensive source of comparable statistics on health and health systems across OECD countries, will be released at the end of June 2008. It will include new data on:

- the number of foreign-trained doctors in OECD countries;
- the number of midwives and nurses, including more information on different categories of nurses;
- the incidence of a number of vaccine-preventable diseases (such as measles, pertussis and Hepatitis B), complementing existing series on childhood vaccination rates for these diseases which are part of the health care quality indicators (HCQI) set; and
- the number of elderly people receiving long-term care at home or in institutions.

OECD Health Data 2008 will be available online or on CD-ROM to subscribers of SourceOECD. Access is also provided to all national data correspondents, officials in national governments and other international organisations, upon request. The database can be queried in English, French, German, Italian and Spanish. Japanese and Russian are available exclusively in the online version (www.ecosante.org/oecd.htm).

Website: www.oecd.org/health/healthdata

Upcoming publication:
📖 *OECD Health Data 2008*

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THE OECD PROJECT ON QUALITY OF CARE CONTINUES TO BREAK NEW GROUND

The Health Care Quality Indicators (HCQI) project continues to break new ground by developing internationally comparable indicators in two less developed areas—mental health care and patient experiences of care.

Regarding mental health care, quality assessment activities have progressed to data collection for four selected indicators across 17 participating OECD countries. The indicators are: unplanned readmissions and excess mortality for patients with schizophrenia and for patients with bipolar disorder. This pilot data collection will test the comparability and robustness of these indicators for international comparison purposes. A report on the results of the pilot will be produced and discussed at the next HCQI Mental Health Subgroup meeting in September 2008. This will result in a recommendation to the HCQI Expert Group in November regarding the suitability of the indicators for regular data collection, beginning in 2009. If successful, this will be the first set of indicators of mental health care quality to be regularly reported across OECD countries.

Until recently, the HCQI project has concentrated on developing indicators of the technical quality of care (i.e. clinical effectiveness and safety). In 2007, the HCQI Project commissioned a review of national and cross-national surveys dealing with the measurement of patient experiences, in order to provide the project with baseline information from which to progress work. The review was undertaken by Andrew Garratt, of the Norwegian Knowledge Centre for Health Services.

At the previous meeting of the OECD Health Committee, member countries reaffirmed the need to develop internationally comparable measures of patient experiences of health care. The HCQI project organised a workshop to consider approaches to strengthening measures, sponsored by The Commonwealth Fund and held in New York in March 2008. The workshop invited 12 leaders from the research community and relevant organisations to share their experience. A report based on their discussions and advice will be released soon. This report is a first step in designing a roadmap for patient experiences measurement, and in developing indicators for regular HCQI reporting. A call has been made for countries participating in the project to join a new HCQI Patient Experiences Expert Subgroup. This Subgroup, along with the existing subgroups on Mental Health, Patient Safety and Primary Care and Prevention, will support the development of specific measures and will advise the HCQI Expert Group on their suitability for comparison and regular data collection. The first meeting of the Patient Experiences Expert Subgroup will be via teleconference in May 2008.

Website: www.oecd.org/health/hcqi

Upcoming publications:
📖 *Drösler, S. (2008), Facilitating cross-national comparisons of indicators for patient safety at the health-system level in OECD countries, OECD Health Technical Paper N. 19, Paris.*
📖 *Garratt, A. (2008), "OECD structured review of national and cross-national patient experience surveys".*
📖 *Garcia-Armesto, S. and Medeiros, H. (2008), "Conceptualising quality of mental health care: key issues for measuring and comparing*

across OECD countries", OECD Health Working Paper.

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SYSTEM OF HEALTH ACCOUNTS REVISION: IMPROVING THE LINK WITH THE SYSTEM OF NATIONAL ACCOUNTS

The OECD, Eurostat and World Health Organization (WHO) have agreed to revise the System of Health Accounts (SHA), leading to the publication of a revised SHA Manual (version 2.0).

There is an ongoing debate amongst health accounting experts about how closely linked SHA and the System of National Accounts (SNA) should be. SHA focuses on health expenditure data collected for a number of dimensions with an objective of informing health policy. SNA focuses on the economy as a whole and places emphasis on the importance of the health sector within the overall macroeconomy. However, it seems possible to meet both perspectives and have a close link between SHA and SNA.

The central framework of the SNA has an integrated accounting structure which is exhaustive and consistent within the boundary of the economic activities it covers. The 1993 revision of the SNA extended the boundaries of the central framework to accommodate satellite accounts. These enable focus on certain fields of economic and social life, such as the environment, unpaid household work or the health sector, in the context of national accounts.

There are three important interrelated reasons for linking health statistics to the SNA through a satellite health accounts framework. Firstly, one of the benefits of SNA is the calculation of value added and production. By linking data on the added value generated in the health sector to expenditures on health, the income generated in the health sector (health sector added value as a percent of GDP) and expenditures (consumption of health services and investments in the health sector as a percent of GDP) can be more precisely measured.

Secondly, currently the SHA focuses solely on consumption and financing, while consumption, financing and production are all integral to the SNA approach. Information from production would allow an analysis of the health sector from the supply side, as the structure of intermediate consumption and the remuneration of the production factors are also reported.

Finally, by using SNA features, double-counting in measuring health expenditures can be avoided. This is very important for the health sector, as health expenditures generally do not show up uniquely as household expenditures. Rather, health expenditure is calculated using data on direct payments by households, reimbursements from health insurers, and health providers' services funded indirectly by households, via taxation. The danger of double-counting, particularly if different agents submit different expenditure and receipt data, is large. By covering the entire economy and using data from different data sources and agents, the SNA is an instrument to avoid double-counting and thus deliver more precise measures.

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

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HOW TO IDENTIFY, MEASURE AND VALUE HOSPITAL PRODUCTS WITHIN A PURCHASING POWER PARITIES FRAMEWORK

The 2nd health-specific output-based Purchasing Power Parities (PPPs) Task Force meeting (Paris, 7-8 February 2008) focused on hospital services, due to the proportion of total health costs that are consumed by hospitals and to the lack of market prices for hospital services produced by government. The approach that was agreed with the experts has three main features:

- Hospital output is measured in terms of the volumes and types of activities that hospitals produce (called "case types").
- Data on costs are used to value output because, in general, prices for hospital services are not available or they are not sufficiently representative (i.e., prices cover less than 50% of the cost of production) to be used in the PPP comparison.
- Secondary data sets are used to estimate a unit (average) cost by product.

Under the approach, inpatient case types should be categorised into medical and surgical, the former being those cases for which no operating-room procedure was reported. The following criteria are used for identifying the list of hospital case types in the PPPs context. The case types should: represent common procedures or diagnoses; account for a significant percentage of hospital expenditures; identify cases likely to be admitted to a hospital; represent procedures which are elective and are the principal procedure within one hospitalisation (for surgical case types); and well represent identified conditions without complications and/or co-morbidities (for medical case types).

Using the above criteria, a list of nine medical and twenty-four surgical case types was identified to represent inpatient activity. Moreover, the full absorption cost principle is used. This means that all costs—direct and indirect (overhead)—relating to the provision of the case types are included in the cost calculation. Main practical challenges in the cross-country unit cost comparisons relate to the variation in the inclusion and exclusion of resource items, the variation in overhead cost classification and allocation, and the estimation of capital costs.

There was also agreement on how to move forward with the project. First, the proposed approach will be used with pilot countries to estimate unit cost by case types. Second, the OECD will produce and circulate an interim report on the methodology for deriving costs per product for outpatient clinics and day-care. Third, for non-hospital-based outpatient services (e.g. doctor or dentist consultations), there will be an assessment on a country-by-country basis of what is currently collected in terms of price/cost information. Finally, networks with universities, international organisations, ministries of health and statistical offices working on costing methodologies for health products will be strengthened.

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THE REMUNERATION OF GENERAL PRACTITIONERS AND SPECIALISTS IN 14 OECD COUNTRIES

Ensuring a sufficient number and adequate mix of different categories of doctors is an important concern in all OECD countries. Despite the fact that health systems employ a large and growing number of health professionals, many OECD countries are concerned about current or future shortages of doctors, especially of general practitioners (GPs). Remuneration levels and other aspects of working conditions are important factors in attracting and retaining skilled doctors.

A recent OECD Health Working Paper reviews and analyses the remuneration of doctors in 14 OECD countries for which reasonably comparable data were available in OECD Health Data 2007 (Austria, Canada, Czech Republic, Denmark, Finland, France, Germany, Hungary, Iceland, Luxembourg, Netherlands, Switzerland, United Kingdom and United States). Data are presented for GPs and medical specialists separately, comparing remuneration levels across countries both on the basis of a common currency (US dollar, adjusted for purchasing power parity) and in relation to the average wage of all workers in each country.

The study finds large variations across countries in the remuneration levels of GPs, and even greater variations for specialists. Measured as a ratio to the average wage, the remuneration of GPs varies from being twice greater in Finland and the Czech Republic, to three-and-a-half times greater in the United States and Iceland. The remuneration of specialists varies even more, ranging from one-and-a-half to two times higher than the average wage for salaried specialists in Hungary and the Czech Republic, to five to seven times higher for self-employed specialists in the Netherlands, the United States and Austria.

Some of the variation in remuneration levels across countries may be explained by the use of different remuneration methods (e.g., salaries or fee-for-services for self-employed doctors), by the role of GPs as gatekeepers, by differences in workload (as measured by working time) and by the number of doctors per capita. However, these institutional and supply-side factors cannot explain all of the variations in remuneration levels for GPs and specialists.

When comparing the remuneration of GPs and specialists in each country, this study finds that in nearly all countries, the remuneration of specialists has tended to increase more rapidly than that of GPs over the past decade, thereby widening the income gap. This growing remuneration gap has likely contributed to the rising number and share of specialists in most of these countries over the past decade, resulting in rising concerns about possible shortages of GPs.

Website:www.oecd.org/els/health/workingpapers

Upcoming publication:

📖 *Fujisawa, R. and G. Lafortune (2008), "The Remuneration of General Practitioners and Specialists in 14 OECD countries: What are the factors explaining variations across countries?" OECD Health Working Paper No. 34, OECD, Paris.*

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HEALTH PROFESSIONALS' MIGRATION IN NEW ZEALAND

In New Zealand, the health workforce accounts for 70% of the costs of delivering public health services and represents 5.5% of the workforce. New Zealand also has the highest proportion of migrant doctors and nurses among OECD countries, as well as high emigration rates of health workers, mainly to other OECD countries. The number of New Zealand-born doctors living in other OECD countries represents half the number of foreign-born doctors in New Zealand, while, for

nurses, the relative numbers match.

There is no specific immigration policy to attract health professionals, although it is relatively easy for doctors and nurses who can get their qualification recognised to immigrate in New Zealand. Short-term migration is increasingly used, in particular for doctors. It provides a solution to address workforce shortages in rural areas, but it does not favour retention and, in fact, attrition rates (for doctors) and turnover rates (for nurses) tend to be quite high.

New Zealand trains proportionally fewer medical graduates than the OECD on average. It also has very few foreign medical students. For nurses, the training rate is close to the OECD average, but out-migration, notably to Australia, partly offsets this effort.

To address health workforce-related challenges, a broad portfolio of policies deserves consideration. These would range from improving salaries and working conditions to developing further skill-mix approaches, attracting back health workers who left New Zealand, and reinforcing the links between education and management of the health workforce policies.

Strengthening coordination between the main stakeholders could help to better address short and long-term shortages. To date, immigration has been a very significant part of the supply of health workers in New Zealand. However, a larger number of overseas-trained health professionals might make New Zealand too dependent on immigration, in a context where many other OECD countries are also looking to recruit foreign doctors and nurses.

New Zealand is one of a series of case studies examined as part of the Health Workforce and International Migration Project. Other case studies to be released as OECD Health Working Papers in 2008 include France, Italy, the United Kingdom, the Unites States and Canada.

Website: www.oecd.org/health/workforce

Upcoming publications:

- *Zurn, P. and Dumont, J.C. (2008), "Health Workforce and International Migration. Can New Zealand Compete?" OECD Health Working Paper No. 33.*
- *Health Workforce and International Migration Project—Case studies on Italy, France, the United Kingdom, the United States, Canada, OECD Health Working Papers.*

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PHARMACEUTICAL PRICING POLICIES AND REIMBURSEMENT POLICIES PROJECT – FINAL REPORT

Over the past twenty years, pharmaceutical expenditures have grown faster than GDP and faster than total health expenditures. In 2005, they accounted for 17% of total health expenditure and 1.5% of GDP, on average, in OECD countries. Private financing accounts for 40% of pharmaceutical spending, on average, and the share of out-of-pocket payment is high, compared with other types of services. Though rich countries spend more and have higher drug price levels, per capita income explains only about one sixth of the variability observed in either per capita drug spending or retail price levels, suggesting that ability to pay is not the main determinant of consumption and price levels.

The pharmaceutical industry operates in a global market, with OECD countries accounting for two-thirds of total sales. Pharmaceutical companies launch their products in 10 markets, on average, beginning with those with higher expected profits (high prices and/or high volumes). Japan, Switzerland and the United States are countries with particularly high ex-manufacturer prices for patented medicines. In spite of continuously increasing R&D investment, the level of pharmaceutical innovation has declined significantly since its peak, with incremental innovations being the norm nowadays.

The vast majority of OECD countries regulate the prices of reimbursed drugs or reimbursement amounts, under policies linked with social or public subsidy for pharmaceuticals. They use various techniques, the most widely used being international benchmarking (comparison with prices paid in other countries) and therapeutic benchmarking (comparison with prices paid for existing drugs). Though cost-containment and value for money are shared objectives in most OECD countries, countries seek to ensure returns on investments that are adequate to encourage continued R&D. As a result, they do not always seek to obtain the lowest possible prices.

Comparison of retail pharmaceutical prices with economy-wide price levels gives an indication of the impact of regulation on drug prices; by this standard, retail pharmaceutical prices are relatively high in Switzerland, Mexico, the Slovak Republic, Canada and the United States and relatively low in Australia, France, Sweden and the United Kingdom.

Beyond national considerations, pricing policies may also affect the availability and prices of drugs in other countries. International benchmarking is the practice with the greatest potential impact, particularly when coupled with the threat of parallel or cross-border trade. It encourages

strategic early launch in high-priced countries and limits possibilities for companies to price discriminate between purchasers with different ability or willingness to pay. It is therefore suspected of contributing to a convergence towards the highest list prices. Furthermore, it incites manufacturers and purchasers to agree on confidential discounts which blur transparency.

Techniques used to regulate prices or define reimbursement levels are also likely to influence the orientation of R&D investments. For instance, international benchmarking may encourage product proliferation intended to limit cross-country price comparisons, while the use of so-called reference pricing encourages manufacturers to differentiate their products by demonstrating benefits in relation to products offered by competitors. Though technically challenging and value-laden, the use of pharmaco-economic assessment probably offers the greatest potential in terms of influencing desirable outcomes of R&D investments, by giving signals to manufacturers on what is valued and at what price.

Website: www.oecd.org/health/pharmaceutical

Upcoming publications:

- *OECD, Pharmaceutical Pricing Policies in a Global Market: Ensuring Affordable Access, Promoting Valued Innovation.*
- *Paris, V. and E. Docteur, "Pharmaceutical Pricing and Reimbursement Policies in Germany", OECD Health Working Paper*

Publication:

- *Kaló, Z., Docteur, E. and Moïse, P. (2007), "Pharmaceutical pricing and reimbursement policies in Slovakia", OECD Health Working Paper, No. 31, Paris.*

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RETAIL PHARMACEUTICAL PRICES SURVEY

Within the framework of the Eurostat-OECD Purchasing Power Parities (PPP) Programme, the OECD and Eurostat undertake a survey every three years to evaluate the level of retail pharmaceutical prices in OECD countries. The purpose of the survey is to provide PPPs for pharmaceutical products which will be used as input to the calculation of PPPs for GDP.

The next pharmaceutical survey will be launched in the third quarter of 2008. As in 2005, the list of drugs (around 150) included in the survey will be drawn from top-selling pharmaceuticals in Europe and will consist of a mixture of original drugs and generics. For each product (name, active principle, dosage, package size), reporting countries have to indicate the retail price for a standardised consumption unit. Reported retail prices are to include distribution margins as well as VAT rates. They represent "total costs of pharmaceuticals to the society" and not only the share of the cost paid out-of-pocket by final consumers.

The national institute of statistics in each OECD country will be responsible for reporting retail prices of pharmaceuticals (prices to be collected in November 2008). Results of the survey will be available by the end of 2009. The methodology used to build the list of products to be included in the survey is under development.

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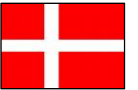
OECD ECONOMIC REVIEWS EXAMINE THE HEALTH SYSTEMS OF DENMARK, GERMANY AND ICELAND

Health issues feature in many Economic Surveys of OECD countries because health is a key element of public expenditure and important for national welfare and economic performance. It has been given a more detailed treatment in the recent surveys of Denmark, Germany and Iceland.



Healthcare enjoys high priority in Denmark: it is the fastest growing area of public spending. This is set to continue with ambitious government plans for more rapid treatment of cancer and cardiovascular diseases and large-scale investments in new hospitals. While the gap in life expectancy with the other Nordic countries, which had widened in the past, is now narrowing, there is room for improving health outcomes. Lifestyle-related factors, for example high alcohol consumption, should warrant more policy attention. At 7.6% of GDP, Danish public spending on healthcare, financed by general taxation, is surpassed only by France, Iceland and Germany. Medical technologies, ageing and income growth will lead to wage pressures and higher service expectations in general. Under these pressures, projections suggest that public spending on health and long-term care measured as a share of GDP could, in the worst case, rise by over 6 percentage points between now and 2050. Three different but potentially complementary strategies would help to respond to the growing demand for healthcare spending, while keeping intact the core elements of the Danish health system, building on universal public coverage in areas where insurance is really needed to ensure access:

- Rebalancing public and private funding slightly differently than today, notably for long-term care. Spending on long-term nursing care as a share of GDP is much higher than in other countries, but 90% of the spending on long-term care is public.

- Strengthening efficiency *via* human resource policies, funding incentives, choice and cost-saving treatment practices. For example, a priority should be to increase average working hours for nurses and develop public health sector pay schemes in line with the private sector.

- Reinforcing the nexus between healthcare and activation measures, thereby reducing the number of people being out of employment due to health problems. For example, prioritise preventive and curative measures to maintain labour market attachment.

In the face of considerable spending pressures stemming from technological and demographic change, Germany needs to reform healthcare financing to make it more efficient and limit the negative impact on employment and growth.

Around 90% of the German population are covered by social health insurance, while the self-employed and high-income individuals can opt in favour of private health insurance instead. The 2007 health care financing reform partially decouples healthcare costs from labour income. In the new financing model, the government sets a uniform rate for all insurers and a central health fund distributes flat premia to insurers, adjusted for the morbidity risk of each member. Health insurance becomes mandatory for all. The OECD Economic Survey of Germany 2008 makes recommendations for further improvements, focusing on four issues.

First, the envisaged gradual increases in budget contributions to the social health insurance system will help reduce non-wage labour costs. The government should reach an agreement on how to finance increasing budget contributions soon, to avoid postponing the implementation of this important reform because of budget pressures.

Second, insurers that cannot cover their costs through the money received from the health fund will have to levy a surcharge on their members. However, the price signal stemming from this surcharge is limited to 1% of members' income subject to contributions and could be strengthened.

Third, the current segmentation of the health insurance system between private and social health insurers raises both equity and efficiency concerns. It is recommended to include private health insurers in the new financing system.

Fourth, the government has introduced greater freedom for insurers in their contractual relations with providers and pharmaceutical companies to allow them to create more product differentiation and enhance competition in the insurance, provider and pharmaceutical markets. The government should monitor closely whether enhanced competition results in the desired outcomes and correct the rules of the game if necessary.

As in the other Nordic countries, all residents of Iceland are covered by public health insurance and health services are mainly paid by the public purse. Hospital treatment is free, although patients face limited co-payments for ambulatory care, most dental care and some pharmaceuticals. Health outcomes are overall quite satisfactory. Icelanders enjoy a good health status as measured by conventional indicators. Life expectancy at birth is the third highest in the OECD. It is the highest for men (79 years in 2005), while for women (83 years in 2005), it is very close to the top. Health-adjusted life expectancy is estimated to be the fourth highest among OECD countries. And self-reported health and quality of life are also perceived as high. While lifestyle is an important determinant of this good health status, the high quality of health care services by international comparison also plays an important role. Income-related health inequality appears to be smaller than in most other countries. However, the health-care system is costly. Health expenditure accounts for 9.5% of GDP (2005) and, since the second half of the 1980s, it has exceeded the OECD average. According to OECD estimates, public expenditure on health and long-term care could reach 15% of GDP by 2050 if no restraining measures are taken.

The 2007 Economic Survey of Iceland devoted a chapter to the challenge of raising cost-effectiveness and spending efficiency more generally. It argued in favour of removing impediments to private provision and open up the health sector to competition. The chapter suggests introducing cost-sharing where it does not exist (as in hospitals), recognizing that concerns about equity need to be taken into account. Such measures would relieve the burden on public finances, as would the introduction of spending ceilings, cost-efficiency analysis and activity-based funding arrangements. The high cost of pharmaceuticals should be reduced by promoting competition and the use of inexpensive generic drugs.

Publications:

- OECD Economic Survey of Denmark, February 2008.
- OECD Economic Survey of Iceland, February 2008.
- OECD Economic Survey of Germany, April 2008.

Website:

www.oecd.org/eco/surveys/denmark
www.oecd.org/eco/surveys/germany
www.oecd.org/eco/surveys/iceland

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HEALTH-SYSTEM EFFICIENCY THROUGH USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES (ICTs)

The aim of this project is to provide OECD governments with advice in relation to the range of policy options, conditions and practices that can influence the implementation and adoption of ICTs for achieving efficiency improvements in the health sector.

The project involves two work streams to describe and assess: i) the indicators for monitoring and benchmarking the use and adoption of ICTs; and ii) drivers and incentives for ICT adoption within the health sector. It will analyse, through case studies, what new policy frameworks, partnership models, and organizational changes are emerging to overcome barriers to adoption and enable effective implementation and use of ICTs.

In the past six months, activity on the project has focused on two objectives. The first was to collect information on how OECD countries were monitoring and evaluating heath ICTs , specifically on surveys or data collections that were considered useful from a policy perspective, determine what the information needs are and the most common indicators used today. For this purpose, the OECD Secretariat circulated in 2007 a brief questionnaire to Member countries. Six countries completed the questionnaire (Australia, Canada, Finland, Norway, Spain and Sweden). Relevant information was also obtained on measurement activities in the United States and at European Commission (EC) level.

A range of approaches, methodologies and definitions have been adopted in the surveys reported by countries. The most common strategy is to run stand-alone surveys of GPs and medical practices. Questions of access and use of ICTs by GPs have been an early priority for statistical measurement across all OECD countries. All surveys included, for example, indicators about the use of computers for administrative or clerical functions. Most surveys also include indicators on the use of specific functions or applications such as the use of electronic health records or of electronic prescribing. A majority of the respondent countries have turned to the more difficult task of monitoring incentives and barriers, particularly as they relate to finance issues, availability of training, concerns about privacy and liability.

The second objective was to undertake case studies on barriers to, and incentives for, ICT adoption and use. Nine countries have submitted proposals, and work on three case studies is currently in progress. These case studies examine implementation of electronic patient summaries (Netherlands), electronic medical records including chronic diseases management tools (British Columbia, Canada), and an integrated province-wide electronic system that links physician's offices and other points of care to patient information (Alberta, Canada).

Preliminary findings from the case studies and results from the questionnaire were discussed at the 2nd meeting of health ICT experts, held in Paris on March 26-28. The meeting also reviewed relevant examples of survey work across OECD countries and the definitions and indicators used to date, pointing to priorities and future directions in which OECD might help to take this work forward in concert with the World Health Organization and the European Commission.

Website: www.oecd.org/health/ICT

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OECD-EC CONFERENCE: IMPROVING HEALTH SYSTEM SUSTAINABILITY THROUGH BETTER VALUE FOR MONEY

A combined OECD/European Commission (EC) conference on "Improving health system sustainability through better value for money" will be held in Brussels on 17 September 2008. The key policy question for this conference is how health systems can improve efficiency of resource use and, thereby, help ensure the financial sustainability of health care systems.

Member states of the OECD and of the EU have highlighted the need for better value for money in health systems during the deliberations of the OECD Health Committee and in the context of the EU's Open Method of Coordination (OMC). Health systems are coming under pressure due to rising expectations for access to quality care in a context of population ageing and rapid technological change. Both organisations have emphasised a range of policies that could encourage more rational resource use in health systems.

The key objective of this conference is to help identify policies and conditions that may lead to better use of health sector resources. This work should help nourish policy analysis in Member States, as well as within the Social Protection Committee (SPC) of the EU and the Health Committee of the OECD.

The main areas for discussion include: current and expected future costs of health care systems; lessons from the use of market-type mechanisms; the scope for efficiency gains through improved

care coordination; the role of user charges and cost-sharing; the need for better information and the role of ICTs; and, getting better value for money from pharmaceuticals.

The conference will be open to delegates from member countries of the two Organisations.

Contact: Howard Oxley

THE PREVENTION OF LIFESTYLE-RELATED CHRONIC DISEASES

A new Health Working Paper published in March 2008 provides an economic perspective on the prevention of chronic diseases, focusing in particular on diseases linked to lifestyle choices. The proposed economic framework is based on the hypothesis that the prevention of chronic diseases provides a means for increasing social welfare or enhancing health equity, in contrast to a situation in which chronic diseases are simply treated once they emerge.

Understanding the pathways through which chronic diseases arise requires an assessment of the determinants of those diseases, as well their interactions, over the life-course of individuals. Lifestyle choices have been shown to be closely associated with a significant portion of the morbidity and mortality generated by chronic diseases. These choices play a central role not only because of their direct influence on health, but also because they mediate some of the effects of other health determinants.

Justification for preventive action is guided by whether the determinants of chronic diseases are simply the outcome of rational choices made in the context of efficient markets or, alternatively, are the effect of market failures and rationality failures preventing individuals from achieving the best possible outcomes. Where such failures exist, preventive interventions can educate and inform choices, and redress poor health outcomes. Interventions that are least intrusive are those that expand the range of options from which individuals can choose, that encourage personal responsibility and self-control, or that aim at making existing options more affordable. Persuasion, information and other non-price devices are often advocated as minimally intrusive interventions which do not significantly affect rational consumers. Other methods, such as taxes and consumption bans, involve higher degrees of interference with individual choice. There is also the risk of government failure associated with attempts to influence corrective failures, as well as rent-seeking.

The evaluation of preventive interventions requires the adoption of an assessment model. This model must capture the impact on both overall social welfare and on the distribution of health across population groups. The assessment model must be relevant to policies developed across a wide variety of government departments, while at the same time producing results that may be comparable with those of evaluations conducted within specific sectors (e.g. health care) when preventive interventions compete for resources from departmental budgets.

The economic framework set out in the paper will help identify opportunities for preventive action with a view to improving individual and social welfare. It will also help in understanding and addressing the potential conflict between increasing overall welfare and improving health equity.

Website: www.oecd.org/health/prevention

Publication:

📖 *Sassi, F. and Hurst, J. (2008), "The Prevention of Lifestyle-Related Chronic Diseases: an Economic Framework", OECD Health Working Paper No. 32, Paris.*

Contact: Franco Sassi

MEASURING AND ADDRESSING PRESSURES ON LONG-TERM CARE SYSTEMS

Several on-going data and analytical activities of the OECD Health Division focus on long-term care (LTC) systems.

Strengthening data on LTC systems is a first priority, involving different work streams. Data on the number of people receiving long-term care at home and in institutions have become part of the regular data collection of OECD *Health Data*. A pilot collection of data on LTC workers (including formal and informal caregivers) was also launched in March 2008 with 17 participating OECD countries. Results from this pilot data collection will be assessed in terms of data quality, comparability and completeness during the second quarter of 2008.

Another major activity is to define the boundary between health and social expenditure in total LTC expenditure. The aim is to enable countries to develop a robust data framework and ensure both comparable and consistent international data reporting. A report "*Conceptual Framework And Methods For Analysis Of Data Sources For Long-Term Care Expenditure*" was completed for the European Commission in late 2007. The report sets out approaches to separate LTC expenditure into its health and social components. It makes recommendations taking into account limitations faced by countries as well as country views on data availabilities and methods for compiling LTC data. The recommended delineation between long-

term *health* care and long-term *social* care is based on the intensity of care of the services received, using a well-known division based on help with two types of restrictions. The first is help with Activities of Daily Living (ADL), restrictions on which curtail independence with personal care activities such as washing and eating. Because these restrictions require complex care, often performed by or supervised by nurses, they are considered as health services. The second type of LTC service is help with Instrumental Activities of Daily Living (IADL). IADL restrictions limit the capacity of an aged or disabled person to function normally within their home or community (e.g. do shopping, household finances and cleaning). Assistance with these functions is considered as social services.

A third stream of work on LTC is a review of policies in the area of healthy ageing. A health working paper is due for release in summer 2008. The paper defines the concept of healthy ageing and similar concepts – such as "active ageing". It then identifies four different groups of policies: i) working longer and promoting social integration; ii) improving lifestyles; iii) adapting health care systems to the needs of the elderly; and iv) attacking underlying social/environmental factors affecting healthy ageing. The paper describes the range of available programmes, largely those within the ambit of health ministries. Available information on cost-effectiveness is assessed, although the lack of studies on the impact of these programmes hampers policy evaluation. The paper draws on two important reviews prepared for the European Union (Walters *et al*., 1999 and Swedish National Institute of Public Health, 2007) that provide a framework for assessing healthy ageing and offer an extensive literature search of this subject.

Finally, country reviews of LTC, to be jointly undertaken by the OECD Health and Social Policy Divisions, are due to commence in the fourth quarter of 2008 under the auspices of the Health Committee and the Working Party on Social Policy. Preparatory work to identify participating countries, raise funds, and refine the scope and calendar of the reviews is underway. The reviews will build on past OECD work on long-term care, the on-going activities described above, and a paper highlighting policy challenges in relation to LTC workforce, including the significant role of migrant caregivers, is also in preparation. By assessing recent reforms and innovative policies or country responses, the reviews will analyse the performance of LTC systems and assess their contribution in avoiding old-age poverty and the impact on the labour market, amongst others.

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

Upcoming publications

- *Conceptual Framework And Methods For Analysis Of Data Sources For Long-Term Care Expenditure.*
- *Healthy Ageing—A Policy Assessment*

Contacts: Francesca Colombo (Long-term care)
Sandra Hopkins (Accounting for LTC expenditure)
Howard Oxley (Healthy Ageing)

SICKNESS AND DISABILITY REVIEWS – AUSTRALIA, LUXEMBOURG, SPAIN AND THE UNITED KINGDOM

This is the second report in the OECD series "Sickness, Disability and Work" analyses. The series addresses the problem faced by many OECD countries of disability benefits having become a benefit of last resort, i.e., a benefit for those people of working age unable to succeed in the labour market but not eligible for work-tested unemployment and social assistance benefits. Pressure on sickness and disability schemes has increased due to the tightening of unemployment schemes, the phasing out of early retirement options, and the increase in labour market demands.

Each of the four countries covered in this report faces different challenges. In Australia, many of the people claiming disability benefits were long-term unemployed. In Luxembourg, claiming a disability benefit often precedes early retirement. In Spain, co-ordination between the decentralised employment services and the centralised social insurance institution is a key challenge. The United Kingdom is dealing with a sharp increase in claims for mental and behavioural illnesses. The report puts forward a range of reform recommendations to help deal with the specific challenges facing each country.

Experiences in the four countries offer some lessons on how to reduce increasing claims for sickness and disability benefits. Good sickness management of workers and the unemployed is important, as is encouraging the transition into employment through well-timed, targeted and accessible support schemes. The report highlights some important reforms. These include the tight monitoring of sickness absences in Luxembourg and Spain, a developed work-capacity assessment in Australia and the United Kingdom, a new approach for people with partial work capacity in Australia and Luxembourg, and new funding mechanisms for employment and rehabilitation programmes in Australia and the United Kingdom. Each of these has the potential to improve current poor outcomes.

The third report in this series, to be published in

late 2008, will cover Denmark, Finland, Ireland and the Netherlands. Lessons learned from the reviewed countries will be discussed at a High-Level policy forum in Stockholm in spring 2009 and will also be published in a synthesis report.

Website: www.oecd.org/els/disability

Recent publication:

📖 *Sickness, Disability and Work: Breaking the Barriers (Vol. 2). Australia, Luxembourg, Spain and the United Kingdom.*

Contact: Christopher Prinz

TASK FORCE ON BIOMEDICINE AND HEALTH INNOVATION

At the 2007 meeting of the OECD Council at Ministerial-level (MCM), Ministers endorsed a mandate for the OECD to develop an OECD Innovation Strategy. Innovation is increasingly acknowledged as the main driver of sustainable growth, productivity, and wealth creation. Thus, governments have a strong stake in setting up conditions that encourage it. But the nature of innovation is changing – due to globalisation, the spread of ICTs and improved connectivity, new forms of networking and competition, changing finance and business models, and changing human capital skills and needs. So policies that have stood OECD countries in good stead in the past may not meet the opportunities and challenges of today and tomorrow.

The OECD Innovation Strategy is a horizontal project which will last until 2010. It aims to provide countries with a more comprehensive, coherent, and timely understanding of trends in innovation and to provide tools they need to promote, to measure and assess innovation and the underlying dynamics of change. The Strategy focuses on positioning government, businesses, and consumers to anticipate and participate in "what's next". This includes understanding why some firms, regions, and countries succeeded in harnessing the power of innovation while others have not. Finally, it will also explore how innovation might be better leveraged to address global challenges, including health.

The Working Party on Biotechnology sees the OECD Innovation Strategy as an excellent opportunity to synthesize the health-related biotechnology studies and policy recommendations produced over the past several years, about how to create an environment that is supportive of health innovation, facilitates access to innovations so that they best serve the public good, and includes a receptive end-market for innovations. Indeed, innovation in biotechnology and related health fields has been reacting to and shaping many of the forces identified above.

The first task of the new Task Force on Biomedicine and Health Innovation is to develop a synthesis report: a simple, concise summary of the main policy messages to be communicated in the Innovation Strategy. The Task Force has identified five issues it will tackle: (1) access to knowledge and intellectual property; (2) new business models and the fusion and exchange of knowledge; (3) the governance of new infrastructures; (4) the demand and take up of health innovations; and (5) the impacts of new technologies on policy. The Task Force met in February 2008 and will meet again in June 2008 to discuss what messages it would like to see included about the essential conditions for generating health-related innovations in biotechnology. Completion of the synthesis report is expected at the end of 2008.

Contact: Bénédicte Callan

KNOWLEDGE MARKETS IN LIFE SCIENCES – APPLICATION TO HEALTH INNOVATION

Knowledge markets encompass a number of different mechanisms where buyers and sellers trade a variety of knowledge-intensive goods and services. Knowledge markets can include infrastructures networking, matching or brokering services; clearing houses; auctions; and pools and exchanges. These are mechanisms for better identifying, accessing, exploiting, and creating value from existing intellectual assets.

There is increasing interest in applying the concept of knowledge markets to the life sciences. Enormous amounts of data, information and knowledge are created throughout the health innovation cycle, much of which remains privately held. In isolation, the information may not be of great value or the producer may not be fully able to exploit it. But in combination with other information, it could arguably have greater value and strategic impact. Proprietary information that may have lost value for the owner over time might provide valuable insights to other companies that are pursuing different research tracks, helping them to avoid similar pitfalls (and thus not waste resources) or redirecting them toward goals that were formerly unrealizable. Knowledge markets could also serve the needs of companies when meeting regulatory requirements — for example, by enabling them to avoid the costs of conducting repetitive clinical and preclinical tests.

A workshop on the application of knowledge markets to health innovations will be held on 16-17 October 2008 in Washington, DC. The Workshop will explore what benefits knowledge markets could bring to drug development, health innovation and health outcomes. It will identify the types of data, knowledge and know-how that

can create added value when traded and the mechanisms by which such exchanges could be realised. It will discuss the difficulties of developing knowledge markets in the life sciences, the existing pressures and initiatives that are driving their creation, as well as the facilitating role that public policy may have.

This work is an outgrowth of an earlier project whose policy report, *Emerging Research Models for the Delivery of Health Innovation*, will be available in the third quarter of 2008. The report explores the major elements (tools, practices, incentive structures) underpinning new models or approaches to organising health innovation in both the public and private sector, in order to improve the efficiency with which laboratory discoveries are translated into new medical treatments.

Contacts: Bénédicte Callan
Ruth Krestin

TARGETED THERAPIES AND PERSONALISED MEDICINES—BIOMARKERS AND PHARMACOGENOMICS

Scientific advances in biotechnology are ushering in a new era of medicine: targeted therapies and personalized medicine are coming of age. Whereas traditional medicine manages a disease through standard treatments, without taking account of existing variability between individuals or groups of population, personalized medicine seeks to adapt treatments to the profile of each individual. And biomarkers are key to making this transition possible.

A biomarker is a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a therapeutic intervention. Many safe and effective biomarkers already exist. There is a great deal of interest in the research and industrial communities to develop and validate new biomarkers that can help deliver safer and more effective drugs and diagnostics to patients.

A Report on *Pharmacogenetics: Opportunities and Challenges for Health Innovation and Care* will be available in the third quarter of 2008. The report looks at the emergence of genetic biomarkers which have gained importance with the sequencing of the human genome. This report reviews the impact to date of pharmacogenetics on research, pharmaceutical R&D and clinical care and discusses the challenges to further uptake and diffusion. It concludes that the widespread adoption of pharmacogenetics is not yet guaranteed and that governments have a role to play in creating an "enabling" environment.

Indeed, despite the growing enthusiasm for biomarkers and the large number and types of actors involved in developing them, biomarker identification, validation, regulation and use in drug discovery and medical testing, is still in its early stages. In 2008, the OECD Secretariat and a steering group of country experts are developing a number of analytical papers that address some key policy issues in the development and uptake of biomarkers. These papers will touch on:

(1) An introduction to the impact and policy implications of biomarkers.

(2) Challenges in the evaluation and validation of biomarkers for clinical use.

(3) Strategies for evidence creation and knowledge sharing around biomarker data.

(4) Biomarker business models.

An expert workshop will be held an 6-7 October 2008 to discuss the analytical papers and their policy recommendations. A policy report based on the papers and the workshop discussion is planned for delivery before the end of 2008.

Contacts: Marie-Ange Baucher
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NANOTECHNOLOGIES AT OECD

The OECD has two fora for activities related to nanotechnologies: i) the Working Party on Manufactured Nanomaterials; and ii) the Working Party on Nanotechnology. These co-ordinated and mutually supporting efforts are intended to provide the conditions for optimal development of this range of new technologies.

OECD's Working Party on Manufactured Nanomaterials (WPMN)

The WPMN was established in 2006 by OECD's Chemicals Committee. The objective is to promote international co-operation in human-health and environmental-safety-related aspects of manufactured nanomaterials (MN), to assist in the development of rigorous safety evaluation of nanomaterials. The work is being implemented through eight projects listed below:

- Development of a Database on Human Health and Environmental Safety Research;
- Research Strategies on Manufactured Nanomaterials;
- Safety Testing of a Representative Set of Manufactured Nanomaterials;
- Manufactured Nanomaterials and Test Guidelines;

- Co-operation on Voluntary Schemes and Regulatory Programmes;
- Co-operation on Risk Assessment;
- The role of Alternative Methods in Nanotoxicology;
- Exposure Measurement and Exposure Mitigation.

OECD's Working Party on Nanotechnology (WPN)

The WPN was established by OECD's Committee for Science and Technology Policy in 2007, with the objective of advising on emerging policy-relevant issues in science, technology, and innovation related to the responsible development of nanotechnology. The WPN seeks to promote international co-operation that facilitates research, development, and the responsible utilisation and commercialization of nanotechnology. Currently, the WPN has six projects underway:

- Statistics and measurement;
- Impacts and the business environment;
- International R&D collaboration;
- Communication and public engagement;
- Policy dialogue;
- Global challenges: Nano and Water.

Website: www.oecd.org/env/nanosafety
www.oecd.org/sti/nano

Contact: Peter Kearns

THE BIOECONOMY TO 2030: DESIGNING A POLICY AGENDA

The bioeconomy is the set of economic activities relating to the invention, development, production and use of biological products and processes. The project 'The Bioeconomy to 2030' by the International Futures Programme (IFP) of the OECD is analysing key long-term trends to help governments map strategies for the bioeconomy in agriculture, health, and industry.

Biotechnology in the health sector, without major structural changes, appears poised to continue delivering incremental changes through to at least 2015, if not to 2030. This is based on the preliminary analysis of global clinical trials which indicate an average of 15 new biopharmaceuticals arriving on the market annually to 2015. While biopharmaceuticals have historically offered a significant therapeutic advantage over small-molecule therapeutics, they will continue to account for a relatively small share (less than 15%) of all new pharmaceuticals. Despite this, by 2030, biotechnological knowledge will be so pervasive, for example for the identification of drug targets, that all new therapies could be based in part on biotechnology.

There is some reason for higher expectations, however, as the development of key elements of health biotechnologies that could lead to more effective and personalized medicines are moving in the right direction. The number of diagnostic tests, gene-drug interactions, and submissions of pharmacogenetic information to regulatory authorities are increasing, while at the same time genome sequencing costs are decreasing. Even if as expected, these technology trajectories continue into the future, major challenges remain. These technologies need to be linked together into a system where information about an individual's genome and validated biomarkers can be translated into treatment. And even if this occurs, costs could be prohibitive. For example, long and expensive clinical trials may be necessary to validate biomarkers. This could also lead, since the benefits of personalized medicines are not likely to appear immediately, to two parallel health systems with their associated cost burdens.

These preliminary results are based on contributions from the project's Steering Group, external expert reports, in-house research, and other OECD departments including the Environment Directorate, the Directorate for Science, Technology and Industry's Biotechnology Division, and the Directorate for Trade and Agriculture. The Project Team is currently preparing a draft final report that will be discussed by the project's Steering Group in June 2008. The final report will be publicly available in early 2009.

Website: www.oecd.org/futures/bioeconomy

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ACCRA HIGH-LEVEL FORUM ON AID EFFECTIVENESS AND HEALTH AS A TRACER SECTOR TO MONITOR PROGRESS

In the lead up to the third High-Level Forum (HLF 3) to take place on 2-4 September 2008 in Accra, the OECD Development Cooperation Directorate (DCD) continues to monitor the contribution of the health sector and Aid Effectiveness agenda.

Chapter 3 of the recently launched Development Cooperation Report (DCR) 2007 looks at Aid Effectiveness and Health. The report acknowledges the continuous progress in this area. This includes:

- The renewed interest and investment in health systems strengthening, and better aligning with country health priorities;

- Progress in harmonisation and alignment of aid (Country Harmonisation and Alignment Tool in HIV/AIDS);
- An increased focus on managing for results and results-based financing through the Health Metrics Network (HMN) and Global Campaign for Millennium Development Goals 4 and 5;
- Emerging compacts for mutual accountability in a set of countries;
- Better harmonisation at global level (informal group of the Heads of the 8 Health agencies and the International Health Partnership).

But the report also suggests that more progress is needed, in particular in order to: i) Harmonise ongoing efforts to strengthen health systems; ii) Track results and progress in a rigorous way; iii) Change behaviour at global and country levels; iv) Ensure country ownership; and v) Address the specific situations of countries in fragile situations.

Three main aspects of the preparation process for the Accra meeting are especially relevant to the heath sector.

First, a Task Team on Health as a tracer sector (including representatives from partner countries, bilateral donors, Civil Society Organizations and multilateral organisations and Global Programs) has just been formalized. It will guide the preparatory work to Accra through the contribution to the roundtable discussion and to the report on Aid Effectiveness and Health (see below).

Second, one roundtable at the HLF will look at the health sector application of the Paris Declaration on Aid Effectiveness, building on lessons and remaining challenges in health. This session will focus on the lessons learned from applying System-Wide Approaches (SWAps) or Programme-Based Approaches in various sectors, including health.

Third, a progress report on Aid Effectiveness and Health will consolidate all ongoing efforts and initiatives. This report will provide concrete examples of the current challenges at country level (ongoing country studies) and global level (a review of Overseas Development Assistance on Health in the past 20 years and one study on the donor constraints in providing long-term health aid). It will also report about results from countries which have been able to set up compacts for mutual accountability with donors, based on long-term planned and funded health strategies. Finally, it should provide clear messages and illustrations from health in the six priority areas identified by partner countries (predictability, untying, division of labour, capacity building, conditionality and incentives).

OECD DCD has been and will remain engaged in various meetings to ensure that the work on health as a tracer sector benefits to and from related processes. Examples include participation in meetings on health systems, global programs, the International Heath Partnership (IHP) initiative in Africa, and NGO workshops on aid effectiveness and health.

Website: www.oecd.org/dac/effectiveness

Publications:

- 📖 *OECD (2007),* Development Cooperation Report, Paris.
- 📖 *TORs of the Task Team on Health as a Tracer Sector and outline of the Report on Aid Effectiveness and Health (available upon request)*

Contact: Elisabeth Sandor

FISCAL DECENTRALISATION CHINESE STYLE: GOOD FOR HEALTH OUTCOMES?

Improving access to affordable health care is one of the main challenges facing policy makers in developing countries, and China is no exception. President Hu Jintao has proclaimed that policies should foster a "harmonious society", but the economic consequences of illness—in rural China in particular—pose a serious obstacle to reaching this objective. Medical costs undermine the health of millions of Chinese by forcing them to pay expenses out-of-pocket in the hope of future earnings, to delay treatment or else to forego it altogether. To cope with this immense challenge, the Chinese government has introduced various institutional innovations—most recently the "new rural type co-operative medical care"—while reforming the administration and governance of social programmes and investment. The Chinese experience is very interesting in that it stands apart from most other countries: while considerable fiscal decentralisation has been undertaken on the expenditure side, the revenue side has been recentralized since a major reform in 1994.

Fiscal decentralisation, Chinese style, deviates substantially from the classical textbook scenario provided in fiscal federalism theory. More decentralised provinces perform better with respect to health outcomes if two conditions are met: first, if a functioning transfer system is established between the province and county levels, and second, if county governments' own fiscal capacity is strengthened. An equally important challenge is to combine fiscal decentralisation with health-sector financing reforms in such a way that out-of-pocket payments are reduced and access to health-care services is improved. This is an important topic for further research. A better understanding of the

factors that could help to improve health-care delivery in China will be a crucial determinant of China's progress towards a harmonious society. Currently, many citizens, particularly in poor and remote areas, are still deprived of access to basic social services.

Website: www.oecd.org/dev/wp

Publication:

📖 *Hiroko Uchimura, H. and Jütting, J. (2007), Fiscal Decentralisation, Chinese Style: Good for Health Outcomes? Working Paper No. 264, OECD Development Centre*

Contact: Johannes Jütting

NEWS ON OTHER ONGOING HEALTH-RELATED PROJECTS

This section lists *other* on-going health-related projects, as well as reports published since the November 2007 issue of this newsletter.

OECD HEALTH DIVISION

OECD-World Bank Review of the Turkish health system

The Turkish Ministry of Health has asked the OECD and the World Bank to carry out a joint review of the Turkish Health System during 2008. Turkey is in the middle of a major modernisation of its health system under the so-called 'Health Transformation Program' which was launched in 2003. As with previous OECD reviews of health systems, the project will assess the recent performance of the Turkish health system against efficiency and equity goals. It will also identify the remaining challenges facing the system before making recommendations for the future.

Website: www.oecd.org/health/reviews

Contact: Jeremy Hurst

Relevant publications since November 2007

📖 *Hofmarcher, M. and Oxley, H. (2007), "Improved health system performance through better Care Coordination", OECD Health Working Paper No. 30, Paris.*

Learn about other analytical projects (at www.oecd.org/health/analyticalprojects) and data projects (at www.oecd.org/health/dataprojects) of the OECD Health Division.

EMPLOYMENT AND LABOUR

Mental health and the workplace

The project provides a comparative assessment of the impact of work status and working conditions on mental health among the working-age population. The results of the study will be published as part of the OECD *Employment Outlook* in June 2008.

Website: www.oecd.org/employment/outlook

Contact: Ana Llena Nozal

SCIENCE AND TECHNOLOGY

The Biotechnology Division is involved in several health-related projects under the work streams of *Biotechnology, Innovation and Health; Genetics and Genomics;* and *Intellectual Property*. Information on these activities is available on www.oecd.org/sti/biotechnology.

Public Consultations on Guidelines for Human Biobanks and Genetic Research Databases

The completion of the mapping of the human genome under the Human Genome Project has opened huge potential for research into genetic and environmental factors that influence disease risk and treatment. The vast amount of data generated is being compiled in human biobanks and genetic research databases. The OECD is developing guidelines for addressing issues arising in the establishment, governance, management and use of Human Biobanks and Genetic Research Databases. Public comments on the draft guidelines are invited until 16th May 2008. The guidelines will be finalised in early 2009.

Website: www.oecd.org/sti/biotechnology

Publication:

📖 *Creation and Governance of Human Genetic Research Databases, Paris: OECD, 2006*

Contact: Christina Sampogna

Guidelines on Quality Assurance in Molecular Genetic Testing

The guidelines, adopted by the OECD Council in 2007, focus on the provision of clinical genetic services, in particular on: quality assurance systems for the tests offered, result reporting requirements, proficiency testing of laboratories performing tests, and the education and training standards for laboratory personnel. The guidelines concern molecular genetic testing offered in a clinical context for the diagnosis of a particular disease or condition and for predictive screening before any clinical signs of a disease or condition

appear. They are relevant to pharmacogenetic tests, which predict the response profile of an individual to a drug or course of therapy. However, they do not address testing carried out only for research purposes. The guidelines are available on the web (in English, French and Japanese, a Spanish version is forthcoming).

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

Contact: Bénédicte Callan

Uptake and Diffusion of Health-Related Biotechnology

This analytical report, to become available in summer 2008, identifies the range of incentives and barriers affecting the uptake into the health care sector of health biotechnologies. Case studies were chosen to illustrate technologies that differ in their stage of development, the type of health products, and in terms of their convergence with other technologies. The case studies discussed are: monoclonal antibody therapeutics; molecular diagnostics and genetic testing, DNA micro-arrays; and the convergence of bio- and nano-technologies in devices and therapeutics.

Contact: Bénédicte Callan

Counterfeiting and Piracy of Pharmaceuticals

Counterfeiting and piracy of pharmaceutical products is an opportunistic crime endangering the lives of patients and consumers around the world. This report, in publication, examines the nature of counterfeiting and piracy activities from the health and safety, public security, business and intellectual property perspectives. It provides a detailed review of the nature of counterfeiting activities (e.g., active pharmaceutical ingredients, finished products, packaging); examines the magnitude of counterfeiting activities on a global and regional basis; analyses the impacts on patients/consumers, the private sector and governments; assesses the manner in which this activity is carried out; and examines the numerous measures for combating counterfeiting (public communication/education, legislative/ regulatory mechanisms, technology, enforcement, securing supply/distribution chain, international cooperation, etc).

Contact: Christina Sampogna

High-Level Forum on Medicines for Neglected and Emerging Infectious Diseases

This summary report will be available in the third quarter of 2008. The High-Level Forum (HLF) addressed how to overcome the dearth of new treatments and preventive technologies which are necessary to tackle the major infectious diseases of the developing world. The report will cover the HLF and preparatory workshop discussions, as well as include the recommendations identified in the Noordwijk Medicines Agenda for creating a coherent policy environment for innovation and improving the incentives companies face for investing in the development of medicines for neglected and emerging infectious diseases. The report will be published as part of the Development Dimension series.

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

Contact: Benedicte Callan

THE ECONOMICS DEPARTMENT

Relevant publications since November 2007

📖 *Economic survey of Chile 2007: Delivering cost-efficient public services in health care, education and housing.*
www.oecd.org/eco/surveys/chile

Contacts: Luiz de Mello
Diego Moccero

ENVIRONMENT DIRECTORATE

Health Activities by the Environment, Health and Safety Programme

The Environment, Health and Safety Programme has several activities related to the impact on health. An update on main events, activities, and new publications is given regularly in the newsletter ***Environment, Health and Safety News***, available at the Chemical Safety portal (www.oecd.org/env/health) and the Health portal (www.oecd.org/health). Beside the activities related to nanotechnologies, readers of Health Update would be interested in:

- *Safety of novel foods and feeds* (Contact: Mar Gonzalez; website: www.oecd.org/biotrack)

- *Health-related chemical testing* (Contact: Laurence Musset; website: www.oecd.org/env/testguidelines)

Valuation of environment-related health impacts with a focus on children.

Work on the valuation of children's health includes country surveys, based on a willingness-to-pay approach, to estimate the health benefits associated with the reduction of a specific environmental risk factor. The surveys will be implemented in late 2008.

Website:
www.oecd.org/env/social/envhealth/verhi

Recent publications

📖 *Health and the Environment – OECD Policy Brief – February 2008.* *www.oecd.org/dataoecd/38/18/40396531.pdf*

Contacts: Pascale Scapecchi
Nick Johnstone

2008 OECD Environmental Outlook

The 2008 OECD Environmental Outlook is a pathbreaking report that marries economic and environmental projections for the next few decades and simulates specific policies to address the key challenges. It identifies four priority areas where urgent action is needed: climate change, biodiversity loss, water scarcity and the impact on human health of pollution and toxic chemicals. The next edition of health update will include a piece on this major report, with a focus on human health impact.

Website:
www.oecd.org/environment/outlookto2030

Recent publications

📖 *OECD Environmental Outlook to 2030.* *www.oecd.org/environment/outlookto2030*

Contact: Helen Mountford

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. Sustainable economic growth balances economic, social and environmental considerations.

OECD member countries discuss and develop both domestic and international policies. The organisation analyses issues, recommends actions, and provides a forum for countries to compare 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 OECD budget as well as the content of the programme of work. In addition to the Council, around 200 specialised Committees and other bodies (Working Parties, Working Groups, and Task Forces) undertake the OECD's programme of work. Member countries' governments nominate participants to the groups.

The main OECD bodies with health activities are:

Committee for Scientific and Technological Policy (CSTP)

- Working Party on Biotechnology
- Task Force on Biomedicine and Innovation

Economic and Development Review Committee (EDRC)

Economic Policy Committee (EPC)

- Working Party 1

Environment Policy Committee (EPOC)

- Working Party on National Environmental Policies
- Working Group on Economic Aspects of Biodiversity

Health Committee

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

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

- Working Party on the Safety of Manufactured Nanomaterials
- Working Group for the Harmonisation of Regulatory Oversight in Biotechnology
- Working Group of National Coordinators of the Test Guidelines Programme
- Working Group on Good Laboratory Practice
- Working Group on Chemical Accidents
- Task Force for the Safety of Novel Foods and Feeds

HEALTH-RELATED OECD PUBLICATIONS

Publications

Health-related books, e-books, and CD-ROMs can be purchased through the online *OECD Bookstore* at http://www.oecdbookshop.org. Select the subject *Social Issues/ Migration/ Health* from the menu. A list of *Key Health Publications* is also available at www.oecd.org/health/keypublications.

Working papers and Technical papers

- *Health Working Papers* make available health

studies prepared for use within the OECD: www.oecd.org/els/health/workingpapers

- *Health Technical Papers* contain methodological studies, statistical analysis, and empirical results on measuring and assessing health care and health expenditure: www.oecd.org/els/health/technicalpapers
- *Environment, Health and Safety Publications* contain documents related, among others, to chemical accidents, biotechnology and the safety of novel foods and feeds, testing and assessment: http://www.oecd.org/env/health
- *Economics Department Working Papers* include, among other topics, studies that addressed the economics of health systems: http://www.oecd.org/eco/Working_Papers
- The *Social, Employment and Migration Working Papers* disseminate selected studies prepared for use within the OECD: http://www.oecd.org/els/workingpapers
- The *Development Centre Working Papers* present studies on developing countries: http://www.oecd.org/dev/wp

Newsletters

- *OECD Health Update*: http://www.oecd.org/health/update
- *DELSA Newsletter*, on work by the Directorate for Employment, Labour and Social Affairs: http://www.oecd.org/els/newsletter
- *OECD Biotechnology Update* covers OECD activities related to biotechnology: http://www.oecd.org/biotechnology
- *Environment, Health and Safety News* by the Environment, Health & Safety Programme: http://www.oecd.org/env/health

Policy briefs

Summarise economic and policy challenges related to OECD work. Health-related briefs are available at: www.oecd.org/health

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- The OECD's *country portal*, for example, www.oecd.org/australia
- OECD Divisions working regularly on health:
  - The *Health Division* http://www.oecd.org/els/health
  - The *Biotechnology Division*: http://www.oecd.org/sti/biotechnology
  - The *Environmental Health and Safety Division* (Chemical Safety): http://www.oecd.org/env/health
  - The *Monetary and Fiscal Policy Division* (Health-related projects): www.oecd.org/eco/structural/health

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FUTURE EVENTS ON HEALTH ISSUES

- The 2nd meeting of the Task Force on Biomedicine and Health Innovation, Paris, France, 9-11 June 2008 (Contact: Bénédicte Callan).
- The 4th Meeting of the Working Party on Manufactured Nanomaterials, Paris, France, 11-13 June 2008 (Contact: Peter Kearns).
- Third High-Level Forum on Aid Effectiveness, Accra, Ghana, 2-4 September 2008 (Contact: Elisabeth Sandor).
- OECD/European Commission (EC) conference "Improving of health systems sustainability through better value for money", Brussels, Belgium, 17 September 2008 (Contact: Howard Oxley).
- The 3rd meeting of the Task Force on Output-based Health Specific Purchasing Power Parities (PPPs), Paris, France, September 2008, Dates TBA (Contact: Seppo Varjonen, Luca Lorenzoni).
- The 3rd meeting of the Mental Health Expert Subgroup, Copenhagen, Denmark, 12 September 2008 (Contact: Sandra Garcia-Armesto and Gabrielle Luthy).
- Biomarkers and pharmacogenomics expert workshop, 6-7 October 2008, (Contacts: Marie-Ange Baucher and Bénédicte Callan).
- The 10th Meeting of Health Accounts Experts and Correspondents for Health Expenditures Data, Paris, France, 8-9 October 2008 (Contact: Sandra Hopkins).
- Meeting of OECD Health Data National Correspondents, Paris, France, 9-10 October 2008 (Contact: Gaetan Lafortune).
- Experts' Meeting on Health Care Quality Indicators, 23-24 October 2008 (Contact: Niek Klazinga, Sandra Garcia Armesto, Ian Brownwood).
- Workshop on the application of Knowledge Markets to Health Innovations, Washington DC, United States, 16-17 October 2008 (Contact: Benedicte Callan and Ruth Krestin).
- OECD/WHO Forum on Health Workforce and Migration, Geneva, Switzerland, 20-21 October 2008 (Contact: Peter Scherer).
- Pharmaceutical Pricing Policy project Symposium, Paris, France, October 2008, dates TBA (Contacts: Elizabeth Docteur, Pierre Moise, Valerie Paris).
- The 4th session of the OECD Health Committee, Paris, France, 17-18 November 2008 (Contact: Janice Owens).

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