

Introduction

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

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EVALUATION OF THE GROUP ON HEALTH AND RENAMING AS THE HEALTH COMMITTEE

An evaluation of the Group on Health was undertaken from April to mid-September 2006 in the context of the In-depth Evaluation of OECD Committees. It involved a review of the mandate, achievements, and relevance of the outcomes of the Group. It addressed the efficiency in producing quality outputs and the effectiveness in bringing about policy development in member countries.

The performance of the Group on Health was rated as high in respect to the criteria of relevance and effectiveness, and as medium to high in respect to efficiency. The evaluation recommended changes to improve the work of the Group and suggested establishing a solid financial basis to ensure continuity and stability of its work.

Responding to the recommendations of the In-depth Evaluation, the OECD Council changed the name of the Group on Health to the **Health Committee**, making the name consistent with other OECD bodies operating at the same level. The Council renewed the mandate of the Health Committee for five years, beginning 1 January 2007.

The Council also approved a reallocation of the regular OECD budget to support the work of the Health Committee. The funding will help the Committee to improve data collection and the development of indicators, which are vital to improve benchmarking of health policies and performance.

STRENGTHENING INTERNATIONAL COLLABORATION ON HEALTH ISSUES

Collaboration with other international organisations and institutions on several health-related activities helps avoiding duplication of work and builds on the experience and comparative advantage of each organisation. A Framework for Co-Operation, signed in 1999 and revised in November 2005 between the OECD Secretary-General and the WHO's Director-General, identified areas for close co-ordination of work between the two organisations. An agreement concluded in January 2006 between the OECD and the World Bank included work on health as one of several areas of co-operation. The OECD also collaborates actively with the European Commission (including DG SANCO, DG EMPL and Eurostat).

The first joint OECD, Eurostat and WHO health accounts (SHA) data collection was successfully launched in December 2005. This main objective of the initiative is to adopt common international standards and definitions to collect data on health

expenditure and their financing, while minimising the data collection burden on national authorities. The second round of this joint SHA data collection was undertaken in December 2006. The OECD collaborates with colleagues from Eurostat and WHO to revise the Manual *A System of Health Accounts*, and its International Classification for Health Accounts. Strong co-operation with Eurostat and WHO-Europe is also underway to improve and harmonise the standards and definitions underlying international data collection on non-monetary statistics, such as data on health employment and hospital activities.

Co-operative efforts to analyse health systems' effectiveness, access and efficiency have included the publication of a joint OECD-WHO report on the performance of the Swiss health systems (see below). The study was undertaken at the request of the Swiss Federal Office for Public Health and is the first in the series *OECD Reviews of Health Systems* to be jointly conducted by the OECD and WHO.

International collaborations are also part of on-going health-related OECD analytical and policy initiatives. These involve sharing of institutional knowledge and policy experience on specific projects, staff exchange, and the participation to, and joint sponsorship of, relevant events. For example, a high-level policy conference on health workforce and migration, organised by the OECD and WHO, is planned for the first semester of 2008.

DEVELOPMENT WORK IN HEALTH ACCOUNTING

The basic methodological framework presented in the manual *A System of Health Accounts* (SHA) has become widely accepted. The SHA manual is currently used in a large and growing number of OECD and non-OECD countries as the standard accounting framework for statistics on health expenditure and financing. The Manual, published in 2000 as "Version 1.0", was considered as work in progress, knowing that revision would be required in the light of experience. That experience, accumulated from pilot implementations in the past six years, has identified the key issues and areas in health accounting methodology requiring refinement and extension.

The OECD health accounts team in collaboration with colleagues from Eurostat and the World Health Organization (WHO) are now working on revising the SHA manual. This is expected to provide better methods and more detailed guidance for improving the comparability of health expenditure data across countries and over time. Revisions to the SHI manual are indispensable for analysing trends in health expenditure and

underlying factors of growth, as well as for making projections for future spending. Health accounts are increasingly expected to provide adequate inputs (together with other statistical resources) for the analysis of the sustainability of financing, macro-level efficiency and equity of utilisation of resources. A further conceptual and methodological challenge is to improve information on the importance of the health sector within the national economy and its contribution to economic development. This requires further methodological improvement towards a solid statistical framework that is comprehensive, consistent and appropriately linked to other statistical systems, in particular to the System of National Accounts.

In 2006, OECD, Eurostat and WHO agreed on the need to avoid developing diverging versions of the health accounts methodology, and decided to work towards a common revised manual for the System of Health Accounts. The aspiration is that the revision of the SHA Manual will be accepted and adopted as a global standard.

The International Health Accounts Team, consisting of health accounts experts at OECD, EUROSTAT and WHO, is currently working on a common programme of work for the SHA revision. The Team is developing a framework for a wide-ranging international consultation process related to the revision of the SHA, with the intention to share all documents in the draft stage. This will allow national and international organisations, as

well as individual experts world-wide, to comment and participate in the SHA revision.

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

Contact: Eva Orosz

DEVELOPMENT OF HEALTH-SPECIFIC PURCHASING POWER PARITIES

Effective and appropriate decision making about health financing and resource allocation requires health expenditure data comparable across countries and over time. Comparisons of health expenditure data are limited, however, by the lack of adequate purchasing power parities (PPPs) for health. The Health Division of the Directorate for Employment, Labour and Social Affairs (ELS) and the Prices and Structural Economic Statistics Division of the Statistics Directorate (STD) are convening a Task Force on Health-Specific PPPs. The objective of the Task Force is to oversee the development of output-based PPPs for health goods and services. These data should fulfill two purposes. First, they will provide a tool for the analysis of the volume of health expenditure in OECD and EU countries. Second, they will provide input to the broader purpose of deriving economy-wide PPPs for international comparisons of volume GDP.

The work of the Task Force is related to two existing projects. The first is the work of the

RELEASE OF OECD HEALTH DATA 2007

The 2007 edition of OECD *Health Data* will be released in mid-July 2007. OECD *Health Data* is the most comprehensive source of comparable statistics on health and health systems across OECD countries. The 2007 edition includes more than 1200 statistical series and indicators, with time series going back to 1960. It offers several improvements, including:


- More comparable data, particularly for "core" indicators which will be highlighted in *Health at a Glance – OECD Indicators 2007*, to be released in November 2007.
- A greater number of countries reporting their health expenditure and financing data according to the *System of Health Accounts*.
- New information on medical and nursing education in OECD countries, as well as additional data on the medical workforce, including the remuneration of different categories of doctors and nurses.

OECD *Health Data 2007* will be available online or on CD-ROM to subscribers of SourceOECD. Access is also provided to all OECD Health Data national correspondents and 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 versions are available exclusively in the online version (<http://www.ecosante.org/oecd.htm>).

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

Upcoming publications:

 OECD *Health Data 2007*

 *Health at a Glance – OECD Indicators 2007*

Contact: Gaetan Lafortune
Marie-Clemence Canaud (Health Data)
David Morgan (Health at a Glance)

current Eurostat/OECD Task Force on PPPs. Resources for the development of health-specific PPPs will be supported by a grant agreement between the OECD and the European Commission.

The second project is the current OECD project for improving the measurement of non-market services. The work of the Task Force will contribute to and benefit from this project, which will culminate in the publication of the *Handbook on measuring Education and Health Volume Output* late in 2008. The Task Force's mandate covers both market and non-market production of health goods and services.

All member countries of the OECD and non-OECD EU members will be invited to nominate participants to serve on the Task Force. Since the Task Force is a technical group, it is important that participants have an interest and/or some expertise in the area of Health PPPs. The first meeting of the Taskforce will be on the 8 June 2007 in Paris. This meeting will follow the second workshop on Measuring Education and Health Volume Output on the 6 & 7 June.

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

Contact: Sandra Hopkins

HEALTH CARE QUALITY INDICATORS

The long-term objective of the OECD's Health Care Quality Indicators (HCQI) Project is to develop a set of indicators that can be used to raise questions about health care quality and be reliably reported across countries using comparable data.

The first results of the 2005 data collection were published in Health Working Paper 22 in March 2006. This *Initial Indicator Report* used previous work of the HCQI Expert group to provide information on 17 indicators that are considered appropriate for international comparisons. The selection and development process of the indicators is described in the [International Journal for Quality in Health Care](#) (Vol. 18, Sept. 2006).

Present activities focus on two issues: i) the methodological difficulties of obtaining and comparing valid and reliable data to construct the selected quality indicators; and ii) attempts to select and develop additional indicators to better cover quality aspects of different health-care services. Work in 2006 on the first issue involved a second round of data collection on a wider set of indicators. This resulted in an update report (to be released in spring 2007) on 19 indicators for international comparisons in 32 countries.

Two themes (patient safety and mental health care) were selected for further work to identify suitable indicators on quality of care.

A seminar on patient safety data systems—jointly sponsored by the OECD and the Irish Department of Health and Children—was held in Dublin in June 2006. An OECD report, released in March 2007, describes the findings of the Dublin conference. Follow-up work on calculating patient-safety indicators based on national hospital administrative data systems was proposed. This work will be based on the patient-safety indicators described in Technical Paper 18. The results will be discussed at a one-day meeting of the patient safety subgroup on 24 October 2007. The meeting will also discuss a summary paper on reporting systems for adverse events. This liaises with similar initiatives to capture patient safety through adverse-event reporting launched by the WHO and the European Commission.

The work on mental health, due to less mature data and data systems, requires a different approach. Discussions at the Mental Health Experts subgroup highlighted the lack of common definitions and boundaries for mental health-care systems. Care settings and patterns of diagnoses differ widely across countries and a 2005 data availability survey revealed extremely limited data on mental health care quality across OECD countries. Therefore, the work for 2007 involves constructing a conceptual framework to provide definitions and boundaries of mental health-care services, as well as a country survey on mental health information systems and data availability. A conference on mental health quality measurement will be held in June 18 and 19 in Copenhagen, co-hosted by the Danish Ministry of Health. The meeting will address relevant country experiences in organising mental health information systems and challenges in improving information in mental health care at the national level. As a result, a conceptual framework and a proposed set of indicators will be issued. The first data collection for an initial set of mental health quality indicators is planned for the first half of 2008.

Work has also started on two additional themes:


- *Responsiveness.* Work on the mapping of national efforts to measure patient experiences and assessing the methodological hurdles in providing comparative data has just begun.
- *Primary care/prevention.* The work will start in spring 2007 and build on the previous work of the expert group. A challenge is to find available databases on ambulatory/primary care to calculate relevant quality indicators.

Overall, 2007 is a challenging year for the HCQI Project. The low-hanging fruits have been picked but the fruit basket is not yet representative of the many quality issues relevant for national assessment. The aim is to expand technical quality work on responsiveness/patient experiences, and to cover a wider spectrum of services (preventative, acute, chronic and palliative care)

and underlying diseases and handicaps. At the next meeting of the expert group, October 25-26, it will become clear how the results will taste.

Website: <http://www.oecd.org/health/hcqi>

Publication:

 Patient Safety Data Systems in the OECD: a report of a joint Irish Department of Health-OECD Conference

Contact: Sandra Garcia Armesto
Niek Klazinga

OECD REGIONS AT A GLANCE: REGIONAL FOCUS ON HEALTH

A number of recent health reforms in OECD countries have promoted decentralisation of a wide range of financing, planning and management activities. Decentralisation is expected to increase the efficiency and accountability of national health systems, but it may also generate geographic disparities if resources and responsibilities are unevenly distributed among regions.

This is why the 2007 issue of the series *OECD Regions at a Glance* devotes its Regional Focus to health. *Regional Focus on Health* presents international comparisons of equity in health care supply and health status based on a common set of regional indicators. The methodology and indicators used in the *Focus* are based on those adopted for international comparisons in *OECD Health Data*. Each indicator is illustrated by graphs and maps, and statistics are downloadable on line.

Regional Focus on Health looks at regional differences in selected indicators of:

- Mortality: age-adjusted mortality rates; premature mortality.
- Morbidity: incidence of cancer.
- Human resources: practising physicians, practising nurses.
- Physical resources: hospital beds, medical technologies.
- Risk factors: prevalence of smoking, prevalence of obesity.

Regional Focus on Health shows large within-country differences in mortality rates between the region with the lowest and the region with the highest age-adjusted mortality rate – up to 75 percentage points for men in Australia and up to 108 percentage points for women in Canada, which is explained to a large extent by the strong concentration of Aboriginal people (who have higher mortality rates than non-Aboriginals) in

certain remote parts of the country.

Large disparities are also found in the number of practising physicians per inhabitant – accounting for up to 2.5 times the national average in the best-endowed region of the United States – and nurses per inhabitant – as large as 60% below the national average in the least-staffed region of Turkey.

Website:

<http://www.oecd.org/gov/regionalstatisticsindicators>

Recent Publication:

 *OECD Regions at a Glance 2007*

Contact: Vincenzo Spiezia

REVIEW OF THE SWISS HEALTH SYSTEM

A joint OECD-WHO review of the Swiss health system highlights many achievements of the Swiss health system but warns against high financial cost and offers several recommendations to compare performance

The Swiss health system performs well on several grounds. Measures of health status compare favourably with other OECD countries. Switzerland achieved universal health-insurance coverage and patients have access to a broad range of modern medical services. Satisfaction with the choice and quality of providers is high. Despite regressive health financing, premium subsidies and cost-sharing exemptions protect access. Despite these achievements, pressures to improve value for money are high. Switzerland spends 11.5% of its GDP on health (2003), the second highest in the OECD after the United States, and only 2.2% of total health spending on health promotion. Furthermore, the governance structure of the Swiss health system – 26 cantons each with responsibility for healthcare provision – hinders coherent national health policies.

The report makes several recommendations.


- First, a better balance between prevention and cure is needed. Disease prevention and health promotion are un-coordinated and poorly funded. Attention should be given to reductions in tobacco and alcohol consumption and investing in mental health and tackling obesity.
- Second, the review recommends establishing a national data collection on quality of care. The existing reliance on professional self-regulation may not be sufficient to guarantee that best-practice standards of care are met.
- Third, minimum national standards in the system of premium subsidies would reduce

large cross-canton differences in subsidy levels and eligibility conditions.

- Fourth, the review recommends increasing cost-effectiveness. Insurance and the supply of care should be organised on a multi-canton basis and redundant capacity cut back. Current payment arrangements, encouraging volumes and higher-cost hospital care, require reform. Greater competition in insurance markets to help control cost needs selective contracting by insurers with providers, but should be accompanied by minimum quality standards and better information on the performance of providers and insurers. Greater use of generics and more foreign competition in the market for non-patented drugs are also needed.
- Last, changes in governance would promote longer-term gains in performance. The review recommends an overarching framework law for health, setting national objectives, funding responsibilities and the distribution of responsibilities across government levels.

Website: <http://www.oecd.org/health/reviews>

Recent Publication:

 *OECD Reviews of Health Systems - Switzerland*

Contact: Francesca Colombo
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Howard Oxley

ECONOMIC SURVEY OF THE RUSSIAN FEDERATION: REFORMING HEALTH CARE

Health issues feature in nearly all *OECD Economic Surveys* 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 survey of the Russian Federation.

The deterioration in basic indicators of health and human welfare that began in Russia in the 1970s and accelerated in the 1990s has yet to be overcome. This is a health crisis and not only a healthcare crisis: problems with access to quality healthcare are by no means the sole causes of very high rates of morbidity and mortality, which largely reflect environmental degradation, poor living conditions and lifestyles, high levels of road deaths, and, increasingly, the spread of HIV-AIDS. Nevertheless, healthcare reform must play a key role in addressing this health crisis. Russia clearly needs to spend more and more efficiently on healthcare. Reform will be critical if planned increases in healthcare spending are to achieve the intended results. The Russian healthcare system today is the product of an unfinished reform. Early reforms were launched in 1991–93,



but little was done in the decade that followed to complete them. Many of the problems that afflict Russia's healthcare system today are a product of its half-reformed state. The government recently pressed ahead with healthcare reform, but progress has been slow and many of the measures required will meet considerable resistance from stakeholders. The major reform priorities include:

- *Closing the gap between formal commitments to the population and available resources* by increasing public healthcare spending and revising the package of medical services provided to the population free of charge.
- *Shifting the structure of provision away from over-reliance on specialist/hospital care and towards more integrated primary care.* This will take time, given the need to improve the quality, reputation and number of primary-care providers.
- *Adopting payment schemes that encourage cost-effective therapeutic choices* by replacing cost-reimbursement or capacity-based methods of paying hospitals with cost-and-volume contracts. Fundholding and other methods of remunerating primary care providers would enhance incentives to keep patients healthy or to treat them on an outpatient basis. Incentives for uneconomic hospitalisation could be further reduced by revising the arrangements for provision of free medicines.

The authorities also need to complete the reform of Russia's mandatory medical insurance system, which is intended to allow patients to benefit from private insurers' competition. However, there is little real competition among insurers. Creating such competition will require substantial up-front investment in better rules, institutions and information, making significant demands on the state's administrative and regulatory capacities and requiring sustained high-level commitment.

Website: <http://www.oecd.org/eco/structural/health>
<http://www.oecd.org/eco/surveys/nonmembers>

Publications:

-  *OECD Economic Survey of the Russian Federation, 2006*
-  Tompson (2006), "Healthcare reform in Russia: Problems and Prospects", *OECD Economics Department Working Papers No. 538*.

Contact: William Tompson

CO-ORDINATION OF HEALTH CARE SERVICES

The demand for health care is increasingly dominated by chronic conditions, often associated with population ageing, such as diabetes, cancer,

congestive heart diseases and asthma. These place increased pressure on health care provision and cost. Breakthroughs in diagnostic and therapeutic technologies permit care to be provided in an ambulatory rather than an inpatient environment. At the same time, the increasing complexity and specialisation of medicine has reinforced the fragmentation of the health-care system across levels of care and professional groups. This has made it difficult for individuals to find the best care in the most appropriate setting

The OECD is carrying out a study on policies to enhance efficiency in health-care delivery through improved care co-ordination. Care co-ordination refers to system-wide efforts or formal policies to ensure that patients receive services that are appropriate to their needs, co-ordinated across service settings and over time, and that support high health outcomes. The study looks at policy approaches and evaluates: a) the importance of co-ordination problems within individual health-care systems and sectors; b) existing co-ordination policies and their scope; and, c) institutional and managerial barriers to improved co-ordination. It uses mainly qualitative data gathered from a survey of 26 OECD and a few non-OECD EU members.


Preliminary results at the November 2006 meeting of the Group on Health suggest that:

- Specific care co-ordination programmes – like disease management – may need to be more focused and better evaluated.
- There is scope for improving efficiency of health-care systems by increasing the capacity to co-ordinate.
- Countries mainly rely on primary care providers and other health care professionals to co-ordinate care in the area of acute care.
- Problems of co-ordination are widespread but especially evident at all interfaces with long-term care.
- Information flows and ICT infrastructures are inadequate.
- Weak governance often impedes care co-ordination.
- A lack of mutual respect among providers also limits the potential for co-ordination.

The final paper of the study, presented at the May 2007 meeting of the Health Committee, discusses problems and incentives for care co-ordination, and describes policy experiences of selected countries. It analyses replies to the survey and country case studies to present policy lessons.

Web site: <http://www.oecd.org/health/efficiency>

Upcoming publication:

 Appropriate health care delivery through better care co-ordination

Contact: Maria M. Hofmarcher
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EFFECTIVENESS IN HEALTH CARE SPENDING

Deriving internationally comparable measures of spending effectiveness in the health care sector and assessing how these are related to institutional and policy settings is important for improving the value for money spent on health care. In that context, an upcoming OECD Economics Department Working Paper by Isabelle Joumard *et al.* explores the possibilities of comparing health-sector performance at three levels: sub-sector, disease and system. The evaluation concludes that each approach has its drawbacks. At the sub-sector level, partial and preliminary analyses reported and carried out by Espen Erlandsen for the hospital sector – which typically accounts for 20 to 40 per cent of total health expenditure – indicate that potential efficiency gains may be sizeable. However, given the incompleteness and heterogeneity of the data, the international rankings can only be indicative rather than conclusive and they are difficult to relate to institutional factors. Similar drawbacks apply to the disease-level approach, register-based data for primary care and pharmaceuticals being unavailable for most OECD countries.

Analysis at the system level is attractive insofar as there are internationally comparable health outcome measures, but linking outcomes to health policies is subject to well-known pitfalls, in that population health status reflects to a large extent environmental and socio-economic factors (such as smoking habits, diet, income and education levels). An output approach – how many treatments are provided by the health care system – might be used instead, but that would not take account of policies of prevention and outputs would need to be adjusted for the quality of care.

Assembling a consistent dataset suitable for international comparisons of quality-adjusted health care outputs is the principal challenge. There is on-going work within the OECD on how health care output volumes should be defined in the context of the national accounts, but it will take a number of years before internationally consistent data are available. Using health status variables is thus, at this juncture, the only option. At the same time, data on health institutions will need to be collected via a questionnaire if the aim of relating performance to policies is to be achieved. Relevant institutional and policy indicators – e.g. depicting the reliance on co-payments and the degree of user choice – will need to be constructed so as to assess how

institutional features interact and eventually affect effectiveness in health care spending. Even then, disentangling the impact of the health care system *per se* from environmental and socio-economic factors will need very careful statistical analysis.

Website: <http://www.oecd.org/eco/structural/health>

Upcoming publications:

- 📖 Erlandsen (2007), "Improving the efficiency of health care spending: what can be learnt from partial and selected analyses of hospital performance", *OECD Economic Studies*.
- 📖 Joumard et al (2007), "Cross-country analysis of efficiency in OECD healthcare sectors: options for research", OECD Economics Department Working Papers.

Contact: Isabelle Joumard

ACHIEVING HEALTH-SYSTEM EFFICIENCY THROUGH INFORMATION AND COMMUNICATION TECHNOLOGIES

OECD health systems are facing tremendous pressure to improve health quality, accessibility and outcomes, and to do so in a cost-effective manner. Policy makers are particularly alarmed about the high rate of medical errors that have recently come to light. Although technology alone cannot solve these problems, properly designed and implemented information and communications technologies (ICTs) offer great potential to address these challenges.

Today's opportunities for digital delivery of health care services are enormous. The language of health ICT has been changing, and references to the concept of e-health have proliferated in international health policy, management and research arenas. National and regional strategies aimed at developing health information infrastructures are emerging across the OECD area and elsewhere. Yet, the potential of ICTs to improve efficiency in health care and the changes required to maximise their benefit are not fully understood and exploited.

The OECD Health Committee discussed priorities and objectives in this area at its meeting on 14-15 November 2006, endorsing a proposal for work on "Assessing incentives for implementation of ICTs in the health sector". The main objectives are to:

- Gain a better understanding of costs and benefits, financial sustainability and organisational constraints.
- Identify conditions and policies for achieving efficiency improvements in the health sector through the use of ICTs.
- Identify emerging best practices.

The key components of the proposed work plan include an analysis of: i) Challenges of valuing ICTs in health care; ii) Drivers and incentives for ICT implementation; and iii) ICTs for improved chronic disease care and patient self-management.

A first expert meeting, sponsored by the German Ministry of Health, was held on 13 April 2007 in Paris to discuss and refine the research agenda for the project.

Website: <http://www.oecd.org/health/ICT>

Contact: Elettra Ronchi

THE ECONOMICS OF PREVENTION

The OECD Health Division launched a project on the Economics of Prevention in January 2007. The project has been conceived against a background of rising concern about the expected growth in the burden of chronic diseases in OECD countries, particularly in relation to changing lifestyles. The project focused on the question of whether and to what extent efforts should be made to prevent non-communicable diseases rather than to accept the consequences of treating and managing them.

A common assumption is that individuals are in the best position to judge their own welfare and to maximise that welfare subject to the income constraints they face. However, the markets in which many lifestyle choices are made do not always work efficiently. Therefore, consumption behaviours that originate in such markets may not always lead to improvements in individual and/or societal welfare. Government intervention may be appropriate when "market failures" are significant and could be corrected, for instance, when consumers lack information about the consequences of their decisions, or when there are spill-over effects (individual behaviour which affects the welfare of others) or when consumers are unable to make sufficiently rational and informed choices (as for children, for example). Prevention policies may provide opportunities for increasing social welfare, but they may also be used to favour a redistribution of health, i.e. to reduce health disparities among population groups.

The project aims at developing a conceptual framework on the economics of non-communicable disease prevention, through which the scope and potential for government intervention will be explored. Appropriate methods for assessing prevention programmes will be devised, taking into account the strengths and weaknesses of conventional methods (e.g. cost-effectiveness analysis) in the area of prevention. The conceptual framework and assessment methods will then be applied to the analysis of

issues and policies in the prevention of conditions linked to diet and physical activity.

A first meeting of national experts from participating countries was held on 27 April 2007 to refine the scope of the project and focus its conceptual framework. A first working paper will be produced by the end of 2007. A second paper, reporting the preliminary findings of an international comparison of trends in selected risk factors and chronic conditions and their determinants, will be released next year.

Website: <http://www.oecd.org/health/prevention>

Contact: Franco Sassi
Jeremy Hurst

MEDICAL MALPRACTICE: PREVENTION, INSURANCE AND COVERAGE OPTIONS

In recent years, systems aimed at covering medical incidents, and particular private insurance-based mechanisms, faced challenges linked to the increasing frequency and magnitude of the damages granted to patients/victims in many OECD countries. Their efficiency as a mechanism to deter malpractice has also been questioned. Typically, some medical professions and establishments are unable to find appropriate coverage at affordable prices in the insurance market, with worrying effects on the cost, safety and quality of health systems in some countries.

The Financial Affairs Division – under the aegis of its Insurance and Private Pensions Committee – has completed an in-depth survey and analysis of the best ways to cover and mitigate medical malpractice in OECD countries. The final report *Medical Malpractice: Prevention, Insurance and Coverage Options* – published in December 2006 – provides a detailed overview and assessment of the various types of public and/or private mechanisms to cover and prevent medical malpractice. This work also reviews and appraises the main factors behind medical malpractice and suggests policy options for policy and decision makers in countries facing these challenges.

Coverage and mitigation mechanisms relative to medical malpractice are built on two main guiding principles in OECD countries:

- On the one hand, coverage and deterrence functions of medical incidents are performed through a combination of *tort law and medical liability insurance policies* in most countries. This mechanism is typically based on an assessment of the liability/negligence of the relevant health professional(s)/institution(s).
- On the other hand, some regimes – mainly in Scandinavian countries and New Zealand – are

based on a *no-fault indemnification of medical incidents*.

Both types of regimes face efficiency and effectiveness challenges and imply different pros and cons. They have also a different impact on medical-risk deterrence and the quality and safety of health-care systems. The choice of either a liability or a no-fault compensation regime thus depends mainly on national cultural and policy circumstances, as well as on the organisation of the health-care system. Policy suggestions offered in the report therefore take the view that there is no one-size-fit-all solution and propose solutions adapted to the peculiar difficulties faced within these two different schemes.


Within a litigation system combined with medical malpractice insurance, policy options first embrace tort reform. The report recommends limiting the excessive and inadequate recourse to court, better pre-defining the notion of fault/liability and reassessing and determining ex-ante the scale of damages granted to victims. Innovative insurance techniques and providers are then promoted as well as the development of market capacity (possibly through the establishment of pools). The report also suggests alternatives for government involvement, including: i) back-stop reinsurance or direct insurance for severe risks and/or when medical liability may not be easily proved; ii) the appraisal of the relevance of, and modalities for, introducing compulsory insurance.

Within a no-fault system, policy options mainly focus on setting predefined criteria for evaluating eligibility to compensation and the scale of indemnification. These criteria should preferably be established with a view to both cost and patients/victims' satisfaction.

Finally, policy suggestions highlight the importance of strengthening medical risk management for both types of regimes. This involves, among others: i) establishing enhanced mitigation measures and reporting of medical errors; ii) developing incentives aligned to these systems; and iii) Setting requirements/best practices and appropriate and proportionate sanctions, when relevant, for health-care professionals.

Website: <http://www.oecd.org/daf/insurance>

Recent publication:

 *Medical Malpractice - Prevention, Insurance and Coverage Options*

Contact: Flore-Anne Messy

DISABILITY AMONG AGEING POPULATIONS AND DEMAND FOR LONG-TERM CARE

As the number and share of the population aged


65 and over will continue to grow in OECD countries, improvements in the functional status of elderly people could help mitigate the rise in the demand for, and expenditure on, long-term care. A recent OECD Health Working Paper assesses the recent evidence on trends in severe disability, defined, where data are available, as one or more limitations in basic activities of daily living (ADLs) among the population aged 65 and over. The study covered Australia, Belgium, Canada, Denmark, Finland, France, Italy, Japan, the Netherlands, Sweden, the United Kingdom and the United States.

One of the principal findings is that there is clear evidence of a decline in disability among elderly people in only five of the twelve countries studied (Denmark, Finland, Italy, the Netherlands and the United States). Three countries (Belgium, Japan and Sweden) report an increasing rate of severe disability among people aged 65 and over during the past five to ten years, and two countries (Australia, Canada) report a stable rate. In France and the United Kingdom, data from different surveys show different trends in disability rates among elderly people, making it impossible to reach any definitive conclusion on the direction of the trend.

The findings from this study suggest that policy-makers should not count on future reductions in the prevalence of severe disability among elderly people to offset completely the rising demand for long-term care resulting from population ageing. The results from the projections up to year 2030 – carried out as part of this study – predict a rise in the number of people in older age cohorts with a severe disability and in need of long-term care. This is the case for all countries, and regardless of different trends in disability prevalence.

Website: <http://www.oecd.org/health/longtermcare>

Recent publication:

 OECD Health Working Papers No. 26

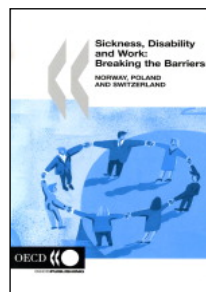
Contact: Gaetan Lafortune

OECD REVIEW ON SICKNESS, DISABILITY AND WORK

Too many workers leave the labour market permanently due to health problems, and too many people with a disabling condition are denied the opportunity to work. This is a social and economic tragedy common to virtually all OECD countries, and an apparent paradox that needs explaining. Why is it that health is improving, yet more and more people of working age end up out of the workforce relying on long-term sickness and disability benefits?

A new OECD series *Sickness, Disability and Work: Breaking the Barriers* explores the possible factors behind this paradox. It analyses national policies

to manage the inflow into sickness and disability benefit programmes and to assist beneficiaries who want to reintegrate into the labour market. The objective is to better understand the mechanisms and policies that lead a person with a health problem or a disability to withdraw from the labour market, temporarily or permanently.




The first comparative report in this series, published in late 2006, examines the cases of Norway, Poland and Switzerland. All three countries face financial pressure from public spending on sickness and disability programmes. Other policy challenges differ. In *Norway*, the key issues are to reduce the high inflow into sickness and disability and to raise the low outflow from these benefits. The main challenges in *Poland* are to raise the low rate of employment of disabled people and to strengthen coordination between different benefit schemes and employment measures. Co-ordination of institutions and policies is also a priority in *Switzerland*, where labour-market problems are pushed into the medical arena. This is visible in the rapid increase in mental health problems as a reason for being on disability benefits.

The second report, to be published in late 2007, will cover Australia, Luxembourg, Spain and the United Kingdom, and the final one in 2008 will cover Denmark, Finland, Ireland and the Netherlands. The three reports will be followed by a synthesis report that will identify lessons learned and illustrate policy dilemmas. It will highlight country-specific examples of “good” and “bad” practices and provide comparative evidence for countries that have not participated in the review.

Website: <http://www.oecd.org/els/disability>

Recent publication:

 *Sickness, Disability and Work: Breaking the Barriers (Vol. 1). Norway, Poland and Switzerland.*

Contact: Christopher Prinz

HEALTH WORKFORCE AND MIGRATION

The OECD launched a project on health workforce and international migration in January 2006. The aim is to understand better the main factors determining changes over time in the employment of doctors and nurses in OECD countries, and the role played by international migration in relation to other health workforce policies.

The first phase of the project has provided data, for each OECD country, on the stock of health

workers by country of training/birth, using mainly professional registers, population censuses, and in some cases labour force surveys. It has also reviewed and analysed recent migration flows and migration policies for health workers.

Initial results were presented at a workshop on health workforce shortages and migration during the 10th European Health Forum in Gastein (Austria) in October 2006 (<http://www.ehfg.org/>). The OECD presented results showing large variations in the proportion of international health worker migrants across OECD countries and significant changes over time in some OECD countries. International migration of health professionals is characterised by multiple interactions between OECD countries, but also by an increasing involvement of non-OECD countries, especially from Asia and Africa. These results will be published later this year.

The next phase of the project will describe and analyse the evolution of health workforce policies and planning in OECD countries and their interaction with migration. It will also rely on in-depth studies in selected OECD countries.

A report based on these country studies will be presented at a joint meeting of the Working Party on Migration and the Health Committee at the end of 2007. This document will also serve as a major input for a high-level policy conference on health workforce issues. The conference, jointly organised with WHO, is planned for the first semester 2008.

Website: <http://www.oecd.org/health/workforce>

Contact: Pascal Zurn
Jean-Christophe Dumont
Jeremy Hurst

PHARMACEUTICAL PRICING AND REIMBURSEMENT POLICIES

The OECD Health Committee is midway through two-year study of pharmaceutical pricing policies. The study aims to inform policy making by evaluating pricing and reimbursement policies and their impact on national policy objectives such as ensuring available, accessible and affordable medicines. The study focuses on the hypothetical *cross-national* impacts of policies – meaning the effect of one country's policies on prices and availability of medicines elsewhere – and on whether and how national policies have a broader *global* impact on R&D investment and innovation in pharmaceuticals.

The project entails two overlapping work streams. The first involves original research on policies and their national impact using case studies of six OECD countries, supplemented by a literature

review on policies and their impact. *OECD Health Working Papers* released in December 2006 and February 2007 review and assess Canada's and Mexico's pricing and reimbursement policies and the market and policy environments in which they operate. Studies of Sweden, Switzerland, Slovakia and Germany are in progress for release in 2007.

Canada and Mexico are among the minority of OECD countries that regulate pharmaceutical prices directly, rather than indirectly as a by-product of reimbursement pricing policy. In both countries, the federal government regulates the prices of patented pharmaceutical products to protect consumers against excessive prices. Regulation has brought Canada's prices for patented medicines roughly in line with European comparators, while unregulated prices of generic products are relatively high. In Mexico, retail prices of patented medicines are lower than in the United States and Canada, but are high relative to the country's low income. Geographic proximity to the U.S. may be a partial explanation, as manufacturers seek to minimise incentives for cross-border trade.

Drug coverage in Mexico and Canada is furnished through multiple payers rather than a single universal scheme and half of drug expenditure is privately financed. Although all Canadians have publicly financed coverage for drugs provided in hospitals, two-thirds of the Canadian population obtains out-of-hospital drug coverage through private health insurance, while most senior citizens and vulnerable populations are covered by provincial, territorial or federal plans. In Mexico, about half of the population has coverage through one of several social security schemes, with the other half relying on public clinics or buying drugs at retail pharmacies without reimbursement benefits.

Canadian drug expenditures have been increasing very rapidly in recent years. Formulary management, now facilitated by a government initiative to undertake common reviews of cost-effectiveness and other considerations, and the promotion of generic substitution have been the main levers used by public plans to improve public expenditure efficiency. Price negotiation has not been significant. Private plans have historically covered all medicines authorised for sale in Canada, although this is changing in light of cost pressure. Overall, new drugs are available in the Canadian market on a timely basis, but maintaining comprehensive availability and accessibility may be an emerging challenge.


Mexico's coverage schemes make medicines on their formularies available free of charge to beneficiaries, although problems of ensuring adequate supply and quality mean that some insurees purchase medicines through retail pharmacies. Public institutions purchase drugs at significant discounts through competitive bidding


for business. Generic products not certified as bioequivalent have been an important component of the private market, although this will change under new requirements being phased in.

In the second phase, the study investigates the cross-border and global impact of policies by exploring, *inter alia*, the practice of benchmarking prices against other countries, the role of parallel trade, and the incentives created by various pricing practices. A synthesis report is expected for publication in the first quarter of 2008.

Website: <http://www.oecd.org/health/pharmaceutical>

Recent publications:

 *OECD Health Working Papers No. 24*

 *OECD Health Working Papers No. 25*

Contact: Elizabeth Docteur
Pierre Moise
Valerie Paris

COUNTERFEITING AND PIRACY OF PHARMACEUTICALS

In response to rising concerns by government and the business community, the OECD has launched a project to assess the effects of counterfeiting and piracy on economies. The objective of the project is to improve factual understanding and awareness of the effects that counterfeiting and piracy of intellectual property rights have on governments, business and consumers. This project will focus on counterfeit and pirated products from an intellectual property perspective (*i.e.* tangible products that infringe trademarks, copyrights, patents and design rights).

Within this project, a number of sectoral case studies will be conducted, illustrating the various forms of counterfeiting and piracy, and the effects on producers, consumers and governments. The pharmaceutical sector has been identified, since counterfeiting of medicines has significant safety, health, social and economic implications. A sector report on the counterfeiting and piracy of pharmaceuticals will be part of the OECD project. A separate and second report focusing solely on the counterfeiting of pharmaceuticals, from a broader, public-health perspective, is also being produced. The report will examine the diverse definitions of counterfeit pharmaceuticals, the nature and scope of counterfeiting activities, and the procedures used. It will assess the trends and magnitude, evaluate the impacts on patients/consumers (especially public health implications) on the private sector and on governments. It will analyse measures employed for combating counterfeiting of pharmaceuticals. Anticipated publication in 2007.

Contact: Christina Sampogna

MEDICINES FOR NEGLECTED AND EMERGING INFECTIOUS DISEASES

The High-Level Forum (HLF) on Medicines for Neglected and Emerging Infectious Diseases (20-21 June, Noordwijk Aan Zee, Netherlands) will build support for an agenda to radically improve the availability of medicines for neglected and emerging infectious diseases that primarily affect the developing world. Discussions will focus on the opportunities for increasing investments in drug development and for improving the effectiveness of existing public and private partnerships for the discovery and development of medicines to treat infectious disease. The Forum will bring together representatives from senior-level industry, government (health, industry and foreign affairs/development), the WHO, charitable health organisations and NGOs from developed and developing countries. The HLF outcomes will include a *Noordwijk Medicines Agenda* which will identify the best opportunities for further OECD-wide action to increase the availability of medicines for infectious diseases.

The HLF will comprise 4 sessions:

1. *Economics of Fighting Infectious Diseases* – This session will focus on the economic rationale for combating infectious diseases.
2. *New Drugs for Infectious Diseases: The Scientific Opportunities* – This session will focus on new models for improving the efficiency in the discovery, development and delivery of medicines for neglected infectious diseases.
3. *Creating Incentives for R&D Investments: the Policy Options* – This session will focus on the major policy mechanisms available to increase incentives for private firms to bring to market new products for infectious diseases.
4. *Building Political Support for a Way Forward: The Noordwijk Medicines Agenda* – This Ministerial-level session will bring together Ministers for Development, Health, and Sciences/Industry to discuss how to build political support for coherent strategies to improve the availability of medicines for neglected and emerging infectious diseases.

Two workshops are part of the HLF preparatory process.

1. One to explore policy options and policy coherence to enhance the availability of medicines (*Workshop on Policy Options and Policy Coherence*, Paris, 3-4 May 2007).
2. The other to examine how scientific advances create opportunities to accelerate drug discovery (*Workshop on Accelerating Drug Discovery for Neglected Diseases*, Paris, 2-3 May 2007).

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

Contact: Barbara Slater
Jack Radisch
Jenny Hedman

AID EFFECTIVENESS IN HEALTH

As part of the OECD Global Forum on Development, a meeting on Aid Effectiveness in the Health Sector was jointly organised in Paris by the Development Co-operation Directorate, the Development Centre, the World Bank and the WHO on 4 December 2006. Approximately 150 participants attended, which included representatives of aid agencies, multilateral organisations, global programmes, developing countries, and civil society.

Participants welcomed the significant progress made recently in assisting the health sector of developing countries, in terms of harmonization and alignment of donor procedures, as well as provision of long-term financing. They noted, however, that the health sector is still experiencing problems such as high transaction costs associated with multiple donors, unbalanced investments across the sector, and aid volatility. Discussions stressed the importance of developing country ownership, mutual accountability between donors and recipients, and better coordination among all stakeholders, with particular emphasis on the role of the global health partnerships.

The meeting acknowledged the need for significant behavioural change by the donors in the health sector at both country and global levels, particularly in light of the future aid increases promised by the European Union. Participants therefore expressed support to increase harmonisation and alignment and strengthen links with the Development Assistance Committee's work on aid effectiveness. More specifically, they concluded that the health sector should be used as a "tracer sector" to monitor progress towards the Paris Declaration on Aid Effectiveness.

Website:
<http://www.oecd.org/development/globalforum>

Contact: Kaori Miyamoto

NEW ACTORS IN HEALTH FINANCING IN INTERNATIONAL DEVELOPMENT

The international development finance system has changed substantially. New public and private actors have begun financing development and official donors are diversifying their financing instruments. What do these changes look like for a "donor darling" like Ghana, where aid has long accounted for a large percentage of GDP? And are

these trends manifest in the health sector, which has traditionally attracted substantial official development assistance (ODA)?

A recent Development Centre case study finds that growing non-ODA flows are poorly captured in national data and policy planning. While the Ministry of Health budget only lists three major sources of funds (private households, the government budget and international donors), the reality on the ground is more complex.

In line with the principles of the Paris Declaration on Aid Effectiveness, donor support through a Sector-Wide Approach (SWAp) has become the dominant aid modality in Ghana's health sector. However, donors also finance health through the Multi-Donor Budget Support initiative and project support for local implementing organisations. Additionally, an estimated 65 per cent of the total health expenditure in Ghana bypasses the Ministry's budget entirely. A large proportion of these payments may derive from remittances, the single most important private capital inflow to Ghana. Finally, new actors are taking on important roles in health finance. While NGOs largely act as implementing agencies, major global programmes – notably the Global Fund to Fight Aids, Tuberculosis and Malaria and the GAVI Alliance – constitute important new channels for ODA. Private donations are also increasingly meaningful and the pharmaceutical industry and private foundations have become very active in Ghana.

This new complexity has important implications for policy makers in developing and donor countries.


Firstly, information systems need to be strengthened to capture all flows and help craft effective policies. This implies building capacity in data collection and monitoring. It also requires that local actors and donor agencies recognise the high potential of non-aid flows for development.

Secondly, further efforts are needed in implementing the Paris Declaration. The move to more government-owned aid modalities is encouraging. However, the emergence of new actors has posed new challenges. Global programmes, for example, have attracted criticism for contributing to a proliferation of co-ordinating mechanisms at country level.

Finally, the major challenge for decision makers is not finance alone, but the larger issue of "ownership". Recipient-country governments must improve co-ordination and communication between their own national public entities. As donors move to general budget support, the Ministry of Health will need to develop new communication and negotiation skills vis-à-vis the Ministry of Finance. As the experiences in Ghana indicate, even a "donor darling" like Ghana still has a long way to go.

Website: <http://www.oecd.org/dev/briefs>

Recent publication:

 *New Actors in Health Financing: Implications for a Donor Darling*

Contact: Denis Drechsler
Felix Zimmermann

SOCIAL HEALTH PROTECTION IN DEVELOPING COUNTRIES

An estimated 1.3 billion people do not have access to effective and affordable health care. The poor are especially vulnerable to health shocks that can cause catastrophic health expenditures when effective social protection is unavailable. This impedes the achievement of the Millennium Development Goals, where health objectives like reducing maternal mortality feature prominently.

A high-level international conference, held in Paris on 15-16 March, addressed the importance of extending health protection to improve the health status of the poor in the developing world. The conference *Social health protection in developing countries – Breaking the vicious circles of health and poverty* was organised by the French government with a closing address by President Chirac. Ministers and senior health officials from developing countries, donors, experts, and international organisations attended the event. The OECD played a key role. Mr. Jütting of the Development Centre contributed a presentation highlighting the need to improve aid effectiveness in health. Mr. Manning, chair of the Development Assistance Committee, presided over the closing session of the Ministerial meeting.

The main issues discussed during the conference ranged from the impact of health investments on poverty reduction and economic growth to practical approaches for expanding health protection and related financing mechanisms. Participants stressed the need to accord priority to including social health protection in reinforced health systems. They emphasised how decisions about structuring health financing mechanisms (social insurance, government budgets, voluntary and community insurance) largely depend on each country history, social and economic conditions and commended the diversity of approaches. The conference called for the commitment and mobilisation of all key players. Participants highlighted the need to improve aid effectiveness in health, especially in light of the proliferation of new actors and funding mechanisms. In his concluding remarks, President Chirac proposed to integrate the development of health financing schemes within poverty reduction instruments and policies of developing countries. He flagged the importance of this issue in the G8 debate about Africa and the social dimensions of globalisation.

Contact: Johannes Jütting

SKILLS, EDUCATION AND HEALTH

Since early 2004, the Directorate for Education and the Directorate for Employment, Labour and Social Affairs have worked with member countries to develop a data strategy for an OECD-wide assessment of adult competencies: the Programme for the International Assessment of Adult Competencies (PIAAC). PIAAC will objectively measure critical generic skills in a representative sample of the adult population of participating countries. It will gather contextual data on the determinants and use of skills, and indirectly assess key skills-related outcomes. Health status is one of the skills outcomes that member countries expressed interest to measure.

Robust linkages exist between education and a range of important health conditions. Indeed, improved health status is a major positive externality of education. The inclusion in PIAAC of a module inquiring about self-reported health and health habits could yield several types of policy-relevant analysis. Cross-country comparisons of education-health gradients would be possible for a larger group of countries than has been carried out to date. Such comparisons provide a baseline for performance monitoring. They also afford insight into types of investments associated with improved health status at the population level.

PIAAC could likewise permit specific analyses relevant to the types of skills and education most strongly associated with different health outcomes and behaviors. A more detailed understanding of the linkages between education, skills and health is a prerequisite for developing cost-effective policies to improve the health status of populations, particularly of the most disadvantaged groups in society.

During 2007, development work on PIAAC aims at finalising a fully-costed analysis plan based on countries' ratings of the policy priority attached to the various potential analytic outputs. The analysis plan will establish the scope of any health-related analyses to be undertaken. An analytic framework for the health-related analyses that PIAAC could allow is available on request.

Contact: Andreas Schleicher
Alistair Nolan

SOCIAL OUTCOMES OF LEARNING: LINKS BETWEEN EDUCATION AND HEALTH

The effects of education are far-reaching. They range from labour market earnings to GDP growth, and extend beyond. The Social Outcomes of Learning (SOL) project, run by OECD's Centre for Educational Research and Innovation (CERI) in collaboration with other OECD bodies – including the Social Policy Division of the Employment,

Labour and Social Affairs Directorate – explores these effects. It focuses especially on health and civic and social engagement, identifying models and bringing together relevant empirical research.

A synthesis of the work to date, *Understanding the Social Outcomes of Learning*, will be published by CERI in May 2007. Detailed analyses can also be downloaded from the OECD website.


The health benefits of learning are potentially very large. First, there is a *cost-containment* aspect. The costs of delivering healthcare services are set to rise substantially, due to demographic and technological factors. If education can help reducing these costs, it merits adequate policy attention. Second, learning can *enhance wellbeing and the quality of life*. Education may not only contribute to preventing illness or enabling more efficient treatments, but may also enable people to live healthy lives more positively. This aspect – albeit harder to quantify – is arguably even more important.

The synthesis report offers these key messages:

- Overall, international evidence shows strong links between education and determinants of health such as health behaviours and preventative service use. Many of these links are causal.
- Learning in later life can have substantial effects on health. One study estimates that for every 100,000 women enrolled in adult learning programmes, we might expect 116-134 malignant neoplasms to be prevented.
- Education affects mortality. A US study shows that an additional year of study reduces the probability of dying in the next 10 years by 3.6 years; another Swedish study shows that an additional year reduces the risk of bad health by 18.5%.
- Some of these benefits can be costed. A UK study estimates that taking women without qualifications to a Level 2 qualification would lead to a reduction of 15% in their risk of adult depression; with an estimated cost of depression of £9billion a year, this would lead to a saving of £200million.
- Not all learning is good for health! Education can increase inequalities, with negative health consequences; and can raise stress levels.

Website: <http://www.oecd.org/edu/socialoutcomes/symposium>

Upcoming publications:

 *Understanding the Social Outcomes of Learning*

Contact: Tom Schuller

THE UPTAKE AND DIFFUSION OF HEALTH-RELATED BIOTECHNOLOGIES

The Working Party on Biotechnology will publish in Spring 2007 an analytical report on the range of incentives and barriers that are affecting the uptake into the health care sector of five health biotechnologies. The selected technologies differ in their stage of development, including innovations that are relatively mature and others that are still very new, but all have reached the market. The case studies include: monoclonal antibodies as diagnostics and as therapeutics; genetic testing DNA micro-arrays; and a drug delivery technology illustrating the convergence of bio- and nano-technologies.

For each technology, the analytical report identifies its clinical utility and factors stimulating and/or inhibiting its diffusion. A striking finding is that in many cases the technology itself has progressed far faster than the institutional mechanisms that are needed to support widespread diffusion and uptake. For more mature technologies, such as molecular diagnostics, the regulatory environment poses pricing problems that inhibit dynamic investment by the private sector and price levels remain above those that would make the technology available to broad segments of the population. Intellectual property issues pose potential stumbling blocks to widespread uptake for several of the technologies. The lack of quality standards, uniform clinical protocols, large-scale population studies and training of clinicians means that clinical and medical practice has not yet adapted to the possibilities offered by the new technologies. Finally, in the bio-nano interface (at a much more emergent stage than the other four technologies) gaps in the financial infrastructure may hinder further research needed to bring the technology to a commercial stage. The report makes clear that institutional frameworks and technology co-evolve, and that, even when breakthroughs occur, diffusion cannot be expected without the necessary institutional adjustments.

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

Contact: Benedicte Callan

THE IMPACTS OF PHARMACOGENETICS ON HEALTH SYSTEMS

A report on *Pharmacogenetics: Opportunities and Challenges for Health Systems* will be available in the spring 2007. The report is based on discussions held at an expert workshop in Rome in October 2005, as well as commissioned consultant papers.

Pharmacogenetics offers new ways of understanding how drugs work and how this


affects both their safety and efficacy in individuals. The potential opportunities for both drug development and clinical care are considerable. In drug development, pharmacogenetics can improve both the research and development process and the quality and efficacy of the products delivered. In clinical care, pharmacogenetics may enable doctors to prescribe more effective interventions and use evidence-based medicine. Pharmacogenetics can help identify those individuals most likely to benefit from a therapy, optimising treatment strategies for both common and complex disorders.

While research in pharmacogenetics is proceeding rapidly, in 2007 relatively few pharmacogenetics-based products have reached the market. A number of scientific, regulatory, and economic challenges need to be overcome if pharmacogenetics is to be taken up more widely by healthcare systems. The report examines the challenges facing pharmacogenetics at different stages in the health innovation cycle and in the clinic. The report concludes that governments have a role to play in creating an "enabling" environment for pharmacogenetics. The six key messages which emerge are:

- Building scientific infrastructures for large-scale association studies is necessary to identify and validate the biomarkers that underpin the use of pharmacogenetics.
- Applying pharmacogenetics to established medicines already on the market will have public health benefits but will require public support to run the necessary prospective studies.
- Pharmacogenetics has the potential to transform the drug development process, but because it threatens existing business models in the drug and diagnostic industries, the incentives to adopt this technology may need to be strengthened.
- Coordination and dialogue with regulatory authorities is critical to strengthening industry investment in the development of pharmacogenetic products.
- The health and economic impacts of pharmacogenetics need to be better understood if the health care system is to adopt these technologies.
- Health care providers will need to be educated about pharmacogenetic assays and treatment options; and to interpret these assays clinically useful information must be easily accessible to them at the point of care.

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

Upcoming Publication:

 *Pharmacogenetics: Opportunities and Challenges for Health Systems*

Contact: Benedicte Callan

**GUIDELINES ON BEST PRACTICES IN
MOLECULAR GENETIC TESTING
LABORATORIES**

The OECD Council will consider the adoption of a *Recommendation on Quality Assurance in Molecular Genetic Testing* in the Spring of 2007. The draft Guidelines respond to a need identified by countries for an international framework that will foster best practice and good governance in molecular genetic testing laboratories. This need was underscored in an OECD survey conducted in 2004 on the quality assurance practices in molecular genetic testing in 18 OECD countries. The draft Guidelines offer principles and best practices for the quality assurance of molecular genetic testing offered in a clinical context. The Guidelines should facilitate the application of best practices for human genetic testing; guarantee an international approach to the exchange of clinical samples and data, thus facilitating access to rare disease testing; and help meet the objectives of OECD member countries in relation to best practices in health care.

The Guidelines address genetic testing for variations in germ-line DNA sequences or products arising directly from changes in heritable genomic sequences that predict effects on the health, or influence the health management, of an individual. They focus on molecular genetic testing for the diagnosis of a particular disease or condition and predictive genetic testing often carried out before any clinical signs of the disease or condition appear. They are relevant to tests for heritable DNA variants that predict the response profile of an individual to a drug or course of therapy and that affect susceptibility to disease, patient prognosis, counselling, treatment and family planning. They do not address testing carried out only for research purposes.

Upon adoption of the *Recommendation* by the OECD Council, the Secretariat will undertake a number of activities to ensure its dissemination. First, it intends to publish a booklet containing the Recommendation and background and explanatory information in the Annotations and Glossary. Second, it will make this information available on its website. Third, it will follow the uptake and use of the Guidelines by member countries.

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

Contact: Benedicte Callan
Iain Gillespie

HEALTH INNOVATION SURVEY

The links between innovation, productivity, health and wealth are well-recognised. However, while investing in and encouraging innovation is a priority for many OECD countries, so is maintaining the affordability, quality and sustainability of healthcare systems. The apparent tension between these two goals can be mitigated. To help meet this policy challenge, the OECD conducted an eight-country survey exploring whether and how countries are trying to make healthcare priorities converge with the direction of health innovation.

The survey explored the mechanisms by which objectives of the health sector and other specific health care goals influence how governments develop policies to promote innovation and improvements in healthcare quality. The survey report, which will be available in Spring 2007, will:

- Outline how various governments, government departments and other important agencies define innovation in health care.
- Document the government programmes that aim to promote innovation in the health sector, to stimulate the development of new innovations in health care and to co-ordinate these efforts.
- Document the range of health care system priorities and policies, health objectives and other special (political and social) circumstances that motivate government policies to promote and intervene in health care innovation.

Upcoming report:

 *Promoting Innovation – Promoting Health*

Contact: Jack Radisch

EMERGING RESEARCH MODELS FOR THE DELIVERY OF HEALTH INNOVATION

An Expert Workshop discussed Emerging Research Models in Paris on 20-21 November 2006. Four case studies and a range of other novel initiatives for discovery research, development and delivery of biomedical innovations were presented at the workshop. These initiatives share a goal of bringing biomedical products and processes more rapidly and effectively from invention to market. Across the OECD, many such initiatives take a “bench-to-bedside” perspective on the delivery of health innovation. The tools they use to reach this goal include:

- The creation of novel organisational networks and structures to increase flows of information across all stages of the innovation cycle;


- The smarter use of information technology and the better exploitation of data for both R&D and clinical practice;
- The creation of new and convergent scientific infrastructures;
- Strategies and financing for improving the translation of discoveries into potential products;
- The modernisation of clinical trials and regulations.

Discussion at the workshop identified areas in which governments could support ongoing efforts. These included: i) Providing vision and leadership to effect a change in culture about health innovation; ii) Supporting the creation of knowledge markets for pre-competitive exchange of data and technologies; iii) Creating metrics of spending on health innovation and its delivery; iv) Identifying new models to leverage intellectual property in collaboration; v) Validating proof models; vi) Understanding the challenges and opportunities from technological convergence in health innovation; vii) Analysing how the value chain is changing in health innovation and policy interventions to deliver on such new value chains.

A Policy Report based on the case studies and the expert workshop discussion will be developed for Spring 2007. The report discusses the tools, incentive structures, or good practices to speed up the time it takes for laboratory discoveries to be translated into new medical treatments and areas where governments may have a role.

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

Upcoming publication:

 *Emerging Research Models for Health Innovation*

Contacts: Benedicte Callan
Jack Radisch

A POLICY AGENDA FOR THE BIOECONOMY TO 2030

The International Futures Programme (IFP) of the OECD specialises in analysing key long-term trends to help governments map strategy and projects. Due to the rapid increase in biotechnological innovation and growing strategic interest in the bioeconomy, the IFP has launched a two-year project on *The Bioeconomy to 2030: Designing a Policy Agenda*. The project covers biotechnology metrics, regulatory issues, business models, policy and regulation, and framework conditions in three main application fields: agriculture and related resources; industry and environment; and health.

Biotechnology has many applications in health, including the production of large molecule therapeutics, recombinant vaccines, enzymes and hormones, diagnostic tests, molecular imaging, pharmacogenetics to target treatment regimes, gene therapy, and tissue engineering.

The project on health biotechnology is developing short-term estimates of the expected outputs of biotechnology over the next five to eight years. It also develops several long-term scenarios of the different pathways that health biotechnologies could follow to 2030. The short-term estimates use clinical trial data and expert opinions to predict market entry dates for new biotechnology products between 2012 and 2015.

The long-term health scenarios are not intended to predict the future, since many alternative outcomes are possible. Predicting technological developments (and uses of new technologies) over a timeline of twenty-five years is especially difficult. Instead, the project focuses on the interactions between health biotechnologies and economic, social, political, and environmental factors. The health scenarios will identify key drivers, potential obstacles and opportunities, as well as bottlenecks and other issues that policy makers and regulators might need to address. Particularly relevant factors to biotechnological health innovation include markets and business models, health delivery systems, regulatory systems, and intellectual property rights.

Preliminary results will be presented to the Project Steering Group on 1 June 2007, with the final results presented in November 2007.

Website:

<http://www.oecd.org/futures/bioeconomy>

Contacts: Anthony Arundel
David Sawaya
Michael Osborne

HUMAN AND HEALTH CARE GENETICS

Two projects of the OECD Biotechnology Division address issues related to biotechnology and genetics. An update on these activities and related events and publications is given regularly in the newsletter *OECD Biotechnology Update*, available from the right-site menu of the Biotechnology portal (<http://www.oecd.org/biotechnology>) and the Health portal (<http://www.oecd.org/health>).

Guidelines on the creation and governance of human genetic research databases

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

Recent Publication:

 *Creation and Governance of Human Genetic*

Research Databases

Contact: Christina Sampogna

Guidelines on licensing of health care genetics


Website:

<http://www.oecd.org/sti/biotechnology/licensing> (English)

<http://www.oecd.org/sti/biotechnologie/licences> (French)

<http://www.oecd-tokyo.org/theme/bio/2006/20060301healthcaregenetics.html> (Japanese)

Recent Publication:

 *OECD Guidelines for the Licensing of Genetic Inventions*

Contact: Christina Sampogna

HEALTH COSTS OF ENVIRONMENTAL POLICY INACTION

At their meeting in April 2004, OECD Environment Ministers called for OECD to undertake new work on the costs of inaction with respect to key environmental challenges. In order to scope out potential areas of work, the Environment Policy Committee hosted a High-Level Special Session on the "Costs of Policy Inaction" in April 2005 (<http://www.oecd.org/env/costsofinaction>). At this meeting, a number of delegates highlighted the need to gain a better understanding of the human-health costs of environmental degradation. In light of this request, the OECD Environment Directorate is undertaking work in this area. The Health Division of the OECD Directorate for Employment, Labour and Social Affairs has also contributed to this project, providing insights based on their expertise on health systems.

Two reports prepared by the OECD Environment Directorate provide a range of estimates of the potential human health costs associated with two environmental pressures – local air pollution and water quality. The reports were presented at the Environment and Health Experts' Meeting, held in Paris on 24 November 2006. They suggest that the prevention of adverse health impacts associated with outdoor air and water pollution (and more generally with environmental degradation) can greatly benefit health status and the economy. This is the case in high and middle-income OECD countries, and even more so in low-income countries. The reports also recommend that OECD countries strengthen interventions to limit air and water pollution. Additional efforts are required in both areas of policy action to limit populations' exposure to exceedingly high levels of air and water pollution. In the absence of sufficient effort, health care costs due to environmental pollution will likely grow

significantly in the future. Appropriate environmental policies should therefore be implemented to address the environmental issues that are most detrimental to human health.

A report – *Cost of Inaction: Annotated outline and Selected Draft Chapters* – synthesising the main findings of these reports was produced in February 2007 and discussed by the Environment Committee at the end of March.

Contact: Nick Johnstone
Pascale Scapecchi

IMPROVING CO-ORDINATION BETWEEN ENVIRONMENTAL AND HEALTH POLICIES


In order to reduce the adverse health impacts associated with environmental degradation, different policy instruments can be applied, alone or in combination. In particular, one can rely on an environmental policy which results in improved environmental conditions (*ex ante*) or on a health policy which addresses the health consequences (*ex post*). Policy evaluation of both types of intervention can help policy-makers decide which policy to support to address environmental health issues.

Despite some important common elements, environmental and health policy interventions differ greatly, for example in terms of the policy evaluation approach and the benefit measures used in these evaluations. These differences undermine the potential for comparative assessment of policy options in the two spheres. Moreover, concern about overall policy coherence arises as decisions regarding environmental health may be taken independently by Ministries of Health and of the Environment. A “whole-of-government” approach would be preferable to promote good environmental health outcomes.

A report was prepared to analyse ways of improving the governance of environmental health issues. It synthesises the main findings arising from three case studies on Canada, France and the United Kingdom, and from a review of the governance literature. It sheds light on the level of co-ordination between environmental and health policies, means to improve policy co-ordination and the obstacles that have to be overcome. The report puts forward evidence-based recommendations to improve the governance of environmental health issues.

Website: <http://www.oecd.org/env/social/envhealth>

Recent publication:

 *Improving Co-ordination between Environmental and Health Policies: Final Report*

Contact: Pascale Scapecchi
Nick Johnstone

VALUATION OF ENVIRONMENT-RELATED HEALTH IMPACTS WITH A FOCUS ON CHILDREN

In 2006, the OECD Environment Directorate undertook the second phase of the work on the valuation of children's health, which consists of implementing surveys in three OECD countries (United Kingdom, Italy and the Czech Republic) to estimate the health benefits associated with the reduction of a specific environmental risk factor.

The first meeting of the Advisory Group and Research Consortium was held in Paris on the 6th and 7th of November 2006. Three reports were presented to assist the research consortium to:

- Select the appropriate valuation framework (Methodological Review of Willingness To Pay (WTP) and Quality-Adjusted Life-Years (QALYs) Frameworks for Valuing Environmental Health Risks to Children);
- Prepare the scenario design (Review of Revealed Preference Studies); and
- Identify an environmental risk factor which is likely to lead to credible estimates for both adults and children (Review and Summary of the Epidemiological Literature on Children's Health Risks Associated with Environmental Exposures).

A fourth report (*Use of Evaluation Tools in Policy-making and Health implications for Children*) focuses on policy evaluation practices in the environment and health fields. It also presents a review of environmental legislation relevant for children in OECD countries to determine whether children's specific vulnerability to environmental hazards is correctly taken into account.

Based upon the findings from these four reports and discussions during the meeting, it was decided that the surveys would be based on a willingness-to-pay approach. Different survey designs are being tested in the three countries in order to determine which valuation methodology and which environmental risk factor is the most appropriate for this specific context. The surveys will be implemented in fall 2007 and preliminary results will be available in mid 2008.

Website: <http://www.oecd.org/env/social/envhealth/verhi>

Contact: Pascale Scapecchi
Nick Johnstone


HEALTH ACTIVITIES BY THE ENVIRONMENT, HEALTH AND SAFETY PROGRAMME

The Environment, Health and Safety Programme of the Environment Directorate has several health-related projects. 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 (<http://www.oecd.org/env/health>) and the Health portal (<http://www.oecd.org/health>). Three activities of special interest to health experts and policy makers are:

Safety of Manufactured Nanomaterial.

Website: <http://www.oecd.org/env/nanosafety>

Recent Publications:


 Current Developments/ Activities on the Safety of Manufactured Nanomaterials: Tour de Table at the 1st Meeting of the Working Party on Manufactured Nanomaterials, London, United Kingdom, 26-27 October 2006


Contact: Peter Kearns
Mar Gonzalez
Noriko Oki

Safety of novel foods and feeds

Website: <http://www.oecd.org/biotrack>

Upcoming publications:

 *Consensus Document on Compositional Considerations for New Varieties of the Cultivated Mushroom *Agaricus bisporus*: Key Food and Feed Nutrients, Anti-Nutrients and Toxicants*


 *Consensus Document on Compositional Considerations for New Varieties of Sunflower: Key Food and Feed Nutrients, Anti-Nutrients and Toxicants*

Contact: Mar Gonzalez


Health-related guidelines on chemical testing


Website: <http://www.oecd.org/env/testguidelines>


Recent publications:


 *16th-18th Addendum to the OECD Guidelines for the Testing of Chemicals*


In the series on Testing and Assessment:


 *No.1 Guidance Document for the Development of OECD Guidelines for the Testing of Chemicals (revised)*

 *No. 57 Detailed Review Paper on Thyroid Hormone Disruption Assays*

 *No. 59 Report of the Validation of the Updated Test Guideline 407*

 *No. 62 Final OECD Report of the Initial Work Towards the Validation of the Rat Hershberger Assay : Phase-1*

 *No. 65 OECD Report of the Initial Work Towards the Validation of the Rodent Uterotrophic Assay - Phase 1*

 *No. 66 OECD Report of the Validation of the Rodent Uterotrophic Bioassay: Phase 2*

 *No. 68 Summary Report of the Uterotrophic Bioassay Peer Review Panel*

Contact: Laurence Musset

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 (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 (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

Along with publications for sale, OECD releases regularly health-related information in working papers, newsletters and policy briefs.

Publications

Health-related books, e-books, and CD-ROMs can be purchased through the online *OECD Bookstore* at <http://www.oecdbookshop.org>. It is possible to tailor information available at the Bookshop by selecting the Subject *Social Issues/ Migration/ Health* from the available menu. A list of *Key Health Publications* is also available at <http://www.oecd.org/health/keypublications>.

Working papers and Technical papers

- ◆ *Health Working Papers* make available to a wider readership health studies prepared for use within the OECD: <http://www.oecd.org/els/health/workingpapers>

- ◆ *Health Technical Papers* contain methodological studies and statistical analysis presenting and interpreting new data sources, and empirical results and developments in methodology on measuring and assessing health care and health expenditure: <http://www.oecd.org/els/health/technicalpapers>
- ◆ *Environment, Health and Safety Publications* contain documents related to chemical accidents, good laboratory practice, biotechnology and the safety of novel foods and feeds, pesticides & biocides, risk management, 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 labour market, social policy and migration studies prepared for use within the OECD: <http://www.oecd.org/els/workingpapers>
- ◆ The *Development Centre Working Papers* present, among other subjects, studies on health-related issues in developing countries: <http://www.oecd.org/dev/wp>

Newsletters

Recent developments on OECD work on health are also described in four *newsletters*:

- ◆ *OECD Health Update*: <http://www.oecd.org/health/update>
- ◆ *DELSA Newsletter*: provides information on the most important developments in the work of the Directorate for Employment, Labour and Social Affairs: <http://www.oecd.org/els/newsletter>
- ◆ *OECD Biotechnology Update* provides up-to-date information on the diverse activities at OECD related to biotechnology: <http://www.oecd.org/biotechnology>
- ◆ The *Environment, Health and Safety News* provides an update on the main events and activities of the Environment, Health and Safety Programme: <http://www.oecd.org/env/health>

Policy briefs



Offer summaries of policy challenges and economic developments related to OECD work. Policy briefs on health-related issues are available on the right of the health portal: <http://www.oecd.org/health>

HEALTH ONLINE

The OECD's website includes much information on health-related issues, which can be accessed through:

- ◆ The OECD's portal: <http://www.oecd.org>
- ◆ The OECD's *health portal*, presenting health-related work administered throughout the Organisation: <http://www.oecd.org/health>
- ◆ The OECD's *country portal*, accessible by using the following form: <http://www.oecd.org/country>. For example, the Australian portal is <http://www.oecd.org/australia>.
- ◆ The portals of OECD Divisions working regularly on health issues are:
 - ◆ 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 *Structural Policy Division* (Health-related projects): <http://www.oecd.org/eco/structural/health>

Information on health-related work administered by other Divisions can be found at the general OECD health portal and/or at the relevant Division's portal, accessible from the OECD portal.

Users can tailor the OECD website to obtain the news, events and documentation related to their needs by selecting the themes that interest them most through *MyOECD*, accessible at the top right-hand corner of the OECD Homepage <http://www.oecd.org> and most other OECD pages.

To receive an email alert for OECD Health Update:

1. Register with MyOECD or log in to MyOECD if you already have an account.
2. Make sure the "Health" theme is checked under your profile, then "Submit"
3. Under "Newsletters", select "OECD Health Update" (second page of the registration process).

To change your interests, update your profile. To unsubscribe entirely from *MyOECD*, send an email to OECDdirect@oecd.org and type "Unsubscribe" in the subject field. You will no longer be able to customise the OECD website or receive email alerts from OECD.

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Seppo VARJONEN (STD/PASS)
Health specific Purchasing Power Parities

Felix ZIMMERMANN (DEV/EXT)
New actors in health financing in development

Pascal ZURN (ELS/HD)
Health workforce planning and migration
Swiss health-system review

FUTURE 2007 EVENTS ON HEALTH ISSUES

- ◆ The 3rd sessions of the OECD Health Committee, Paris, France, 24-25 May (Contact: Pat Chardome).
- ◆ The 1st meeting of the Steering Group of the Bioeconomy and Biosecurity Projects, 1 June, Paris (Contact: Anthony Arundel, David Sawaya, Michael Osborne).

- ◆ Workshop on Measuring Education and Health Volume Output, 6 & 7 June, Paris (Contact: Francois Lequiller).
- ◆ The 1st meeting of the Task Force on Health Specific Purchasing Power Parities (PPPs), 8 June, Paris (Contact: Sandra Hopkins, Paul Schreyer and Seppo Varjonen).
- ◆ Conference on mental health quality measurement, Mental Health Experts Subgroup of the HCQI Project, 18-19 June, Copenhagen, Denmark (Contact: Sandra Garcia-Armesto and Mr Niek Klazinga).
- ◆ High Level Forum on Policy Coherence: Availability of Medicines for Neglected and Emerging Infectious Diseases, 20-21 June, Noordwijk-Aan-Zee, Netherlands (Contact: Barbara Slater, Jack Radisch, Jenny Hedman).
- ◆ Comparative country seminar, thematic review on *Sickness, Disability and Work*: discussion of the preliminary draft report on Australia, Luxembourg, Spain and the United Kingdom, end of June (28-29 June, Luxembourg) (Contact: Christopher Prinz).
- ◆ The 3rd meeting of experts on pharmaceutical pricing policy, Paris, France, 24 September 2007, Paris, France (Contact: Elizabeth Docteur, Pierre Moise, Valerie Paris).
- ◆ The 9 Meeting of Health Accounts Experts and Correspondents for Health Expenditures Data, Paris, France, 8-9 October (Contact: Sandra Hopkins).
- ◆ Meeting of OECD Health Data National Correspondents, France, 9-10 October (Contact: Gaetan Lafortune).
- ◆ Meeting of OECD Health Data National Correspondents, France, 9-10 October (Contact: Gaetan Lafortune).
- ◆ Experts' meeting on Health Care Quality Indicators, Patient safety subgroup, Paris, France, 24 October (Contact: Sandra Garcia-Armesto and Mr Niek Klazinga).
- ◆ Experts' Meeting on Health Care Quality Indicators, 25-26 October (Contact: Mr Niek Klazinga and Sandra Garcia-Armesto).
- ◆ The 21st Meeting of the Working Party on Biotechnology, Paris, France, 12-14 November (Contact: Stella Horsin).
- ◆ The 2nd meeting of the Steering Group of the Bioeconomy and Biosecurity Projects, 15 November, Paris (Contact: Anthony Arundel, David Sawaya, Michael Osborne).
- ◆ The 4th sessions of the OECD Health Committee, Paris, France, 19-20 November (Contact: Pat Chardome).
- ◆ Proposed joint session of the Health Committee and the Working Party on Migration, Paris, France, 21 November (Contact: Peter Scherer, Jean-Pierre Garson).
- ◆ The 3rd Meeting of the Working Party on Manufactured Nanomaterials, Paris, France, 28-30 November (Contact: Peter Kearns).

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OECD Health update
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