A new OECD report, *Pharmaceutical Pricing Policies in a Global Market*, assesses the impact of different drug pricing and reimbursement policies in OECD countries. It finds that current practices threaten drug access and affordability in lower-income OECD countries, and distorts incentives for research and development.

Pharmaceutical expenditures—in common with overall healthcare spending—continue to outstrip the average growth of OECD economies. The pharmaceutical sector now accounts for about one fifth of health spending, on average, in OECD countries, rising to a third of health expenditure in Hungary and the Slovak Republic, where pharmaceutical expenditure account for 2 percent of GDP. (continued page 2)
The pharmaceutical market is complicated by several factors. One of these is insurance, which subsidises pharmaceutical expenditures and reduces financial barriers to access, thus increasing the use of medicines. Patent protection provides industry with a monopoly on the market and opportunities to benefit from high prices and profits. Most countries regulate prices for at least some part of the pharmaceutical market, in an effort to ensure affordable access to medicines.

Today’s pricing policies promote a convergence of list prices at levels that are less affordable for lower-income OECD countries. Prices of innovative products are too often defined with reference to what others pay, as opposed to the value offered by the product.

This practice encourages firms to launch drugs in countries where it can set a price freely at market entry or negotiate high prices. It also distorts the signals that the market sends about the value of new medicines. In addition, confidential rebates between buyers and firms create a gap between the list price and the real price paid, meaning that payers increasingly benchmark to artificial prices.

About a third of countries have begun to use pharmaco-economic assessment to decide whether a medicine is worth what its manufacturer wants to charge. This approach, although technically challenging, is promising because it evaluates the costs and benefits of a medicine, and explicitly links purchasing decisions to a drug’s ability to deliver a desired health outcome for a particular population. It gives better signals to the pharmaceutical industry as to which new drugs are highly valued, and so could help promote the right level and type of R&D investment.

As countries vary in income, health care costs and epidemiology, it would be expected that the economic value of a new drug would vary accordingly. One possibility for the future development of the pharmaceutical market would be for policy-makers to agree that variation in prices and expenditures is appropriate and desirable, and to define prices for a product based upon its value in that country. Although attractive as an approach to increase affordable and access while promoting valued innovation, such a scenario depends on the success in limiting the extent of parallel and cross-border trade.

To provide policy-makers and stakeholders with an opportunity to exchange views on the issues in light of the OECD study, a high-level symposium, Pharmaceutical Pricing Policies in a Global Market: Ensuring Affordable Access, Promoting Valued Innovation, was held in Paris on 27 October. Following introductory remarks from OECD Secretary-General Angel Gurría and Symposium Chair Julio Frenk, the future dean of Harvard’s School of Public Health, participants engaged in three rounds of discussion on the topics of affordable access, value for money and valued innovation, and the cross-national impact of policies. A ministerial panel discussion, moderated by Deputy Secretary-General Aart de Geus and featuring health ministers and state secretaries from Hungary, Mexico, Portugal and Switzerland, offered ideas and insights on steps forward, areas for international collaboration and future work by OECD. An agenda, presentations by invited experts and the Secretariat, and the Secretary-General’s speech are available at the project website (see address below).

Recent publication:
Website: www.oecd.org/health/pharmaceutical
Contacts: Elizabeth Docteur Valérie Paris

PHARMACEUTICAL PRICING AND REIMBURSEMENT POLICY IN GERMANY

A working paper on pharmaceutical pricing and reimbursement policies in Germany is the sixth and last to be published as part of the OECD project on pharmaceutical pricing policies. It describes German pricing policies in the broader context of pharmaceutical policies and assesses their performance against a set of policy goals.

The German population benefits from comprehensive coverage and good access to pharmaceuticals. However, the impact of increasing out-of-pocket payments (due to increased co-payments and de-listing of OTC drugs) on affordability and effective access for the poorest part of the population should be monitored.

Germany has succeeded in containing pharmaceutical expenditure growth, compared to other OECD countries. This is largely due to structural reforms, which include maximum reimbursement amounts and constraints on physicians’ prescriptions, but is also to one-shot measures, such as increases in rebates, cost-sharing, and delisting.

Ex-manufacturer and retail prices of pharmaceuticals have been found to be relatively high in Germany. For patented medicines not subject to maximum reimbursement amounts, this situation may be explained by several factors, (i) manufacturers freely set their prices at market entry, (ii) health insurance funds are ‘price takers’, since they are obliged to cover any new drug which is not explicitly excluded from the benefit basket at the central level; they cannot apply differentiated copayments, or restrict use for some indications, and could not, before 2007, negotiate prices with manufacturers, and (iii) manufacturers face incentives to set high prices since Germany is often referred to by other countries using international benchmarking to
regulate the prices of their own pharmaceuticals. For generics, relatively high prices have been attributed to a lack of competition in the distribution chain, and the adverse effect of maximum reimbursement amounts.

Reforms were introduced in 2007 in an effort to tackle some of these issues. Health insurance funds have been given new opportunities to contract with manufacturers. They can now select providers through calls for tenders, conclude price-volume agreements, and provide incentives to pharmacists to deliver the “contracted” products. In parallel, the Institute for Quality and Efficiency in Health Care (IQWiG) will assess the cost-effectiveness of new patented drugs, compared with other available therapeutic alternatives, in order to set a cap for reimbursement by statutory health insurance funds.

New contracting opportunities are believed to have lowered generic prices, although this cannot be assessed through publicly available data. They appear to overlap and occasionally conflict with other existing policy instruments, such as maximum reimbursement amounts, and prescription targets. However, these are expected to disappear with time.

Recent publication:

Website: www.oecd.org/health/pharmaceutical

Contacts: Valérie Paris
Elizabeth Docteur

WHO–OECD DIALOGUE ON MIGRATION AND HEALTH WORKFORCE

The WHO–OECD hosted dialogue on migration and other health workforce issues in a global economy was organized jointly by the World Health Organization (WHO) and the OECD in collaboration with the Swiss Government (Geneva, 20–21 October 2008). The meeting brought together around 150 participants from 35 countries, half of them non-OECD members. Core objectives were to strengthen international collaboration, to identify policy options and to identify priority areas for future research.

The conference was structured around four sessions: (1) Health workforce and international migration: where do we stand, what do we know? provided an overview of recent trends in health workforce migration; (2) Health workforce and international migration: country experiences considered determinants of migration of doctors and nurses as well as linkages with domestic training and human resources management; (3) Retaining the health workforce: challenges for low-income countries discussed how developing countries can better use their human resources; and (4) Policy options provided an opportunity to discuss current policies and what works well.

The Dialogue recognized that health workers are the cornerstone and drivers of health systems. The shortage and uneven distribution of health workers are key constraints to the provision of essential health services, jeopardizing the current efforts to meet the Millennium Development Goals related to health. Experience suggests that addressing health workforce migration issues necessitates a broad range of policies. In response to this, some specific policy developments implemented in several countries were outlined, including need-based planning, reinforcement of the role of intermediate skilled health professionals, action put in place to retain health workers in rural and remote areas and improving co-operation between the different stakeholders at the national and international level.

The Dialogue suggested that:

- progress continue towards a draft code of practice on the international recruitment of health personnel;
- coordination improve between relevant stakeholders within countries (which include donors, government ministries, employers and NGOs) as well as coordination between countries;
- the review and assessment of bilateral agreements and other forms of international co-operation aimed at better managing the international migration of health workers continue;
- additional case studies on key origin countries such as India, China or the Philippines be undertaken, and
- a framework for monitoring migration be put in place, in order to provide a broader picture of changes and make informed policy responses.

Website: www.oecd.org/health/workforce

Contact: Jean-Christophe Dumont

The conference drew on a series of country case studies, as well as the recently published The Looming Crisis in the Health Workforce: How can OECD countries respond? (see above).
THE LOOMING CRISIS IN THE HEALTH WORKFORCE: HOW CAN OECD COUNTRIES RESPOND?

To respond to growing demands for additional doctors and nurses, OECD countries have adopted different combinations of human-resource management and migration policies. However, some similar patterns can be identified.

Intake to medical schools has followed a U-shaped curve in many countries, with a downswing in the 1980s and early 1990s and an upswing towards the end of the last decade. Upward trends in graduation rates have only recently become identifiable in a few countries and, on average across the OECD, the number of medical graduates in 2005 still lies below the 1985 level.

Regarding migration, the contribution of foreign-trained doctors is significant and has increased over time in many OECD countries (see chart). Continuing reliance on migration of health professionals could become problematic for the health systems of certain OECD countries. Despite recent upward trends in doctors’ and nurses’ training rates, potential gaps between the supply and demand of health professionals are likely to emerge in the future, especially in light of demographic changes and increasing incomes.

Human resource management policies can contribute to making the best use of available skills. A review of countries’ experience reveals examples of useful practices, for example, the management practices of ‘magnet hospitals’ for nurse recruitment and retention; the provision of flexible retirement policies and adapted work conditions for older health workers; and the introduction of ICT systems, better care coordination and disease-management programmes to improve workforce productivity.

There are important dilemmas confronting policy makers at both a national and international level when looking for alternative solutions to the health workforce crisis. Supply-side solutions to address structural imbalances between supply and demand do not carry equal weight. At the domestic level, trade-offs are likely to emerge—for example between cost-efficiency and quality-control.

At the international level, there is growing awareness of the implications of migration for resource-poor countries with low health professional densities. International migration can exacerbate the severity of these countries’ problems, regardless of the fact that the human resource needs in the health sector of developing countries are far greater than the number of immigrant health professionals in OECD countries.

The ability to recruit from countries with high health professional densities may not be sustainable in the long-term, if all countries source their recruits from a limited number of origin countries. All these issues call for better tracking and monitoring of the effects of different policy mixes adopted by countries.

The Looming Crisis in the Health Workforce is the synthesis report from a project on the management of health-related human resources and international migration, which was carried out between 2006 and 2008, jointly with the WHO.

Recent publication:


Website:  www.oecd.org/health/workforce

Contacts: Jean-Christophe Dumont
Francesca Colombo

RELEASE OF INTERNET UPDATE FOR OECD HEALTH DATA 2008

An Internet update for OECD Health Data 2008 was released on the OECD Health Data website at the end of October. The update includes more recent data on health expenditure, health employment, hospital activities and long-term care recipients at home or in institutions.

The online version of OECD Health Data 2008 (www.ecosante.org/oecd.htm) is automatically updated, but users of the CD-ROM version of the database will need to download and install the update file from the database website at www.oecd.org/health/healthdata.

OECD Health Data 2008 is available online to subscribers of SourceOECD or on CD-ROM (both
as a single-user version or a network version). Access is now also provided to all national data correspondents, officials in national governments and other international organisations via OLIS, OECD’s on-line information system. The database can be queried in English, French, German, Italian and Spanish. Japanese and Russian are available exclusively in the online version.

**Website:** [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata)

**Contacts:** Gaetan Lafortune  
Marie-Clémence Canaud  
[health.contact@oecd.org](mailto:health.contact@oecd.org)

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**HUMAN RESOURCES IN THE HEALTH SECTOR: STRENGTHENING INTERNATIONAL DATA COLLECTION**

The OECD, Eurostat and WHO have agreed to work more closely to coordinate their data collection on health sector employment. This agreement builds on the success of the Joint OECD, Eurostat and WHO Health Accounts Questionnaire.

In a climate where many OECD countries face shortages of health professionals, comparable data on the supply of health care providers will provide useful benchmarks. These will assist in setting priorities for policies regarding training and employment conditions in the health sector.

One example where this has been of use: an Advisory Committee to the Japanese Ministry of Health, Labour and Welfare recently recommended a change in policy to increase Japan’s capacity to train doctors by 50%, with the aim of increasing the number of doctors per capita in that country from the current rate of 2 per 1000 population to the OECD average of 3 per 1000.

At a meeting held at the end of September 2008, the OECD, Eurostat and WHO shared information on their current work programmes, and explored the possibility of developing a joint data collection.

There was general agreement among the three organisations that any international data collection on health employment should be based on international standards such as the International Standard Classification of Occupations (ISCO), in order to promote data comparability. The three organisations welcomed the progress made by the International Labour Office (ILO) in improving the definitions of health-related occupations as part of the ISCO 2008 revisions. They agreed to provide a common set of comments to ILO to further improve some of these definitions.

The OECD, Eurostat and WHO (European Office) also agreed to explore the further development of a joint data collection in the area of health employment and other health care statistics, based on two key principles: (i) the need to be able to respond efficiently to the information needs of the different organisations; and (ii) the need for a transparent process through which national data correspondents will be kept informed and consulted.

The three organisations recognised that it will be a challenge to combine existing questionnaires. Next steps will involve identifying similarities and differences, with a view to reaching agreement on a common set of variables for joint collection. Approval will be sought by decision-making bodies in each organisation before any joint data collection is implemented.

**Contact:** Gaetan Lafortune

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**NEW OECD/KOREA POLICY CENTRE OPENS ITS DOORS**

The Joint OECD/Korea Policy Centre was officially opened on 7 July 2008. It resulted from the integration of four pre-existing OECD/Korea Centres, including the Regional Centre on Health and Social Policy, which was originally established in 2005.

The health and social research programme of the new Centre promotes policy dialogue and information sharing on health and social policies between OECD countries and non-OECD Asia/Pacific economies.

The main priority of the Centre’s health and social programme is to strengthen data-collection mechanisms, with the aim of building a solid evidence-base for policy analysis. Activities focus on three main areas: social protection statistics (jointly with the ILO and the ADB); pensions policies (jointly with the World Bank); and health expenditure and financing statistics (jointly with the Asian Pacific National Health Account Network, APNHAN, and in collaboration with the WHO). Annual meetings to discuss each of these topics are held in Seoul.

The Centre has encouraged the development of health accounting systems, in order to track health expenditures and financing flows in the Asia/Pacific Region. Seven *System of Health Accounts Green Papers* have been released, covering Bangladesh, Chinese Taipei, Hong Kong China, Mongolia, Korea, Thailand and Sri Lanka. Two more papers on China and Malaysia are in production.

The Centre has hosted annual meetings of Asia-Pacific Health Accounts Experts jointly with APNHAN since 2005. These meetings offer a venue for taking stock of recent developments in health accounts work at a regional and national level, for discussing technical issues and data-collection improvements, and for reviewing the quality of health accounting data and practices in the region. They also provide an opportunity to collate Asia-
Pacific contributions to the global revision of the System of Health Accounts manual.

**Recent publications:**
- SHA-Based Health Accounts in the Asia/Pacific Region (2007): Bangladesh, Chinese Taipei, Hong Kong SAR, Mongolia, Korea, Sri Lanka, Thailand
- OECD/Korea Policy Centre Green Papers

**Forthcoming publications:**
- SHA-Based Health Accounts in the Asia/Pacific Region: China, Malaysia

**Website:** [www.oecd.korea.org](http://www.oecd.korea.org)

**Contact:** Francesca Colombo

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**ADDRESSING PRESSURES ON LONG-TERM CARE SYSTEMS**

There is upward pressure on the demand for long-term care (LTC) services, deriving from population ageing and a growing number of dependent elderly. The OECD Health Division is carrying out data and analytical work to provide key findings, policy-oriented suggestions and options for LTC reform.

In addition to the established data collection on long-term care expenditure, the OECD Health Division also collects data on LTC resources and utilisation. OECD countries had an average of 40 LTC beds per 1 000 people aged 65 and over in 2006, most of which are located in nursing homes.

A large proportion of care is not provided in the LTC units of hospitals or in nursing homes, but in the homes of people requiring such care. However, a pilot study of 12 OECD countries found a larger proportion of total LTC workers in institutions rather than in homes.

The average share of LTC recipients among the oldest age cohort (80 and over) is almost six times the proportion of recipients aged between 65 and 79 (see chart). The gap is larger in the case of women, who account for the majority of LTC recipients overall. Women also represent over 60% of informal LTC caregivers, and over 70% of formal LTC workers. In most countries, the majority of long-term care is provided by informal caregivers, usually in the home of the dependent person.

These data signal some of the challenges that confront LTC labour markets in OECD countries. Faced with a steady or increasing number of elderly people who are disabled, or who need assistance in carrying out activities of daily living, the long-term care workforce in many OECD countries is under pressure. This is due mostly to declines in the supply of informal carers and difficulties in attracting and retaining caregivers to a gruelling profession.

It is also a ‘pull’ factor behind the immigration of low-skilled long-term care workers in some countries. Foreign LTC workers represent around one fifth of the total LTC workforce in Canada and the United States. Apart from immigration and increasing the LTC workforce with domestic residents and further training, other solutions are being considered. These include reducing the need for LTC workers through better coordination of care and enhancing the role of telemedicine.

A review of country experiences highlights the difficulties. For example, how should informal carers be compensated, while maintaining incentives for participation in the formal labour market? Can retention be increased through better remuneration and training? Can scaling up of training programmes help to address shortages and quality shortcomings? And are migration policies targeting LTC workers a viable solution?

**Forthcoming publication:**
- Fujisawa, R. and Colombo, F. "The long-term care workforce in OECD countries. Profile, responses to shortages and selected policy challenges"

**Website:** [www.oecd.org/health/longtermcare](http://www.oecd.org/health/longtermcare)

**Contacts:** Francesca Colombo
Rie Fujisawa
Christine Le Thi

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**2008 JOINT HEALTH ACCOUNTS QUESTIONNAIRE**

This year marked a significant increase in the number of countries submitting data to the Joint OECD, Eurostat and WHO Health Accounts Questionnaire (JHAQ). A combined total of 30 OECD and EU countries returned the Joint Questionnaire—a net increase of four compared with 2007, and eight over the situation of two years ago. Timeliness has also increased. For the first time, Austria, Iceland, New Zealand and Sweden submitted System of Health Accounts...
(SHA) data for the Joint Questionnaire. The prospects for 2009 look equally promising with several additional countries expected to contribute.

The basic methodological framework of the OECD manual *A System of Health Accounts* has become widely accepted since its publication in 2000. It has been adopted as the standard accounting framework for statistics on health expenditure and financing.

The first joint questionnaire was sent out in December 2005. Its purposes were to reduce the burden of data collection for national authorities, to increase the use of international standards and thereby to harmonise national health accounting practices. The positive results and feedback from data providers led to an enhanced 2007 questionnaire and an increase in responses. The 2008 questionnaire has continued to build on this success.

Once validated, the SHA Database allows for the storage, validation and dissemination of the detailed SHA Tables. This database is made available to delegates via OECD.Stat. In addition, summary SHA tables with relevant methodological information will also be made available via the OECD Health Accounts web-page. The full results from the 2008 Joint Health Accounts collection are expected to be published during the 4th quarter of 2008 prior to the 2009 questionnaire being sent out this December.

With the large number of countries submitting the questionnaire this year and the prospect of several more countries planning to submit for the first time or re-initiate SHA implementation in the coming years, the SHA Database provides a valuable source of harmonised and comparable health expenditure and financing data.

**Website:**
www.oecd.org/health/sha/implementation

**Contact:** David Morgan

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**IMPROVING ESTIMATES OF EXPORTS AND IMPORTS OF HEALTH SERVICES AND GOODS**

Globalisation, the increasing importance of the health sector and the removal of regulatory obstacles to economic activities have all fuelled the growth of international trade in health goods and services. Better communications and transportation have facilitated the movement of people, both as patients and independent service suppliers. The demand for statistics on the trade in health goods and services is increasing in order to monitor such trends.

Recent judgements of the European Court of Justice have made it clear that health services in EU Member States do not occur in isolation. Increasingly, there are flows of patients from one Member State to another, sometimes as a matter of individual choice, and sometimes organised through Ministries of Health or sickness funds.

It is estimated that 1 million people travel to Asian countries to receive health care each year, and in doing so contribute approximately US$2 billion to the region’s economy and export income. In Switzerland, exports of hospital services (i.e. services provided domestically to non-residents) were estimated at 3% of the expenditure for inpatient services and 1.4% of total health expenditure in 2001.

Exports and imports of health goods and services in the estimation of overall health spending is not covered well in the current System of Health Accounts (SHA) framework. The changing face of delivery and payment mechanisms (e.g. e-health, tele-diagnosis, the purchase of pharmaceuticals across the internet) has led to increased difficulties in monitoring and tracking the variety of transactions using traditional data sources such as Balance of Payments statistics.

The SHA manual, currently under revision, should include guidelines for health expenditure which relate to both current and future trends in expenditure patterns.

A proposed OECD project aims to provide reliable, timely and comparable estimates of the imports and exports of health goods and services. Inherent in this is a need to identify the diverse range of transactions and flows between domestic health care sectors and non-residents.

In particular, the project aims to:

- improve and revise the current framework of the System of Health Accounts with regard to the treatment and reporting of imports and exports;

- develop guidelines and best practices in the measurement of exports and imports of health goods and services, and evaluate the feasibility of data collection;
• assess the feasibility of collecting and reporting trade in health services according to different categories of entitlement of non-residents, e.g. intra- and extra-regional trade, temporary residency, etc.

Contact: David Morgan

NEW OECD RESEARCH ON WHAT DETERMINES HEALTH

Spending on health care represents a sizeable share of GDP in most OECD countries—9% on average, and more than 15% in the United States in 2006. Health spending is growing rapidly, reflecting population ageing and an increasing demand for better services which are often technology intensive and costly. Since health care is largely financed by the public sector, governments are striving to enhance the efficiency of health systems.

With this in mind, the OECD Economics Department has carried out an extensive analysis to shed light on the contribution of health care and other determinants to the health status of the population, and to provide evidence on whether or not health care resources are producing similar value-for-money across member countries.

There is no perfect measure of a population’s health status. Mortality and longevity indicators (including life expectancy at various ages, premature and infant mortality) remain the best substitutes. While these indicators suffer from some limitations—for example, they are not adjusted for deaths caused by external factors such as accidents and homicide, and they fail to reflect the prevalence and severity of sickness and functional disability—they are highly correlated with more sophisticated measures, such as the Health-Adjusted Life Expectancy (HALE).

Econometric estimations suggest that changes in health spending, in lifestyle factors (such as smoking, alcohol consumption and diet), education, pollution and income have been important factors behind increases in life expectancy and declines in premature mortality since the early 1990s. Educational attainment, income per capita and the consumption of fruit and vegetables have increased in most OECD countries over this period, while smoking and alcohol consumption have generally fallen.

Panel regressions, however, suggest that the surge in health spending per capita—more than 50% in real terms between 1991 and 2003—contributed most to increasing life expectancy at birth in OECD countries, adding about 1.25 years out of a total of 3 years.

Significant cross-country differences in health status remain unexplained, even after accounting for health spending and socioeconomic and lifestyle factors. These unexplained differences can shed light on relative country performance in transforming health care resources into health status.

It is assumed that the omitted variables do not play an important role and that the estimation methods are robust. Supporting this are the very low correlations between the unexplained differences in health status, and recent values of key variables which could not be included in panel regressions – such as income dispersion, obesity and population density.

In addition, the use of a ‘data envelopment analysis’ (DEA) to derive estimates of countries’ relative performance in transforming health care resources into longevity yields results which are remarkably consistent with panel data regressions. These suggest that potential efficiency gains might be large enough to raise life expectancy at birth by almost three years on average for OECD countries, while a 10% increase in total health spending would increase life expectancy by three to four months.

Understanding the links between institutions and the performance of health systems is essential in order to achieve the substantial gains which seem within reach of most OECD countries. At this stage however, it is difficult to relate the estimated differences in efficiency to particular features of health systems, because of the scarcity of data on health institutions. Filling this information gap is the focus of ongoing work carried out by the OECD Directorate for Employment, Labour and Social Affairs, in close cooperation with the OECD Economics Department.

Recent publication:

Contact: Isabelle Joumard

THE OECD HEALTH COMMITTEE SURVEY ON HEALTH-SYSTEM CHARACTERISTICS

The recent OECD Economics Department analysis of health status determinants assessed health spending efficiency using life expectancy and resources injected in health care systems, as well as lifestyles and socio-economic factors (see above).

A second step in this work will explore the links between different institutional characteristics of health systems and their relative performance in spending efficiency.

In May 2008, the Health Committee agreed to develop an information base on health systems’ institutional characteristics. This will draw on
information from recent data collections, supplemented by a survey to collect qualitative information on health financing and coverage, health care delivery, governance and resource allocation in member countries’ health systems.

Along with the quantitative data already available in OECD Health Data, the information collected through the survey will be used to construct indicators of health system characteristics. Indicators could be developed, for instance, to categorise countries according to the public-private mix in financing and provision of health care, the degree of competition among health coverage schemes and providers, the degree of decentralisation in health care decision making, and the extent of patients’ choice.

The survey was prepared during the spring and summer of 2008, and benefited from the comments of Health Committee delegates. It is composed of three sections: health financing and coverage, health care provision, and governance and resource allocation.

The on-line questionnaire was launched on 8 October, and is to be completed by the end of November. The Secretariat will report on the work to the Health Committee in spring 2009.

Contacts: Valérie Paris
Elizabeth Docteur

THE LINK BETWEEN EDUCATION AND OBESITY

Many governments in OECD countries are placing an increasing emphasis on education as a means of tackling the growing obesity epidemic. The Health Division has conducted a detailed analysis of data on education and obesity from a number of countries to further explore this link. The analysis was done in collaboration with the Centre for Educational Research and Innovation (CERI, Education Directorate), as part of the Economics of Prevention project.

The distribution of obesity by level of education in OECD countries shows greater disparities for women, with more educated women displaying substantially lower rates, while mixed patterns are observed for men.

Least educated women are at greatest disadvantage in Korea, Spain, Italy and France, where their chances of being overweight or obese are many times higher than those of their most educated counterparts. Conversely, disparities for women are minimal in England and Australia. Disparities in obesity among men are largest in France, Austria, Spain and Italy, but are still substantially smaller than among women. Male disparities are relatively minor in other countries. In Korea, a reverse gradient is apparent, such that more educated men tend to be more obese.

There is a broadly linear relationship between the number of years spent in full-time education and the probability of obesity. This suggests that the marginal return from education in reducing overweight and obesity is approximately constant.

The causal nature of the link between education and obesity has not yet been proven with certainty. However, using data from France it was possible to ascertain that the direction of causality runs mostly from education to obesity. The strength of the association was only minimally affected after examining reduced educational opportunities among young people who are obese.

The positive effect of education on obesity is likely to occur through at least three factors: greater access to health-related information and improved ability to handle such information, clearer perception of the risks associated with lifestyle choices, and improved self-control and consistency of preferences over time.

However, it is not just the absolute level of education achieved by an individual that matters, but also how such a level of education compares with that of the individual’s peers. The higher the individual’s education relative to her peers, the lower the probability of the individual being obese.

Forthcoming publication:
A joint Health/CERI Working Paper will be released by the end of 2008

Websites: www.oecd.org/health/prevention
www.oecd.org/edu/ceri

Contacts: Franco Sassi
Koji Miyamoto

MENTAL HEALTH AND THE WORKPLACE

Although work can be beneficial to mental health, there is growing concern as to whether employment patterns or working conditions are evolving in ways that may cause or aggravate mental illness.

A recent OECD Employment Outlook chapter provides some new evidence. It documents recent trends in mental health among the working-age population in OECD countries and assesses how changes in the labour market and working conditions affect mental health, using data from a variety of national surveys.

The study finds that in spite of the steep rise in disability benefit receipt for mental illness in many countries, available indicators do not suggest an overall increase in mental health problems.

However, mental health appears to have worsened in certain countries and for certain workforce...
groups. Also, the reported incidence of certain potentially stressful working conditions has increased in Europe. European countries that have experienced the largest increases in the reporting of work-related mental problems also tend to see the largest increases in the reporting of stressful working conditions. In particular, increases in working hours, discrimination and low job satisfaction have been associated with increases in mental health problems.

Finding a job is more beneficial for mental health than being out of work. Mental health suffers when individuals move from employment to unemployment, or inactivity. Longitudinal analysis also shows that the type of employment has a substantial impact on mental health. Employees who change from standard to “non-standard” employment – measured by the type of contract or working hours – generally experience a decline in their mental well-being. However, individuals who were previously unemployed experience a substantial improvement in their mental health when they gain employment. The effects tend to be smaller if they move into a “non-standard” job.

This finding suggests that the policy response to mental health problems in the working-age population should focus on providing direct assistance to the individuals experiencing mental health problems. The goal of targeted policies should be both to support the retention of workers with mental health problems in employment, and to reinforce activation programmes for those already out-of-work. The avoidance or mitigation of stressful working conditions for these workers can also play a significant role in supporting both retention and activation.

**Recent publication:**  
Chapter 4 in “OECD Employment Outlook, 2008” (“Are All Jobs Good for Your Health? The Impact of Work Status and Working Conditions on Mental Health”).

**Website:** [www.oecd.org/els/employment/outlook](http://www.oecd.org/els/employment/outlook)

**Contact:** Ana Llena-Nozal

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**OECD—WORLD BANK REVIEW OF THE TURKISH HEALTH SYSTEM**

Since the beginning of 2008, the OECD and the World Bank have been carrying out a joint review of the Turkish health system. Turkey is in the middle of a major modernisation of its health system under the so-called ‘Health Transformation Programme’, which was launched in 2003. An important milestone occurred in April 2008, when legislation was passed introducing Universal Health Insurance in Turkey.

A first draft of the report of the Review, sent to the Turkish authorities at the end of June, assesses the recent performance of the Turkish health system against efficiency and equity goals and examines the impact of the Health Transformation Programme. It also identifies some remaining challenges facing the health system and makes suggestions about future policies.

The report has now been finalised in the light of comments on the first draft from the Turkish authorities. The final report will be published in early December, with a launch in Ankara.

**Website:** [www.oecd.org/health/reviews](http://www.oecd.org/health/reviews)

**Contact:** Peter Scherer

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**FORTHCOMING REVIEW OF THE RUSSIAN HEALTH SYSTEM**

The OECD has initiated a review of the health system of Russia. This is one of a series of reviews in the Directorate for Employment, Labour and Social Affairs relating to the process of accession of new countries to the OECD. Other reviews will include labour markets and social policies.

As with earlier reviews of health systems—for Finland Korea, Mexico, Switzerland and the forthcoming report on Turkey—the aim is to evaluate the strengths and weaknesses of the Russian health system, and assess how well the country meets the broad objectives of health policy that are common to the OECD. It will also review current policies and assess alternative approaches that might help improve performance.

**Contact:** Howard Oxley

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**Mental Health Policy Brief**

A new Policy Brief collects together key information from a number of recent projects on mental health in OECD countries, as well as relevant data from OECD Health Data.

The Policy Brief outlines the prevalence of mental health problems, their costs and the services available for their treatment. It draws on a chapter in OECD Employment Outlook 2008 to examine the relationship between employment and mental health (see above).

The Policy Brief also presents work from OECD Health Care Quality Indicators Project in developing indicators to measure the quality of mental health care.

**Recent publication:**  
Mental Health in OECD Countries, OECD Policy Brief

**Contact:** Michael de Looper
A JOINT EU/OECD CONFERENCE: IMPROVING HEALTH SYSTEM EFFICIENCY: ACHIEVING BETTER VALUE FOR MONEY

A conference on this subject was held on the 17 September 2008 in Brussels. This collaborative exercise brought together 150 health experts from the two organisations, from the national administrations of member countries and from academia. Based on a series of short background documents, the conference aimed at taking stock of work in the following areas: the potential role of better care coordination, competition and market-type mechanisms in encouraging efficiency and quality; ensuring greater efficiency in pharmaceutical spending; the role of health care quality indicators and ITC; and, the scope for user charges in health systems. The EU and the OECD will jointly publish the conference proceedings.

Contact: Howard Oxley

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OECD REVIEWS ON SICKNESS, DISABILITY AND WORK

A third report in the OECD series Sickness, Disability and Work analyses sickness and disability policies in Denmark, Finland, Ireland and the Netherlands.

This series addresses the problem faced by many OECD countries of long-term sickness and disability benefits having become a “benefit of last resort”, i.e. a benefit for those people of working age unable to succeed in the labour market, but not eligible for work-tested unemployment and social assistance payments.

Pressure on sickness and disability schemes has increased due to the tightening of unemployment schemes, the phasing out of early retirement options, and the increase in labour market demands.

Countries face different challenges. Denmark and the Netherlands have seen rapid increases in the number of young people claiming disability benefits. Both these countries, and Finland, are increasingly seeing people with mental ill-health leaving the labour market to claim disability benefits.

In Finland, people with disability face high unemployment rates; Ireland has very low employment rates for people with disability, which create a high risk of income poverty; and in both Ireland and Finland there is a need for better cooperation across institutions. The report puts forward a range of reform recommendations to help deal with the specific challenges facing each country.

Experiences in all four countries offer interesting lessons on the importance of financial incentives for the main ‘actors’ and institutions. Denmark is a forerunner in regard to incentives for the main public actor—the municipalities—whereas the Netherlands, and to a lesser extent Finland, have strong incentives for employers, one of the main private actors.

Interesting lessons also arise with regard to the political economy of reform. The Netherlands has undertaken comprehensive structural reform in response to widespread perception that the status quo is no longer sustainable. In contrast, Ireland has resisted reform, largely because fewer numbers of people have been on disability-related payments over the past 15 years, compared to other countries. The direction and sequence of policy change in Denmark and Finland is best understood when bearing in mind the strong involvement of social partners in designing and implementing reform.

Additional countries which will be studied in the course of the thematic reviews are Canada and Sweden. Lessons learned from all reviewed countries will be discussed at a high-level policy forum in Stockholm in May 2009 and published in a synthesis report thereafter.

Recent publication:

"Sickness, Disability and Work: Breaking the Barriers (Vol. 3). Denmark, Finland, Ireland and the Netherlands"

Website: www.oecd.org/els/disability

Contact: Christopher Prinz

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POLICY INITIATIVES CONCERNING DIET, HEALTH AND NUTRITION

The OECD Trade and Agriculture Directorate recently completed a study of policy initiatives in diet, health and nutrition undertaken by Ministries of Food and Agriculture. The findings are based on a survey conducted by the OECD Secretariat and a literature review.

The study finds that there has been an increase in government initiatives, mostly centred on increasing available information on diet and health to enable consumers to make more informed food choices, and promoting the consumption of fruit and vegetables.

These initiatives often take place through collaborations between different government agencies, via food labelling information and publicity campaigns, nutritional education programmes for children and adults, promotion of fruits and vegetables, and partnerships with the food industry and producer groups.

There is mounting evidence from a number of OECD countries that school-based programmes
are particularly effective, and so efforts are increasingly focussing on school-aged children.

Defining government roles in modifying food choices is a delicate policy issue. Arguments can be made for intervention, because of rising public costs due to poor food behaviours. But there may also be welfare losses for individuals if choices are restricted. Governments, therefore, opt for promoting an environment conducive to healthy food choices through incentives and information.

Ministries of Food and Agriculture in most OECD countries do not currently play a major role in promoting healthy diets. They are, however, becoming more involved, recognising that the complexity of the issue needs the collaboration of a wide range of actors, including government agencies and the private sector, such as the food industry and retailers.

**Forthcoming publication:**

Policy Initiatives Concerning Diet, Health and Nutrition

**Website:** www.oecd.org/tad

**Contact:** Linda Fulponi

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**HEALTH FEATURES IN THE THIRD HIGH-LEVEL FORUM ON AID EFFECTIVENESS**

Health topics featured significantly in the Third High-level Forum on Aid Effectiveness (HLF3) held in Accra, Ghana on 2–4 September 2008.

A side-event on the Predictability of Health Aid contributed to the debate on aid effectiveness. The discussion illustrated why aid is currently unpredictable, and pointed out the difficulties that this provides for planning and budgeting in developing countries.

The side-event discussed aid blockages and promising ways to make health aid more predictable, options for increased spending on health, and the contribution of results-based financing to longer-term funding and use of country systems.

A Round Table on sectoral application of the Paris Declaration emphasised some of the key factors needed to ensure solid planning and avoid narrow sectoral approaches in aid delivery. The need to invest in key areas such as results-based management, as well as public, financial and information management was highlighted. Time is needed to achieve successful sector reforms. The progress towards better alignment through HIV interventions were showcased.

The Task Team on health as a tracer sector (see the November 2007 issue of Health Update) had prepared a Report (Effective Aid – Better Health) which received wide coverage in various fora.

The health contribution to HLF3 demonstrated the importance of monitoring progress in aid effectiveness in the health sector. The OECD work stream on health as a tracer sector will continue. One concrete development will be the Workshop on Innovative Financing for Development, building on the lessons from health.

The Secretary-General of the OECD, Angel Gurria, linked aid and health in the plenary session on the final day, noting that “Predictability is very important for health, which relies on long-term and recurrent funding to deliver key services”.

**Website:** http://www.oecd.org/dac

**Contact:** Elisabeth Sandor

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**IMPACT OF INTELLECTUAL PROPERTY RIGHTS ON DRUG PRICES IN DEVELOPING COUNTRIES**

This paper analyses the impact of trade related intellectual property rights (TRIPS) on drug prices in seven middle-income countries. An econometric and an explorative analysis, as well as a short case-study on South Africa, provides three key messages: firstly, the introduction of TRIPS in the selected countries tends to have no major impact on the development of drug prices. Country specific factors such as excessive procurement and marketing costs seem to be more important determinants for the observed high price levels.

Secondly, the application of TRIPS safeguards that allow countries to override TRIPS requirements appears to be an important lever to contain drug prices by encouraging competition. There is, however, scope for improvement in the efficient use of these safeguards.

Lastly, with respect to policy implications, middle-income countries should address inefficiencies in local marketing and procurement costs, whereas OECD countries need to improve the coherence between trade and aid policies.

**Forthcoming publication:**

Determinants of drug prices in developing countries—how important are intellectual property rights?

**Contact:** Johannes Jütting

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**INNOVATIVE FINANCING FOR DEVELOPMENT: WHAT ARE THE LESSONS FROM HEALTH?**

As part of the OECD Global Forum on Development, the Development Co-operation Directorate (DCD) and the Development Centre (DEV), together with the Brookings Institution and
IESE Business School (University of Navarra) held a one-day workshop on *Lessons for development finance from innovative financing in health* in Paris, on 7 October 2008.

The second half of 2008 represents a crucial time for high-level discussion of international development, particularly development finance and aid effectiveness. The workshop took place after the Third High-Level Forum on Aid Effectiveness (Accra, 2-4 September) and a few weeks before the Doha conference on financing for development.

Participants in this Global Forum Workshop discussed their experiences with innovative financing mechanisms for development. Focusing on the health sector, and drawing more particularly on a case study on the International Finance Facility for Immunisation, the meeting allowed for a useful lesson-sharing exercise aiming at the improvement and future design of financing mechanisms. Presentations and background documents are now online.

**Website:**
[www.oecd.org/development/globalforum](http://www.oecd.org/development/globalforum)

**Contact:** Elisabeth Sandor

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**HEALTH AND THE ENVIRONMENT**

How much does the environment affect human health? Are air pollution and tainted water shortening our lives and those of our children? These questions have aroused increasing interest in recent years, particularly since the adoption of Agenda 21 at the UN Conference on Environment and Development, which drew the attention of policy makers to the links between health and the environment.

Air pollution is one obvious environmental health threat in OECD countries, contributing to a number of illnesses, such as asthma, and in some cases leading to premature death. Of particular concern is the fact that children are more vulnerable to air pollution than adults, and increased rates of infant mortality have been recorded in highly polluted areas.

At the global level, air pollution is estimated to be responsible each year for approximately 800 000 premature deaths, or 1.4% of all deaths worldwide and 6.4 million years of life lost, or 0.7% of the world total. This burden of disease is most important in developing countries.

Concerns about the impact of air pollution on health and the economy have resulted in measures to mitigate emissions of the most harmful pollutants, such as particle pollution (acids, organic chemicals, metals, and soil or dust particles) and ozone, which affects the respiratory system. Despite national and international interventions and decreases in major pollutant emissions, the health impacts of air pollution are not likely to decrease in the years ahead, unless appropriate action is taken.

Water is another key environmental health issue. Unsafe water supply, sanitation and hygiene are responsible for 3% of all deaths and 4.4% of all years of life lost (YLL) worldwide. But the poorest developing countries are the worst affected; 99% of these deaths occur in non-OECD countries and 90% of those dying are children. Although the health impacts of water-related diseases remain very low in OECD countries (around 0.2% of deaths), some OECD countries are affected more than others.

Other health issues associated with emerging environmental hazards, such as chemical products, will also need to be addressed. Chemical products are used in virtually every man-made product and play an important role in the everyday life of people around the world. However, harmful exposure to chemical products can lead to health problems such as skin diseases, chronic bronchitis, nervous system dysfunctions and cancers as well as damaging the environment.

Policies which improve air and water quality are often cost-efficient. Reductions in levels of particulate matter are beneficial in health terms. Economic studies of water supply and sanitation interventions in both OECD and non-OECD countries demonstrated that benefit-cost ratios vary from 1 to 3.1, suggesting significant cost savings for healthcare. The fact that most of these cost-benefit analyses only consider the health impacts of specific interventions suggests that total benefits (including benefits to the economy and the environment as well) may be underestimated.

Without sufficient efforts, the costs of healthcare from environmental pollution are likely to become greater in the years to come (see also *Short Takes* at the end of this *Health Update*). Appropriate environmental policies should therefore be implemented in order to address those environmental issues that cause the strongest effects on human health.

**Recent publications:**

- OECD (2008), *“OECD Environmental Outlook to 2030”*
- OECD (2008), *“Health and the Environment”, OECD Policy Brief*

**Website:**
[www.oecd.org/environment/outlookto2030](http://www.oecd.org/environment/outlookto2030)

**Contact:** Dian Turnheim
COST OF INACTION ON KEY ENVIRONMENTAL CHALLENGES

Countries today face numerous environmental challenges, such as climate change, air and water pollution and their aggregate health effects, natural resource management, natural disasters and industrial accidents. The costs of not responding adequately to these challenges can be considerable, in some cases representing a significant drag on OECD economies.

Based on a literature review in selected areas of environmental policy, this OECD report suggests that the economic costs of failing to introduce environmental policies that are “sufficiently ambitious”, can be considerable. For example, in non-OECD countries, 1.7 million deaths and 4.4% of the burden of disease (e.g. reduced years of healthy life) have been attributed to unsafe water supply, sanitation and hygiene according to the WHO. Ninety per cent of the deaths involve children under 5 years old.

This report provides introductory perspectives on the methodological issues in evaluating costs of inaction, and discusses some of the future problems likely to be encountered in this very complex area.

Recent publication: OECD (2008), “Costs of Inaction on Key Environmental Challenges”.

Website: www.oecd.org/env

Contact: Nick Johnstone

PUBLIC MANAGEMENT REFORMS IN THE IRISH HEALTH SECTOR

The Public Governance and Territorial Development Directorate (GOV) recently completed its first comprehensive public management review of the Irish Public Service.

These reviews draw on traditional areas of GOV work such as e-government, human resource management and public budgeting, but focus on how they can better support one another in order to advance reform objectives.

One of the innovations of the Ireland review was to use case studies to examine how public management reforms have played out in specific sectors. For the case study “Reconfiguration of Hospital Services in the Health Sector”, the Irish government asked the OECD to examine the difficult task of better rationalising hospital services in the North East region of Ireland so as to ensure high-quality health services. A number of recent events had lowered trust in public health in the region, and finding a workable solution would provide a blueprint for conducting similar reforms in the rest of the country.

The OECD report found that successful reform would require the following elements:

- better integration of health care delivery across acute hospital, primary and community care, and long-term care. This would help to ensure the transition of patients from more expensive acute care to other types of care that are more adapted to their needs.
- increased efficiency through the use of activity-based costing, in order to provide a better align costs and performance and to direct resources where they are most needed.
- a performance dialogue between the Department of Health and Children and the Health Service Executive (HSE), in order to increase accountability and to improve the clarity of roles.
- informed planning through better data collection, e.g. by establishing a national diagnosis-related group (DRG) database in order to better understand patient behaviour, and gain better information on the level and cost of medical consultant activity.
- better labor force analysis and personnel planning, capital expenditure planning, and business and communications plans in order to ensure that budgets, staff and facilities are in place to support change.


Website: www.oecd.org/gov

Contact: Edwin Lau

PRIVATE HEALTH INSURANCE REGULATORY REFORMS IN BRAZIL

This report reviews the regulatory oversight in core economic sectors of the Brazilian economy, including private health insurance. Setting up autonomous sectoral regulatory authorities has been one of the challenges faced by Brazil, in an effort to modernize its
governance framework and adapt it to a market economy.

Brazil reformed its health system at the end of the 1980s, moving towards a National Health Service, and replacing former systems of social insurance. A duplicate private health insurance system emerged to meet the preferences of a socially and economically diverse population.

The reforms called for a regulatory framework to remedy the impact of market imperfections on the private health insurance market. This led to the establishment of ANS, the National Agency for Supplemental Health, which is in charge of ensuring that the private health industry meets its regulatory requirements.

Private health financing is very large in Brazil, accounting for 53% of total health expenditure in 2006. Private health insurance represents 27% of total health expenditure, covering 24% of the population. In terms of net PHI expenditure per capita, expressed in purchasing power parity, Brazil is similar to Ireland or Australia, and is above Spain, Mexico and Italy. This corresponds to a wide and diversified market, with various forms of operators that are progressively consolidating. However, access remains unequal across regions and social groups.

The report discusses the governance arrangements of the national regulatory agency, ANS, its relative autonomy, and the extent of its regulatory powers. It also makes recommendations for reinforcing the capacity for oversight in Brazil by strengthening the powers of ANS, improving transparency and increasing social participation in regulatory processes.

This is one of the first regulatory reviews of countries involved in the OECD Enhanced Engagement process, following that of Russia in 2006. This review will be followed by the review of China, which will include an analysis of governance reforms in the health care sector.

Recent publication:

Brazil, Strengthening Governance for Growth. OECD Reviews of Regulatory Reform (also available in Portuguese).

Website: www.oecd.org/gov/regref

Contact: Stephane Jacobzone

GUIDELINES ON THE CREATION AND GOVERNANCE OF HUMAN BIOBANKS AND GENETIC RESEARCH DATABASES

The OECD Working Party on Biotechnology is developing Council Guidelines on human biobanks and genetic research databases (HBGRDs) through an expert group of member countries. The Guidelines are intended to assist both OECD and non-OECD governments in the development of policies applicable to HBGRDs and to provide guidance for private and public sector HBGRDs.

Research involving data and samples from human biobanks and genetic research databases analysed in conjunction with personal or health data is becoming increasingly important, not only for healthcare but also for drug discovery.

The Guidelines will assist in all aspects of HBGRDs. They cover governance structure and oversight mechanisms, privacy and confidentiality, terms of participation, and access. In addition, funding mechanisms, benefit sharing, intellectual property and commercialisation, protection and security of human biological materials and data are covered. The qualifications, education and training of staff, disposal of materials and data and the process for discontinuation of a HBGRD are also covered.

In Spring–Summer 2008, the draft Guidelines were subject to broad international consultation. The response from a broad spectrum of stakeholders representing OECD member countries and non-member economies was very positive. The draft Guidelines are in the process of being revised for adoption by Council in 2009. The next stage is for the Working Party on Biotechnology to approve a final version in November 2008.

Recent Publication:


Website: www.oecd.org/sti/biotechnology

Contact: Christina Sampogna

KNOWLEDGE MARKETS IN THE LIFE SCIENCES

In the biomedical sector, new mechanisms are emerging to facilitate the trade of a variety of intellectual assets including data, materials, expertise and services. Such ‘knowledge markets’ encourage knowledge sharing and creation—they also increase the speed and efficiency with which health-related research is translated into innovative goods and services.

The Biotechnology Division of the OECD organized an Expert Workshop on ‘Knowledge Markets in the Life Sciences’ in Washington, DC on October 16–17, 2008. Its purpose was to explore how knowledge markets could be used more broadly and to identify what governments may need to do to help make such new markets become a reality.

The workshop explored:

- what knowledge markets are by discussing real world examples of exchange mechanisms;
what are the business, economic and policy incentives behind the creation of knowledge markets in the life sciences;

what types of health data, information, and know-how could create greater added-value if more easily exchanged or traded;

what impacts knowledge markets have on biomedical innovation and health outcomes; and

the factors, including government policies, that influence their development.

The workshop was the first policy meeting to consider how new exchange mechanisms improve access and use of the vast amounts of data, knowledge and information created in the biomedical sciences. Understanding how financial pressures in the biomedical industries are dovetailing with public policy priorities, and ‘not-for-profit/not-for-loss’ business models delivering greater access to intellectual assets, was an innovative part of the workshop.

There was a clear sense that the biomedical research infrastructure is evolving toward a more discrete and collaborative structure. Suggestions on how government policies can influence the emergence of knowledge markets were made.

A Chairman’s summary of policy messages will be made available before the new year, and a Policy Report will be developed in 2009. These will be discussed and agreed by OECD countries through the OECD Working Party on Biotechnology.

Website:  www.oecd.org/sti/biotechnology

Contact:  Bénédicte Callan

BIOMARKERS IN HEALTH—POLICY ISSUES FOR DEVELOPMENT AND USE

An October 2008 workshop organized by the OECD Biotechnology Division discussed how to improve the development and use of biomarkers in health care.

A biomarker is a biological indicator which can be used to monitor the presence or absence of a disease, the progression of a disease, the effect of a treatment, and the toxicity of a drug. Biomarkers are important because they will help deliver safer and more effective drugs to patients and they will be a part of the solution to the pharmaceutical sector’s R&D productivity problems.

Topics of the workshop included data and knowledge sharing for biomarker research, evidence-base and clinical evaluation of biomarkers, the regulatory and policy framework, and business models.

Workshop participants emphasized that the policy environment for biomarker development in precompetitive and ‘proof of concept’ R&D phases functions well. However, there are significant problems surrounding the evaluation of biomarkers which impact both development and use in clinical practice.

There is a need to create an evidence base. The paucity of relevant data, knowledge and studies needed for evaluation has multiple sources (e.g. lack of biomarker data sharing, lack of investment in larger scale clinical evaluation studies and difficulty of accessing health outcomes information). The costs of building the evidence base and of evaluating and disseminating results will have to be shared by industry and government. There is little consensus on how this should be done.

There are significant business challenges in bringing diagnostic biomarkers to market. Diagnostics rate lower with health care payers than do therapeutics. Moreover, evaluating the health and economic benefits of novel diagnostic tests has proven difficult. Firms are unwilling to invest heavily in the development of diagnostic biomarkers unless they are associated with the prescription of a particular drug which leads to a return on the test.

If there are large data requirements for the clinical evaluation of diagnostic tests, experts predict a shift in the diagnostic business model towards that of therapeutics—fewer products make it to market, and they will need to be reimbursed at rates that better reflect their value in health care.

Looking forward, the linkage of multiple markers will deliver individual risk profiles for predictive or diagnostic health data. These tools will be harder to evaluate than the present diagnostic tests, challenging health practitioners, patients and government policy, and creating an uncertain future for personalized healthcare. Better education and training of clinicians, along with better point-of-care information will be required. The experts also noted that direct-to-consumer diagnostic tests and services are rising.

Workshop participants called for better dialogue amongst stakeholders. Governments have a role to play, in order to build consensus on the method of evaluation and the value placed on biomarkers. The workshop proceedings will be developed into a Policy Report, for discussion by the Working Party on Biotechnology, and will be published in 2009.

Website:  www.oecd.org/sti/biotechnology

Contact:  Marie-Ange Baucher
**BIOMEDICINE AND THE OECD INNOVATION STRATEGY**

In November 2007, the Working Party on Biotechnology established a new Task Force on Biomedicine and Health Innovation. This Task Force has been developing a Synthesis Report on the main policy messages emerging from recent work on innovation and health.

The Task Force focused on five issues: (1) access to knowledge and intellectual property, (2) new business models and the fusion and exchange of knowledge, (3) the governance of new research infrastructures, (4) the demand and take up of health innovations in health systems, and (5) the impacts of new technologies on policy.

These messages will be useful information for inclusion in the OECD Innovation Strategy, which was mandated by a Ministerial level Council meeting in 2007. Innovation is increasingly acknowledged as the main driver of sustainable growth, productivity and wealth creation, and so governments have a strong stake in setting up conditions that encourage it.

The Innovation Strategy seeks to identify how the nature of innovation is changing—due to globalisation, the spread of ICTs, improved connectivity and networking, new competitors, new financing and business models, and changing human capital skills and needs—and how policies may need to adapt to meet the opportunities and challenges of today and tomorrow.

The Working Party on Biotechnology sees the OECD Innovation Strategy as an excellent opportunity to synthesize the health-related biotechnology studies and policy recommendations that have been produced over the past several years. These have discussed how to create an environment that is supportive of health innovation, facilitates access to innovations so that they best serve the public good, and includes a receptive end-market for innovations.

The Synthesis Report will be discussed by the Working Party on Biotechnology in November, and a publication based on this report is expected to be released in early 2009.

**Website:** [www.oecd.org/sti/biotechnology](http://www.oecd.org/sti/biotechnology)

**Contact:** Bénédicte Callan

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**HEALTH CARE REFORM IN THE CZECH REPUBLIC**

In the Czech Republic, public finance reform needs to remain a policy priority, particularly in light of upcoming fiscal challenges stemming from population ageing.

A chapter in the 2008 Economic Survey of the Czech Republic considers the initial steps and further reform plans in health care.

**Recent publication:**

OECD Economic Survey of the Czech Republic 2008

**Website:** [www.oecd.org/eco/surveys/czech](http://www.oecd.org/eco/surveys/czech)

**Contact:** Andreas Woergoetter
A BRIEF GUIDE TO THE OECD

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

OECD member countries discuss and develop both domestic and international policies. The organisation analyses issues, recommends actions, and provides a forum for countries to compare experiences, seek answers to common problems, and work to co-ordinate policies.

The Council of OECD is the highest decision-making body of the Organisation. It decides on the annual OECD budget as well as the content of the programme of work. Its members are the Ambassadors of the member countries to OECD, and it is chaired by OECD’s Secretary-General. Once a year, the Council meets at the level of Ministers from member countries. In addition to the Council, around 200 specialised Committees and other bodies (Working Parties, Working Groups, and Task Forces) undertake the OECD’s programme of work. Member countries’ governments nominate participants to the groups.

The main OECD bodies with health activities are:

Committee for Scientific and Technological Policy (CSTP)
- Working Party on Biotechnology
- Task Force on Biomedicine and Innovation

Economic and Development Review Committee (EDRC)

Economic Policy Committee (EPC)
- Working Party 1

Environment Policy Committee (EPOC)
- Working Party on National Environmental Policies
- Working Group on Economic Aspects of Biodiversity

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

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

HEALTH-RELATED OECD PUBLICATIONS

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

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

Newsletters
- OECD Health Update: www.oecd.org/health/update
- DELSA Newsletter, on work by the Directorate for Employment, Labour and Social Affairs: www.oecd.org/els/newsletter
- OECD Biotechnology Update covers OECD activities related to biotechnology: www.oecd.org/biotechnology
Policy briefs

Policy Brief

OECD Health Update

OECD HEALTH ONLINE

- OECD portal: www.oecd.org
- OECD health portal: www.oecd.org/health
- OECD country portal: e.g., www.oecd.org/australia
- OECD Divisions working regularly on health:
  ♦ Health Division: www.oecd.org/els/health
  ♦ Biotechnology Division: www.oecd.org/sti/biotechnology
  ♦ Environmental Health and Safety Division (Chemical Safety): www.oecd.org/env/health
  ♦ Monetary and Fiscal Policy Division (Health-related projects): www.oecd.org/eco/structural/health

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WHO’S WHO IN THIS ISSUE OF HEALTH UPDATE

Members of the OECD Secretariat can be contacted at: firstname.lastname@oecd.org.

Marie-Ange BAUCHER—Biotechnology Division
Bénédicte CALLAN—Biotechnology Division
Marie-Clémence CANAUD—Health Division
Francesca COLOMBO—Health Division

Michael DE LOOPER—Editor, OECD Health Update
Elizabeth DOCTEUR—Deputy Head, Health Division
Jean-Christophe DUMONT—Non-Member Economies and International Migration Division
Helen FISHER—Media enquiries
Rie FUJISAWA—Health Division
Linda FULPONI—Agro-food Trade and Markets
Stephane JACOBZONE—Regulatory Policy Division
Nick JOHNSTONE—Environment Directorate
Isabelle JOUMAR—Monetary and Fiscal Policy Division
Johannes JUTTING—Development Centre
Gaetan LAFORETUNE—Health Division
Edwin LAU—Regulatory Policy Division
Christine LE THI—Health Division
Ana LLENA-NOZAL—Division for Employment Analysis and Policy
Gabrielle LUTHY—Assistant, Health Division
Koji MIYAMOTO—Centre for Educational Research and Innovation
David MORGAN—Health Division
Janice OWENS—Secretary, OECD Health Committee
Howard OXLEY—Health Division
Valérie PARIS—Health Division
Christopher PRINZ—Division for Employment Analysis and Policy
Christina SAMPOGNA—Biotechnology Division
Elisabeth SANDOR—Senior Coordinator on health, Development Co-operation Directorate
Franco SASSI—Health Division
Peter SCHERER—Head, Health Division
Dian TURNHEIM—Environment Health and Safety Division
Andreas WOERGOETTER—Head of Division, Economics Department
FUTURE HEALTH-RELATED EVENTS AT THE OECD

- The 3rd Task Force meeting on Health Purchasing Power Parities. Paris, France, 8–9 December 2008 (Contact: Luca Lorenzoni)
- The 4th session of the OECD Health Committee. Paris, France, 10–11 December 2008 (Contact: Janice Owens)
- The 5th meeting of the Working Party on Manufactured Nanomaterials. Paris, France, March 2009 (Contact: Peter Kearns)
- The 5th session of the OECD Health Committee. Paris, France, 28–29 May 2008 (Contact: Janice Owens)

EDITOR

Michael de Looper
Editor, OECD Health Update
2, rue André-Pascal
75775 PARIS Cedex 16
France
Tel: (33-1) 45 24 76 41
Fax: (33-1) 45 24 90 98
E-mail: Michael.Delooper@oecd.org

MEDIA ENQUIRIES

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

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The OECD Health Update newsletter offers the latest information on health-related work at the OECD.

Intended mainly for delegates to OECD meetings with an interest in health, OECD Health Update will also be informative for the wider health community.

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