

## HEALTH SPENDING AND THE ECONOMIC CRISIS



Health expenditures have risen relentlessly over the past four decades. In many countries during periods of economic expansion, this rise has been similar to the rate of GDP growth. However, when GDP growth faltered, health expenditure continued to rise, leading to an increase in the ratio of health expenditure to GDP.

Except in a handful of cases (e.g. Canada and Finland in the 1990's) real health expenditure did not fall subsequently, so that countries have tended to emerge from downturns with a higher ratio of health expenditure to GDP.

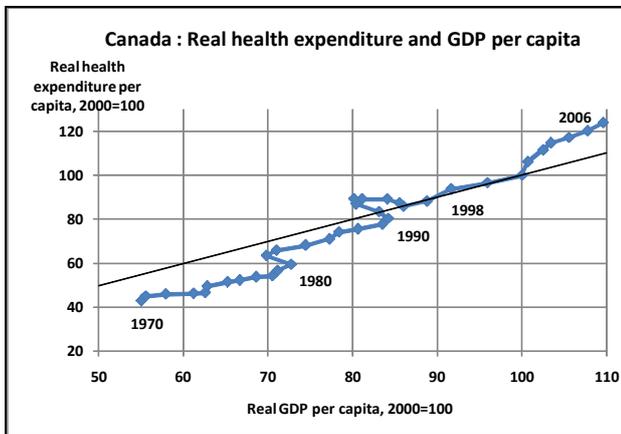
The current economic crisis is more severe than any downturns experienced in the previous 40 years. If health expenditure continues to rise, this will imply a very sharp increase in the ratio of health expenditure to GDP.

Immediate contraction in health expenditure is not desirable, however, even from a macroeconomic viewpoint: during the downturn, health expenditure plays the role of an "automatic stabiliser" holding up aggregate demand.

The issue is a longer term one: what happens once the recovery occurs and public and private finances need to be restored to a viable basis? Will it be necessary for health systems to contract as occurred in Finland and Canada during their recovery from the recession of the early 1990's, and if so what are the possible implications for access to care and for its quality? How can health system managers plan for implementing any necessary slow down or contraction in expenditure? What are the priority cost centres for policy attention in health systems? *(continued page 2)*

HEALTH SPENDING AND THE ECONOMIC CRISIS.....1	HIGH-LEVEL FORUM—'SICKNESS, DISABILITY AND WORK: ADDRESSING POLICY CHALLENGES IN OECD COUNTRIES' .....10
INFORMATION AND COMMUNICATION TECHNOLOGIES IN HEALTH SYSTEMS.....2	HEALTH CARE QUALITY INDICATORS: ENHANCING DATA AND COMPARABILITY .....11
RELEASE OF <i>OECD HEALTH DATA 2009</i> .....3	PROGRESS IN REVISING THE SYSTEM OF HEALTH ACCOUNTS MANUAL .....11
POLICIES FOR HEALTHY AGEING .....3	PILOT STUDY ON HEALTH-SPECIFIC PPP'S .....12
PREVENTING LIFESTYLE-RELATED CHRONIC DISEASES .....4	HEALTH ACCOUNTS IN THE ASIA-PACIFIC REGION: CHINA.....12
MEASURING DISPARITIES IN HEALTH STATUS AND IN HEALTH CARE .....5	COGNITIVE IMPAIRMENT, MENTAL HEALTH AND TRANSPORT .....13
TRENDS IN THE OBESITY EPIDEMIC .....5	A BRIEF GUIDE TO THE OECD.....14
FUTURE SUPPLY OF MEDICAL RADIOISOTOPES IS AT RISK .....6	HEALTH-RELATED OECD PUBLICATIONS.....14
SOCIO-ECONOMIC DIFFERENCES IN MORTALITY: IMPLICATIONS FOR PENSIONS POLICY.....6	OECD HEALTH ONLINE.....15
GROWING DEMANDS ON THE LONG-TERM CARE WORKFORCE .....7	SUBSCRIBE TO <i>HEALTH UPDATE</i> .....15
NEW STUDY ON ADVANCED ROLES FOR NURSES .....8	WHO'S WHO IN THIS ISSUE OF <i>HEALTH UPDATE</i> .....15
REVIEW OF THE TURKISH HEALTH SYSTEM .....8	FUTURE HEALTH-RELATED EVENTS AT THE OECD .....16
HEALTH CARE REFORM IN THE UNITED STATES ...9	MEDIA ENQUIRIES .....16
NEW ZEALAND: CHALLENGES FOR THE NEXT PHASE OF HEALTH CARE REFORM ..... 10	EDITOR .....16

Are there productivity gains which could be achieved which would enable health services to continue to be supplied without increased outlays? Should countries which currently demand little or no payment from patients impose changes to discourage superfluous demand, as Germany has done during this decade? What is known about the impact and success of such measures?



Better data are needed to inform the answers to such questions. The current OECD collections of salaries of particular types of health professionals will need to be expanded into broad indicators of the remuneration paid to health professionals in general. Data on other input costs, including pharmaceuticals and medical equipment, will also need to be improved.

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## INFORMATION AND COMMUNICATION TECHNOLOGIES IN HEALTH SYSTEMS

There is a widespread agreement on the quality benefits that might derive from widespread adoption of information and communication technologies (ICT) in the health sector. Health ICTs are increasingly seen as part of an inevitable process of modernization of the health care system and "e-health as the way of doing business in the 21st century healthcare".

Recognizing this potential, many OECD governments have developed nation-wide strategies, set targets, allocated significant resources and established coordination bodies to promote widespread use of ICTs. Despite this support, implementation of ICTs is proving a difficult and risky undertaking. Getting doctors and hospitals to adopt ICTs requires overcoming a host of financial, technical and logistical obstacles.

OECD project is identifying main blockages and policies, incentives or institutional arrangements under which ICTs can deliver the desired efficiency and quality improvements. Work is based on a review of the literature and an analysis of lessons

learned from case studies in six OECD countries.

Four key questions define the policy issues under study:

- How can OECD countries reap efficiency and quality gains in the health sector through ICTs?
- What are the policies, incentives and institutional arrangements under which an ICT initiative can be effective?
- How do policy makers evaluate the impact of ICT programmes?
- Are there good practices to draw upon?

Preliminary analysis of findings from case studies show that there are a number of actions that governments can take to help pave the way for effective implementation of ICTs.

All case studies show that implementation of ICT can result in substantive changes in the health sector, and in the relationships among health care providers and the roles they perform. They highlight how ICT projects can support 'transformation' in four high-impact areas:

- Primary care renewal (e.g. chronic disease management);
- Improved access to care in rural and remote areas (e.g. to support multipurpose service delivery, tele-health);
- Patient safety; and
- Quality improvement activities (e.g. care coordination and performance reporting).

In all case studies, a range of incentives acted as key motivators and were critical in guiding implementation and effective use.

The case studies illustrate the benefits that can result from a 'value-based approach'. Such an approach is grounded in 3 simple principles: (i) the goal is value for patients, (ii) care delivery is organized around medical conditions and care cycles, and (iii) results are measured.

For example, in British Columbia (Canada), the aim was to deliver more effective chronic care management, a new framework for evidence-based medicine, and then with experimentation with a chronic disease management toolkit integrated with electronic medical record. Financial and other incentives rewarded clinicians who led the shifts to collaborative and evidence-based care. By tracking patient care processes through best practice guidelines and flow sheets, the toolkit allowed physicians to conduct systematic patient monitoring, improve their practice, and report on improvement, particularly for the management of chronic diseases such as diabetes and heart failure.

For many of the ICT efforts included in the case

studies, once the initial funds run out the most significant challenge is the development of a sustainable business model. This appears to have been widely recognized and a number of these business models are emerging.

To discuss these and other findings, national ICT experts from over 14 OECD countries, and representatives from the European Commission, the World Health Organisation and the private sector met in Paris on 25–26 May 2009.

Although the evidence is still incomplete, delegates agreed that there is much more to the adoption of health information technology than cost-efficiency. ICT applications are proving highly desirable—if not necessary—to sustain primary care renewal and to promote better performance and patient safety. Reducing the financial barriers, and obtaining reliable ways to evaluate the benefits of ICTs can be expected to accelerate effective adoption of ICTs.

#### **Forthcoming publications:**

 *Improving Chronic Disease Management through ICTs: British Columbia's Physician Connect Initiative*

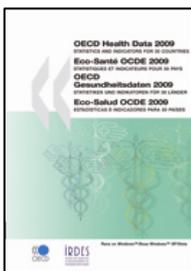
 *Information Technologies in rural and remote areas—The Great Southern Managed Health Network in Western Australia*

 *Information Technology for Performance Reporting: Lessons Learned from the Massachusetts EHealth Collaborative case study*

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## **RELEASE OF OECD HEALTH DATA 2009**



The 2009 edition of *OECD Health Data*, the most comprehensive source of comparable statistics on health and health systems across OECD countries, was released on Wednesday 1 July.

In addition to updating the large number of data series monitoring progress on health status, changing risk factors to health, and the resources and expenditures of health care systems, the 2009 edition adds new information to track developments in the health and long-term care systems, including:

- The availability and utilisation rates of high-cost medical equipment, such as magnetic resonance imaging (MRI) units and computed tomography (CT) scanners, showing some large variations across OECD countries;

- The number of long-term care providers, including both formal and informal caregivers, for a subgroup of OECD countries. These new data complement the extension of the database last year to track the growing number of people receiving long-term care at home and in institutions;
- The total number of people working in the health and social sector, showing that they account for a large and growing part of total employment in nearly all OECD countries. 10% of people were employed in the health and social sector on average across OECD countries in 2007, up from less than 9% in 1995.

*OECD Health Data 2009* is available either online or on CD-ROM to subscribers of *SourceOECD*. Access is also provided to all national data correspondents, officials in national governments and other international organisations, upon request. The database can be queried in English, French, German and Spanish. Italian, Japanese and Russian are available exclusively in the online version ([www.ecosante.org/oecd.htm](http://www.ecosante.org/oecd.htm)).

#### **Recent publication:**

 *OECD (2009), OECD Health Data 2009*

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## **POLICIES FOR HEALTHY AGEING**

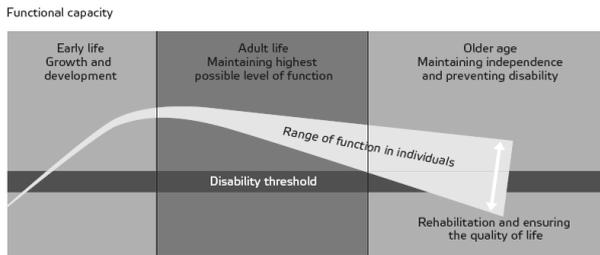
A review of current policies to prevent the onset of old-age disability, or so-called “healthy ageing policies”, was released in February 2009.

With the ageing of OECD countries’ populations over the coming decades, maintaining health in old age will become increasingly important. Successful policies in this area can increase the potential labour force and the supply of non-market services to others.

They can also delay the need for longer-term care for the elderly. A first section of the report briefly defines what is meant by healthy ageing and discusses similar concepts—such as “active ageing”. The report then identifies four different groups of policies: i) working longer and promoting social integration; ii) improving lifestyles; iii) adapting health care systems to the needs of the elderly; and iv) attacking underlying social/environmental factors affecting healthy ageing.

Within each, the range of individual types of programmes that can be brought to bear to enhance improved health of the elderly are described. A key policy issue in this area concerns

whether such programmes have a positive effect on health outcomes and whether they are cost effective.



### A life course approach to active ageing

Looking at specific programmes, the report also suggests that important improvements to the health and welfare of older cohorts seem possible from some combination of: delaying retirement, increased community activities, improved lifestyles, health-care systems that are better adapted to the needs of the elderly, particularly where they are combined with more emphasis on cost-effective prevention.

However, this study also finds that, while there is considerable evidence that certain policy instruments can help improve the health status of the elderly, it remains unclear as to which are the most (cost) effective. Thus, more research is needed in this area if policy choices are to be (more) evidence-based. But whatever the choice of specific programmes, progress towards healthy ageing would probably be enhanced by placing individual programmes within broader policy frameworks that bring together the full range of measures so as to make them mutually reinforcing.

#### Recent publication:

 Oxley, H. (2009), "Policies for healthy ageing: an overview", *OECD Health Working Papers No. 42*

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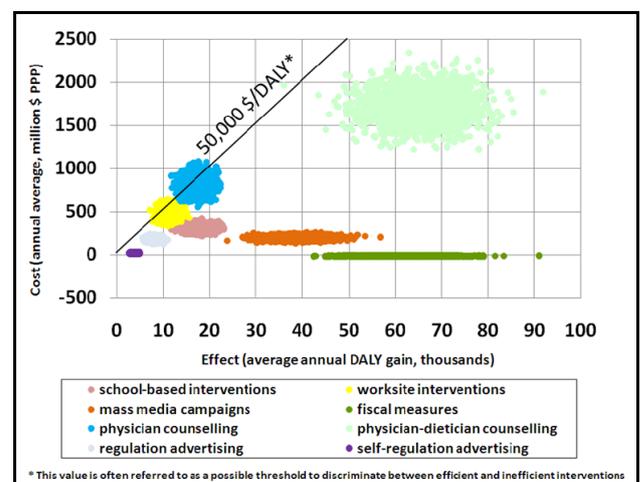
## PREVENTING LIFESTYLE-RELATED CHRONIC DISEASES

OECD countries are increasingly concerned about the spread of unhealthy dietary habits and sedentary lifestyles. Worries have been prompted by rising rates of overweight and obesity, and by an increasing burden associated with chronic diseases such as diabetes.

Most OECD governments have implemented a range of policies to promote healthy lifestyles. These efforts have been hindered by the limited availability of evidence about the effectiveness of interventions in changing lifestyles and reducing

obesity. Evaluations of the cost-effectiveness and distributional impacts of such interventions are even fewer and narrower in terms of numbers of options considered.

The OECD undertook an economic analysis of strategies for the prevention of chronic diseases linked to poor diets, sedentary lifestyles and obesity. The analysis was carried out in collaboration with the WHO, based on a micro-simulation model broadly set in the framework of the WHO-CHOICE (CHOosing Interventions that are Cost-Effective) approach. The aim of the analysis is to assess the efficiency of a range of policy options to tackle unhealthy lifestyles and related chronic diseases, as well as the distributional impacts of such strategies relative to health care costs and health outcomes.



Most of the preventive interventions evaluated as part of the project have favourable cost-effectiveness ratios, relative to a scenario in which no systematic prevention is undertaken and chronic diseases are treated once they emerge. However, none of the interventions assessed in the analysis significantly reduce the scale of the obesity problem, if implemented in isolation. Although the most efficient interventions are found to be outside the health sector, health care systems can make the largest impact on obesity and related chronic conditions by focusing on individuals at high risk. Interventions targeting younger age groups are efficient in the long term, but they will not have significant health effects at the population level for many years.

Successful prevention does not always generate reductions in health expenditure, even when the analysis is limited to a set of diseases that are more directly affected by diet, physical activity and obesity. Governments should determine what levels of resources they are willing and able to spend on prevention, and they may use the findings of this economic analysis to assess what portfolio of interventions would make the best use of such budgets.

**Forthcoming publication:**

 "The cost-effectiveness of preventing obesity and chronic diseases", joint OECD/WHO Working Paper (July 2009)

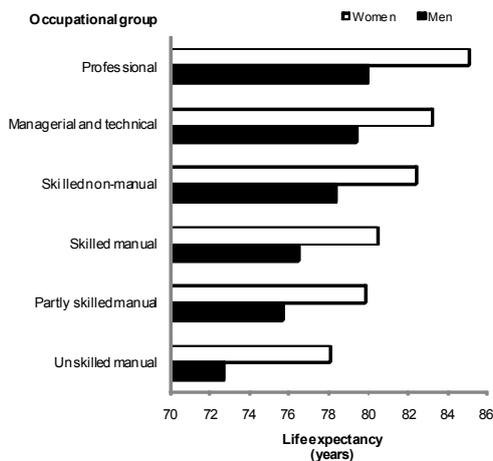
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## MEASURING DISPARITIES IN HEALTH STATUS AND IN HEALTH CARE

In every OECD country, people in lower socioeconomic groups tend to have higher rates of disease, disability and death. They use fewer preventive and specialist health services than expected on the basis of their need, and in some countries they pay a proportionately higher share of their income to do so.

Most OECD countries have endorsed the reduction of inequalities in health status and the principle of adequate or equal access to health care based on need as major policy objectives. These policy objectives require an evidence-based approach to measure progress.



**Occupational group differences in life expectancy, England and Wales, 2002–2005**

Source: ONS Longitudinal Study, 2007

This Working Paper assesses the availability and comparability of data for selected indicators of inequality in health status and in health care access and use across OECD countries. It focusses on disparities among socioeconomic groups, and illustrates these by using national or cross-national data sources to stratify populations by income, education or occupation level.

A number of options are provided for future OECD work on measuring health inequalities, through a small set of indicators for development and inclusion in the *OECD Health Data* database. As a first attempt, the 2008–2009 *OECD Health Data*

collection round assembled information on self-rated health by income category from approximately 10 countries.

Some indicators appear to be more advanced for international data collection, since comparable data are already being collected in a routine fashion in most OECD countries. These include indicators of inequalities in self-rated health, self-rated disability, the extent of public health care coverage and private health insurance coverage, and self-reported unmet medical and dental care needs.

Increased availability and comparability of data will improve the validity of cross-national comparisons of socioeconomic inequalities in health status and health care access and use. Harmonisation of definitions and collection instruments, and the greater use of data linkages in order to allow disaggregation by socioeconomic status, will determine whether health inequalities can be routinely monitored across OECD countries.

**Recent publication:**

 de Looper, M. & G. Lafortune (2009), "Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries", *OECD Health Working Papers No. 43*

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## TRENDS IN THE OBESITY EPIDEMIC

This recent OECD Health Working Paper provides an overview of past and projected future trends in adult overweight and obesity in OECD countries.

Using individual-level data from repeated cross-sectional national surveys, some of the main determinants and pathways underlying the current obesity epidemic are explored, and possible policy levers for tackling the negative health effect of these trends are identified.

Projected future trends show a tendency towards a progressive stabilisation or slight shrinkage of pre-obesity rates, with a projected continued increase in obesity rates.

The results suggest that diverging forces are at play, which have been pushing overweight and obesity rates in opposite directions. On one hand, the powerful influences of obesogenic environments (aspects of physical, social and economic environments that favour obesity) have been increasing over the course of the past 20–30 years. On the other hand, the long-term influences of changing education and socio-economic conditions have made successive

generations increasingly aware of the health risks associated with lifestyle choices, and sometimes more able to handle pressures.

The distribution of overweight and obesity in OECD countries consistently shows pronounced disparities by education and socio-economic condition for women (with more educated and higher socio-economic status women displaying substantially lower rates), while mixed patterns are observed for men.

The findings highlight the spread of overweight and obesity within households, suggesting that health-related behaviours, particularly those concerning diet and physical activity, are likely to play a larger role than genetic factors in determining the convergence of BMI levels within households.

**Recent publication:**

📖 *Sassi, F., M. Devaux, M. Cecchini & E. Rusticelli (2009), "The obesity epidemic: analysis of past and projected future trends in selected OECD countries", OECD Health Working Papers No. 45*

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

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## FUTURE SUPPLY OF MEDICAL RADIOISOTOPES IS AT RISK

The OECD Nuclear Energy Agency organized a workshop on the security of supply of medical radioisotopes on 29–30 January 2009. Over 80 delegates discussed how to ensure reliable future supplies of Technetium-99m (Tc-99m), a medical isotope essential in nuclear medicine imaging.

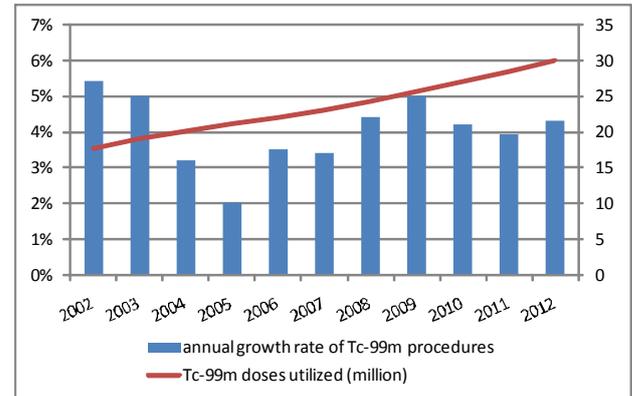
Radiopharmaceuticals employing Tc-99m are widely used in cardiac imaging and scans of lungs, bones and thyroid. Due to their short shelf life, an efficient supply chain is fundamental to assure good service to patients. But there have been repeated regional and global disruptions in supply in recent years. Further disruption is likely in the near future, if no action is taken.

A reliable supply may be ensured in the short-term through the development of contingency plans and by increasing communication along the producer-consumer chain (i.e. between the reactors, isotope producers/distributors and health care professionals).

In the longer-term, the problem looks more serious. Nuclear reactors are designed to last around 50 years and future global demand for isotopes is highly uncertain due to competing, although up to now still more expensive, imaging techniques. Ascertaining whether the existing economic model provides the right incentives at

every stage of the production of radiopharmaceuticals and assessing whether the cost-effectiveness of alternative diagnostic techniques may improve in the medium term would provide crucial information to policy makers. Such assessments will require the involvement of health care authorities.

### Historical and forecast demand for Tc-99m procedures and doses in the US



Adapted from: National Research Council of the National Academies (2009), *Medical Isotope Production Without Highly Enriched Uranium*, National Academic Press, Washington, D.C.

The Nuclear Energy Agency is developing a work-plan based to help inform the discussion between the relevant stakeholders and to assess what solutions and practical measures could be taken.

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## SOCIO-ECONOMIC DIFFERENCES IN MORTALITY: IMPLICATIONS FOR PENSIONS POLICY

Death is certain, but the rate at which people die isn't. How income affects mortality and life expectancy, and what are its implications for pension systems, is the subject of a recent working paper from the Social Policy Division.

This is of particular concern to policymakers because systematic differences in mortality rates across socio-economic groups impinge on the equity and redistribution aspects of pension systems.

Building on previous studies, the paper highlights links between higher levels of income and education, and increased life expectancy after adjusting for other factors such as age, sex, race and marital status. Higher-status occupations have much lower death rates than those of lower-

status, and the differentials are higher for men than for women.

This suggests that the lifetime value of pensions differs significantly across socio-economic groups. In the United States, for example, black males with less than higher secondary education have pensions worth 20% less than the average, whereas Hispanic women fare 13% better than the average.

The paper also provides new estimates of mortality differentiated by income level, using longitudinal data from Germany, the United Kingdom and the United States. Results give a gap in male life expectancy at age 40 of five years between rich and poor in the United Kingdom, with somewhat smaller gaps in the United States and Germany.

The implications of higher life expectancy among the well-off are that UK pensions are worth around 5% less than the average for poorer men and 5% more for richer. The differentials are similar, albeit slightly smaller in Germany and the United States. For women, the differences are much less pronounced. The largest difference is observed for American women; since richer women are living longer than the average, their pensions are also worth 9% more than the average.

These findings have important implications for pension policy. Specifically, how retirement benefits are linked to earnings when working—how redistribution between different socio-economic groups occurs within a pension system, and how differences in mortality across groups reduce or boost this redistribution.

Differences in mortality related to income reduce the progressivity of the pension system, with greater falls for Germany and the United Kingdom than for the United States.

Pension systems that pay the same replacement rate to everyone perhaps unwittingly reward those with longer life expectancy—most usually richer people. Socio-economic differences in mortality suggest that lower-income workers should receive higher pension replacement rates than high earners to avoid the hazard of the poor cross-subsidising the rich.

**Recent publication:**

 Whitehouse, E.R. & A. Zaidi (2008), "Socio-Economic Differences in Mortality: Implications for Pension Policy", *Social, Employment and Migration Working Paper No. 71*

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## GROWING DEMANDS ON THE LONG-TERM CARE WORKFORCE

Who provides long-term care to seniors and other people dependent on help for their activity of daily living? Are we experiencing a shortage of long-term care (LTC) workers? What strategies have countries adopted to address recruitment and retention difficulties? This working paper offers an overview and reviews responses to the growing demand for LTC workers across OECD countries.

In view of population ageing and trends in disability among seniors, it is not surprising that the number of LTC workers has steadily grown over recent years in most OECD countries. The majority are female, working in the informal sector and employed on a part-time basis. In some OECD countries, foreign-born LTC workers have grown to account for up to one-quarter of the LTC workforce. Generally, these workers are middle-aged women from neighbouring countries.

Facing a growing demand for LTC workers, OECD countries pursue three main types of policies:

- First, they have sought to expand supply by developing training programmes and career structure to improve the attractiveness of LTC jobs. Some countries have tried to recruit LTC workers from underrepresented or inactive populations, such as the retired elderly or unemployed people. Some countries, such as Canada, Italy, Japan and Spain have set up policies to facilitate the migration of low-skilled workers to take up LTC jobs.
- A second set of strategies consists of making better use of available labour capacity, for example through better wages and additional benefits. Many OECD countries help support the income or employment of family and other informal carers—either financially or through respite care and other non-financial benefits—in order to help them reconcile work and caring responsibilities.
- A third set of policy solutions relates to reducing the need for LTC workers. The use of information and communication technologies in LTC, such as telemedicine and electronic health records, as well as policies promoting healthy ageing and self-care are examples. A number of countries have also opted to promote healthy-ageing policies, emphasising self-care.

Yet these strategies face associated costs and challenges. Scaling up training programmes and increasing wages and benefits raise public costs in a sector which is already under significant financial strain. Financial compensation to support informal carers needs to be formulated, so that it does not reduce the attractiveness of formal labour market jobs, particularly for women and low-wage workers.

The paper has shown that there is a dearth of data and information, especially regarding what policies work best to build a high-quality and sustainable care workforce. These issues, in addition to those related to the financial sustainability of LTC systems, will be addressed in the 2009–2010 work programme on long-term care.

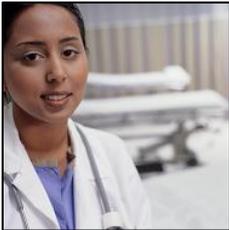
**Recent publication:**

 Fujisawa, R. & F. Colombo (2009), "The Long-Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand", *OECD Health Working Papers No. 44*

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## NEW STUDY ON ADVANCED ROLES FOR NURSES



The OECD is undertaking a new study on the working conditions of nurses, with a particular focus on the changing roles and skills mix between nurses and doctors.

Nurses are usually the most numerous health profession in OECD countries, outnumbering physicians by about three-to-one. They play a critical role in providing health care, not only in traditional settings such as hospitals and long-term care institutions, but increasingly in primary care (especially in offering care to the chronically ill) and in home settings.

The search for a more efficient use of scarce human resources, in a context of growing cost pressures and efforts to maintain or improve quality of care, is leading to experimentation with new roles for nurses in different countries. This experimentation is supported by regulatory and legislative reforms, such as legislation to enable nurses to prescribe pharmaceutical drugs.

This new OECD study, which is co-funded by the European Commission, will review recent initiatives to broaden nurse practices in different OECD countries, and will examine available evidence on the impact on cost and quality of care. It will build on earlier OECD work related to policy changes in health workforce management, which focussed on advanced roles for nurses in England and the United States (*OECD Health Working Papers No. 17, October 2004*).

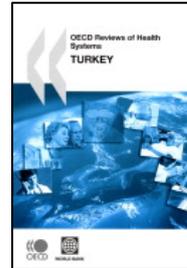
The study will review recent experiences in a greater number of European and non-European countries, and will draw lessons on how new approaches to defining the roles and responsibilities of nurses and doctors might best

be implemented. Results from this study are expected in the first half of 2010.

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## REVIEW OF THE TURKISH HEALTH SYSTEM



On 18 February 2009 a Review of the Turkish Health system was released in English and in Turkish in Ankara. This study, which was carried out jointly with the World Bank, is the fifth review of a national health system which the OECD has undertaken.

The Review highlights that the achievements of Turkey over the past five years have been remarkable in the health care field. Turkey has transformed an unequal and dysfunctional set of partial health care entitlements into a universal entitlement which is underwritten by a rejuvenated hospital sector and an innovative family doctor service.

These achievements need to be consolidated. Better access to hospital services has been underwritten by improved productivity. However, more information is needed on the quality of care provided by Turkish hospitals.

The reform began with improvement in access to the hospitals which Turkish citizens have traditionally turned to for care. However, the government has recognized that improvements in the health status of the population—the ultimate goal of any health system—cannot be achieved by treating diseases and accidents in hospitals alone. It is through the avoidance of serious illnesses, through better public health programmes and appropriate primary care that this goal can best be achieved.

In this respect, the new family doctor system is clearly the way forward. The Report argues that better access to primary care through generalizing the family doctor trials to the whole country is urgent.

The financing challenge facing the whole health insurance system will make it necessary that private institutions which have access to public health insurance funding are subject to the global budget constraints in the same way as publicly owned hospitals. In this matter, Turkey can learn a lot from other OECD countries such as Germany and Japan, which have successfully held increases in health expenditure to a rate consistent with overall economic growth rates.

In order to reduce the burden on employers and encourage employment, contributions to the

Social Security Institute (SSI) by employers were reduced from 21.5% of salaries paid to 16.5% in October last year. This will, it is hoped, have encouraged employers to continue to pay contributions in the face of the current downturn, but it almost certainly means that the total funds available to the SSI from such contributions will have been reduced.

The Report suggests that the Turkish health system will have to rely, at least in part, on budgetary subsidies to the SSI. But the capacity to fund such subsidies will be severely undercut in the current crisis. So, it will be necessary to move to early imposition of global budgets for all categories of health expenditure, and to adjust the payment rates to providers to conform to them.

As in Germany and Japan, this will mean uncomfortable restrictions in the rates of payment to hospitals and to primary care providers. Payments for pharmaceutical purchases will also need to be capped, which will imply either price adjustments or securing larger rebates from suppliers. Capacity controls for private sector facilities, already in place, may need to be tightened if their patients are to continue to benefit from public insurance coverage.

The Report identifies a number of reforms which can both improve care quality and reduce cost pressures. Expansion of nurse training and of the roles attributed to nurses in assessing and administering care can both improve overall care quality and reduce cost pressures, since this will reduce the need for the expensive planned expansion of physician numbers. Formalising user fees would provide additional resources and reduce the ability of providers to impose informal charges on patients. Family practitioners can be encouraged to help reduce cost pressures by receiving rewards for avoiding unnecessary referrals and tests (and by being penalised if they move in the other direction). All such measures will need to be accompanied by a clear campaign of public information to set out the constraints the system now faces.

**Recent publication:**

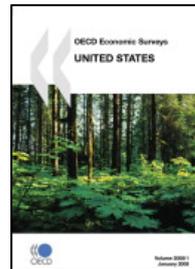
📖 OECD/The World Bank (2008), *OECD Reviews of Health Systems: Turkey*

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

**Contact:** Mark Pearson

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## HEALTH CARE REFORM IN THE UNITED STATES



In spite of improvements, on various measures of health outcomes the United States ranks relatively poorly among OECD countries. Health expenditures, in contrast, are significantly higher than in any other OECD country.

While there are factors beyond the health care system itself that contribute to this gap in performance, there is also scope to improve the health of Americans while reducing, or at least not increasing, spending.

A recent chapter in the *OECD Economic Survey of the United States 2008*, also published as an Economics Department Working Paper, focuses on two factors that contribute to this discrepancy between health outcomes and health expenditures in the United States: inequitable access to medical services and subsidized private insurance policies; and inefficiencies in public health insurance.

It then suggests two sets of reforms likely to improve the US health-care system. The first is a package of reforms to achieve close to universal health insurance coverage. The second set of reforms relates to payment methods and coverage decisions within the Medicare programme to realign incentives and increase the extent of economic evaluation of different medical procedures.

**Recent publications:**

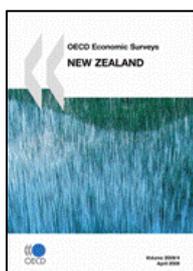
- 📖 Carey, D., B. Herring & P. Lenain (2009), "Health Care Reform in the United States", *Economics Department Working Paper No. 665*
- 📖 *OECD Economic Survey of the United States 2008*
- 📖 *Economic Survey of the United States, 2008, OECD Policy Brief, December 2008*

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

**Contact:** David Carey

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## NEW ZEALAND: CHALLENGES FOR THE NEXT PHASE OF HEALTH CARE REFORM



New Zealand spends less per capita on its health care system than many OECD countries, and its health outcomes are satisfactory. Yet, as elsewhere in the OECD, trends in demography, technology and costs are exerting mounting pressures on spending, jeopardising fiscal sustainability.

The fiscal framework in New Zealand, which imposes budget constraints on health and other spending, provides a foundation for cost control. However, structural reforms are also needed.

Health care spending rebounded over the last decade in the context of a strong economy and fiscal position. The government shifted toward quality and equity objectives, and the experiment with the generally unpopular “quasi-market” competition ended. But large boosts to hospital wages and primary care subsidies have failed to elicit commensurate gains in quantity or quality of output. The new government has pledged to address these shortcomings while avoiding further major restructuring of the sector.

Another concern is to safeguard health care delivery in the face of looming workforce shortages. As a high immigration country with large and poor minorities, New Zealand is striving to promote more equal health outcomes. Improved access to care and more efficient management of chronic conditions—the big clinical challenge of an ageing society—is being sought through an emphasis on primary and preventive care, and a better performing hospital sector.

A number of needs have been identified to achieve these goals. These include bolstering efficiency incentives, improving information flows, clarifying institutional roles and introducing checks and balances appropriate to achieving greater accountability among providers, funders and users of health care.

### Recent publication:

 *OECD Economic Survey of New Zealand 2009*

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

**Contact:** Alexandra Bibbee

## HIGH-LEVEL FORUM—‘SICKNESS, DISABILITY AND WORK: ADDRESSING POLICY CHALLENGES IN OECD COUNTRIES’

A High-Level Forum—the culminating point of several years of work on the thematic review of “Sickness, Disability and Work” policies—was held in Stockholm on 14–15 May 2009.

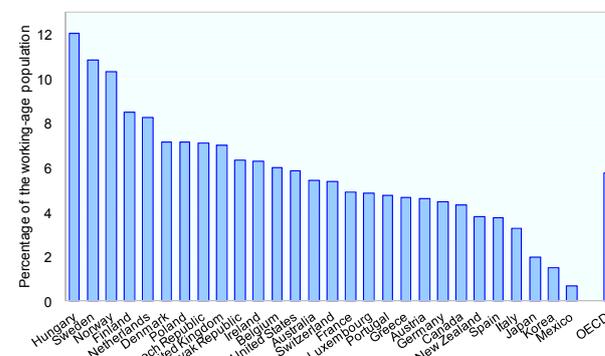
The Forum was hosted by, and co-organised with, the Swedish Government. It was attended by some 140 people from 25 countries, and the European Commission.

The main objectives of this Forum were to:

- disseminate the key policy messages of the thematic review to ministers and high-level executives;
- provide a platform for information exchange, policy learning and cooperation for executives in a large number of OECD countries; and
- hear about the types of new information and analysis that countries need in the future for better disability policies.

The Forum was initially planned prior to any signs of crisis, at a time of increasing concern about the success of unemployment schemes and the failure, in most OECD countries, of disability schemes from the point of view both of the individual and society. Since then, the challenges and priorities have changed. However, there was strong agreement among policymakers and experts alike that rising unemployment should not be hidden in disability schemes. As the Finnish minister said, “we should avoid overreactions like in the recession of the 1990s and make sure to keep our systems in order and ongoing reforms on track”.

There was agreement that the best response to the crisis is a combination of job retention measures, job creation through infrastructure investment and promotion of skills acquisition and training.



**Enormous variation across the OECD in the use of disability benefit**

Feedback on proposed future work indicated a strong interest by Member countries on the proposal to broaden our knowledge on the rise in mental illness as a cause of disability benefit claim, especially among younger adults. There was also some interest in investigating in more detail the impact of the health care system on the functioning of the social protection system.

All relevant information on the Forum, including links to the programme, the background reports, the list of participants and the press release, can be found on the website.

**Website:**

[www.oecd.org/els/disability/stockholmforum](http://www.oecd.org/els/disability/stockholmforum).

**Contact:** Christopher Prinz

### HEALTH CARE QUALITY INDICATORS: ENHANCING DATA AND COMPARABILITY

The HCQI project has taken a major step in improving data comparability for the health care quality indicators. Following a process of methodological analysis, a suite of data quality criteria and rules for standardization were agreed on at the October 2008 Expert Group meeting. These were applied to the new data collection round, which was completed at the end of April 2009.

The purpose was to solve potential comparability problems derived from the variability in data sources and methods of calculation across countries.

Additional information was collected through the annual questionnaire for each indicator, according to 5 criteria:

- Representiveness and scope of the data used for calculations. Only nationwide data (e.g. a census) or representative sample qualify for inclusion
- Completeness of the data source. Only data that cover all population groups or all relevant providers qualify for inclusion
- Regularity of data. Data sources should be able to be updated regularly—at least every 5 years for population surveys, and at least biennially for the other data sources
- Stability of the data source. A source is considered stable if it has been updated at least twice
- Ability to track patients through the system. For indicators where the definition prescribes that the base for calculation is the patient.

Further, countries were requested to submit data so as to allow for uniform age- and sex-standardisation using the OECD 2005 population

as a reference. All the indicators in 2008–2009 data collection are now adjusted for differences in the composition of populations across OECD countries.

30 OECD countries were able to provide data meeting the new quality standards. The set of HCQI indicators has been expanded to 40, including 18 new indicators covering primary care for chronic conditions, mental health care and patient safety. The results of this data collection form the basis for the Quality of Health Care chapter in *Health at a Glance 2009*.

The outcome of the application of the data quality and standardisation criteria has been satisfactory and these requirements will become a regular feature of the HCQI project.

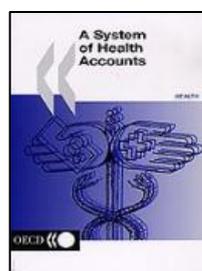
**Forthcoming publication:**

 Chapter on Quality of Health Care, in 'Health at a Glance 2009', November 2009

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

**Contacts:** Niek Klazinga  
Ian Brownwood

### PROGRESS IN REVISING THE SYSTEM OF HEALTH ACCOUNTS MANUAL



The revision of the System of Health Accounts (SHA) Manual, jointly conducted by OECD, WHO and Eurostat, is picking up pace.

The initial proposals for the second wave of units have all been posted on the SHA website. These units cover basic SHA definitions, health providers, health financing schemes and sources, and the beneficiaries of health systems. WHO have conducted a series of regional consultations on these units in April, May and June in Nairobi (African region), Seoul (Asian region), Geneva (Middle-East and Non-OECD Europe) and Fiji (Pacific Islands). OECD was represented at all except the Fiji meeting.

There are three current development projects feeding into the SHA revision. The project on private health expenditure is coming to a conclusion with a workshop on 12 June in Paris. A final report is planned for end June.

The project on improving measurement on trade in health goods and services is now getting underway. The OECD Health Division is coordinating work with the OECD Statistics and Trade Directorates, as well as WHO.

Further information on the SHA Revision can be

found on the website, and questions directed to [SHA.contact@oecd.org](mailto:SHA.contact@oecd.org).

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

**Contact:** William Cave

### PILOT STUDY ON HEALTH-SPECIFIC PPP'S

Purchasing Power Parities (PPPs) are price comparisons of goods and services across countries, and have been carried out for a number of years by the OECD, jointly with Eurostat.

For health services, PPPs have consisted of comparisons of costs per unit of input such as doctor's wages. A better estimation method than comparing costs per unit of input is the comparison of costs per unit of output, and this is the object of the current pilot study.

The feasibility of an output-based approach using information available at country-level through secondary administrative data sets was evaluated. The objective was to estimate a unit cost for selected hospital products in six countries: Australia, Canada, France, Korea, Norway and the United States. The study was coordinated by the OECD and was carried out between April–November 2008.

The proposed approach proved to be feasible. The use of routinely collected information on cost by product has several advantages as compared to a specific data collection for PPPs, viz. larger sample size, greater external data validity, limited costs of collecting data, and a larger number of observations.

The approach used in the study limits possible biases from different coding and patient classification systems in two ways: the first relates to the case types (product) definition, and the second to the use of cost by DRG data.

As to the former, a limited but representative set of products were identified and carefully defined as a first step in the estimation process. This allowed for the selection of diagnoses and procedure codes that match that definition. Regarding the latter, the review of the correspondence between case types and DRGs for two countries—Australia and Norway—allowed for an evaluation of within-DRG variability.

Several lessons were learned from the work carried out with countries.

Firstly, the time invested to carry out the study depends on the diagnoses and procedure codes used in each country, the availability of mapping tables, and the cost object (patient versus group).

The study confirms that it is of great importance for the availability of data that the payment

system is linked to providers' activity, as it makes available detailed cost information which can be used to feed the PPPs comparison.

The proposal of categorizing services into three groups—inpatient medical, inpatient surgical and outpatient surgical—proved to be useful. However, when comparing figures across countries it is of great importance to clearly define the boundaries between day care and outpatient care.

Finally, the pilot study corroborates the practical difficulties in international cost comparison that stem from the fact that a universally accepted costing methodology does not currently exist in the health care sector. There is some evidence that top-down and bottom-up costings generate comparable estimates for the cost of inpatient admissions.

A second round of the study is being carried out in 2009, with the aim of enlarging the number of participating countries to about fifteen. Goals for this round include:

- devising a method of dealing with differences in resource items inclusion/exclusion,
- constructing a first set of volume measures of health services per capita,
- refining the criteria for the case type selection, and
- finalising the current products list.

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

**Contacts:** Luca Lorenzoni  
Paul Schreyer  
Francette Koechlin

### HEALTH ACCOUNTS IN THE ASIA-PACIFIC REGION: CHINA



As part of the System of Health Accounts series, the OECD/Korea Policy Centre has released Technical Paper No. 8, *SHA-Based Health Accounts in the Asia-Pacific Region: China 1990–2006*.

China has provided nationwide spending estimates classified by financing sources and by providers for the years 1990–2006, and in doing so has institutionalized the National Health Accounts (NHA). NHA data are now formally incorporated into routine information systems and are being published annually by the Chinese National Bureau of Statistics. Currently, NHA compilation is undertaken by the China Health Economics Institute for the Department of Planning and Financing of the Ministry of Health.

Average annual growth for total health expenditure in China was 11.4% from 1978 to 2006 (at constant prices). Total health expenditure (THE) as a proportion of Gross Domestic Product grew from 3% in 1978 to 4.9% in 2003, then declined for three years to be 4.7% in 2006.

The general government sector financed 62% of THE in 1990, but the proportion declined to 36% by 2001, before increasing to 41% by 2006. The local and central government sectors accounted for 90% and 10% respectively of health spending funded through general government in 2006. Private health expenditure as a share of THE increased from 38% in 1990 to 59% in 2006. Out-of-pocket payments—which made up the largest proportion of private health expenditure—also increased from 36% of THE in 1990 to 49% in 2006.

There is evidence that private spending has become the predominant health financing source in China. At the beginning of the 1990s, public spending still covered 60% of total health expenditure, with private expenditure covering the rest. Now, these proportions are reversed. Furthermore, private spending increasingly takes the form of out-of-pocket spending, rather than through insurance. In OECD countries, three-quarters of health spending is public, and out-of-pocket spending only accounts for 20% of total spending.

**Recent publication:**

📖 Yuxin, Z. (2008), "SHA-Based Health Accounts in the Asia-Pacific Region: China 1990–2006", Joint OECD/Korea Policy Centre SHA Technical Papers No. 8

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

**Contact:** Luca Lorenzoni

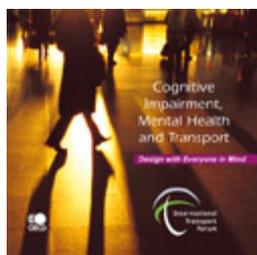
The International Transport Forum is an inter-governmental body within the OECD family. The Forum is a global platform for transport policy makers and stakeholders.

**Recent publication:**

📖 *International Transport Forum (2009), "Cognitive Impairment, Mental Health and Transport", ITF, Paris*

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

## COGNITIVE IMPAIRMENT, MENTAL HEALTH AND TRANSPORT



Cognitive impairment and poor mental health affect a large number of people, for whom the use of public transport can present a challenge.

This new release from the International Transport Forum is one of the first publications to deal with transport policy issues related to cognitive impairment and mental health. It aims to help those who plan, design and run transport systems and infrastructure to understand and find practical solutions to these issues for the benefit of the travelling public as a whole.

## 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](http://www.oecdbookshop.org). Select the subject *Social Issues/ Migration/ Health* from the menu. A list of *Key Health Publications* is also available at [www.oecd.org/health/keypublications](http://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](http://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](http://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](http://www.oecd.org/env/health)
- *Economics Department Working Papers* include studies that addressed the economics of health systems: [www.oecd.org/eco/Working\\_Papers](http://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](http://www.oecd.org/els/workingpapers)
- The *Development Centre Working Papers* present studies on developing countries: [www.oecd.org/dev/wp](http://www.oecd.org/dev/wp)

### Newsletters

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

**Policy briefs**

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

**OECD HEALTH ONLINE**

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

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## FUTURE HEALTH-RELATED EVENTS AT THE OECD

- HCQI Patient Experiences subgroup. Paris, France, 25 September 2009 (Contact: Isabelle Vallard or Aidan Curran)
- 4th Task Force meeting on Health Purchasing Power Parities. Paris, France, 6 October 2009 (Contact: Isabelle Vallard or Aidan Curran)
- 11th Meeting of National Health Accounts Experts. Paris, France, 7–8 October 2009 (Contact: Isabelle Vallard or Aidan Curran)
- Health Data National Correspondents Meeting. Paris, France, 8–9 October 2009 (Contact: Isabelle Vallard or Aidan Curran)
- HCQI Primary Care subgroup. Paris, France, 22 October 2009 (Contact: Isabelle Vallard or Aidan Curran)
- HCQI Patient Safety subgroup. Paris, France, 23 October 2009 (Contact: Isabelle Vallard or Aidan Curran)
- The 6<sup>th</sup> session of the OECD Health Committee. Paris, France, 14–15 December 2009 (Contact: Janice Owens or Isabelle Vallard)

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## OECD Health Update

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

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