Health Update

Internal Co-ordination Group for Health (ICGH)

No. 2 – JANUARY 2006

Introduction

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

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OECD-WHO FRAMEWORK FOR COOPERATION

A Framework for Co-Operation was signed by OECD Secretary-General Donald Johnston and Director General of the World Health Organization (WHO) Lee Jong-Wook on Tuesday, 8 November 2005 in Geneva, Switzerland. The occasion formalised an agreement to reinforce organisational co-operation by establishing modalities for the joint planning and co-ordination of their work. It also set forward a set of mutually agreed priorities for future co-operative efforts in four areas: statistical description of health systems; analysis of health systems (including their financing and efficiency), biotechnology, food safety, chemicals management and environment; and development assistance. The agreement replaces one previously agreed in December 1999.

JOINT OECD-EUROSTAT-WHO HEALTH ACCOUNTS DATA-COLLECTION INITIATIVE LAUNCHED

The System of Health Accounts (SHA) proposes an integrated system of comprehensive and internationally comparable accounts and provides a uniform framework for reporting health expenditure data. Since the release of the OECD SHA Manual in 2000, experience has shown that implementing the SHA and harmonising national practices constitute demanding tasks both for national agencies and international organisations. Last year, OECD, Eurostat and WHO agreed to intensify their collaboration through a joint data-collection initiative that involves the 25 EU member countries and the 11 OECD member countries that are not members of the EU. The main goal is to reduce the data-reporting burden of national authorities providing data to international organisations. Moreover, a joint effort to prepare methodological guidelines and verify data will be made in the interests of increasing the use of international standards and definitions.

The discussion on the draft questionnaire of the joint data collection was one of the most important items on the agenda of the OECD Experts Meeting (September 29-30), and the EUROSTAT Technical Meeting (September 21-22). As a result, the final version of the questionnaire benefited from the feedback provided by health-accounting experts.

The joint questionnaire was sent to countries concerned in mid-December, with a deadline for returning the completed questionnaire of 31 March, 2006.

Website: http://www.oecd.org/health/sha; (See documents associated with the joint questionnaire.)

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HEALTH EXPENDITURE DATA DEVELOPMENTS IN THE ASIA PACIFIC REGION

A joint meeting of the OECD/Korea Regional Centre on Health and Social Policy and the Asia Pacific National Health Accounts Network was held in Seoul, Korea on 5-6 December 2005. Key outcomes from this well-attended meeting included a proposal that the network should meet annually in future to discuss countries' progress with implementation of the System of Health Accounts, as well as implementation of a health expenditure data questionnaire jointly agreed by OECD and the World Health Organization.

The OECD/Korea Regional Centre on Health and Social Policy was created in 2005 to promote policy dialogue between OECD countries and non-OECD Asian economies (as well as between the OECD Secretariat, Korean and other Asian OECD members); to provide capacity-building assistance in the Asian region; to conduct information-sharing and policy analysis on health and social policy topics and to translate these research outcomes into policy action.

OUT-OF-POCKET SPENDING FOR HEALTH CARE

Out-of-pocket expenditures are increasing as a share of total expenditure on health in many OECD countries, although there are significant differences across countries in the extent and design of cost-sharing requirements. Given the increasing role of out-of-pocket spending in total financing for health in many countries, there is demand from policy

makers for more information, including basic data for comparisons at the international level.

Moreover, there is the need to search for ways to improve sources and estimation methods for private expenditure on health more general, because it is widely recognised that there is greater uncertainty about the level and structure of private spending than is the case for publicly financed health care. Against this background, the OECD organised a workshop on out-of-pocket spending in September 2005 to explore ways of improving the international information base and to have an exchange of good practice examples. The workshop was funded by a grant from the German Federal Ministry of Health and Social Security.

Presentations at the workshop included a report on a recent study commissioned by the German Ministry of Health and Social Security on detailed cost-sharing regulations and spending levels in nine OECD countries, and presentations on current data reporting standards in the United States and Korea. The Secretariat provided an overview of recent trends and policy issues, as well as an assessment of avenues for future improvement of data through alternative data sources (*e.g.* household surveys) and estimation strategies.

TRAINING COURSE IN HEALTH FINANCING

The OECD regularly conducts training courses through the Joint Vienna Institute (Vienna, Austria) for officials from countries in the course of economic transition. In November 2005, the OECD's Non-member Economies and International Migration Division and the Health Division, both part of the Directorate for Employment, Labour and Social Affairs, co-operated in developing a course on *Sustainable Financing for Health Care: Improving Information and Regulation*.

The main goal of the course was to show how information needed for policy-makers contemplating or undertaking health-system reforms can be supplied through health accounts. The first part of the seminar provided an overview of recent reform experiences in OECD countries, with a focus on efforts to ensure sustainable financing in light of growing health expenditures. Key issues in improving the measurement of health-system performance were examined. The second part covered the basic theoretical and methodological issues of the System of Health Accounts (SHA), as well as experience with SHA implementation in OECD countries. Case studies of Germany, Norway and Portugal that were presented by leading health-accounts experts from the three countries provided an in-depth look at the technical complexity and organisational conditions required for successful SHA implementation. Finally, a discussion of future challenges for health financing closed the seminar.

Twenty-seven participants came from the ministries of health, ministries of finance and statistical offices of eleven Central and Eastern European countries, including Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Serbia and Montenegro, the Slovak Republic and Slovenia. The evaluation by participants suggested that the goals of the course were well-met and that participants were satisfied with their experience.

Website: http://www.jvi.org; for more details on the JVI.

HEALTH AND LONG-TERM CARE EXPENDITURE PROJECTIONS

In follow-up to previous work on social expenditure projections related to ageing trends, the OECD Economics Department carried out a new set of projections of health and long-term care public spending for the period 2005-2050. These projections extended the previous framework by incorporating both demographic and non-demographic drivers of expenditure. Main **non-demographic drivers** are income growth, the effect of technical progress and some specific effects such as the decrease of informal long-term care associated with a higher projected participation of women and older workers in the labour force. The treatment of **demographic drivers** has also been improved by adjusting the effect of ageing by the possibility of remaining healthy longer.

The results point towards an increase in total OECD health spending in a range of 2 to 7 percentage points of GDP for the period 2005-2050 (from an average expenditure level of around 7% of GDP in 2005), a range which reflects the many uncertainties surrounding these projections. Under reasonable assumptions – and assuming that public authorities implement adequate measures to contain spending – pressures would still produce an average increase of

3 to 4 percentage points of GDP over the same period, a number that has to be considered in the context of other ongoing social-expenditure pressures (*e.g.* pensions, social minima) and potential lower growth prospects associated with ageing trends. Starting from a low base, demand for **long-term care** is going to increase steadily over the next decades and is projected to account for roughly half of the increase in expenditures. On average, ageing accounts for most of the spending pressures of long-term care, in contrast to **health care** expenditures where non-ageing factors are more important.

Results differ markedly across countries, depending on relative influence of ageing and non-ageing related factors and catch-up effects. A group of countries stands out with very large increases of health spending. It includes countries that will experience a dramatic change in their population structure starting from a low expenditure base (Korea, Mexico, Slovak Republic, Poland), and fast-ageing countries that could be confronted with a substantial increase in the demand for formal long-term care (Italy, Ireland, Spain). In contrast, countries such as Iceland, Denmark and Sweden are in the lower range of projected expenditure increases because they are in a mature phase of their ageing process and already devote a relatively high share of their GDP to public health spending.

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TRACKING HEALTH CARE QUALITY

The aim of the OECD Health Care Quality Indicators Project is to develop a set of indicators that can be used to raise questions for future investigation regarding quality of care across OECD countries. Since its initiation in 2001, the Project has focused on an initial set of indicators that were based on previous work completed by the Commonwealth Fund and the Nordic Group of Countries. The Project's work has become internationally known through its Expert Group and its five indicator panel reports in the priority areas of cardiac care, diabetes care, mental health care, primary care and prevention and patient safety (released in 2003).

Initial reports completed – The first two major technical reports of the HCQI Project were released in January 2006. The quality framework laid out in *OECD Health Working Paper 23: HCQI Conceptual Framework Paper* represents an exhaustive review and synthesis of the major health system frameworks in use in both OECD countries and international organizations such as WHO. It focuses the present work of the HCQI Project on the areas of effectiveness, patient safety and responsiveness while situating the project in the broader context of health systems performance. The purpose of *OECD Health Working Paper 22: The HCQI Initial Indicators Report* is to present a set of indicators that are designed to raise questions for further investigation regarding quality of care across countries. The paper discusses the many methodological issues and solutions in comparing health care quality across countries and the key results of the paper are presented below.

Key Results of the HCQI Initial Indicators Report, OECD Health Working Paper 22

- Differences across countries in quality of care indicators may exist for a variety of reasons, including disease incidence, prevalence of risk factors (age, gender, etc.) and quality of care. The indicators in the HCQI Initial Indicator Set should be used to raise questions for further investigation on why differences exist.
- No country is among the best countries on all the indicators and no country is among the worst countries on all the indicators. In addition, most countries have one or more indicators where their high performance may warrant further investigation to determine if possible "best practices" exist for modelling by other countries.
- After extensive data comparability studies, the indicators recommended as suitable for use in an initial HCQI indicator set are:
  - Breast Cancer Survival
  - Mammography Screening
  - Cervical Cancer Survival
  - Cervical Cancer Screening
  - Colorectal Cancer Survival
  - Incidence of Vaccine Preventable Diseases
  - Coverage for basic vaccination
  - Asthma mortality rate
  - AMI 30-day case fatality rate
  - Stroke 30-day case fatality rate
  - Waiting time for femur fracture surgery
  - Influenza vaccination for adults over 65
  - Smoking rates

Focusing the list of future indicators – The HCQI Project undertook to focus the list of future indicators by reviewing data availability and importance ratings for all of the 85 potential Phase II indicators. The HCQI Project team also gathered data from participating HCQI countries from March to November 2005 on the availability of data for 85

potential indicators that were recommended for use in the HCQI Project as part of the expert panel reviews in the five areas cited above. Based on a review of data availability and clinical and policy importance, the Expert group recommended five new measures for data collection in early 2006. Data collection will start in late January. These are:

Diabetes	• Lower extremity amputation rates • Annual eye exam
Patient safety	• Postoperative hip fracture • Complications of anaesthesia
Primary care and prevention	• Hospitalisation for ambulatory care sensitive conditions

Website: http://www.oecd.org/health
Under the theme: health care quality

Recent papers:

- *OECD Health Technical Papers No. 14-18*

Forthcoming papers:

- *OECD Health Working Papers No. 22 and 23*

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RELEASE OF *HEALTH AT A GLANCE – OECD INDICATORS 2005*

The new edition of one of the OECD's flagship publications, *Health at a Glance – OECD Indicators 2005*, was released in November 2005. The main purpose of this publication is to present, to a broad audience, a selection of key indicators from *OECD Health Data* in a clear and user-friendly format, along with a brief interpretation of the data.

The release of the 2005 edition of *Health at a Glance* led to widespread media coverage, which was further enhanced by the simultaneous release of country specific press announcements by a number of member countries. The translations of the publication into German, Italian, Japanese, Korean and Spanish, in addition to the usual English and French versions, should also lead to a greater dissemination.

The publication provides striking evidence of large variation across the 30 OECD countries in health spending and financing, as well as in the design of health-care delivery systems and the outcomes they achieve. Compared to previous editions, it contains an expanded set of indicators related to health promotion and disease prevention. *Health at a Glance* shows among other things that OECD countries spend, on average, only 3% of their health budgets on prevention and public health programmes, in spite of the growing awareness that a greater focus on prevention might help to improve population health while reducing pressure on health care systems.

Health at a Glance – OECD Indicators 2005 presents comparative data on four key dimensions: health status (life expectancy and leading causes of mortality), health care resources and their utilisation (practising physicians and nurses, medical technologies, vaccination coverage among children and elderly people, and hospital activities), health expenditure (including a breakdown between spending on curative care, pharmaceuticals and public health programmes), and non-medical determinants of health (tobacco, alcohol and food consumption, as well as overweight and obesity problems).

This new publication highlights opportunities for all OECD countries to improve some aspects of the performance of their health systems.

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

Recent publication:

- *Health at a Glance – OECD Indicators 2005*

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EFFICIENCY IN HEALTH-CARE SERVICE DELIVERY

The demand for health care is becoming increasingly dominated by chronic conditions – often associated with population ageing – such as diabetes, cancer, congestive heart diseases and asthma. These conditions are placing increased pressure on health-care systems in terms of both service delivery and costs. Breakthroughs in diagnostic and therapeutic technologies have permitted care to be provided in an ambulatory

rather than an inpatient environment. At the same time the increasing complexity and specialisation in medicine has reinforced the fragmentation of the health care system across levels of care provision and among professional groups. This development has made it more difficult for individuals to find the best care in the most appropriate setting.

Care coordination refer to system-wide efforts or formal policies to insure that patients receive services that are appropriate to their needs, integrated across service settings and over time and that support higher health outcomes. The main objective of this OECD project is to assess the scope for (and the current role of) care coordination in achieving higher quality care at lower cost through a comparative analysis of such policies across countries.

This study will first look at policy approaches intended to increase efficiency in health-care delivery, identifying: a) the importance of coordination problems within individual health care systems and sectors; b) existing coordination policies and their scope; and, c) institutional and managerial barriers to improved coordination. The latter includes problems such as governance/responsibilities for care at different levels of government, poor transfer of information between health professionals and institutions; fragmented financing of care; payment incentives and the professional profiles of providers. This information will be gathered by a survey supplemented by a literature review. A second part of the project will attempt to link this institutional information to data on effectiveness and efficiency (*e.g.* health outcomes and inputs).

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COMPETITIVE MECHANISMS FOR ENHANCING EFFICIENCY OF HOSPITAL SERVICES

In a recent meeting, the OECD Working Party on Competition and Regulation focused on competitive mechanisms for enhancing the efficiency of hospital service provision. Because of the high percentage of national income and government budget typically associated with the provision that hospital services and because there is substantial evidence of hospital services could often be delivered more efficiently than they are, a number of OECD countries have increased the extent to which competitive mechanisms are adopted to increase the efficiency of hospital care delivery.

Hospital services are complex set of products and services than comprise many different types of patient-oriented activities. Services are not all equally subject to competition. For some services, such as emergency services, a hospital may have few if any competitors. For other services, such as inpatient scheduled surgeries, a hospital may compete for patients with other hospitals that offer comparable care. Tertiary services, such as open-heart, transplant, burn unit and neonatal, may not be offered by many hospitals. For some services, such as diagnostic services, specialist consultations and outpatient services hospitals may at times compete with diagnostic centres, doctors' offices and ambulatory surgery centers. Many laboratory services can also be performed in independent laboratories.

Competition between providers of hospital services can have a number of impacts, including reducing excessive hospital stays, reducing costs of providing care and improving quality of care. Mechanisms for increasing competition or market forces include:

- Collecting and distributing improved information on provider performance;
- Supporting new entry when entry and exit costs are low;
- Encouraging independent or private operation of facilities;
- Improving allocation of human resources, particularly through reducing anticompetitive restrictions by professionals;
- Introducing prospective pricing in combination with benchmarking;
- Physician-led purchasing;
- Providing for greater consumer choice, particularly when waiting lists are long;
- Introducing contestable management of hospitals; and
- Applying competition law in circumstances where public policy focuses on pro-competitive mechanisms.

The impact of the introduction of competition depends on the form of competition, the health-care financing system, the hospital payment system, the types of services in question, the types of potential providers, the possibility for entry of new providers, the regulatory system and the social mores the governed the provision in demand for health care. A competitive mechanism that might work in one

system will not necessarily transfer well to another. Moreover, competitive mechanisms may at times increase costs. As health policy makers increase reliance on competitive mechanisms, they may need to think carefully about structural market conditions and potentially involve competition authorities when it appears that participants in the market are acting to restrain or eliminate competition.

Future publications:

- *OECD Competition Committee Roundtable, "Competitive Mechanisms for Enhancing Efficiency in the Provision of Hospital Services"*

Contact: Sean Ennis

GEOGRAPHICAL EQUITY OF HEALTH SYSTEMS IN OECD COUNTRIES

A number of recent health care reforms in OECD countries have promoted decentralisation of a wide range of financing, planning and management activities. Decentralisation is expected to increase the efficiency and accountability of national health systems, but it may also generate geographic disparities if resources and competencies are unevenly distributed among regions. In order to ensure geographic equity in health, it is essential that decentralisation be accompanied by effective equalisation mechanisms.

Observable international differences indicate that some OECD countries could benefit from the experience of other members in this field. How do national governments assess the health needs of their regions? What are the resource allocation mechanisms available to respond to these needs? Are there significant international differences in the degree of geographic equity in health among OECD countries?

The OECD project on geographical equity of health systems aim to answer those questions by:

- understanding how national governments allocate resources to regions,
- making international comparisons of equity in health care supply and health status based on a common set of regional indicators.

The methodology and indicators used in this project are based on those adopted for the purpose of international comparisons in OECD's *Health at a Glance (2003)*.

The project is based in the Directorate of Public Governance and Territorial Development (GOV) and is led by the Statistics and Indicators Unit (SIU) in co-operation with the Health Division (HD) of the OECD Directorate for Employment, Labour and social Affairs.

Website:
http://www.oecd.org/gov/territorialindicators

Future publications:

- *OECD Regions at a Glance 2007*

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OECD REVIEW OF FINLAND'S HEALTH SYSTEM

A review of the Finnish health system has been completed by the Health Division at the request of the Ministry of Social Affairs and Health in Finland. The report on the review was released at a press conference in Helsinki on 7 December, 2005.

The report concludes that overall, the Finnish health system performs well. Finns are more satisfied with their health care system than people in many other OECD countries. It is low-cost in terms of health spending as a share of GDP (7.4% in 2003 compared with OECD average of 8.8%) and municipal spending on health services has been well controlled. Deaths from heart attacks and strokes have dropped sharply over the past 30 years and delivery of quality medical care includes high rates of screening for cancer, high rates of kidney transplants as a proportion of patients with renal failure, and rapid treatment of broken hips.

The system is not perfect though. Public spending on prescribed drugs has rising more rapidly than health expenditure generally, partly because public reimbursement is open-ended under Finland's National Health Insurance scheme. There are inequities in access to general practitioner services – people with access to occupational health service doctors seem to have higher rates of consultations than those who rely on health centre doctors, after allowing for income and need. Until recently, many patients faced long waits to see a doctor at a health centre and there were extensive waiting lists for

elective surgery. However, the introduction of waiting-time targets by the government in March 2005 seems to be reducing these waiting times.

The Finnish health system now faces severe challenges including: technological changes which are pushing up the costs of hospital services and prescribed medicines; rising patient expectations; and a rate of population ageing which will be much more rapid than other European countries between 2010 and 2020.

Recent reforms to the system are well designed but they do not go far enough. The OECD report includes over 20 recommendations for improving the system. These include to:

- improve access to health centre doctors to increase equity;
- reduce the number of districts managing hospitals;
- introduce financial incentives to support the new waiting-time targets to improve responsiveness;
- expand the role of nurses in health centres to meeting consumer expectations; and
- introduce budgets for prescribed drugs in health centres and occupational health services to keep costs under control.

The OECD review of the Finnish health system – entitled "OECD Reviews of Health Systems: Finland" – is the latest in a series of health system reviews which so far include Korea and Mexico. A review of the health system of Switzerland is under preparation for expected publication in spring 2006.

The full text of this report is available on line via this link:
http://www.oecd.org/bookshop?pub=812005191P1

Those with access to all OECD books on line should use this link:
http://www.sourceoecd.org/9264013822

HEALTH ISSUES IN THE OECD ECONOMIC SURVEYS

Health issues feature in nearly all *Economic Surveys* of OECD member countries because health is a key element of public expenditure and important for national welfare and economic performance. It has been given a more detailed treatment in the recent surveys of Hungary, Norway and the United States.

In *Hungary*, improving the efficiency of health care is one of the key challenges facing the authorities. The broad conclusion of the special chapter on Policies to Improve the Health Care System is that although problems in the health system have not, as yet, emerged in worryingly high health spending, there are difficulties in the way the system is organised and operates. Many reforms have been introduced since the early 1990s but results have been mixed, with concerns remaining about hospital care, the weak "gatekeeping" function exerted by doctors and drug prescriptions which make for a very high proportion of total health care expenditure. Reflecting both population ageing and the presently poor health status of the population, health care is an area where the demand for services is expected to increase. The chapter discusses ways to modernise the hospitals, including options for giving them more scope in managing resources and greater incentives to introduce efficiency enhancing improvements. To help reduce unnecessary use of inpatient services, mechanisms are suggested for strengthening the "gatekeeping" function of general practitioners and for reinforcing controls over treatment decisions. Finally, the chapter considers ways to contain the cost of subsidies to pharmaceutical companies.

In *Norway*, a series of wide-ranging reforms in recent years designed to make greater use of market mechanisms has succeeded in eliminating shortages, raising efficiency and improving citizen satisfaction. Nevertheless, the special chapter on The Performance of the Health Care Sector indicates that spending accelerated after the reforms, and per capita spending on health is now the second highest in the OECD. Centralisation of hospital ownership may have increased political influence, encouraging spending that cannot be justified on cost-benefit grounds. Co-payments by patients are modest, and the background of swelling oil wealth may have sapped willingness to control costs. Some procedures are arguably too well-remunerated, leading to supply-driven interventions, while absence of diagnosis-related groups in other areas (*e.g.* psychiatry) may have resulted in sub-optimal supply. Generalist doctors have a gatekeeper role, but they are said to over-refer patients to hospitals. Thus, future health reforms in Norway should concentrate on value for money. Spending overshoots by hospitals should be only partially reimbursed, and the possibility to replace the management of hospitals in chronic deficit

should be used more actively. Market forces to rein in spending would arguably be more effective if they acted more intensively at the interface between the patient and the health service supplier. To increase the incentives to demand lower cost treatments, patient co-payments should be gradually raised, with exceptions made for those on low incomes or the chronically sick.

In the *United States*, under current programme rules, federal government spending on health care is projected to nearly triple in relation to GDP to 11½ per cent by 2050. Almost half of that expenditure is devoted to Medicaid, the programme for the indigent, under which the federal share varies from one-half to three-quarters, the remainder being paid by the states according to their *per capita* income. In these circumstances, it is not surprising that the Administration has proposed cuts to the federal Medicaid contribution. However, the rate of expenditure growth on the programme may be such that many states would not be able to assume greater responsibility for financing than they already have, given their limited ability to raise revenues. The *Survey* recommends that a shift of all expenditures for the elderly and disabled beneficiaries from Medicaid to Medicare, the federal programme for the elderly, should be considered, as it would concentrate responses to the nation-wide challenge of ageing at the federal level, while Medicaid would be largely re-focused on the working poor.

Publications:

- *OECD Economic Survey of Hungary, 2005*
- *OECD Economic Survey of the United States, 2005*
- *OECD Economic Survey of Norway, 2005*

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HEALTH WORKFORCE PLANNING AND MIGRATION

In most of the countries of the world, including OECD members, concerns about shortages of health workers – nurses, in particular – have emerged in recent years. In that context, a better understanding of the role that international migration plays, and could play in the future, in the management of health human resources in OECD countries, is important. Moreover, despite increased movements and heightened policy interest in this area, the quality and comparability of international data on migration of health professionals have hardly kept pace.

The first phase of a new OECD Project will provide an account, for each OECD country, of the stock of health workers by country of birth, using mainly censuses, population registers and labour force surveys. Based on those elements, a statistical compendium on the stock of health worker immigrants in OECD countries by detailed country of birth and occupation will be prepared. The second phase of the project will review and analyse recent migration flows and migration policies for health workers and medical students. This will provide input to a report on current trends and policies on the international mobility of health professionals to be presented at the Working Party on Migration and the Group on Health.

The third phase of the project will describe and analyse over time health workforce policies and planning in OECD countries and their interaction with migration. In addition, a high-level policy conference on workforce planning strategies may be jointly organised with WHO. This work should help to formulate policy options for facilitating a coherent approach on health workforce policies and migration among OECD countries.

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MEDICAL MALPRACTICE COVERAGE IN OECD COUNTRIES

In a number of OECD countries, mainly Australia, Canada, the United States, and several European countries, premium rates for medical malpractice insurance policies have been steadily rising since 2002. Percentages vary and generally high-risk specialties or public and private health care establishments have been more affected. In some extreme cases, the availability of these specific policies has dramatically dropped. Main insurers and reinsurers are withdrawing from the market, while others refuse policies with high risk-exposure, or set premiums at nearly unaffordable prices for physicians, hospitals or private clinics.

Along with these worrying developments for some OECD governments and major insurance market players, high-profile medical scandals with their attendant publicity have often darkened the picture. Actually, this crisis is all the more complex for policy makers and other private stakeholders that it potentially affects the confidence of citizens in the health care system and in health care providers while belonging to a more general trend towards increase scope of liability.

Against this backdrop, and at the request of some of the Delegates to the Insurance and Private Pensions Committee (IPPC), the insurance unit under the aegis of the Financial Affairs Division has elaborated an analytical report as well as comparative tables. These documents, which will be published upon final IPPC approval, seek to provide an overview of the various schemes and mechanisms established in OECD countries to cope with medical malpractices and their main features and challenges. The paper outlines key factors contributing to the current concerns in some OECD countries and provides a set of policy options and alternatives that may be considered to overcome these difficulties.

Contact: Flore-Anne Messy

PHARMACEUTICAL PRICING POLICY

Pharmaceutical pricing decisions raise important international considerations that complicate national decision-making. How do national pharmaceutical pricing policy decisions affect innovation in the pharmaceutical sector? How do such decisions impact pharmaceutical costs elsewhere? Are policy changes needed to safeguard continued pharmaceutical innovation and to promote innovation that matches national health priorities? Are policy changes needed to ensure that the benefits of innovation are widely available and affordable on a world-wide basis?

The OECD Project on Pharmaceutical Pricing Policy seeks to improve the basis for informed policy-making in the area of pharmaceutical pricing and to shed light on the impact of policies of various types.

A meeting of experts in pharmaceutical pricing policy was held in Paris in December 2005 to discuss the overall work plan for the Project and the plans for implementing the project's first phase of work, which focuses on original data collection using a case-study approach. Meeting participants included experts nominated by 22 OECD member countries, representatives of the European Commission and the World Health Organisation, and experts nominated by the Business and Industry Advisory Committee to the OECD (BIAC).

Expert meeting participants discussed a draft framework for describing and assessing pharmaceutical pricing policies and their impact, and a glossary for defining terms and their usage in the Project. These analytical tools are intended to provide guidance to the development of original data and information, as well as the management of pre-existing data and information used in the Project.

Experts also discussed proposals for undertaking focused case studies of the policies and pharmaceutical markets of selected member countries, intended to serve as one of the main inputs to analysis of cross-cutting issues presented in the Project's final report. Experts at the December meeting underscored the prospective value of the case studies, and the need to ensure adequate representation of key policies and market variables in the set of countries selected for review. They also emphasised the importance of coordination with ongoing work on pharmaceutical pricing policies by other international organisations and possibilities for coordination with such work were considered.

Following the first expert meeting, the draft taxonomy and framework for assessment is being enhanced and revised. Planning for the case studies is under way and work on other components of the Project – including review of the health policy and economic literature on pharmaceutical pricing policy and the impacts of these on pharmaceutical research and development, price levels, access to pharmaceuticals and other outcomes; preparation of the outline and draft chapters of the final report on the Project – continues in parallel.

A second meeting of experts will be convened in 2006 to discuss findings from the original data collection undertaken through the case studies, as well as plans for the synthesis of information on pharmaceutical pricing policies and analysis of their impacts. At the second meeting, experts will consider the prospective production of analytical papers focusing on key issues in the assessment of the cross-national impact of pharmaceutical pricing policies, and discuss plans for a symposium

designed to explore key policy and technical issues, to examine options for ensuring that pharmaceutical pricing policies meet health and economic policy goals, and to discuss avenue for furthering dialogue for policy makers on these topics.

Contact: Elizabeth Docteur
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BIOTECHNOLOGY, INNOVATION AND HEALTH

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

A new OECD publication, *Health Technology and Decision Making*, analyses the barriers to, and facilitators of, evidence-based decision making in OECD health care systems. It examines how countries can successfully manage the opportunities and challenges arising from health-related technology by optimising decision making processes, recognising the value of innovation, dealing with uncertainty, and producing and co-ordinating health technology assessment. The report also considers the capacity of health systems to respond to the particular challenges of fast-developing health-related biotechnologies.

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

- A survey of health and innovation policies which will: (1) document national health care priorities and policies, health objectives and other special circumstances that are related to the government efforts in the field of health care related innovation; (2) identify the key drivers behind government programs aimed at promoting innovation in health-care sector; (3) document government programs which promote innovation in the health sector or stimulate the development of new health-care technologies; and (4) explore conditions across the whole innovation cycle that affect biomedicine.
- Case studies identifying and analysing incentives and barriers to the uptake and diffusion of specific health-related biotechnologies, such as: monoclonal antibodies; genetic testing; DNA micro-array and bio-chips; cell and tissue engineering; and the bio-nano convergence.
- A workshop and an analytic report on new biotechnology research and innovation models for health which will explore the conditions and factors common among these models that move discovery more quickly, efficiently, and appropriately and achieve better health outcomes.

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

Health Technology and Decision Making
available through the OECD bookshop

Upcoming Publication:

- *Report of Berlin Workshop on Biomedicine and Innovation in Health Care*

Contact: Bénédicte Callan
Jack Radisch

THE IMPACTS OF PHARMACOGENETICS ON HEALTH SYSTEMS

An OECD workshop addressing international perspectives on pharmacogenetics was held in Rome on October 17-19 2005. The workshop, co-sponsored by the Italian and Canadian Governments, was held against a background of growing concerns around the safety and efficacy of new and existing drugs, and the falling productivity of the pharmaceutical R&D process.

Today it takes on average up to 12 years and about $800 million to bring a drug to the market. Much of this represents the costs of early failures. Of the 5,000 to 10,000 compounds screened by a researcher in a pharmaceutical company laboratory, only one will ever become a medicine. The economic burden of adverse drug reactions to health-care systems is also significant: for example, in the United States the cost of drug-related morbidity and mortality exceeded $s177.4 billion in 2000.

Pharmacogenetics can offer solutions as it provides new ways of understanding how drugs work and how this affects both their safety and efficacy. The opportunities from such understanding are considerable, particularly in driving a more efficient and effective clinical research and innovation enterprise.

The aim of the workshop was to stimulate cross-sectoral exchange on progress in the field, experience in regulatory approaches, economic impact assessment, and public-private sector co-operation. The audience comprised 130 representatives from regulatory agencies, industry, patients' organisations and health policy departments as well as health economists, academic researchers and clinicians.

Consensus was reached at the workshop on the potential of pharmacogenetics to offer new and exciting opportunities for drug development and health care. Speakers presented examples of successful applications of pharmacogenetics (most notably the use of the anti-breast cancer drug Herceptin) where pharmacogenetics is influencing drug development, trials, safety and use today and improving the evidence linking interventions to successful health outcomes. There was consensus too that, in general, health policy making is simply not keeping up with the implications of pharmacogenetics (and the use of biomarkers in evidence based medicine more generally).

Outputs from this workshop will form part of a policy report that will focus on the likely impacts of pharmacogenetics on health innovation and delivery, as well as on the policy choices that countries will need to make to respond to these developments.

Contact: Elettra Ronchi

POLICY COHERENCE FOR THE AVAILABILITY OF MEDICINES FOR EMERGING AND NEGLECTED INFECTIOUS DISEASES

Due to the threats presented by potential pandemics, OECD countries are increasingly considering the economic and social consequences of emerging and neglected diseases in developing countries. The United Nations Millennium Development Goals have particularly focused the attention of OECD Member countries on the organisation of a high-level forum in mid- to late 2006 preceding, if possible, the G8 Summit in Russia.

To involve OECD countries in improving the availability of medicines, a necessary first step is to estimate the economic burden of emerging and neglected diseases. To this end, an initial literature review has been performed on the economic consequences of infectious diseases around the world, especially in developing countries. This study focused on the consequences of HIV/AIDS, Malaria, Tuberculosis and SARS, distinguishes short, medium and long term negative economic consequences of infectious diseases, such as:

In the short and medium term;

- Direct costs due to the health expenditures.
- Loss of productivity caused by absenteeism and disability, and the reduction of a skilled labour.
- Decrease of savings in households affected by disease.
- Panic movements in trade and financial markets which can be transmitted to other countries.

In the long term:

- Reduction of human capital transmission (due to the premature loss of skilled labour).
- Reduction of foreign direct investment and trade.

In addition this review identifies pandemic scenarios in OECD countries and in East and South East Asian countries. These scenarios only estimate short term economic consequences and demonstrate the potentially high impact for the health and trade sectors.

There is scope to consider how OECD Member countries may address these potentially negative consequences by improving the availability of medicines for emerging and neglected infectious diseases in developing countries.

Contact: Jean-Baptiste Chesneau

BEST PRACTICE IN GOVERNANCE AND MANAGEMENT OF HUMAN GENETIC RESEARCH DATABASES

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

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

The workshop concluded that:

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

The full report of the Tokyo Workshop is expected to be published shortly. The OECD Council has agreed that best practices guidelines for management and governance of Human Genetic Research Databases should be developed based on the work of the carried out at the Tokyo workshop.

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

Upcoming Publication:

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

Contact: Christina Sampogna

DRAFT GUIDELINES FOR THE LICENSING OF GENETIC INVENTIONS

Biotechnological, including genetic, innovations have been the subject of intellectual property rights for decades. More recently, as the number of such innovations has increased, their use in and importance for the human health care field has also grown.

In this light, the OECD has undertaken work in the field of licensing and biotechnological inventions. Specifically, the OECD has been developing draft Guidelines for the Licensing of Genetic Inventions ("draft Guidelines").

The need for draft Guidelines was highlighted during an expert workshop examining issues of pertaining to intellectual property, licensing practices and genetic inventions, and subsequently

endorsed by the OECD Committee on Scientific and Technological Policy meeting at ministerial level in January 2004 and by OECD health ministers at their meeting in May 2004.

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

The draft Guidelines are in the process for consideration by the OECD Council for their adoption as a Recommendation.

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

Contact: Christina Sampogna

GUIDELINES ON BEST PRACTICES IN MOLECULAR GENETIC TESTING LABORATORIES

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

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

These guidelines will offer short and succinct principles and best practices that relate to quality assurance systems, result reporting, education and training, and insofar as possible, clinical validity and utility. The guidelines should facilitate application of best practice in relation to human genetic and genomic testing, guarantee an international approach to exchange of clinical samples and data facilitating access to rare disease testing, and help meet the general objectives of OECD member countries in relation to best practices in health care.

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

Contact: Elettra Ronchi

HEALTH ISSUES IN OECD'S ENVIRONMENTAL PERFORMANCE REVIEWS

The external costs of environmental pollution include a range of public health impacts, and are often measured in terms of increased health care expenditure or reduced labour productivity. The increasing incidence and prevalence of chronic illness (*e.g.* asthma, allergy, cancer, obesity, diabetes) have raised concern about contributing environmental factors in OECD countries, such as exposure to pollutants or an overly sedentary lifestyle. Also, increasing incidence of birth defects and childhood cancers has raised concern about prenatal and gestational exposure to chemicals in the environment.

National environmental health trends and related policy measures are examined in OECD Environmental Performance Reviews, as part of the "environmental and social interface" chapters, introduced at the beginning of the second cycle of reviews in 2000. Progress is assessed vis-à-vis the country's own objectives related to environmental health – as established in domestic policies, or subscribed to through international instruments (*e.g.* Stockholm Convention, Rotterdam Convention, Children's Environmental Health Action Plan for Europe). Since 2003, several countries have asked for increased analysis of environmental health issues in their environment reviews. Thus, the reviews of Sweden (2003) and the United States (2004) featured special chapters on environment and health, and the environment-social chapter of the review of France (2004) enhanced its treatment of environmental health issues.

Overall, the reviews confirm that environmental conditions impact human health significantly in OECD countries, with both negative and positive implications for health costs. Some estimates place the "environmental burden of disease" (that part of the total burden of disease which is attributable to environmental factors) as high as 20% in OECD countries. But better environmental conditions also lead to public health benefits – both by reducing health risks, and by facilitating healthy lifestyles. The old medical dictum "prevention is the cheapest cure" has been upheld by a number of cost-benefit studies of environmental policies. For example, recent federal regulatory reviews in the United States concluded that the 1970 Clean Air Act has led to benefits (mainly in terms of avoided premature mortality and health costs) which exceed costs by more than a factor of four. With rising awareness of the public health costs associated with an overly sedentary lifestyle, some governments have begun integrating public health-related objectives into nature conservation policies. For example, Sweden and the United Kingdom strive to ensure public access to natural areas and green spaces to support recreational activities, and thus promote overall fitness and wellbeing.

Future reviews will continue to assess countries' performance with respect to their environmental health objectives and related challenges, including:

- rising costs associated with the "environmental burden of disease," particularly from chronic diseases;
- the disproportionate share of the environmental disease burden borne by children, who have greater sensitivity and more exposure to certain environmental contaminants;
- the potential inter-generational health effects of exposure to chemicals in the environment;
- the inequitable distribution of exposure to environmental risks and hazards, with economically disadvantaged groups disproportionately exposed;
- the potential to harness synergies between environmental and public health policies to reach environmental health objectives more cost-effectively.

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

Contact: Martha Heitzmann

VALUATION OF ENVIRONMENT-RELATED HEALTH IMPACTS

The human health impacts associated with environmental degradation represent significant costs. However, their relative magnitude remains largely unknown. Moreover, different methodologies are adopted to value such costs. For instance, while the estimation of the economic impacts using concepts such as the 'value of a statistical life' or 'quality adjusted life years' are widely advocated, their practical application by the governments of OECD member countries remains relatively rare.

A new project on these issues, supported by the Secretary-General's Central Priority Fund, is to be undertaken by the Environment Directorate (in collaboration with the Directorate for Employment, Labour and Social Affairs). It will provide valuable information on the economic costs of environmental degradation on human health, and insights into the means by which policy priorities are established. It will do so by providing a range of estimates of potential human health costs with respect to a sub-set of environmental pressures – notably local air pollution and water quality. The results, which are to be finalised by late 2006, will be used by government officials in both Environment and Health Ministries.

Contact: Pascale Scapecchi
Nick Johnstone

VALUATION OF ENVIRONMENTAL IMPACTS ON CHILDREN'S HEALTH

The project on the valuation of environment-related health impacts, set to begin in January 2006, will focus particularly on children's health. This three-year project will allow cross-country comparisons and will provide a considerable input in the valuation of environmental health risks. Initial outputs will include a report on valuation methodologies in health and environmental economics, as well as a review of policy developments in the OECD with respect to children's environmental health to be prepared by the end of 2006.

The main findings from the workshop on the valuation of environmental health risks to children, held in fall 2003 at the OECD, have been synthesised in a report which proposes an in-depth

analysis of the main methodological difficulties associated with estimating the social value of a reduction in risk to children. It also underlines key policy implications and inputs for further research. The proceedings of the workshop will be published in the next few months.

In addition, an overview of the current programmes designed to elaborate children's environmental health indicators has been produced. It examines the consistency of these programmes with OECD guidelines on the development and measurement of indicators, in order to determine their usefulness to OECD member countries.

Contact: Pascale Scapecchi
Nick Johnstone

Website (Report):
http://www.oecd.org/dataoecd/18/11/35381312.pdf

Overview of current programmes:
http://www.oecd.org/dataoecd/18/12/35381349.pdf

INTEGRATED MANAGEMENT SYSTEMS FOR OCCUPATIONAL SAFETY, HEALTH, ENVIRONMENT AND QUALITY

The OECD Chemical Accidents Programme has undertaken activities in the area of management systems standards for occupational health and safety, environment and quality, with focus on identifying their similarities and differences. As a result, a report on "Integrated Management Systems (IMS) – Potential Safety Benefits Achievable from Integrated Management of Safety, Health, Environment and Quality (SHE&Q)" was published in August 2005 (EHS Publication, Series on Chemical Accidents, No. 15; see http://www.oecd.org/env/accidents). The integrated management of SHE&Q in the chemical industry is gaining more and more acceptance. The Chemical Accidents Programme is currently developing guidance for the implementation of integrated management of SHE&Q. The work led by Korea started in 2004. A first draft of the guidance document was reviewed at a meeting of the ad hoc Expert Group in September 2005. The next meeting of the group is planned for September 2006. It is anticipated that a pilot programme will be conducted in 2006–2007 to 'test' the draft SHE&Q guidance and obtain feedback from users.

Contact: Marie-Chantal Huet

CHEMICAL SAFETY TESTING FOR HEALTH EFFECTS

The OECD's Chemicals Programme addresses protection of human health from risks posed by chemicals and chemical products (including pesticides, cosmetics, medical products, etc.). As part of that work, a number of tests are being incorporated into international Test Guidelines, to allow all OECD member countries to afford the same high level of safety to their people and their environments. At present, good progress has been made in areas related to the safety of women and their unborn children from chemicals that may have potential to affect reproduction or development. A Test Guideline on developmental neurotoxicity, looking at the effects of chemicals on learning and development in children and babies, is nearing completion, as is a Guidance Document on Reproductive Toxicity testing. In addition, a new Guidance Document (GD34) has recently been published to give useful information to scientists in government, industry and research on how to develop testing methods to ensure that new tests, especially important alternative tests that can be used to reduce the number of animals used in testing, continue to provide the level of safety required by regulators in the protection of human health and the environment.

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

Contact: Drew Wagner

SAFETY OF MANUFACTURED NANOMATERIALS

The OECD's Chemicals Committee held a Special Session on the Potential Implications of Manufactured Nanomaterials for Human Health and Environmental Safety, 7th June 2005. This was the first opportunity for OECD member countries, together with observers and invited experts, to begin to identify human health and environment safety issues associated with manufactured nanomaterials. The Committee recognised that nanotechnology offers a wide range of potential benefits which will

impact on a large number of sectors. At the same time, it was noted that there should be a responsible and co-coordinated approach to the safety of the technology.

The Chemicals Committee also recognised a convergence of views around the need for: i) international coordination on regulatory schemes; ii) development of assessment methodologies and testing schemes; and iii) sharing and exchanging information amongst delegations. There was a strong consensus on the need for harmonisation in baseline information. It was agreed that countries shall begin to work together in a proactive way. This should ensure human health and environmental safety while the economic advantages may be taken of the opportunities the technology can provide.

An OECD Workshop on the Safety of Manufactured Nanomaterials took place on 7th - 9th December 2005, in Washington, D.C. The Workshop, hosted by the United States under the auspices of the Chemicals Committee, considered information that is relevant to the human health and environmental safety concerns from a regulatory point of view (*i.e.*, definitions, nomenclature, characterisation; hazard identification; hazard and exposure assessment methods; and regulatory frameworks). Its objective was to determine the "state-of–the–art" for the safety assessment of manufactured nanomaterials with a particular focus on identifying future needs for risk assessment within a regulatory context. Its conclusions and recommendations will be presented in a report for consideration at the 39th Joint Meeting of the Chemicals Committee and Working Party on Chemicals, Pesticides and Biotechnology, to be held 15-17 February 2006.

Contact: Peter Kearns

WORK WITH NON-MEMBERS ON THE SAFETY OF NOVEL FOODS AND FEEDS

The work of OECD's Task Force for the Safety of Novel Foods and Feeds remains focused on the promotion of harmonisation in the safety assessment of novel foods and feeds, especially with respect to products of modern biotechnology. Its main output is consensus documents related to food and feed safety assessment, which provide information that is important in the risk assessment of transgenic (genetically modified) crops intended for human and/or animal consumption (*i.e.* information on the major nutrients, toxicants, anti-nutrients and allergens of specific food/feed crops).

The Task Force recognises that modern biotechnology has become an increasingly global issue. For this reason, it has increasingly involved observer delegations and invited experts in its work. In the beginning, this included participants from Argentina; Russia; Slovenia; FAO; and the Business and Industry Advisory Committee to OECD (BIAC). But in recent meetings, there has been an increasing participation from other key non-member economies such as: Brazil, Chile, China, India, Latvia, South Africa, the Philippines and Thailand. This has been achieved under the auspices of OECD's Centre for Co-operation with non-members.

Building on a Special Session (held in October 2004) on the use of consensus documents, the Task Force addressed at its meeting in June 2005 how to involve more actively the expertise and interests of non-member economies. One practical outcome is that Thailand and South Africa have now started to work on two consensus documents in co-operation with member countries. These documents are on papaya (Thailand) and cassava (South Africa). This will broaden the expertise that is available to the Task Force, while addressing a wider range of food and feed products that are of global interest.

Website: http://www.oecd.org/biotrack; Consensus Documents available for download

Contact: Peter Kearns

ENDNOTE: A BRIEF GUIDE TO THE OECD

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

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

answers to common problems, and work to co-ordinate policies.

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

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

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

OECD Council

Committee for Scientific and Technological Policy (CSTP)

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

Economic and Development Review Committee (EDRC)

Economic Policy Committee (EPC)

- Working Party 1 on Macro-Economic and Structural Policy Analysis

Environment Policy Committee (EPOC)

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

Group on Health

- Health Care Quality Indicators Experts
- Health Data National Correspondents
- Health Accounts Experts

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

- 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 ONLINE

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

- OECD's portal is http://www.oecd.org
- OECD's health portal, presenting health-related work administered throughout the Organisation, is http://www.oecd.org/health
- The portal of the OECD Health Division is http://www.oecd.org/els/health
- The portal of the OECD Biotechnology Division is http://www.oecd.org/biotechnology
- Information about health-related work administered by other Divisions within the OECD Secretariat can be found at either or both the general OECD health portal or at the Division's portal, accessible from the main OECD portal.

To receive an email alert for the OECD Health Update, when it is issued bi-annually:

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

To register or change your interests, simply update your profile via "MyOECD" in the top right of the

OECD Homepage at http://www.oecd.org. To unsubscribe entirely from the MyOECD service, send an email to OECDdirect@oecd.org and type "Unsubscribe" in the subject field. This means that you will no longer be able to customise the OECD website to your interests or receive any email alerts from the OECD.

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Pharmacogenomics

Christina SAMPOGNA (STI/BIO)
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Human genetic research databases

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Biotechnology, innovation and health

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

Drew WAGNER (ENV/EHS)
Test guidelines on toxicity

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

FUTURE EVENTS ON HEALTH ISSUES

- Expert meeting on Quality Assurance Molecular Genetic Testing – Drafting session on Guidelines, Berlin, Germany, 29-31 January 2006 (Contact: Elettra Ronchi)
- The 1st meeting of the OECD Group on Health, Paris, France, 30-31 January 2006 (Contact: Pat Chardome)
- The 39th Joint Meeting of the Chemicals Committee and Working Party on Chemicals, Pesticides and Biotechnology, to be held 15-17 February 2006
- The 19th Session of the Working Party on Biotechnology, Paris, France, 20-21 February 2006
- The 20th meeting of the Working Group on Human Health-Related Biotechnologies (WG-HHRB), Paris, France, 22 February 2006
- Meeting of experts on trends in disability among elderly people and implications for costs of care, Paris, France, 27-28 February 2006 (Contact: Gaetan Lafortune)
- 11th Meeting of the Task Force for the Safety of Novel Foods and Feeds, Berlin, Germany, 6-8 March 2006 (Contact: Peter Kearns)
- OECD experts' workshop on the institutional characteristics of regional health care resource allocation mechanisms in OECD countries, April 2006 (Contact: Carine Ferretti)
- Meeting of the *OECD Working Party on Territorial Indicators*, June 2006
- Meeting of the HCQI Expert Group, September 14-15, 2006 (Contact: Edward Kelley)

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