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Organisation de Coopération et de Développement Économiques
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English - Or. English

COUNCIL

Council

DRAFT RESOLUTION OF THE COUNCIL REVISING THE MANDATE OF THE HEALTH COMMITTEE

(Note by the Secretary-General)

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English - Or. English

Background

1. The Health Committee was set up in 2006, when the pre-existing 'Group on Health' was transformed into a Committee [C(2006)175 and C/M(2006)20/PROV]. Its current mandate was to expire on 31 December 2011, but in order to complete the Committee evaluation of its substructure, in accordance with Rule 21 c) of the Rules of Procedure, an extension until end March 2012 was granted by Council on 13 December 2011 [C(2011)138 & C/M(2011)20/PROV, Item 219].

2. This document contains a proposal for the renewal and revision of the mandate of the Health Committee. The proposed mandate has been developed taking into consideration the recommendations of the In-depth Evaluation of the Health Committee [C/ESG(2006)5/REV1 and C/M(2006)16/PROV, Item 208].

3. At its meeting on 20 and 21 June 2011, the Health Committee considered the mandate of the Committee and approved it by written procedure on 30 September 2011 for transmission to Council. The changes proposed in the new mandate are relatively minor in extent, but reflect three major reorientations of the work of the Committee:

i) **An emphasis on prevention and health promotion.** The purpose of health policies should not be to increase the amount of health activity, but to ensure the efficient production of health. In many respects, OECD country health systems put an excessive emphasis on health care, especially hospital care. Health care is expensive, and sometimes is not very efficient. Tackling the causes of ill-health – especially poor diet, inadequate physical activity, harmful use of alcohol and tobacco – is demonstrably often a better use of scarce health resources than is investing in treating conditions once they have emerged. The Committee has worked on prevention and health promotion in the past – notably in its work *The Economics of Prevention: Fit not Fat* but new drafting of the mandate reflects the fact that the Committee sees one of its main tasks as presenting the case for prevention using hard economic analysis of the facts (see second tiret of paragraph 1 and paragraph 3).

ii) **Greater acknowledgement of the importance of long-term care.** Long-term care of the frail elderly is a particularly complex policy area, which cuts across both health and social policies. It has also been one of the main causes of increased spending in recent years, possibly contributing as much to total spending as the rest of health spending combined. The Committee has undertaken a significant amount of work on long-term care in the past, looking at workforce issues; the financing of long-term care, and the quality of care. Much of this work has been done with the Employment, Labour and Social Affairs Committee. Text acknowledging the importance of long-term care is included in tiret 1 of paragraph 1.

iii) **More prominence given to work with non-Members.** The Committee has adopted a more open approach to work with non-Members [changes made to paragraph 3.a), d and f)]. The Committee is making its work and its networks of experts more open to other countries. Specific engagement plans will be produced for the Enhanced Engagement countries. For other countries, the Committee is open to working with any credible international effort – i.e. it will not try to develop links with individual countries, but where there is an area where the OECD can contribute, it will seek to do so in co-operation with other international organisations.

4. These changes should be considered alongside the implementation of the six recommendations of the In-depth Evaluation, which were:

i) *the scope, focus and medium to long-term policy objectives of the Group[*] should be clarified and figure explicitly in a renewed mandate, having in mind the mission and competence of the OECD;*

ii) *where the Group on Health is a formal participant in a horizontal project with another body, a mechanism involving the direct participation of Chairs should be established to ensure that it can be more fully engaged in programming, designing, implementing, and eventually diffusing the work than currently is the case;*

iii) *new arrangements for improving the quality of policy-level consultations between the Group and the Social Partners should be established in the context of a renewed mandate; progress made towards reaching an agreement on these new arrangements would be regularly communicated to the Group;*

iv) *an exercise to clarify the relevant competencies of the OECD and the WHO in the field of Healthcare policy should be undertaken by the Group on Health with a view to examining to what extent and how collaboration between the two organisations could be enhanced; the results of the exercise would be reviewed as necessary to take into account changes to the two organisations' priorities and work programmes;*

v) *a greater effort to diffuse the country-specific reports should be made by the Group, given that they potentially contain lessons and examples that could be of interest to policymakers in other Member countries;*

vi) *the Group should remain actively attentive to the possible emergence of policy issues of interest in an Outreach context and be prepared to modify its Outreach Strategy as necessary.*

5. These recommendations, which were the focus of the second round monitoring in 2008 [C(2008)8], have been reflected in the working practices of the Committee. In particular:

- The Health Committee regularly reviews its long-term objectives – most recently following the October 2010 Meeting of the Committee at Ministerial Level. The discussion by Ministers led to the identification of a number of broad themes that can guide the work of the Committee over the next five years, which can be summarised as being developing comparable data; measuring and improving quality of care; efficiency, including in particular the appropriate use of prevention; planning the future health workforce; and the links between health, growth and well-being. There was a general theme of putting more effort into trying to explain differences across countries, rather than simply documenting these differences. These 'mandates' were subject to resources being made available to undertake work via the usual Programme of Work and Budget process. The Committee discussed these requests at a subsequent meeting, and they are informing the preparation of the Programme of Work and Budget (PWB) for 2013-14.

- The Committee has worked in close collaboration with a number of other directorates in recent years, notably the Economics Department; the Directorate for Science, Technology and Industry and the Employment, Labour and Social Affairs Committee. Horizontal work is now accepted as a vital part of the work of the Committee [paragraph 4.a) of the proposed mandate], and a number of co-operative projects are being considered for the 2013-14 PWB.

[*] 'Group on Health' at the time of the IDE in 2006.

- The Committee devotes significantly more attention to consultations with the social partners prior to meetings. The Committee and BIAC co-organised a conference in June 2011, and the Secretariat regularly meets with the BIAC health committee. Paragraph 4.c) reflects this focus.

- Collaboration with other international organisations is increasingly intense and the mandate acknowledges this in paragraph 4.b). Much data is now collected jointly with WHO and EUROSTAT; WHO officials attend all OECD meetings; and a number of projects (for example, the work on tackling obesity) are undertaken jointly.

- The Committee dropped country-specific reviews from its work programme, reflecting the limited scope for using them for more general policy learning in other countries (although the Committee is open to suggestions from countries, and it recently undertook an update of its previous review of Switzerland, with the full marginal cost of the review being borne by the country being reviewed). Instead, it has identified a different approach to country reviews: identifying a discrete area to be reviewed (the Quality of Health Care); a common framework of analysis; shared financing; and a clear objective of extracting policy lessons at the end of the process.

- The Committee revised its Global Relations Strategy in December 2010, opening the expertise of the Secretariat and the Committee to assist in international global health processes. This is reflected in the revised mandate, as discussed above.

6. At its 1 December 2011 session, the Committee evaluated its substructure, composed of three sub-groups: the OECD Health Data National Correspondents Expert Group; the OECD Health Accounts Expert Group and the OECD Health Care Quality Indicators (HCQI) Expert Group. These three groups broadly match the three main areas of data development by the Committee, though work analysing the data collected is also undertaken by each sub-group. The three groups considered their working practices. In preparation for the meeting of the Committee at Ministerial level in 2010, and subsequently in the consideration by the Committee of the medium term guidance on future work given by Ministers, the work of all three groups is to be oriented away from generation of data frameworks and the collection of data, towards explaining differences across countries. This intensifies the need for work across the groups – to understand why some countries spend more on particular areas of health requires an appreciation of whether they perform more activities, or deliver higher quality care, for example. Co-ordination between the OECD Health Data National Correspondents Expert Group and the OECD Health Accounts Expert Group has been assured by the holding of meetings back-to-back, with part of their meetings held jointly to consider issues which affect both groups. The Committee considered that its substructure continued to be relevant and agreed revised mandates for these three sub-groups [see DELSA/HEA(2011)20].

7. In addition and considering that work on prevention has now occupied a large proportion of the work programme of the Committee for a long period of time, and the work is of such complexity, that the Committee also agreed at that same session that its substructure should comprise a fourth group, an Expert Group on the economics of Prevention, and agreed on its mandate. Initially, an informal group on prevention was gathered for a particular project on the Economics of Prevention –which led eventually to the publication *Obesity and the Economics of Prevention: Fit not Fat.* The Committee sees a need to expand this work in a number of directions, notably to work on the prevention of harmful use of alcohol, or do further work incorporating the costs of care for different chronic diseases, such as various cancers, cardiovascular disease, and diabetes, into the empirical work, so that comparisons of 'prevention versus cure' can be made. In accordance with the provisions of Article 21 b) of the Rules of Procedure, the Executive Committee is being notified of the creation of this sub-group [see CE(2012)5].

8. It is proposed that the revised mandate, as set out in the draft Resolution in the Annex hereto, should remain in force until 31 December 2016, unless the Council decides otherwise. The draft Resolution would supersede all previous provisions concerning the mandate of the Committee. The Committee would return to the Council to propose a revision to its mandate should there be any major developments that warrant such a change.

Proposed Action

9. In the light of the preceding, the Secretary-General invites the Council to adopt the following draft conclusions:

THE COUNCIL

a) noted document C(2012)28;

b) adopted the draft Resolution of the Council revising the mandate of the Health Committee as set out in the Annex to document C(2012)28, which will enter into force on 1 April 2012.

ANNEX

DRAFT RESOLUTION OF THE COUNCIL REVISING THE MANDATE OF THE HEALTH COMMITTEE

THE COUNCIL,

Having regard to the Convention on the Organisation for Economic Co-operation and Development of 14 December 1960;

Having regard to the Rules of Procedure of the Organisation;

Having regard to the In-depth Evaluation of the Group on Health [C/ESG(2006)5/REV1 and C/M(2006)16/PROV, Item 208];

Having regard to the Resolution of the Council establishing the Health Committee [C(2006)175 and C/M(2006)20, Item 264], as extended on 13 December 2011 [C(2011)138 and C/M(2011)20/PROV, Item 219];

Having regard to the Resolution of the Council concerning the participation of non-Members in the work of subsidiary bodies of the Organisation [C(2004)132/FINAL] and the revised global relations strategy for the Health Committee [DELSA/HEA(2010)32 and DELSA/HEA/M(2010)3/REV1];

Recognising that good health is necessary for people to flourish as citizens, family members, workers and consumers, that improvements in health contribute to higher economic growth and improved welfare and that high-performing health systems are key to achieving better population health;

Acknowledging that while the health sector represents a large and growing share of OECD economies, health systems will face important challenges in the future, in particular in view of ageing populations; changing lifestyles; and technical change;

Having regard to the proposed revision of the mandate of the Health Committee [C(2012)28];

DECIDES:

A. The Health Committee has the following mandate:

1. The overarching objective of the Health Committee shall be to foster improvements in the performance of Members, and as appropriate, non-Members' health systems in the following key areas:

   – Financial sustainability and efficiency of their health and long-term care systems;

   – Better preventive services and health promotion; and

   – The provision of high-quality health care to all.

2. This shall be accomplished by the provision of Output Results that assist policymakers in designing, adapting and implementing policies for achieving high-performing health systems.

3. In this context, the Health Committee will provide a forum for Members and, when appropriate, non-Members to share views and experiences on, and consider responses to, current and emerging health issues and challenges. This will be achieved, by building a body of health data, by filling gaps in health data and analysis at the international level, and by undertaking international comparisons and economic analysis of health systems, including disease prevention, health promotion and public health programmes, bearing in mind the competences and mission of the OECD, and the fact there is no one ideal health system. More specifically, its activities will consist of:

    a. Encouraging co-operation among Members and non-Members in developing health accounts on a consistent basis, and in other relevant health data and information sharing.

    b. Developing and promulgating health care indicators, and standardised, comparable sets of data and statistics, as a basis for research and analysis assessing the performance of OECD health systems.

    c. Assessing options for sustainable financing of efficient health systems.

    d. Assessing the performance of Members' and, where relevant, non-Members' health systems.

    e. Undertaking policy analysis and evaluation to identify effective, efficient and high-quality policies and practices.

    f. Working with non-Members on issues where such co-operation is mutually beneficial, promoting the sharing with non-Members of the health data systems and the expertise, information and experience which reside in Member countries.

    g. Actively disseminating results through publication of studies and participation in conferences and meetings with policy-makers and stakeholders.

    h. Co-ordinate initiatives and undertake joint activities with other relevant OECD Committees on policies around primary prevention (e.g. Education Policy).

4. In order to efficiently implement the aforementioned activities, the Committee shall:

    a. Maintain close working relationships with other relevant bodies of the Organisation, seeking to (i) be actively engaged in, and where appropriate lead, joint work and ensure that it is undertaken in a co-ordinated manner; (ii) complement and support work that other bodies are leading; and (iii) ensure that other work of the OECD considers the impacts on health systems.

    b. Maintain, as appropriate, and in conformity with the OECD Convention and Rules of Procedures, relations with other entities, particularly the WHO, seeking to achieve non-duplicative, co-ordinated and complementary work programmes in areas of shared interest and mutual benefit, conducting joint projects where appropriate and ensuring that the experience and expertise of other bodies is appropriately incorporated into the Committee's health work.

c. Ensure that the views and expertise of non-government institutions are drawn upon in the conduct of OECD's health work, utilising, inter alia, the Business and Industry Advisory Committee to the OECD (BIAC), the Trade Union Advisory Committee to the OECD (TUAC) and contacts with relevant non-governmental organisations, including organisations representing patients and health professionals and outside experts.

d. Steer and review the progress of work and its financial status, and co-ordinate the work programmes of its subsidiary bodies and receive regular reports from them to ensure analysis and policy recommendations are fully integrated and evaluated.

5. Where possible, Members shall appoint to the Health Committee high-ranking officials concerned with development, implementation or administration of health policies in their own countries.

6. For the purpose of its activities in the health sector, the Organisation shall periodically collect all relevant statistics and other information; in principle, these data will be assembled by the Secretariat and published under the responsibility of the Secretary-General.

7. The Health Committee will advise the Council on appropriate priorities for work on health and long-term care.

B. The mandate of the Health Committee shall remain in force until 31 December 2016.