oecd Observer

No. 229 – November 2001 www.oecdobserver.org

SPOTLIGHT ON HEALTHCARE

Measuring up

Health ministers' views

Patient advice

DNA Confidential

Norman Rockwell

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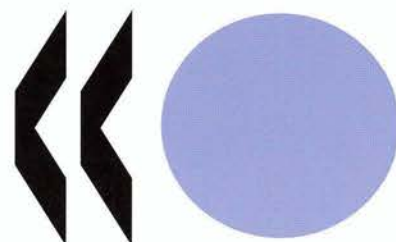

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oecd Observer
www.oecdobserver.org

oecd Observer

www.oecdobserver.org
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2001 subscription rate:
FF282 – US$50 – €43 – £30 – ¥5,900
ISSN 0029-7054
Tel.: +33 (0) 1 45 24 82 00
Fax: +33 (0) 1 45 24 82 10
sales@oecd.org

Founded in 1962
The magazine of the Organisation for Economic Co-operation and Development

OECD Publications
2 rue André-Pascal
75775 Paris cedex 16, France
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www.oecd.org

Published in English and French by OECD and Financial Times Business Ltd, Maple House, 149 Tottenham Court Road, London W1T 7LB. Tel: +44 (0)20 7896 2525

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Adrian Northey, +44 (0)20 7896 2109

PRINTING:
PRE-PRESS: Facsimilie Graphics
PRINTERS: St Ives

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FT Business
FINANCIAL TIMES

Brazil's prospects

Bumpy road

Although I tend to agree with several points in the article by Joaquim Oliveira and Tristan Price ("Brazil: More Than Just Potential", *Observer* No. 228, September 2001), I fear the authors are too optimistic.

The long-term view for Brazil has indeed improved over the past 10 years or so. But, unfortunately, we must cross endless short-term bridges to get there. There are various traps along the way, as well as several challenges.

First, growth remains constrained by the balance of payments – in spite of a substantial devaluation of the local currency vis-à-vis the US dollar over the past three years. Any hiccup in the world economy, any temporary rise in the risk-aversion of world financial investors, etc., bring this reality to the fore. The vulnerability of our external financing continues to haunt us, perhaps suggesting that we have not done enough in order to stimulate an "export culture" in the private sector and to convince trade partners (US-Europe) to reduce barriers to a wide number of our products.

Second, real interest rates are too high – at about 11-12% today. Managing the public sector finances with such high rates is almost impossible. The authors were absolutely correct to point out that "hard budget constraints have been imposed at all levels of government" and that the fiscal policy framework is much better now. Still, our public sector deficit remains at 2% to 3% per year, resulting from growing primary surpluses overshadowed by ever rising debt-servicing obligations.

Total public sector debt now stands at about 55-60% of GDP and, with general elections approaching, talk of restructuring will inevitably pop up. Watch for nervousness in local financial markets, volatility, etc.

Third, political uncertainties will continue in the run-up to those general elections, due in October 2002, with concerns now raised about future economic policy direction and the commitment to reforms that favour long-term stability.

I am sure that Brazil will tackle those challenges in its own unique manner. But the road ahead is bumpy and the "great future", it seems, may still be a long way off.

Rodrigo Maciel,
Rio de Janeiro, Brazil

Déjà vu

The OECD's Brazil economic survey comes with a long echo. As a young reporter, I attended a 1980s news conference in Rio de Janeiro at which Brazil was presented as having "excellent long-term prospects". It made me think of Harry Hopkins' famous comment during the Great Depression: "People don't eat in the long run."

Brazil has been the country of the future at least since I got here in 1977. The problem with this long tomorrow is that it never quite comes. There's always a temporary obstacle in its way. In the late 1970s, Brazil was stymied by the energy crisis but "long-term prospects" were good. In 1982 it was debt re-negotiation but, "for the long term," prospects were excellent. Brazil made progress in the 1990s until the Mexico crisis and then the Russia crisis and then the Asia crisis got in the way but, "for the long term..." In truth, Brazil is vulnerable today not because of some temporary condition demanding removal but because change is always half-finished. Masterful improvisations ("Brasilia, The Real Plan") mask weak institutions.

Some advances are incorporated into the body politic, while others wither. The Central Bank and the Securities and Exchange Commission (CVM) enjoy well-deserved acceptance. But the courts dither and the schools decay. It's a Brazilian paradox that banks are safe but the streets are not.

In *Raizes do Brasil*, historian Sergio Buarque de Hollanda said, "We place our reliance upon a web of personal relationships, rather than the impersonal workings of modern institutions." He touched upon the joy, and the frustration, of a great nation, one still in the making.

Tom Murphy, senior editor, *AE-Brazil* (www.aebrazil.com)

On the cover

Before the Shot
Norman Rockwell (1894-1978)

The cover composition of this issue is based on a Norman Rockwell picture for the front page of *The Saturday Evening Post* of 15 March, 1958. Called "Before the Shot", the cover shows a patient scrutinising his doctor's diploma before receiving an injection. The cover of the *Post* was to become a showcase for Mr Rockwell for more than 40 years, giving him a large audience and helping to make him one of the world's most popular painters of the last century. *The Saturday Evening Post* was founded in the United States in 1728 by Benjamin Franklin and is now used by the Benjamin Franklin Literary & Medical Society as "a valuable asset for reaching medical consumers and for helping medical researchers obtain family histories".

The *Compleat* Healthcare System

Donald J. Johnston, Secretary-General, OECD

"Look to your health: and if you have it, praise God." This quotation is drawn from Izaak Walton's seminal work, *The Compleat Angler*, a book which is to be found in the library of every fishing aficionado. Walton lived in the 17th century. At that time, the general belief was that health was "a blessing that money cannot buy".

True, we see around us in friends and family a connection between good genes and longevity. But, unlike the days of Walton, we no longer accept the premise that the benefits of health and consequent longevity are left to God and chance. Taxpayers' dollars, education and good public policy, as well as scientific advances, have raised the health of our citizenry within the OECD many-fold in subsequent centuries. That is why at the OECD we have embarked upon an ambitious three-year project to measure and analyse the performance of healthcare systems in member countries. What are the factors that affect performance? Why are outcomes so different, even with seemingly similar inputs?

The fact that more of us live longer is something to celebrate, but longevity, in turn, poses daunting challenges to our health and social security systems.

OECD countries spend an average of 8-10% of GDP on healthcare. And that amount will rise in the years ahead as cost and demand pressures increase. Health, always at the top of the individual's list of priorities, has moved to the top of the economic as well as the social agenda, especially since the quality of our "human capital" has been recognised as the foundation of economic growth and prosperity in all advanced economies. So, how much money we spend and how we invest it in achieving acceptable levels of healthcare has become a public preoccupation and hence a political imperative.

For example, how is it that the United States spends almost twice as much per person as Canada on healthcare and yet Canadians have a slightly higher life expectancy? France, in turn, spends less per head than Canada and enjoys more hospital beds and doctors for every inhabitant than either Canada or the United States. Why? Are we using the right indicators for measuring performance? Is our information base skewed? If life expectancy is one useful measure of our well-being, does it camouflage the flaws that health systems may have? Of course, longevity also raises economic issues never faced by previous generations. The fact that more of us live longer is something to celebrate, but longevity, in turn, poses daunting challenges to our health and social security systems. These are all areas in which the OECD is deeply involved.

The thrust of the OECD three-year health project is focused on a number of major policy challenges. First is the rising demand for medical services, due mainly to population ageing and the rapid innovation and diffusion of medical technology. Second is the concern about efficiency in provision of healthcare services. And third is the challenge of equity – that is, to address the problems of unequal access and provision.

The OECD Health Project will measure and analyse health system performance, in order to explain the variations between member countries. It will also assess the effectiveness of different ways to integrate healthcare systems with long-term care, including for older and disabled persons. As the Spotlight in this edition of the *OECD Observer* shows, we will be drawing on the co-operation of leading experts from around the world, including from other international organisations. Businesses, medical professionals, patient and other civil society groups: all of their contributions will be important, so that our work can give policymakers the evidence they need to base reforms on and improve their health systems. It is my hope that in the future OECD countries will emphasise preventive medicine and the important role of education as a determinant of good health. Then, armed with prevention and cure, we will be able to borrow from Izaak Walton's title and write *The Compleat Healthcare System*.

I see the OECD Health Project as one of the most important undertaken by the organisation in recent years. Measuring health performance is a vital part of this endeavour and is the subject of a high-level conference of ministers, officials and international experts to be held in Ottawa in early November. Our aim is a very practical one: to help public policymakers meet the health challenges of the 21st century. ■

Improving health systems' performance

Gro Harlem Brundtland, Director-General, World Health Organization

Last year the World Health Organization dedicated its *World Health Report 2000* to improving the performance of health systems. We did so because we recognised that the good health of nations is key to human development and economic growth and we felt it was important to analyse health systems' performance and to share what we knew with governments and the international community.

The challenge is to develop health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair. Recent research indicates that the way health systems are designed, managed and financed seriously affects people's lives. We know that equitable health outcomes are essential for global prosperity and the well-being of societies. We also know that better health is key to reducing poverty, particularly among the nearly three billion people who live on less than US$2 per day.

Good performance is very difficult to achieve if total health spending in a country is less than about US$60 per capita. Bringing health spending up to this threshold would cost US$6 bn a year, or less than one quarter of 1% of total global spending on health.

Our research has shown that virtually all countries are not obtaining as much as they could from available health resources available to them. In response to many requests, the WHO has been working closely with member states in an initiative to enhance the performance of health systems.

The effectiveness of health systems is the subject of intense public debate all over the world. The *World Health Report 2000* plugged into this debate and helped to shift the focus from opinion and ideology toward evidence and knowledge. For the first time it contained a composite index of health systems' performance. Using five different measures it analysed the extent to which health systems produce better health and the extent to which these benefits are distributed equitably. It examined the degree to which health systems respond to people's legitimate needs, and the fairness with which they are financed. It also related the composite performance to the resources available, to create an efficiency index. These indicators are used to compare performance in 191 countries and to identify the types of policies that work and those that do not. They also help countries monitor their own performance over time.

The report showed that significant improvements in performance are possible. The question we are now asking is: which factors are critical in making a difference? Four appear to stand out: social inequality; total health spending below a critical threshold of about US$60 per capita; the magnitude of the HIV/AIDS epidemic; and the overall effectiveness of governments. We have also identified three areas where we think that further work may be rewarding. First, we need to look at what could happen if all countries raised their performance to the maximum possible – without increasing resources. Preliminary research suggests that disability-adjusted life expectancy could increase from less than 57 to approximately 70 years. In Sub-Saharan Africa, the potential for change could be even more dramatic – from 37.5 to 64 years of disability-free life – just by making better use of existing resources.

Second, the overall effectiveness of government seems to have a particularly strong influence on health systems' performance. On the basis of initial work it seems possible that the health systems performance index of the least-well-governed countries could increase by up to 50% through better governance alone.

Third, the data in the *World Health Report 2000* suggested that good performance is very difficult to achieve if total health spending in a country is less than about US$60 per capita. This finding is very significant in making the case for additional development assistance. In 2000, the WHO estimated that 41 countries had expenditure below this threshold in 1997. Bringing health spending up to US$60 per capita would cost about US$6 billion a year, or less than one quarter of 1% of total global spending on health. The potential pay-off is an increase of about eight years in disability-adjusted life expectancy in those 41 countries.

In moving forward, the WHO initiated a consultative process on the framework, methods and data sources for health system performance assessment. We have established a scientific peer review process to guide further development. We have hosted technical consultations on important topics involving the world's best scientists on the relevant technical area. And, we have established an Advisory Group on Health System Performance Assessment with members from the WHO's Executive Board and the Advisory Council on Health Research.

The WHO can help governments define priorities for action, and not only in terms of better and more equitably distributed health outcomes. The choice of how to finance services is critical. The costs of healthcare can tip the balance from bare subsistence to real poverty. However, providing services is not enough. Unless people are treated with dignity and protected from financial exploitation, they will not use the services – and precious resources will be wasted as a result. ■

Pfizer forum

A world of ideas on public policy.

Partnerships Offer Hope In Sub-Saharan Africa

by Henry A. McKinnell, Ph.D.

The healthcare crisis in sub-Saharan Africa is one of the great human tragedies of our time. The magnitude of this crisis has provoked a valuable debate on how best to provide healthcare to those suffering from epidemic diseases. The key is partnership. Through partnerships, we can replace the destructive cycle of poverty and disease with a virtuous cycle of investment and health. To do so requires a new model of cooperation among governments, private companies, and nongovernmental organizations.

Each partner has a critical role to play. From national governments, for example, partnerships derive their political will. South Africa's government provides political will to support Pfizer's Diflucan Donation Program, a novel public/private alliance to ease the suffering of AIDS patients. Working with the United Nations and the World Health Organization, Pfizer recently expanded that program to fifty of the world's least-developed countries. Our company has also formed a partnership with the Academic Alliance for AIDS Care and Prevention in Africa to establish the continent's first large-scale HIV/AIDS treatment and training facility. Located in Uganda, this facility will train physicians from throughout Africa in the latest HIV/AIDS treatments, as well as provide world-class care for AIDS patients.

Political will finds expression in more than a willingness to forge new alliances. It is also evident in the creation of an economic and social climate where innovation can take root and flourish, including the protection of private and intellectual property.

We can replace the destructive cycle of poverty and disease with a virtuous cycle of investment and health

Facing large-scale medical emergencies, some governments have been tempted to seize pharmaceutical company patents and assign them to others. This practice – known as "compulsory licensing" – has highly destructive consequences. If governments weaken intellectual property rights, they risk undermining the ability and willingness of pharmaceutical companies to discover new cures and treatments. They also discourage the technology transfer that is essential to raise the quality of healthcare in developing countries.

If governments provide the will, the private sector provides the way. Private businesses and NGOs can supply medicines as well as the tools of prevention and education, particularly at the field level. From these organizations, our partnerships draw expertise for improving and expanding medical infrastructure, and for accurately measuring results.

As a prime example, the International Trachoma Initiative – funded by Pfizer, the Edna McConnell Clark Foundation, the Bill and Melinda Gates Foundation, and others – seeks to eliminate the world's leading cause of preventable blindness. The donation of Pfizer's antibiotic Zithromax® (*azithromycin*) is only one facet of this broad-based campaign, which links treatment with prevention to achieve lasting impact. Since 1996, research-based pharmaceutical companies have committed more than $1.2 billion to long-term programs to fight diseases in sub-Saharan Africa and other less-developed areas.

While not the perfect solution, these partnerships hold great potential, given that we are entering a golden age of pharmaceutical research. Over the past two decades, drug companies have invested billions of dollars in R&D programs. That investment has resulted in the discovery of more than forty new medicines and new indications aimed at the diseases that plague sub-Saharan Africa. Many more are on the way. A survey of pharmaceutical companies in late 2000 found 103 AIDS drugs either in clinical trials or awaiting FDA approval. These medicines will bolster the 64 existing treatments. In 1987, there was only one.

In ensuring access to these new medicines, the watchword should be "partnership," with governments and the private sector showing that access and innovation are not antithetical concepts. It is time to expand our partnerships to a wider range of governments, companies, NGOs, and others committed to global health. Together, we can and must confront humanity's killers.

Dr. Henry A. McKinnell is Chairman of the Board and CEO of Pfizer Inc. This article is adapted from his remarks at the 2001 World Economic Forum in Davos, Switzerland.

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• News brief •

Competition in the spotlight

A global network of competition authorities is needed to boost anti-trust policy co-operation among developing and developed nations, EU Competition Commissioner Mario Monti told the launch meeting of the OECD's Global Forum on Competition in Paris in October.

The proposal, backed by the US in particular, would seek consensus on basic policy and enforcement and help countries that are developing anti-trust rules tackle the various commercial, political or cultural difficulties that can arise.

"In the globalised world," said Mr Monti, "effective competition authorities are increasingly seen as the trustee, if not of good governance then certainly of the possibility of good governance."

The proposal was just one of the issues addressed by the Global Forum at its first meeting on 17-18 October, which brought together representatives from the OECD's 30 countries and 26 non-member governments. Focusing primarily on how competition policy can be effective in developing countries, delegates acknowledged that rules and implementation must take into account the size, level of economic development, legal environment and business culture of the countries concerned. They discussed several key issues, including merger control, anti-trust violations and hard-core cartels.

"The response has been overwhelming," said the Forum's chairman, Frederic Jenny of France's Competition Council. "There is a great need for co-operation among [the world's] competition authorities, in part due to the globalisation of the economy."

Speaking after the meeting, Bernard Phillips, head of the OECD's Competition Law and Development Division, said, "We want to see more and more countries take up competition laws. The work has scaled up considerably in the last year and will scale up again in the future."

Mario Monti

The next meeting of the Global Forum on Competition is scheduled for February 2002. ■

Soundbite

"People demand more than the basics. They expect quality and expect it now. Managing those expectations is a challenge for all of us. But in the end, we have to meet them … I do believe … that people can be persuaded that they have to pay for good public services. I don't believe the public is any longer fooled by the notion of short-term tax cuts at the expense of long-term investment. But the issue is: how do they pay? Do they buy the services themselves, or do they pay collectively through taxation? For reasons of equity and efficiency – never forget the National Health Service is renowned world-wide as immensely cost-effective, if under-funded – I prefer the latter route. The vast majority in any event can't afford private schools or healthcare."

- *Speech by the UK's prime minister,* ***Tony Blair****, on public service reform, October 16, 2001.*

Taxing stock options

How can a multinational company offer stock or share options to its employees when the rules governing those options are different in the various countries where it operates? And how will they be taxed? These thorny questions have made multinationals very cautious when introducing plans into different countries, so as to avoid unpleasant tax and regulatory surprises. But stock option schemes have a reputation as a good way of attracting staff, especially to start-up companies, and a good way of keeping employees loyal. They give employees the right to buy shares in the company they work for at a pre-determined, fixed price in the future. If share prices rise, the employee can buy shares at the lower, fixed price, then sell them at current market prices at a profit. If share prices fall, employees can simply let the options expire – nothing gained, but nothing ventured either.

Now the OECD is looking at how such schemes can do more to encourage entrepreneurship, particularly in start-ups. One report due out in November will assess the effectiveness of share option schemes and look at differences in the ways they are treated within the OECD area for tax and regulatory purposes. Some countries tax stock options when they are granted, for example, while others tax them when they are exercised and/or sold. Moreover there is a lively debate as to whether gains realised through the exercise of options should be treated as employment income, or more lightly taxed capital gains. OECD expert, Peter Avery, said the report would provide ideas for improving policies that govern options.

The OECD is also looking at cross-border tax issues related to stock options. Tax treaty experts from OECD countries will meet in Amsterdam in November to debate how stock options should be taxed when people move abroad, and who should get the revenue. Guidelines on this issue are expected some time after 2002. ■

• News brief •

Steel market glut

The steel trade is suffering from a glut on the market. Workers and communities in many steelmaking areas are being affected, as is the ability of a growing number of firms to upgrade and maintain competitive facilities. Overproduction and overcapacity worldwide mean that many companies are struggling to survive. Should governments step in?

These were the questions addressed at a high-level meeting convened by the OECD in September. Government officials and industry representatives addressed the problem of how to deal with uneconomic or inefficient excess steelmaking. Specific attention was paid to measures that could reduce steelmaking capacity, which in the absence of special conditions or supports, would not otherwise be viable.

Market distorting practices were still prevalent in the global steel market, officials agreed, and called for government assistance with the social and environmental costs to permanently close steel plants. Government officials pointed out the need to refrain from subsidies and other measures that distort competition and trade, but agreed to evaluate the long-term economic viability of their steel facilities in an open global market, and consider policies to facilitate the reduction or closure of inefficient plants. A second meeting is planned for December 2001 for governments to discuss longer-term objectives, and options to resolve the steel market glut.

For background papers on this meeting, see the OECD website, under "Enterprise, industry and services". ■

Supporting stability

The events of 11 September were a stark reminder that international stability can never be taken for granted. But "people should be reassured that governments have taken the necessary steps to maintain stability and will continue to co-operate to minimise the negative economic effects," OECD secretary-general, Donald Johnston said on 1 October. "The OECD's expertise, committees and instruments of co-operation will be very effective in efforts to combat terrorist activities, to address the conditions that can lead to support for terrorism and to mitigate the negative impacts flowing from recent terrorist events." Much OECD work already addresses important subjects that can help, such as financial security and the fight against money laundering, data protection and cyber-security, and biohazards and chemical safety. The organisation also fosters co-operation among aid donors, helping to boost development and reduce the poverty that can lead to support for terrorism. "It is clear that OECD countries see an open multilateral economic trade and investment system as a strong impulse to growth and development," Mr Johnston said. ■

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Donald Johnston

Tourism faces rocky short term

Tourism will undoubtedly be affected by the events of 11 September in the United States, compounding the economic downturn that was already under way, but long-term prospects for the industry remain extremely positive: this was the main message from an international meeting of travel and tourism policy experts at OECD on 24 October. The negative impact will be visible mostly in the US and in those markets that depend on US visitors. US air traffic is down sharply, and transatlantic traffic is estimated to be down by as much as 30% on some routes. According to IATA figures, international aviation travel was on a declining trend anyway in 2001, in line with the economic situation. Moreover, traffic was extremely buoyant during the late 1990s and 2000, so any drop was bound to be marked. (In 2000 there were some 61 million outbound trips made by Americans, up by 6% compared with 1999.) Also, tourism within other regions, such as Europe, is expected to remain quite buoyant, if falling a little in line with the economic downturn.

World Travel and Tourism Council forecasts after 11 September point to a decline in tourism of some 10-20% in the United States, and less in other markets. The absence of US visitors will be widely felt: the top destinations of US visitors in 2000 were the UK, France and Germany, although nearly a third of this was business travel. US travellers – 40% of whom flew out of New York, Los Angeles and San Francisco – spent an average $1 345 abroad on each trip. Several countries at the OECD meeting reported candidly on the short-term challenges they now face. France, for instance, is not underestimating the problem: its tourism ministry has set up a Crisis Management Unit to monitor the economic and social impacts on everything from hotels and hostels to museums and car rental.

Despite the poor short term, experts at the meeting emphasised that tourism would remain a major growth area in OECD countries. For tourism policy, the main immediate priority is to restore consumer confidence and to consolidate the image of tourist destinations through appropriate promotion campaigns, experts said. ■

For more information, contact Alain.Dupeyras@oecd.org

After the attacks

How have the world's economic prospects and policy challenges changed since the events of 11 September in the United States? In this interview, Ignazio Visco, the OECD's chief economist, offers some valuable insights.*

©AP/SIPA/ Bernadette Tuazon, Richard Drew

Becoming clearer: left, September 11, 2001; right, October 10, 2001

The OECD is in the throes of finalising its twice-yearly *Economic Outlook for the global economy in an unusual time of uncertainty. What repercussions do you think the terrorist attacks in the United States on 11 September will have on overall economic prospects?**

Ignazio Visco: The impacts will be significant, but, as you say, uncertain. The tragic events in the United States had an immense human toll. The direct economic impact on people, properties and some firms is tragic, but relatively moderate for the US economy, certainly smaller than the Kobe earthquake in Japan. The indirect impact, on confidence, financial markets and investors is very uncertain, but potentially quite large. The fact is, this indirect impact is difficult to assess because there are no close historical precedents with which parallels can be drawn. We believe that it might be large in the short run. Stock markets have already fallen. Consumer confidence in the United States plunged in September. Employment, housing starts, retail sales and output will all be affected. There will be more profit warnings, and large companies in the travel industry, insurance and leisure will face serious difficulties. How long this will last depends to a large extent on political developments.

You mention the indirect impact on confidence. To what extent will psychology play a role?

The effect might be considerable. There are questions on the speed of return to a world where businesses feel safe enough to engage in large international operations and borders are open as usual, to flows of goods, capital and people. Perhaps the current fears will be dispelled quickly, thanks to a credible international co-ordinated effort to combat terrorism. In such a case, our economies, which had been generally performing well, will rebound strongly and return to healthy growth. But there are also downside risks of a long drawn-out process, punctuated by setbacks. Businesses could decide to repatriate investments, costly security measures could multiply, and governments could re-erect borders to protect themselves from a more uncertain environment. This could mean the return to slow and uncertain growth patterns, but it is really too early to speculate about this.

How do you prepare your projections against this background of uncertainty?

We start by laying out a "central" scenario. This contains a normative assessment of the political developments, one that necessarily excludes dramatic events. In this central scenario, we take into account both the current state of economic fundamentals (and their interaction with highly uncertain expectations) as well as the monetary and fiscal policy responses. Accordingly, we will assume that oil prices will remain broadly stable, exchange rates unchanged, and that stock markets will not be subject to a wave of panic selling.

So, what does this central scenario tell us?

The short-term outlook could unfold in four successive stages. First, activity in the third quarter will be directly affected by the direct disruptions associated with the terrorist attacks: activity in the United States is lowered by temporary (hopefully recoverable, at least partially) loss of activity, especially in the sectors of financial intermediation, air travel, tourism and retail trade. The direct impact on other countries is minimal. Transatlantic flights from Europe were cancelled for a few days, and disruptions may be expected for some time yet, but except for that there was no direct impact.

Second, consumer and business confidence will fall in the United States and most other countries around the world. The sharp stock market decline (by 8-12% in the US and Europe, and 5% in Japan) is a hint of what may be coming. Confidence will initially be affected by the events, then by the stock market fall and by the rise in unemployment. Judging from the reaction to the Gulf conflict over a decade ago, and from the recent global stock market decline, it is likely that confidence will be sharply eroded around the world. Following the Gulf crisis, confidence plunged sharply in the US and in Europe (although not in Japan), and there was a global adverse reaction to the South East Asian crisis in 1998. This could affect economies at least until the end of the fourth quarter, with a negative effect on demand,

including household consumption. Growth in the second half of this year will be negative in the US – the sign of a recession – and very low in the EU. Conditions in Japan are already quite dismal, and the reduction in world trade will make matters worse.

Third, a "wait-and-see" attitude will prevail among consumers and investors, perhaps through the first half of next year. Faced with large uncertainties, businesses will keep deferring investment decisions, households postponing large purchases, and the real estate market could slow down sharply. There will be a global stagnation during this period. Spending decisions will also be affected by the decline in financial wealth, which by now probably exceeds the gains in housing wealth.

Fourth, recovery and return to growth. Once the aftermath of the attacks has vanished, activity in the OECD should turn around. The precise timing is difficult to predict. Hopefully, it will take place around the middle of next year, when a sentiment that "business is back to normal" starts to prevail and the expansionary stance of monetary and, in a number of countries, fiscal policy will be fully felt. If everything goes well, growth could gather momentum in 2003.

This is the central scenario, but what if the situation develops differently, if those dramatic events you mention come into play?

Our assessment is subject to change as information becomes available and events keep unfolding. So we must approach this exercise with substantial humility. There is no doubt, however, that the United States will be affected by the recent events. How much this effect will spread to other countries is a source of uncertainty. Trade linkages play a crucial role, and there is also some evidence to suggest that global links might have become more important – for instance, stock market fluctuations, confidence, foreign direct investment flows are more correlated – even if this is still a subject of debate. Europe was already slowing down significantly before the terrorist attack, and this might be reflected in low growth also next year. The situation in Japan can only become more complicated as a result of the attack – one issue, for example, is whether the government will launch a massive clean-up of banks' portfolios in these uncertain times. Some emerging countries will be hit by the "flight to quality", especially the most vulnerable ones, but it seems that countries in Central Europe and Russia have so far been relatively protected.

Is there anything that can be done to manage this difficult period? Hardly a time of business-as-usual for policymakers, is it?

To a large extent, the prospect for recovery depends on actions by policymakers around the world to restore confidence and support demand. These actions have so far been impressively appropriate. Central banks have already eased aggressively in nearly all member countries (the Fed, European Central Bank, Bank of Japan, Bank of England, etc.) and (small) additional rate cuts are possible. Large amounts of liquidity have been injected in the financial system to reduce the risk of insolvency. Public resources have been allocated in the United States for the reconstruction effort, to bail out airlines, and to step up the military and security efforts. In Europe, most governments will probably let automatic stabilisers play freely.

Perhaps the current fears will be dispelled quickly, but there are downside risks of a long drawn-out process, punctuated by setbacks.

All important steps, but are there specific policy messages you would like to emphasise to improve the situation further?

I see three key areas. The first is the quality and effectiveness of action, the second is preparedness for the unforeseen, and the third is to keep the eye on the long term. On the first issue, it is important that governments do not overreact to recent events. As the Federal Reserve Chairman has said, "it is more important to do the right thing than to react quickly". Large injections of liquidity and sharp increases in spending would support demand immediately, but they could rekindle inflationary pressures and require a sharp policy tightening in 2003. Similarly, recent initiatives to bail out airlines, or to help insurance companies, have to be followed with care. There are risks that the progress painfully made in recent years to level the playing field, establish clear competition policies, and refrain from state interventions might be threatened. Hence, governments should avoid measures that they may regret subsequently.

On the second point, it is important that OECD countries be prepared for the uncertainty that is likely to prevail in the next few months. Unforeseen developments may occur, and it is essential to have contingency plans as well as room to manoeuvre if the situation becomes more difficult. We will help in this respect by providing a toolbox of standardised shock scenarios (inter alia on oil prices, stock markets, exchange rates).

Finally, long-term risks should not be neglected. We are thinking about briefly considering, in the context of the forthcoming *Economic Outlook*, some longer-term risks concerning reductions in trade, capital flows and the movement of people, and if possible, try to shed some light on the outcomes of such possible trends.

Could less economic openness be one of those risks?

Clearly, the closing of borders – whether formally or not – to goods, capital and persons would mean that the world economy would become less efficient. This might impact negatively not only on advanced countries, but also on emerging economies, which have a lot to lose. So it is important that the international community does not retreat on its progress towards a more open world. The future world summits on trade and sustainable development (scheduled for Johannesburg next year) should be seen as opportunities to reaffirm the commitment to an open world. The progress towards a more open world would be facilitated by the recognition that large groups of people have been left behind and have not enjoyed improvements in living standards. The global economy should stay open, but ambitious actions are also needed to fight poverty and support growth in the developing world. ■

* *Economic Outlook*, No. 70, OECD, December 2001. Electronic copies will be available from November 20 at 11 am Central European Time.

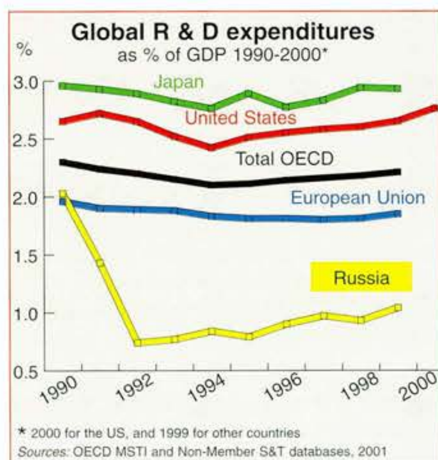
Russia's innovation gap

Mario Cervantes and **Daniel Malkin**, OECD Directorate for Science, Technology and Industry

It may seem puzzling to talk of an innovation gap in Russia, for so long a bastion of scientific knowledge. Yet that is precisely what has been developing since the collapse of the Soviet Union. Investment in research and development (R&D) has declined dramatically in the past decade, from just over 2% of GDP in 1990 to little more than 1% in 1999, compared with an OECD average of 2.2%. Yet, before the 1990s, the country was widely regarded as a science and technology powerhouse, able to hold its own in fields such as theoretical physics and nuclear technology and a world leader in space technologies. The collapse of the Soviet economy, particularly the industrial/military complex, to which most Russian R&D investment was directed, brought down a system that was based largely on technological prestige and bureaucratic planning.

Financial crises, decaying equipment, unemployment and higher wages in other sectors drove large numbers of researchers – and some technicians too – away from science and technology, or indeed out of the country altogether. In the early 1990s permanent emigration of Russian scientists and technologists to Germany, Israel, the United States and Canada increased sharply. The "brain drain" has since abated and Russia still ranks alongside the top OECD countries in the number of researchers in the active population. Nevertheless, the number of personnel working in science and technology is barely half what it was in 1990, at a time when demand for skills in most OECD countries remains high.

The transition to a market-based economy appears to have bypassed the R&D sector, with institutional inertia setting in, rather than personal initiative, and dwindling resources compounded by distorted patterns of financing inherited from the former Soviet Union. The government still finances the lion's share of R&D expenditure in Russia, with only a third coming from industry, significantly lower than in advanced OECD countries where business is the main source of increased spending on R&D. The only type of R&D funding that has grown substantially in the past decade is foreign funding, which more than doubled to 10.3% of the total in 1999 (up from 4.6% in 1995), thanks to grants and foreign investment. But the danger of such foreign funding is that it is volatile and subject to changing business perceptions, as well as competition from other countries.



* 2000 for the US, and 1999 for other countries
Sources: OECD MSTI and Non-Member S&T databases, 2001

Institutional rigidities remain a major constraint on R&D, and there are few opportunities for the private sector to use R&D investment to increase economic performance. As a result, the bulk of R&D continues to be performed by the academies of sciences (public laboratories subordinated to various ministries and technological institutes).

Official figures show a relatively high share of R&D being performed by the business sector, but this is largely because Russia's 2 500 research and technological institutes are included in the numbers. In fact, the weak supply-demand link from these institutes to business is a major flaw in Russia's nascent innovation system. Matters are made worse by the fact that the share of government-performed R&D devoted to longer-term basic

science has increased relative to applied research programmes, which are more likely to meet immediate economic and social needs. University research, so important for innovation elsewhere, makes only a minimal contribution to R&D in Russian science and technology. Yet, without research universities, a link is missing in the diffusion of knowledge and technology, as well as in the building of public/private partnerships for innovation of the type that have benefited OECD economies.

In fact, despite the magnitude of its assets and its world-class achievements in several scientific disciplines, the output of the Russian science and technology sector is rather modest. Russia ranks seventh in the world for the number of scientific publications it produces, around 3.5% of the total. And the volume of its resident patent applications has continually decreased over the 1990s (one per 10 000 population in 1997 compared with 4.5 in the United States, 2.5 in the EU and 3.8 in the Nordic countries).

The market may well drive innovation, but public action is necessary to reduce risks and provide incentives to transform knowledge into new products and processes. The OECD has often argued that governments have to play an active, if targeted, role in fostering innovation.

Framework conditions, such as well-functioning tax, competition, and product and labour market policies, must be put in place to incite firms to upgrade and invest in R&D and innovation. Fostering interaction between public research and industry is a matter for governments too. There is a marked lack of incentives for public research institutions to engage in closer relationships with industry in Russia. Regulatory reforms are clearly needed, including measures to facilitate the mobility of researchers and public/private partnerships. In fact, research funding could be used to encourage such partnerships.

Another missing link in Russia's emerging innovation system is venture capital. Whatever little there is comes from foreign funds and is oriented towards loans, with very little finance directed towards equity positions in new technology-based companies. Greater involvement from Russia's institutional banking sector – still weak following the financial collapse of 1998 – is needed to create a critical mass. Business advisory and information services for scientists and young entrepreneurs are also needed to build the management skills for creating new firms. The emergence of a new cadre of Russian universities, linking scientific curricula with business and entrepreneurial skill development, is a step in this direction.

Inset photo ©ITAR-TASS; Main photo: ©ITAR-TASS/Alexander Babenko

Glory days

Forty years ago, on April 12, 1961, Yuri Gagarin (inset) became the first man in space. He orbited the earth once – 108 minutes at an altitude of 188 miles. Russia celebrated the event in 2001 amid protests about squeezed resources for space exploration. The main photo is of Soyuz-TM-11, whose 1990 mission was to Mir, the manned space station that stayed 15 years in orbit before being brought back to Earth, ironically in 2001. The 1990 flight was launched jointly with Tokyo Broadcasting Systems (TBS), a private Japanese television network which paid several million US dollars to participate in this first ever commercial flight to Mir.

In short, narrowing Russia's "innovation gap" will demand reforms to link the emerging innovation infrastructure to the science system. It will also require intensive and permanent interaction between industry and public research. The traditional manufacturing and resource-based industries, which account for two-thirds of industrial investment in R&D, have little incentive to invest in innovation and generate little domestic demand for innovative firms in Russia. As a result, innovation must rely on export markets.

A strong intellectual property rights (IPR) set-up will also be needed. Progress has been made in setting rules and enforcing intellectual property rights in line with international obligations, but greater effort is needed. The commercialisation of new ideas in research institutions is held back by the lack of consistent and clear rules on the ownership, management and protection of intellectual property. Without clear rules and protection, the incentive to innovate will be diminished. One step should be to improve the diffusion of legal information on IPR-related court decisions as a way of ensuring transparency and encouraging investment.

This is quite a list of challenges and political leadership is now needed to drive through reforms and remove Russia's institutional rigidities. There are signs of this happening, with government-supported incubators for high-tech start-ups and innovation technology centres that link research and production capabilities, for instance.

But these initiatives are too piecemeal. More effort is needed to make financing more widely available, and to create a more transparent, fluid knowledge market. That means making sure that translating ideas into practice brings rewards.

It also means investing in people and laboratories and encouraging Russian business, including smaller firms, to invest in R&D. This will help create employment opportunities for Russian scientists and researchers and encourage talent to migrate back. Such changes would help Russia regain its place among the big hitters in global science and technology. And they would give its economy the boost it badly needs too. ■

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Introduction

How healthy is our healthcare?

Health before wealth is one of the oldest sayings in the book. Yet, while good health is obviously a foundation of human welfare, a lot of wealth is absorbed in its pursuit. OECD countries spend an average of 8-10% of GDP on healthcare. And that amount will rise in the years ahead as cost and demand pressures increase. Who cares, some might say, as long as we are living longer and healthier than ever before? If only the question were that simple.

As the OECD's secretary-general, Donald Johnston, points out in our editorial, the United States spends twice as much per person as Canada on healthcare and yet the average Canadian has a higher life expectancy than the average American. France spends less per person than Canada and yet has more hospital beds and doctors per inhabitant than either of the other two. And French women have one of the highest life expectancies of all. For one thing, this shows the importance of using the right indicators for measuring healthcare performance. Life expectancy may be a useful measure of our well-being, but it depends on many factors apart from healthcare, such as standards of living, diet and physical activity.

Still, more people are living longer. This poses a daunting challenge, for as the OECD's Stéphane Jacobzone and Howard Oxley explain in this spotlight, elderly care is where most health spending is concentrated. The increase in pressure on healthcare systems that ageing will bring cannot be met without managing scarce public resources wisely. Consumers demand value for money. But as several writers point out, including Angela Coulter of the Picker Institute, they do not want their health services to be pared down to the bone. Naturally, they want health services that deliver results. They want policymakers to be more patient-oriented, to find out whether more operations have been successful, to ensure that clients get real satisfaction.

It may be that, in some cases, public spending on health has to rise to achieve efficiency. Performance indicators help to establish this, and Sheila Leatherman of the US-based Center for Health Care Policy and Evaluation shows the pitfalls and potential of using different measures. Coming up with the right indicators requires considerable analysis, particularly in the increasingly difficult area of long-term care, as Keio University's Naoki Ikegami explains. For Mr Ikegami and all our writers, consumers, not just accountants, will judge whether improvements are being made.

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Under pressure

Healthcare performance is also about responsibility. Who do we blame when the service goes wrong? Legend has it that Chinese emperors used to pay their doctors only when they were well, since if the emperors were ill the doctors were clearly not doing their job properly. Many centuries later there is still an interest in paying doctors by results, provided these can be reliably identified. Again, this underlines the importance of measurement. As leading surgeon David Khayat passionately holds, it may also mean that a new ethics culture is called for, to help guide doctors in their changing and highly pressurised professional roles.

Malpractice in the medical profession is a cause of public alarm in several countries and consumers are becoming "impatient", as Janne Graham, a patients' spokesperson and witness, tells us. Also, the rise of biotechnology and genomics raises ethical questions that health professionals alone cannot answer. Elettra Ronchi and Anne Carblanc from the OECD warn that genetic coding and DNA information might have to be better protected by policymakers if public confidence in these potentially beneficial technologies is to be won. How can medical services cope with all these pressures and still achieve improvements? To judge by the candid contributions of five health ministers to our roundtable – from Canada, Finland, Mexico, New Zealand and the United States – policymakers are rising to the challenge. A difficult road awaits them, but it is clear that more evidence and record of experiences are needed to help them build policies that work. For, as fertility expert Kajsa Sundström describes in the case of Sweden, policies that do not take full account of the behaviour and desires of the people they are aimed at may simply fail.

The *Observer* would like to thank Gaëtan Lafortune for his helpful comments and advice in the preparation of this Spotlight on Healthcare.

Information power

Information is also crucial. As Tim Kelsey from the Dr Foster company explains, better information leads to more pressure for accountability and this in turn should lead to better health system performance. Education too is important, whether in improving professional training or health education for all, including children. Such action can start now, but the effects will be long-term. There is a risk that education will increase pressure on health services, as better informed patients become even more demanding. But education is also key to successful preventive care, and governments can do more to encourage lifestyle improvements that not only lengthen life expectancy, but can reduce some of the burden on healthcare systems. Yet even this is not so simple. Today's consumerism pulls in the opposite direction, with modern problems, like obesity from too much junk food or lack of exercise, having to be overcome (see Databank, p. 69).

Finance will always be a tricky question. As the OECD's Nicole Tapay reminds us, more work has to be done to find out how public and private insurance might work together to help strengthen our health systems. Getting the regulatory framework right is vital. Different rules can work against each other, making it hard to achieve a fully integrated health system, as Niek Klazinga from Amsterdam University explains in connection with the Dutch health model.

Most people in OECD countries enjoy good access to health services; yet, some do not. And for millions outside the OECD area, health is still a luxury item. All these challenges are compounded by uncertainties. Health services can be stretched in emergencies, and, as we have recently been painfully reminded, whole systems can be tested by biochemical and other types of terrorism. Such events may be few and may not affect overall long-term spending costs, but they raise management questions, about surveillance, responsiveness and confidence. We all want good value, but how do we put a price on human safety?

Fuelling uncertainty is the fact that health, especially in relation to infectious diseases, is a global public good. Some infectious diseases like TB are staging a comeback and new ones are emerging. Many of them migrate across borders. Solutions have to be cross-border, too. As Brett Parris from World Vision International argues, an OECD strategy for improving healthcare performance would be compromised (even ineffective) if it did not take worldwide performance into account. The World Health Organization's work described by the director-general, Gro Harlem Brundtland, in our leader column should ensure that the global dimension plays a central role.

Many of the contributors to this spotlight on healthcare are participants at the high-level OECD conference in Ottawa on 5-7 November, Measuring Up: Improving Health Systems Performance in OECD Countries, hosted by the government of Canada. Measuring health performance is a vital part of the job ahead, but it is only the first step towards better healthcare. Investment in time and resources will be needed. It will be worth it, because our wealth does indeed depend on our health.

Rory Clarke, Editor, *OECD Observer*

Healthcare expenditure
A future in question

Stephane Jacobzone, OECD Education, Labour and Social Affairs Directorate, and
Howard Oxley, OECD Economics Department

Healthcare costs are rising as patients become more demanding and new technologies spread. The trend is likely to accelerate in coming years as the ageing of the baby-boom generation and lengthening lifetimes cause the number of elderly people in OECD countries to rise sharply. But how much will it cost to take care of this elderly population, and should we adapt public health spending to cope?

Public expenditure on health soaks up a large part of government budgets. And there are fears it could rise as ageing in OECD countries accelerates. Already, three-quarters of spending on healthcare and long-term care for the elderly is financed through the public sector. The over-65 age group accounts for 40-50% of healthcare spending and their per capita healthcare costs are three to five times higher than those under 65. In 10 years' time the baby-boom generation will begin to retire. Calculating exactly how much more money will be needed, who will provide it and the best way to spend it, is as complex a task as it is urgent.

The sums at stake are enormous. Overall health spending, including long-term care for the elderly, already accounts for around 9% of GDP in OECD countries. And there is a question mark over how much money will be available in the future, given an expected slowdown in GDP growth as the progressive decline in fertility rates since the late 1960s causes labour supply to expand more slowly.

Healthcare costs have stabilised at an average of just over 8% of GDP across 24 OECD countries for most of the past decade, with long-term care for the elderly – from home help to long-term institutional care – averaging a further 1%. How much expenditure might increase is difficult to say as there are numerous factors at play whose impact is quite uncertain. Past studies provide only limited guidance. Key factors that might explain rising costs up to the early 1990s appear to have been rapid introduction of new technologies and strong incentives to supply health services, and higher demand for healthcare, itself a reflection of rising incomes and a more educated public.

Overall health spending, including long-term care for the elderly, already accounts for around 9% of GDP in OECD countries. And there is a question mark over how much money will be available in the future.

Furthermore, the fact that the cost of healthcare is largely covered by insurance may have spurred some extra demand too. But the precise effect of each factor is hard to measure, and statistical analysis has been able to account for only about half of the total increase in costs. Even more puzzling, these studies generally find that change in the age structure of the population has had little effect on expenditure, even though the increase in per capita care costs in recent years has, to a large extent, been concentrated among the elderly.

Despite these difficulties, the OECD and national researchers have attempted to project increases in health and long-term care costs over the period to 2050*. The result indicates that the ratio – the proportion of individuals aged 65 and over in the population – will double over the next 50 years in OECD countries. Using this as a starting point, countries forecast an increase in expenditure over the 2000-2050 period of 3 to 3.5 percentage points of GDP, averaged over the 14 countries for which this data is available. But the differences across countries are large, with increases of 4 percentage points or more projected for Australia, Canada, the Netherlands, New Zealand and the United States. Some of the variation arises from slower growth in the dependency ratio in some countries. But the key difference probably lies in their varying assumptions about other factors affecting health and long-term spending, for example, the impact of technological change.

There is some uncertainty surrounding these estimates though. Take life expectancy, for instance. This may increase by more than the projected 4.5 years, which means a larger share of the elderly in the total

population. At the same time, a significant part of expenditure on healthcare and long-term care is concentrated in the last few years of life. So, if the average age at which dependency or illness sets in also increases in step with longer lifetimes, then costs will go up by less. Moreover, recent trends suggest that there have been reductions in disability in a number of countries and, if this were to continue, the need for long-term care for the old and frail – particularly in high-cost nursing homes – will not increase by as much as expected.

Much will also depend on what kind of healthcare the elderly demand or are offered. US studies show that most of the increase in expenditure among more senior age groups reflects a more intensive use of high-cost technology. The number of older people undergoing procedures such as coronary artery bypass graft or hip replacement multiplied by between three and 10 times for the oldest age groups between 1987 and 1995. Because individual countries have not included the possible effects of such shifts in their calculations, the increase in spending could be much higher than expected. Policymakers may have to consider whether the recent spread of new technologies is worth encouraging further, particularly as research has shown that in certain cases cheaper, older methods are as effective.

Though the increase in per capita care costs in recent years has, to a large extent, been concentrated among the elderly, studies generally find that change in the age structure of the population has had little effect on expenditure.

Future demand for long-term care will also be a challenge. Most of these services are provided by the state in the Nordic countries – long-term care expenditure represented 3.8% of GDP in Sweden in 1997. But in countries such as Spain, Italy and Greece, where the elderly have traditionally been cared for within the family, spending is estimated to be less than 0.5% of GDP. Demand in future years will clearly be affected by families' ability, and willingness, to care for their parents. That will depend to a great extent on questions like whether the participation rate of women in the paid workforce will rise further and on whether the real, rather than the official, age of retirement increases or not. The public sector will probably continue to finance at least part of the additional supply of care, though the elderly themselves may be asked to help pay more, as they are likely to be better off than in the past.

Demand is by no means the only uncertainty affecting healthcare forecasts. Pressures from new "pathologies" like AIDS and antibiotic-resistant bacteria could change the outlook considerably. Another item to consider is future labour costs in the health sector; these are a great unknown though may rise in some countries. Budget tightening has already led to complaints of worsening work conditions from healthcare workers in some countries. Indeed, some countries are currently finding it difficult to recruit and retain nurses (the UK, for instance, recruited heavily from Spain in 2001) and other medical personnel, and as the labour market is expected to become tighter in coming years, this may increase wage pressures.

Nonetheless, there is considerable scope for policy to limit spending increases or to improve the effectiveness of healthcare. There is some evidence that healthcare spending is lower – and has grown less rapidly – in countries with "gatekeeper" systems where family doctors oversee access to specialists and hospital care. But there are political limits to cost-containment policies.

Governments will also need to pay more attention to the goals of public health spending. Up to now, the bulk of spending has been on curative acute care medicine whereas much healthcare is now becoming focused on treating chronic conditions, particularly among the elderly, rather than on communicable diseases as in the past.

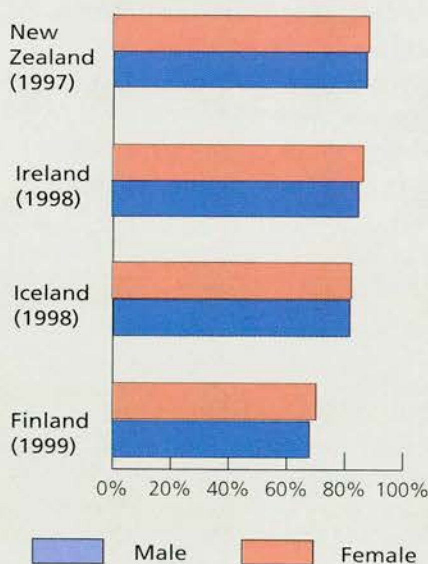
But it would be better if these chronic conditions could be prevented, by lifestyle improvements, for instance. Such changes are notoriously difficult to introduce but they could prove to be the best long-term method of improving healthcare performance.

Governments could also consider public and private partnerships to reduce the overall burden on the public finances. Getting a better balance between inpatient and outpatient care is also important as

The "feelgood" factor

"You are as old as you feel": maybe, but are you as healthy as you feel? If that is the case, most people in OECD countries are doing fine, with US, Canadian and French men topping the feelgood factor list, with more than 90% of them reporting good health. In fact, according to the OECD's book, *Health at a Glance*, men generally feel better than women, except in Finland, Iceland, Ireland and New Zealand (see chart). But there are indications that people's idea of good health becomes more demanding as healthcare improves. The levels of both men and women reporting good health have changed little over the past 25 years in Finland, the Netherlands, Sweden and the United States, but this may reflect increased expectations for health. And despite the subjective nature of this particular health measure, indicators of self-rated general health have been found to be a good predictor of future healthcare use in several countries.

• *Health at a Glance*, OECD, 2001.



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Still fighting fit

medical technology makes it more feasible to treat people outside the hospital environment. However, without some brake on individual demand, cost control will only be achieved by rationing.

Finally, healthcare suppliers need to be careful about using medical technology too much in areas where marginal benefits are low and costs are high, such as the use of chemotherapy beyond a certain point, and perhaps not enough in other areas where cost-effectiveness is more attainable, such as the timely use of thrombolytics after a heart attack.

Much healthcare is now becoming focused on treating chronic conditions, particularly among the elderly, rather than on communicable diseases as in the past.

Technology has been one of the driving forces behind past cost increases and it is time this is given closer scrutiny, so that only those technologies yielding significant improvements should be fully funded by the public purse. Pressure on health systems will no doubt continue strong in the future as populations age. All the more reason for policymakers to find ways of improving productivity of healthcare systems and searching for better value in delivering quality to citizens and patients. ■

* National models were used to forecast likely spending trends, based on population projections by Eurostat for EU countries, and national statistical agencies for the remaining ones. Some common assumptions were applied for estimating future employment and GDP growth for all countries. The 14 countries were Australia, Belgium, Canada, the Czech Republic, Denmark, Finland, Japan, Korea, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom and the United States.

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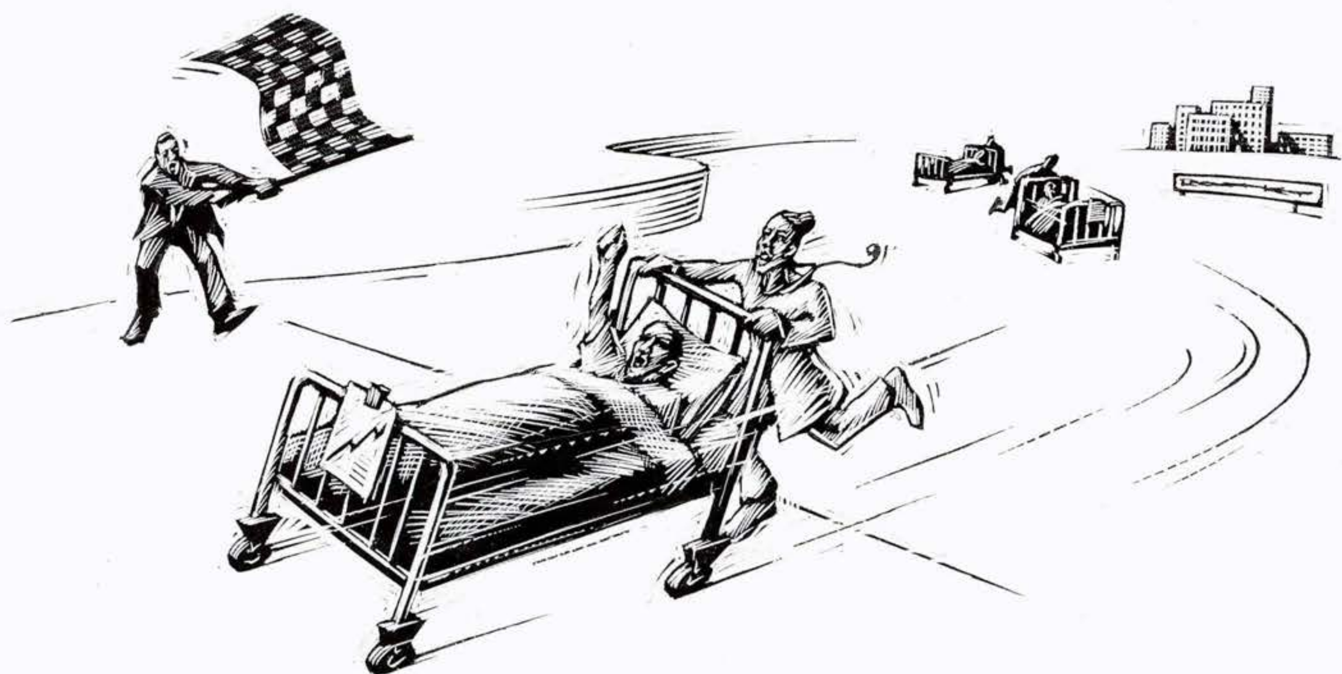
Measuring up
Performance indicators for better healthcare

Sheila Leatherman, President, Center for Health Care Policy and Evaluation, Minneapolis*



Industrial countries spend a large proportion of GDP on healthcare. But how can they be sure they are getting value for money? One way is to use performance indicators, but these can have their drawbacks, as well as their advantages.

There is no doubt vaccination works, yet 20,000 people die every year in developed countries from vaccine-preventable diseases, according to WHO estimates. Numerous studies over the years have found no evidence that antibiotics help treat the common cold, yet 40-60% of doctors still prescribe them. These are just two examples of the gap between knowledge and performance in our healthcare systems.

Why does this gap exist? A key problem is the sheer weight of new knowledge. In the mid-1960s, about 100 articles from randomised clinical trials were published. By the 1990s, approximately 10 000 such articles were being published every year and nearly half (49%) of all the extant medical literature has been published in the past five years. The result is an estimated 15-20 year time lag between identifying more efficient treatment and incorporating it into routine practice. The gap applies across the board, from complicated clinical conditions to routine medical problems, such as the common cold.

Other key problems include the complexity of healthcare systems, the increasing demands fuelled by patient expectation, ageing and new technologies, as well as the reality of constraints and poor distribution of resources. Improving the performance of healthcare systems is becoming a priority in many countries as a result of economic pressure to optimise health spending, as well as increasing evidence of the scale of deficiencies in quality of care.

The scientific evidence is accompanied by widespread concern about eroding performance. In a 1998 survey of five countries, more than half the doctors questioned in Canada (59%), the United States (57%) and New Zealand (53%)

reported that their ability to provide quality care had worsened over the past five years. Some 46% of UK physicians and 38% of Australians told the same story. Only a quarter or less of the physicians surveyed reported that their ability to provide high quality care had improved over the period. A similar survey of nurses in Canada, Germany, Scotland, England and the US in 1998-99 found that between 17% and 44% of them believed quality had deteriorated in the past year.

These findings cannot be dismissed as simply the complaints of demoralised clinicians, since patients respond similarly. In the 1998 survey, the public indicated overwhelmingly that the health systems in their country required fundamental change.

Consensus is emerging on the principal areas to cover in performance measurement: namely, effectiveness, efficiency, responsiveness and equity. But once you have defined your terms, how can performance measurement actually improve quality? There are numerous possible methods, but scant evidence available to provide a basis for selecting one. Factors such as underlying values, financing and organisational arrangements come into play.

The choice of method will also depend on whose behaviour you are trying to change: providers, professional bodies, citizens or managers. Identifying a "best method" may not be realistic, but being aware of the possible approaches, their strengths and limitations, and the experience of countries that have tried them, can help in making a choice.

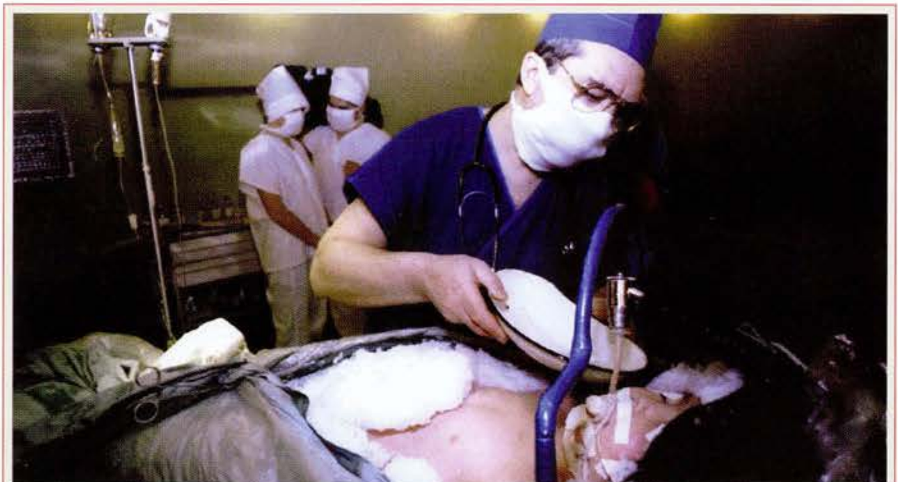
Performance indicators are employed for four basic functions: facilitating accountability; monitoring healthcare systems and services as a regulatory responsibility; modifying the behaviour of professionals and organisations at both a macro (population) and micro (patient) level; and forming policy initiatives.

Public demand for accountability is rife and nations are responding in their own ways. OECD countries generally apply three models of accountability in healthcare – professional, economic and political. They use various combinations of these, all of them relying on performance indicators to some degree.

Tony Blair's decision to invest significant new resources in the National Health Service (NHS) was influenced, in part, by data showing his country to be spending a lower proportion of GDP on health than most northern European countries.

Professional accountability, dominant in most health systems historically, views the physician as the key to controlling quality and uses certification, accreditation, licensing and litigation as instruments for enforcement. But the professional model of accountability is increasingly regarded as insufficient unless accompanied by one of the other two.

The economic model, of which the US is the clearest example, is based on the idea that the competitive market can be used to enforce accountability. Health plans can influence physicians' choice of treatment by declining to fund some practices or encouraging others. And accountability through public reporting is believed to have resulted in improved performance in certain areas. For example, the rates of beta-blocker prescribing following heart attacks rose from 62% in 1996 to 85% in 1999 after standardised reporting was introduced. The political model meanwhile views the citizen as receiving a public good, so the government's role is to act as an agent of change on behalf of the public.



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Ice surgeon

Are there cheaper, safer alternatives to anaesthetics, even for serious operations? Surgeons at the Institute of Circulatory Pathology at Novosibirsk in Siberia believe there are. Here, a surgeon packs ice on a patient in preparation for open heart surgery. The institute says that by lowering the body temperature to about 75°F and the brain temperature to 60-65°F, they can stop the heart for 75-90 minutes, long enough to perform the operation without anaesthetics. Normally, in order to operate on the heart, doctors must stop it so they can make the precise incisions needed to repair defects. But this cuts the flow of blood and oxygen to other organs and can cause permanent damage, even death. As the brain will only survive for a few minutes without oxygen, either blood must keep flowing or the body's need for oxygen must be reduced. This is precisely what the ice method achieves. The temperature of the patient's brain is lowered enough to stop the heart long enough to operate, restoring circulation afterwards, including the full functioning of the brain. According to experts, the results of the procedure are comparable to conventional operations, but at a lower cost. Japan and the UK used the method half a century ago, but abandoned it after bypass machines were introduced. The Novosibirsk Institute is the only centre in the world that continues to use the method.

Objective measures of performance are increasingly used at several levels. They can dramatically influence policy, for instance. UK Prime Minister Tony Blair's decision to invest significant new resources in the National Health Service (NHS) was influenced, in part, by data showing his country to be spending a lower proportion of GDP on health than most northern European countries. And the US was influenced to train more general practitioners when data showed that it trains a higher proportion of specialists than most European countries.

Patient empowerment is not just politically correct, it can cut costs and improve quality.

Importantly, performance indicators can help to make policy priorities explicit, for example by defining national priorities and then identifying specific performance targets within those priorities. Australia has had a system of identified national health priorities since 1996; namely asthma, depression, diabetes, cardiovascular and injury, with reports describing the best available data in most priority areas.

The UK's NHS, after finding that outstanding claims for alleged clinical negligence in its hospitals have reached $5.6 billion, has set targets for reducing serious harm, such as a 40% reduction in prescribing errors by 2005.

Assisting healthcare professionals in practicing evidence-based medicine is a key objective for improving quality. Performance indicators, embedded in clinical guidelines and peer reviews, are among the most common approaches aimed at bridging the knowledge gap, but have limited effectiveness when used alone to change physician behaviour.

Still, scepticism remains, as was demonstrated in a recent survey of more than 100 doctors in England. Some 85% said they would ignore the guidance of the newly established National Institute for Clinical Evidence, responsible for developing the evidence basis for guidelines and protocols, if they thought it was wrong. There are promising signs of potential in incorporating practice guidelines into computer support systems. Indeed, analysis shows that the use of computer-generated prompts can improve preventive services and how drugs are prescribed.

New York success story

Experience in the US suggests that institutions too can use performance data to improve care processes, to identify poor performers, and to respond to patients' preferences or complaints. One often-cited example is the decision by the New York State Health Department to publish mortality rates after coronary artery bypass graft (CABG). In the first five years of the programme (1987-92), the mortality rate in New York declined twice as fast as the national average. But in the face of this dramatic success, so far there has been little effort to achieve similar results with this method either for CABG in other states or for other types of treatment in New York. What's more, nobody is sure why this approach has not been more widely adopted – is this a problem of professional resistance, technical capability or resources?

A US movement sometimes referred to as informed consumerism has been relied upon as a means of using competitive market forces and individual choice to drive up performance. But an article in JAMA in 1999 found that patients/consumers have made very little use of performance data when making healthcare decisions, continuing largely to rely on word-of-mouth. One reason may be that most of the published performance data was very specialised and not useful for most patients, such as CABG mortality rates.

However, performance data designed specifically for consumers, such as information about success rates for common procedures and treatments, may be the most efficient way of delivering data to the public.

Patient empowerment is not just politically correct, it can cut costs and improve quality. There is now a body of literature showing that better-informed patients have better outcomes, choose less risky procedures and avoid equivocal treatments. This should increase our confidence that patients can not only make constructive use of performance data designed for them, but can also be reliable informants for performance assessment.

Performance data designed specifically for consumers, such as information about success rates for common procedures and treatments, may be the most efficient way of delivering data to the public.

Another issue is cost. Since employers are the dominant buyers of healthcare in the US, they theoretically have both the motive and clout to buy health services or insurance coverage based on performance. But in reality, price trumps all other performance data. Two studies, which between them looked at more than 1 500 employers across the US, concluded that their use of performance data was limited, again at least partly because the data was not packaged to be useful to them.

Performance measurement and reporting have clearly made dramatic advances in the past decade but more needs to be done so that fair and accurate assessments can be predictably and credibly provided. Performance indicators, whether length of waiting lists or choice of treatment for a particular ailment, may light the way forward, but face significant challenges.

The state of the art of performance measurement is embryonic, with insufficient understanding of exactly how data can help achieve change, under what circumstances and with what consequences.

New resources will be required to build capacity, most notably in informatics and information technology. Most importantly, performance data will have to be made even more useful to target audiences with clear, measurable and achievable goals for improvement. ■

* Read the full paper at: http://www1.oecd.org/els/health/canconf/ programme.htm

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Private lives

Elettra Ronchi and **Anne Carblanc**, OECD Science, Technology and Industry Directorate

The right to privacy and medical confidentiality is taken as read in OECD countries. Yet with new genetic technologies, information about a patient can give clues to the health and physical attributes of the patient's whole family, and even future children. There are calls to improve data performance in healthcare, but are existing data protection systems strong enough to cover these new realities?

The use of information technology in the healthcare sector has spurred rapid growth in health-related databases. Genomics, bioinformatics and technologies for genetic testing are adding to this growth. In most OECD countries, health data and genetic data are currently treated in the same way as other personal or sensitive data in terms of protection. But how can we effectively protect privacy in these new types of data and in the electronic ways of processing and storing it at the global level? Right now, international debate suggests, we could do better.

Genetic data is generally covered by confidentiality and personal data protection laws, combined in most countries with recourse to over-arching constitutional protection, or human rights legislation. But even this arsenal may not be enough to cover the very specific and detailed information contained in genetic and genomic data. A person's "genetic fingerprint" may reveal important information not only about the individual being tested, but also about family members such as a hereditary predisposition to develop breast cancer or Huntington's disease, which may ultimately have a great impact upon his or her life, including reproductive choices and even life insurance. So privacy and data protection in this area are an important policy issue.

In considering personal data arising from genetic testing there are several elements that could be clarified, notably the definition of personal data in relation to genomics and the distinction between genetic/genomic data and other health data. Other examples would be to clarify the settings, purpose and modalities of collection of genetic/genomic personal data (medical context, specific research, criminal, etc.), as well as the circumstances under which such data could be transferred, shared and passed on for secondary purposes. If a person has consented to donate DNA for a study on obesity, can the same DNA be used subsequently for research on asthma? And then can the information be used for commercial purposes?

Clearly, we have to ensure that data about a person's genetic make-up remains private. The question is, how? Is "knowing and voluntary" consent the general condition to have such data collected, stored and used? There is an issue of whether the same consent requirements apply to public health use of the data, public security use of the data or commercial use of the data. And the circumstances, if any, under which one family member has the right to access the genetic information of another family member have to be cleared up too. There is also the whole question of what rights the individual, or even a community, has over data arising from genetic testing once it has been gathered and stored for a particular purpose.

Many research centres and private laboratories are setting up DNA banks of entire populations. There seems to be no agreement as to how long this DNA can be stored and little uniformity as to what type of information should be given to those who donate their DNA. Another critical issue is privacy protection when linking databases and biological samples.

International bodies and professional organisations overwhelmingly agree that protecting the identity of an individual in data

If a person has consented to donate their DNA for a study on obesity, can the same DNA be used subsequently for research on asthma? And then can the information be used for commercial purposes?

collection and storage is a key concern. People may avoid tests or treatment if they fear the results will not be totally confidential. All current guidelines cite the need for "appropriate technical measures" to protect data, yet little progress has been made in clarifying what the term "appropriate" should signify and how this goal can be achieved in practice. And there has been little discussion of the possible consequences of making key health data irreversibly anonymous and whether this is truly desirable.

There may be cases where it would be important to identify individuals, for example, if a gene mutation reveals that some individuals might be at risk of life-threatening side effects from a particular drug. We also need clear definitions of what constitutes anonymous data, where the subjects are, in theory at least, permanently unidentifiable; coded data where only those with the key to the code can access information to identify a particular person; and de-identified data where the identity is easier to re-establish.

A 1997 report to the US secretary of health and human services on privacy and health research provides a compelling review of security issues. As this document highlights: "security has many dimensions; the special challenge (in the health sector) is to keep data sequestered and protect its integrity, but at the same time to keep it accessible for authorised users who have legitimate need to use it".

Over the past decade the OECD has built expertise in privacy and confidentiality issues using a science and rules-based approach. Benchmark principles on data protection were developed by the OECD in 1980 and have been integrated into laws and regulations in many countries.

The OECD also developed in 1992 and 1997 guidelines on security of information systems and cryptography policy, which identifies the basic principles that governments should take into consideration when developing policies on security or cryptography.

But we need to know how the OECD's "Guidelines governing the Protection of Privacy and Transborder Flows of Personal Data", "Guidelines for the Security of Information Systems" and "Guidelines on Cryptography Policy" could apply in the context of genetic testing.

This would involve exchanging information to identify practices currently available for protecting privacy and ensuring adequate security, and issuing practical guidance (on the basis of this exchange of information) on how to implement the OECD guidelines on privacy, security and cryptography in the context of data arising from genetic testing. All of this has an economic impact, as it may affect the use of informatics for analysing genomic data, the globalisation and commercialisation of research in genomics and subsequent improvements in health.

But there are also social questions. There is growing public concern that in the absence of appropriate safeguards, data arising from genetic testing and related databases may negatively affect human rights and democratic freedom. Lack of public acceptance could impede progress in research and development, and potential improvements in the health of populations around the world.

Developments in genetic research offer the possibility of better prevention and treatment for a host of health problems, but policymakers need to address public concerns about the privacy problem to ensure that the benefits of the new technologies are realised. ■

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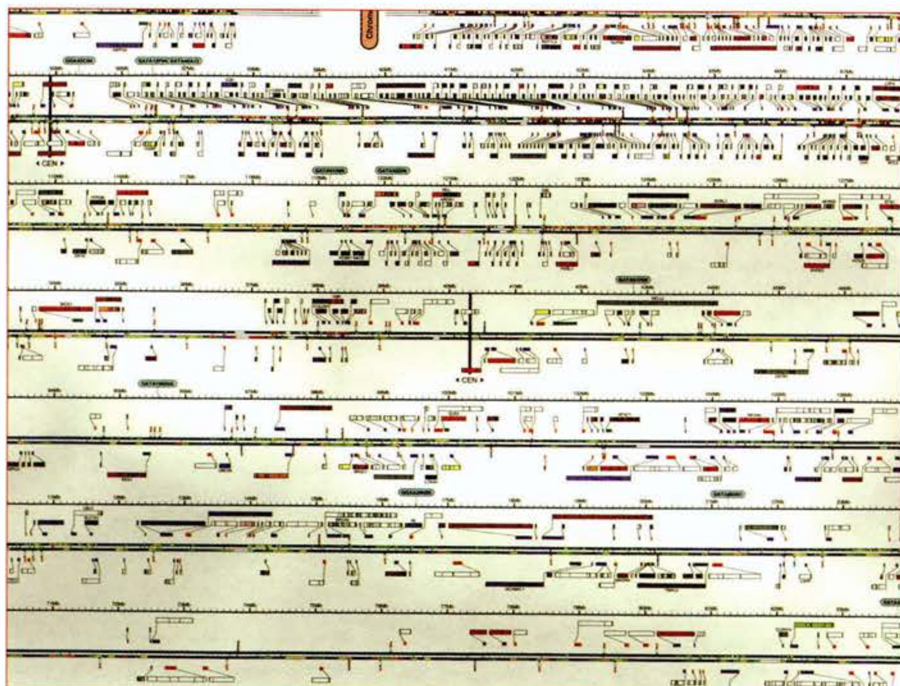
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Genetic masterpiece

What OECD ministers are doing

Citizens in all OECD countries want to know that they will get the high-quality health services they need, when they need them. They also want to know that they are getting value for their money. Governments face the dual challenge of improving healthcare performance and demonstrating that improvement if they are to preserve public confidence in health systems and institutions.

Canada
•page 23

In the section that follows, five health ministers from OECD countries have been invited to answer a straightforward question:

Finland
•page 24

"What action are you taking to improve health-service performance in your country and how will you gauge that improvement?"

Mexico
•page 24

Several of the ministers are participating in Measuring Up: Improving Health Systems Performance in OECD Countries, being held in Ottawa, Canada, November 5 to 7, 2001.

N. Zealand
•page 25

The five ministers are: conference host, Allan Rock, health minister of Canada; Minister Osmo Soininvaara of Finland; Minister Julio Frenk from Mexico; Minister Annette King of New Zealand; and Secretary Tommy Thompson from the United States. They represent a cross-section of OECD interests. Their countries have different levels of wealth, they vary from large to small, and they have different approaches to private and public delivery of health systems. Yet they share a common concern for reform and action to improve health services in a way that is consistent with best practices and public demands. And they show a keen interest in learning from one another.

US
•page 25

Canada
Building durable quality

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Allan Rock,
Minister of Health,
Government of Canada

Having successfully turned around the fiscal deficits of the early to mid 1990s, Canada's federal, provincial and territorial governments have been able to turn their attention to longer-term investments in the health system.

In Canada, the healthcare system is run largely by the provincial and territorial governments. The federal government plays a key financing role, supporting health research and information, promoting new approaches to healthcare and adopting modern information technologies. Health Canada is also responsible for ensuring the availability of, and access to, health services by Aboriginal peoples, who are increasingly assuming the management and delivery of their own healthcare systems.

Recognising that more money alone will not achieve the results we need, Canadian governments signed an historic Agreement on Health in 2000. The agreement outlined a common vision and specific priorities for renewing our publicly funded healthcare services, as well as for reporting on performance. We agreed that improving access to timely, high-quality health services for Canadians is a key priority. We are co-ordinating efforts to ensure appropriate supply and distribution of health professionals. We are building on successes already seen in many innovative pilot projects in primary healthcare. We continue to emphasise disease prevention and health promotion. We are also working together to develop a Canada-wide health "infostructure" that will feature electronic health records and such technological services as telehealth.

For accountability, the agreement commits federal, provincial and territorial governments to public reporting. This includes the development of a performance measurement framework that will encompass health status indicators such as life expectancy; health outcomes, for example reduced burden of disease and illness; and quality, such as patient satisfaction and hospital re-admission rates.

Canadian governments have agreed to report in all of these areas, and to develop mechanisms to support appropriate, third-party verification of those reports. The first such reports will be made public by September 2002 and will be followed by "comprehensive and regular public reporting by each government on the health programmes and services they deliver".

Canada is aware of the international dimension of health issues and the value of sharing experiences and knowledge across borders. Our hosting of the OECD Conference on Health System Performance Measurement and Reporting in Ottawa this November demonstrates our commitment. After all, in today's global economy, health policy is everyone's business. ■

Canada

Health spending per capita, US$PPP, 1998 $2 360
Health spending as % of GDP, 1998 9.3%
Public funding as % of total spending, 1998 70.1%
Doctors per 1 000 people, late 1990s 2.1 doctors
Hospital beds per 1 000, 1998 4.1 beds
Life expectancy for women, 1998 81.5 years
Life expectancy for men, 1998 76.1 years

What actions are you taking health-service performance and how will you gauge that

Finland
Exceeding the norm

©Lehtikuva Picture

Osmo Soininvaara,
Minister of Health and Social Services, Finland

In Finland, it is the 448 municipalities that are responsible for providing social and health services. Our decentralised system seems to deliver value for money. Indeed, according to international opinion polls, the Finns are more satisfied with their healthcare than citizens in many other countries. Simultaneously, the share of GNP used for health services is among the lowest in the European Union. The ongoing trend is to emphasise outpatient care in the overall balance of health services. After a major reform in 1993 the government no longer regulates the system by setting norms and guidelines, but by means of legislation, financial incentives and information management.

Recession in the 1990s forced us to make deep cuts in the public sector, which also led to a rapid increase in the productivity of the healthcare system. It can even be said that the system's technical efficiency has achieved a very remarkable level and it is hard to see where it can be improved further. From now on our focus will be on achieving a more efficient allocation of resources. Are we doing it right? Where are the priorities and how should the division of tasks be arranged within and between different organisations?

The financial limitations of the public sector, ageing of our population and an impending lack of labour will put great demands on health service performance. The government has launched a national health project, with the objective of outlining the reforms needed to secure the future of Finland's health services. Main tasks include improvement of health service performance and efficiency, allocation of resources and financing of healthcare. A first progress report is expected as soon as March 2002.

It has become evident that there is a need for more detailed and more up-to-date information for accurate system assessment. In addition to traditional measures, like cost-benefit analysis and other budget-related factors, assessing availability of both services and manpower, as well as waiting times, will be important. ■

Finland

Health spending per capita, US$PPP, 1998 $1 510
Health spending as % of GDP, 1998 6.9%
Public funding as % of total spending, 1998 76.3%
Doctors per 1 000 people, late 1990s 3.1 doctors
Hospital beds per 1 000, 1998 7.8 beds
Life expectancy for women, 1998 80.8 years
Life expectancy for men, 1998 73.5 years

Mexico
A national crusade

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Julio Frenk,
Secretary of Health, Mexico

The Mexican healthcare system faces complex challenges. The country has accumulated a health "backlog". At the same time, it must confront emerging problems, like certain non-communicable diseases common in developed nations, such as heart disease and diabetes. Quality of care is another challenge. Long waiting times in ambulatory services and an insufficient supply of drugs are frequent sources of complaint. Lastly, financial problems associated with healthcare already represent a serious public burden that has to be managed.

Several strategies have been implemented. To relieve the health backlog, programmes aimed at providing effective access to basic health services for the poor have been established. Emerging problems are being confronted through a clear definition of priorities, the promotion of healthy lifestyles and the early detection of non-communicable diseases. The National Crusade for the Quality of Health Services aims to improve the quality of services through the definition of codes of practice for health professionals, the use of clinical guidelines in public institutions, and the certification of professionals and health units. In order to provide financial protection against the costs of illness, the National Health Program proposed the creation of a popular insurance scheme, the promotion of social security, and of pre-paid plans for those population groups with the ability to pay.

Mexico is moving towards a new civic culture. Public institutions are increasingly obliged to inform society about their activities. In response to these demands, the Ministry of Health will report on the evaluation of the health system's performance to the population, to the National Health Assembly, to the legislature (via presentations to the Commission of Health in Congress), and to the health sector and the Federation, with reports to the National Sanitary Council and the National Health Council. Finally, the present administration will also incorporate regular perception surveys into its management tools. The results of these surveys will be disseminated widely through print and electronic media. ■

Mexico

Health spending per capita, US$PPP, 1998 $419
Health spending as % of GDP, 1998 5.3%
Public funding as % of total spending, 1998 48%
Doctors per 1 000 people, late 1990s 1.7 doctors
Hospital beds per 1 000, 1998 1.1 beds
Life expectancy for women, 1998 77 years
Life expectancy for men, 1998 72.4 years

to improve
in your country
improvement?

New Zealand
Toolkits for improvement

©Fotopress/NZ Herald/Mark Mitchell

Annette King,
Health Minister, New Zealand

The New Zealand Health Strategy (NZHS), which I launched in December 2000, provides the framework for making our public health service meet the needs of New Zealanders. This strategy provides the overall context within which the health sector should operate, including the Ministry of Health and the newly formed District Health Boards (DHBs). It contains principles to guide the sector, as well as goals and objectives for priority health issues.

Thirteen population health areas have been selected as priorities in the short to medium term. To help DHBs the ministry has produced a series of toolkits, one for each priority area. The toolkits contain background information and evidence or guidance on treatments or interventions that will make the maximum impact upon population health. The ministry has produced these toolkits in conjunction with specific expert groups comprising individuals from academic, clinical and NGO backgrounds. The intention is to update the toolkits every six months.

All DHBs have signed accountability agreements with the Minister of Health, reflecting priority areas of the NZHS. The ministry will work with DHBs to develop appropriate indicators that reflect the focus of the toolkits. These indicators will then be reflected in the accountability agreements. The ministry is also required by legislation to submit an annual report to parliament on progress made on the NZHS.

The 13 priority population health objectives are to: reduce smoking; improve nutrition; reduce obesity; increase the level of physical activity; reduce the rate of suicides and suicide attempts; minimise harm caused by alcohol and drug use; reduce the incidence and impact of cancer; reduce the incidence and impact of cardiovascular disease; reduce the incidence and impact of diabetes; improve oral health; reduce violence in relationships, families, schools and communities; improve the health status of people with severe mental illness; and finally, ensure access to appropriate child healthcare services. ■

New Zealand

Health spending per capita, US$PPP, 1998 $1 440
Health spending as % of GDP, 1998 8.1%
Public funding as % of total spending, 1998 77%
Doctors per 1 000 people, late 1990s 2.3 doctors
Hospital beds per 1 000, 1998 6.2 beds
Life expectancy for women, 1998 80.4 years
Life expectancy for men, 1998 75.2 years

United States
Affordable access

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Tommy G. Thompson,
Secretary of Health and Human Services, United States

Since arriving at the Department of Health and Human Services (HHS) in February, I have committed the entire department to becoming more responsive. We need to respond more effectively and more quickly to the needs of our customers – the American people. The health and well-being of our society is an important trust, one we are working to fulfill with energy and dedication.

To that end, HHS has cut bureaucratic red-tape and is working more closely with states to provide funding for innovative programmes helping them offer health insurance to some of their most vulnerable populations. This enables more than one million low-income Americans to gain access to quality medical care. Our Centers for Medicare and Medicaid Services, which administer Medicare (our nation's health insurance programme for seniors), are actively working to provide millions of older and low-income Americans timely and cost-efficient payments of their medical bills. Under the leadership of President George Bush, we are also working to modernise and strengthen Medicare and add a prescription drug benefit to it.

HHS has also launched nationwide organ donation and preventive health initiatives and substantially increased funding for the National Institutes of Health, home to the country's premier medical research facilities. The president's budget includes significant funding for community health centres to help meet the needs of underserved communities. Minority and women's healthcare are also high priorities. And we are continuing to strengthen the president's anti-bioterrorism initiative.

Fundamentally, we are working to ensure that the American people enjoy ready access to quality, affordable healthcare and that the health research that has impelled breakthrough therapies and treatments over the past century will grow even stronger in coming decades. Medical innovation, research and responsiveness are our calling and challenge. We intend to answer the calling and meet the challenge for the sake of all our citizens. ■

United States

Health spending per capita, US$PPP, 1998 $4 165
Health spending as % of GDP, 1998 12.9%
Public funding as % of total spending, 1998 44.8%
Doctors per 1 000 people, late 1990s 2.7 doctors
Hospital beds per 1 000, 1998 3.7 beds
Life expectancy for women, 1998 79.4 years
Life expectancy for men, 1998 73.9 years

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Long-term care
A complex challenge

Naoki Ikegami, Dept. of Health Policy & Management, Keio University School of Medicine
John P. Hirdes, Dept. of Health Studies & Gerontology, University of Waterloo
Iain Carpenter, Centre for Health Service Studies, The University of Kent

Long-term care is a particularly thorny issue for healthcare policymakers because it is so intertwined with other areas of public policy, like housing and social security. Yet it is an increasingly important area of healthcare. Quality indicators can help to achieve improvements.

What exactly is long-term care? The definition given by the Washington DC-based Institute of Medicine in 1986 is a useful start: "a variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home or community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies". This definition offers some hints as to why it has been difficult to establish long-term care as an integral part of social security.

The first of these lies in the difficulties encountered when identifying the line between public and private responsibility. It is easy to agree that care for an elderly woman who is alone, impoverished and frail should be a public responsibility. But what if her husband is alive, or there is money in the bank – should she still qualify for public services? And, with most hands-on care for older people in the community provided by family members, would offering formal services cause families to withdraw their care?

Cost is clearly another concern, but formally establishing long-term care as an independent social security programme may not be as costly as some may fear. For a start, compared to healthcare, allocating long-term care resources should be easier because needs do not change as rapidly, and high-cost technology is not as important. Moreover, elderly individuals may prefer the care given by family or friends. Within Japan's first year of implementing its public long-term care insurance programme, expenditures have been more than 10% lower than projected.

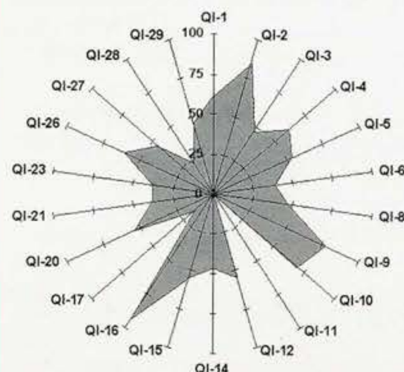
Long-term care poses challenges to policymakers because these services are intertwined with the medical, social and housing sectors, with no clear criteria for delineating the responsibility of each.

With the global ageing of society, a new framework for the sharing of public/private responsibility is clearly needed. Equitable access to a standard package of long-term care services and ensuring their quality will be key responsibilities of government.

Measurement is therefore vital. There are three facets of quality in long-term care: compassionate care as given by family members, comfort as provided in the service industries, and professional competence of the staff. The last aspect has not received the attention it deserves. Those receiving long-term care are not in a state of steady and irreversible decline: the quality of life of individuals and their informal caregivers can be improved, accidents (such as falls) avoided, the rate of decline slowed down and hospitalisation avoided if appropriate care is provided.

Uneven quality

Radar plot of percentile ranks by quality indicator, Ontario chronic-care hospitals, 1995



No health facility, no matter how excellent, performs well in all areas of quality. In the figure above, which plots the Quality Indicators for a facility as it ranks in percentiles among the Ontario chronic-care hospitals, the further out each indicator is plotted from the centre of each radar axis (the shaded area), the greater the proportion of facilities which have better quality. So, for example, for QI16 on the radar, which measures those with dehydration, this particular hospital performs well, but for QI17, measuring those who are bedfast, the hospital performs poorly. Using Quality Indicators, strong and weak areas in each facility can be audited and compared.

To measure the professional competence of care, at least three sets of tools must be available: reliable and valid assessment instruments; a database of the assessment information; and statistical methods for evaluating quality. Regarding the first, the development of the Minimum Data Set in the US, which began to be developed in the 1980s, was a breakthrough towards

monitoring and improving the quality of care by obtaining accurate information on the functional, cognitive and emotional status, and the care provided in institutional settings.

It grew out of the need for a uniform, comprehensive assessment system based on strict criteria of reliability and validity. The MDS has been mandated in virtually every nursing home in the US since 1991, and for Ontario's complex continuing care hospitals/units since 1996. It has been translated and validated in over 20 countries. Moreover, its use has improved the quality of care.

MDS assessments have enabled the development of quality indicators (QIs), like those developed by David Zimmerman *et al.* (see references), examining items like the incidence of new fractures, behavioural symptoms and cognitive impairment, as well as indicators like dehydration, changes in range of motion, weight loss and use of physical restraint or hypnosis.

A home care version (MDS-HC) and a mental health version (MDS-MH) of the MDS have been developed by interRAI, an international non-profit organisation of researchers and clinicians.

These instruments share core assessment items so that seamless care can be provided regardless of site, while also having specific items tailored to meet specific needs of each individual. For example, MDS-HC has items on informal support, ability to perform household chores, adherence to care programmes, etc.

The statistical methodology has been developed to monitor the quality of nursing homes in a given jurisdiction. However, comparisons among countries are problematic and adjusting for the differences in status of the newly admitted patients and the differences in the rates of decline of those already admitted, are needed. Large databases also have to be built. One study, based on MDS data from Denmark, Italy, Iceland, Japan and the US, shows that no one country excels in all the indicators used, even when assessing subgroups of patients and after adjusting for physical dependency and cognitive impairedness.

No one country excels in the quality of its long-term care.

Five indicators were used for evaluating quality: falls by patients during the previous month; the presence of pressure ulcers; faecal incontinence, restraint use and social engagement and interaction with others. The US ranked first or second in prevalence of falls and restraint use in all sub-groups assessed, but it presented the lowest percentage of residents with little or no social engagement. Italy has a higher prevalence of faecal incontinence. Iceland and Japan had virtually no pressure ulcers.

More sophisticated quality indicators for institutional care and home care have recently been completed. For home care, the provisional results coming from Ontario Community Care Access Centres (CCACs), which act as single-point entry agencies providing access to community and institutional services, show that there are wide variations in practice patterns. For

Man and Superman

For a generation of moviegoers, Christopher Reeve was the Hollywood incarnation of comic book hero Superman. But since being paralysed in an equestrian accident in 1995, Mr Reeve has devoted much of his time to helping to make life easier for people with disabilities. "You are not defined by your injury," is his message to other spinal-cord injury sufferers. In 1999, Mr Reeve became chairman of the board of the Christopher Reeve Paralysis Foundation (CRPF), a US organisation that supports research to develop effective treatment and a cure for paralysis caused by spinal cord injury and other central nervous system disorders. CRPF also funds grants that improve the quality of life for people with disabilities. Mr Reeve has since returned to acting, notably as the wheelchair-bound hero in a television remake of the Alfred Hitchcock classic *Rear Window*.

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instance, there is a 2.6-fold difference in the rates of inadequate pain control among existing CCAC clients, with prevalence rates reaching a high of almost 47% of clients.

The methodology for evaluating quality in long-term care is now ready for use. If quality measures could be combined with reimbursement on a case-mix payment basis, the system would be even more effective. For example, the presence of pressure ulcers will lead to a higher payment to a nursing home because of the higher costs of care, but it would also lead to the facility being flagged for poor quality. In other words, using MDS data in such counter-balancing ways would help to provide more accurate assessments. Such systems are used in Ontario and have been validated in Sweden, Japan, UK, Finland and Spain, following the US experience, where Medicare uses it to calculate its per diem rate to nursing homes.

Policymakers have to be aware that the initial investment must be made to adequately train clinicians who will be actually using these instruments and administrators whose job it will be to analyse the databases. Long-term care deserves greater attention and the gap that divides health and human service professionals has yet to be bridged. ■

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Which patients get the worst deal?

Angela Coulter, Chief Executive, Picker Institute Europe

OECD countries tend to be great rivals when it comes to comparing their healthcare. What do the patients think? Results from a recent survey reveal some interesting common features, and disparities too.

Patient-centred care is the latest fashion in health policy, yet attempts to make health services more responsive to the people they serve have been on the agenda for some years. The emphasis has shifted though and is now leaning towards using surveys to gain feedback from patients and incorporating the results into performance assessment frameworks. Do these surveys work?

The Picker Institute has some considerable experience in the matter. We use carefully designed surveys to obtain detailed reports of patients' experiences of specific dimensions of patient care, including information and communication, co-ordination of care, respect for patient preferences, emotional support, physical comfort, and involvement of family and friends.

We ask patients whether or not certain processes and events occurred during the course of a specific episode of care. In other words, we want to know whether such or such an incident happened or not – for example, whether patients knew which doctor was in charge of their overall care. These surveys have been used since 1987 in hospitals in the United States and since 1997 in Germany, Sweden, Switzerland and the UK.

Analysis of recent results reveals many common problems and wide discrepancies in the quality of hospital care in these countries.

In all countries the most commonly reported problems concerned communication about clinical issues. These include insufficient information in the accident and emergency (A&E) department, insufficient information about tests and treatments, and not enough involvement in treatment decisions. *(See graph p 30.)*

The differences between countries in the extent of problems reported were striking. As a rough rule of thumb, in our view, a problem score of more than 20% requires attention. The Swiss surveys achieved

The survey results show that problems exist in all the hospitals surveyed. In fact, the same topics were given high problem scores across the board.

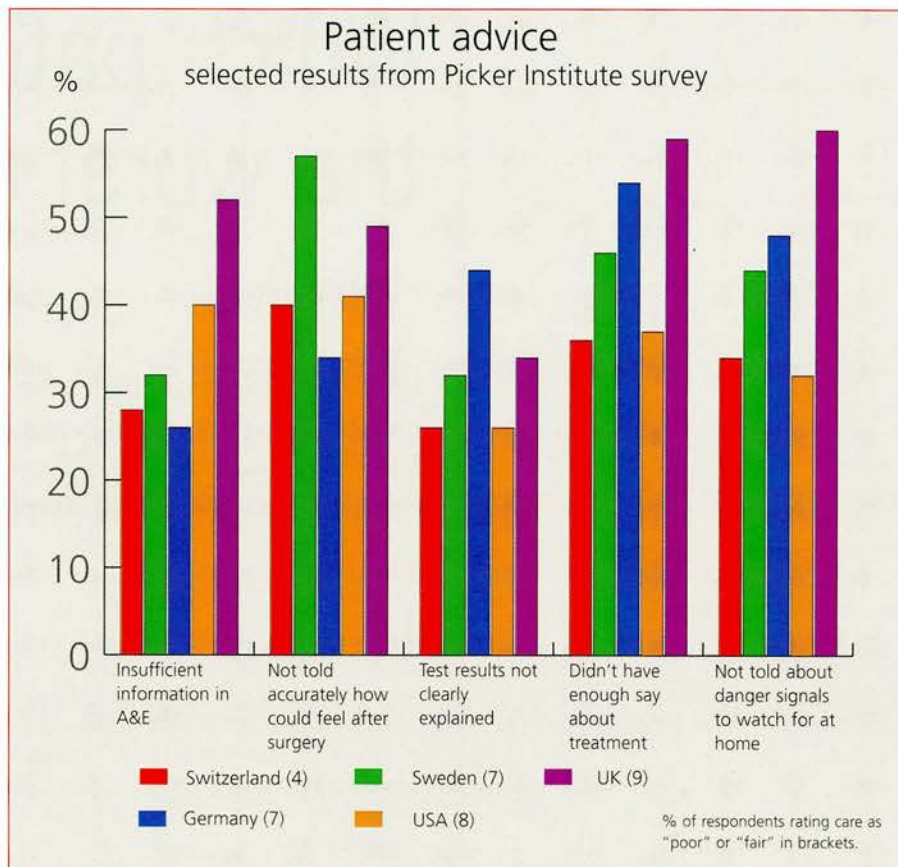
problem scores of more than 20% in only seven cases out of 44 possible problems. The figure in Germany was 15 out of 44, among Swedish patients the problem scores exceeded 20% in 18 out of 41 cases (three questions were excluded from the Swedish surveys), and in the US it was 20 out of 44. The equivalent figure in the UK was the highest, at 24 out of 44 in answer to specific questions such as whether patients were given sufficient information to help look after themselves after they

leave hospital. But when asked to rate the overall level of care they received, only 9% of UK patients surveyed classified it as "poor" or at best "fair" (see graph).

One has to be very cautious when making international comparisons with these figures. Considerable effort was made to ensure that our questionnaires would be interpreted the same way in the different countries, but different expectations on the part of patients in each country may still have been responsible for some of the discrepancies.

Another note of caution is that, with the exception of the US, the number of hospitals surveyed in each country was small and may not be representative.

Nevertheless, it is clear from these results that problems exist in all the hospitals surveyed. The same topics were given high problem scores across the board – for instance lack of information to help patients look after themselves after discharge from hospital was a problem everywhere – but the rates varied between countries, with Switzerland achieving the best results and the UK the worst.



Most surveys tend to ask patients to give satisfaction ratings about treatment. The Picker approach of asking factual questions about events helps to make results easier to interpret. After all, having to wait more than 15 minutes after pressing the call button before someone comes to help is a fact, not an opinion.

These surveys are consequently much more useful when it comes to setting priorities for quality improvement since they can help to pinpoint any problems and help identify precise action.

Interestingly, few patients respond critically when asked to rate overall quality of care, even if responses to specific questions paint a negative picture.
Our surveys confirm that patients often want more information than they are given and that a significant proportion would like to be more actively involved in their own care. Surely more should now be done to address these problems.
The surveys also tell us more about systemic problems. One reason for the differences observed between, say, Switzerland and the UK, may lie in the fact that British hospitals are more under-staffed. This point is glaring, since UK respondents to our surveys were seven times more likely to report problems with the availability of doctors (30%) than the respondents from Switzerland (4%), and 15 times more likely to report such problems with nurses (30% as against 2% in Switzerland).

Of course, Switzerland spends nearly twice as much per capita on healthcare. But it may also be the case that Swiss hospitals place greater emphasis on improving the quality of patients' experiences. All Swiss hospitals are now required to survey their patients on a regular basis, and hospitals in England will have to carry out annual patient surveys from 2002.

Knowing that a problem applies in your hospital or your ward can motivate change. Comparisons between countries, between hospitals, or even between departments within a hospital, can provide useful benchmarks against which to judge progress too.

People who commission Picker surveys are encouraged to compare their results against the best from our surveys in Europe and the US, giving them a "stretching target" for improvement. They can then aim to be better than the best. And if the results are made public, they may prove to be a particularly powerful lever for change.

Note on methods

The initial development work for the surveys reported here was carried out mainly in the USA.

The questionnaires used in the four European countries were for the most part direct translations of the US questionnaires, which were then tested with patients for cultural and linguistic relevance and comparability of meaning in each of the countries and adapted where necessary.

Responses have been translated into problem scores indicating the percentage of patients reporting a less than satisfactory response to each of the specific questions.

Data came from postal surveys carried out in acute care hospitals in each of the countries. Questionnaires were mailed to patients' home addresses within one month of discharge from hospital.

The analysis was restricted to data collected from in-patients over a 12-month period in each of the countries.

Completed questionnaires were received from 2 249 patients from five hospitals in the UK, 7 163 from nine hospitals in Switzerland, 2 663 from six hospitals in Germany, 3 274 from nine hospitals in Sweden, and 47 576 from 272 hospitals in the USA.

Response rates varied but were greater than 50% in all cases. ■

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Caring professional

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Patients do not always trust health professionals, whether nurses or doctors. How can you be sure that you are being given the right dose of the right painkiller when you are in no fit state to debate the issue from your hospital bed? The answer for some patients in the US has been to "bring your own nurse". Patients are increasingly hiring their own private nurse to monitor their care, or at least a "sitter" to tend to their personal needs, fearing that overworked hospital staff will not be able to provide adequate service. It may not be covered by your health insurance, but at least it buys you peace of mind. One thing is certain. Private agencies that supply nurse's aides report a dramatic rise in requests from hospitalised patients in the past few years. And they do not necessarily have a medical role. Some patients without family nearby like to have someone on hand to help them get to the bathroom, or simply keep them company in the long hours of the night.

Above: Film still from *Carry On Again, Doctor*, 1979

The OECD Health Project

The OECD three-year Health Project began in 2001. Its focus is on measuring and analysing the performance of healthcare systems in OECD countries and factors affecting performance. The aim is to help decision-makers formulate effective policies to improve their healthcare systems.

The Health Project involves four broad components. First, health system performance will be measured and analysed. This means collecting better data on resources, activities and prices and developing better estimates of labour productivity. Second, the project will seek to explain variation in performance, in particular looking at those human resource policies (including remuneration) that best contribute to efficient and effective health service delivery across OECD health systems. It will assess the interaction between public and private health insurance, and its impact on health systems. It will evaluate the technologies likely to have the most significant economic and social effects on the future of healthcare systems, including genomics, robotics and telemedicine. Third, the Health Project will examine care for frail elderly persons. And fourth, there will be an overall system assessment, to evaluative healthcare reforms of the past decade.

The OECD Heath Project will involve contributions from experts from governments and health institutions in member countries and beyond. The project will enable the Organisation to strengthen its collaboration with international organisations, in particular, the World Health Organization. ■

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Quality healthcare
What consumers want

Janne D. Graham*

All people are consumers of health services. It is about time they were treated as such. Only then will quality be improved.

A few years ago I was invited to a South Asia/Pacific regional conference in India to speak about the approach to quality being taken by the organised health consumer movement in Australia. I was apprehensive about the task. Most of the countries represented were developing countries and many of them were reputed to have poor access to even elementary healthcare. Why would they be interested in our views of quality? And even if they were interested, how useful would the results of consultations with consumers in Australia be in their diverse settings?

My concerns were unfounded. It became quickly apparent that consumers and public health workers in developing economies had no intention of making the mistakes we have made in OECD countries. As they see it, we have worked for access and availability at the cost of quality. They intend to work for access to quality.

The people at that conference shared the issues that we had found in our consultations in Australia. Users of health services want safe, appropriate interventions, treatment and care. We want to be treated with dignity and respect.

We have all heard stories of the surgeon who amputated the wrong leg. Who really is affected? The consumer.

We want information that is accurate, timely and relevant. We believe that if this is to happen then consumers must be involved and consulted, not only in relation to their own healthcare, but also about service planning and delivery, health evaluation and research.

To say that patients want safe, appropriate treatment is most obvious. We have all heard stories of the surgeon who performed very successful surgery, but amputated the wrong leg or removed the healthy kidney. Many errors are avoided because of intervention or questioning by a consumer or carer. Errors increase when we are not heard.

At a recent enquiry in my locality, it transpired that two daughters of a patient questioned the blood that was about to be transfused as not being the same as their mother's blood type. Their concerns were ignored and the patient died. Aside from sanctions and litigation, who really is affected by such an error? The consumer. Health professionals often argue that consumers are not in a position to make judgements about technical competence. Maybe so. But if we judge technical competence by outcomes, then surely consumers are the best judges. Yet who currently designs the performance indicators?

And who is to judge whether there has been dignity and respect in the treatment and care process? Surely, only the consumer. Only consumers can determine whether they have received information that meets their needs.

The closest most health services come to measuring these consumer experiences is the occasional satisfaction survey. But I have yet to see a health service that encourages complaints and fully uses them as a quality improvement tool. Targeting a reduction in complaints is not a sign of improvement. What is needed is an effective evaluation of the accessibility of complaints procedures and the introduction of incentives, such as feedback and proof of real action, to encourage and support complaints.

It is difficult when we are sick and vulnerable, to be faced with a health professional who, at least in our perception, has greater knowledge and power. Alas! Consumers have no professional or employment base from which to lobby for their interests. So to participate as equal partners they need to be able to consult, to develop policy and strategies and to train for their advocacy role. At that conference in India participants from developing and developed countries agreed that consumers, through their organisations, should have the resources to participate in all health planning and research. Only then will we stand a fighting chance of creating quality health services. ■

* Janne Graham is a consumer representative and a former chairperson of Australia's unique national health consumer organisation, Consumers' Health Forum. Ms Graham has recently recovered from an iatrogenic condition (pulmonary oedema/cardiac failure) following admission for cellulitis.

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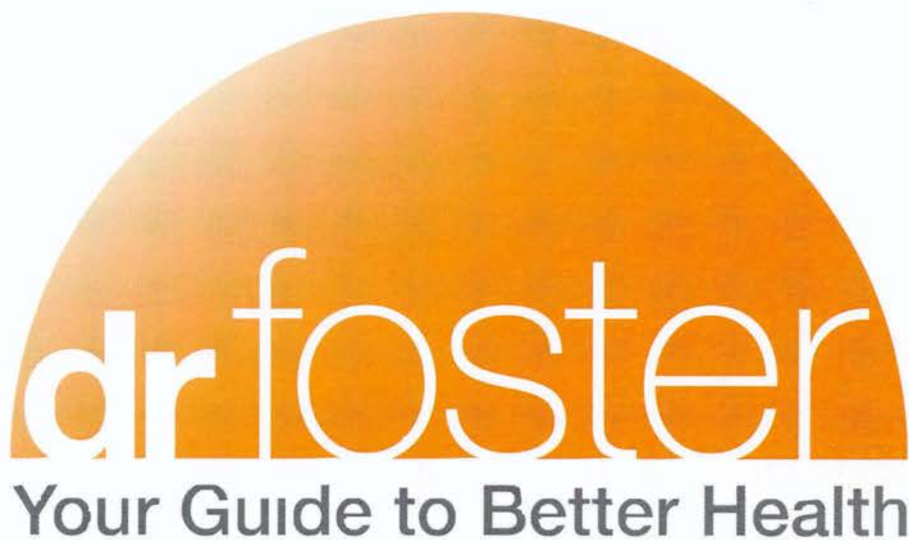
Fostering quality healthcare

Tim Kelsey, Chief Executive, Dr Foster, UK

Patients increasingly expect choice as well as quality in healthcare. But in order to make informed choices, they need to know how well different hospitals or doctors are performing compared with their colleagues elsewhere. This consumer power helps hospitals to improve, as the case of Dr Foster, a UK company, shows.



In 1859, Florence Nightingale created the world's first performance tables of hospitals. The school histories tend to miss this part out, but the Victorian reformer's best work was conducted far away from the battlefields of the Crimea. Florence Nightingale was the architect of the modern British (arguably European) hospital – and, most importantly, the means of measuring its performance.

"It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm," she wrote in *Notes on Hospitals*. Nightingale demonstrated that high death rates, which were invariable then in large hospitals, were preventable.

Until very recently, the pioneering idea that a hospital (or for that matter the medical profession more generally) should be accountable to its end-user was largely ignored. Odd pockets of academic research kept alive the idea that health services were capable of – and should be subject to – comparison. Without scrutiny, there is little prospect of invariable quality.

In many respects it seems that the current British government is extremely determined in its health service reforms, built as they are around a very clear commitment to public accountability. But the British health service consumer has become more sceptical of the integrity of official publication and more demanding of independent, authoritative information on performance.

Earlier this year, an independent inquiry into the high level of deaths of children following complex heart surgery at the Bristol Royal Infirmary marked a turning point. It called resoundingly for better information to be published by independent authorities.

Dr Foster (named after one of the UK's best-known nursery rhymes), was set up to meet this growing public demand. It is an independent organisation and a private company, supported by the Department of Health, and professional and patient organisations. It provides authoritative information about the services and standards of hospitals and other healthcare providers in the UK and Ireland.

It works with leading academics in the United Kingdom (including Sir Brian Jarman, one of Britain's most famous general practitioners and medical professors) to develop indicators that are useful to the public in making the most of their health service.

It publishes health service guides – the Hospital Guide, the Birth Guide, the Consultant Guide, the Family Doctor Guide and so on – to the widest possible audience in partnership with media owners.

National and local newspapers publish extracts from these guides as special supplements. The guides are published as books and on the Internet and soon they

will be available as pamphlets at supermarkets. It is a high-profile initiative that has proved that comparative performance information can be published and in a way that is meaningful to the ordinary user.

The first guide on hospitals is a good example of how Dr Foster works. It allows patients to evaluate the quality of care in hospitals, right down to specific care services. For now it covers acute services in general hospitals, but comparative guides of mental health, maternity care, nursing homes and primary care are under preparation. Patients can locate the hospital of their choice and read about it. The aim is to give a fair evaluation. For instance, it points out that one hospital has staffing shortages, but is nonetheless efficient for its treatment of stroke patients.

Not everybody has regarded the existence of independent benchmarks as a good thing for the National Health Service. On one occasion, confronted in a room by eight or nine civil servants, I was told that the NHS did not want to "wash its dirty linen in public" and "there are some things that should be dealt with internally".

But the real opinion formers take a very different view. A number have joined the Ethics Committee which oversees the publication of the Dr Foster guides. They include Sir Donald Irvine, president of the General Medical Council. Another former member, Sir George Alberti, president of the Royal College of Physicians, has compared the current information revolution confronting the British health service to that faced by the medieval clergy when the Bible was first translated into English.

People should welcome, rather than run away from, accountability, which has the power to improve services and foster trust between doctor and patient. Measuring hospitals is in everybody's best interests.

When Dr Foster started, our attention was drawn to the decade-old publication of surgeon-specific data in heart surgery in New York State – and the fact that this had driven mortality rates down by over 40% in some hospitals. "Doctors and hospitals did not like to look bad compared to their peer colleagues of [other] institutions," says Arthur Levin, director of the Center for Medical Consumers in the US. That seems an unarguable benefit – that publishing performance information can so effectively improve standards.

People should welcome, rather than run away from, accountability, which has the power to improve services and foster trust between doctor and patient.

Creating independent indicators is one part of a process which also needs to recognise the importance of educating consumers to understand them. Dr Foster spends much of its time experimenting with different media to make these indicators accessible to people – and relevant.

We have discovered that very few people are aware of their rights in selecting their healthcare provider. We have also discovered that when people are made aware of them, they use them. A good example followed the publication of our Birth Guide in the summer of 2001. In a very discernable way, women in late-stage pregnancy moved from one acute hospital (which was identified as under-staffed) to local midwife-led birth units. The acute unit is now very focused on improving its staffing situation.

The Dr Foster data clearly supports the view that there is unacceptable variation in hospital and other health service standards in the UK. Helping consumers to make more informed choices is one good way (possibly the best) of eradicating these deficiencies. People are not stupid and neither doctors nor governments have the right to treat them as such.

We have discovered that very few people are aware of their rights in selecting their healthcare provider. We have also discovered that when people are made aware of them, they use them.

What the data also shows is that the British health service is increasingly effective at its job – adjusted mortality rates have been falling year on year by 2.5%. But, for now, the public perception is wholly on the varying standards between healthcare providers. Finding a way of making sure they understand the good news as well as the bad is a political imperative.
British health ministers have always supported the Dr Foster project because they see it as complementary to their own initiatives on involving the public more in the health service. They publish management-focused indicators; ours are patient-focused.

There are good ways in which the private and public sectors can work together to improve healthcare delivery. This is one. Dr Foster has already been approached by a number of OECD governments to investigate the possibility of exporting the model overseas.

People often ask me about the impact of empowering patients with comparative information. Give people better information and they will use it. Does this mean they will all start moving house to be near the best performing hospitals, or doctors? That didn't happen in America. It hasn't happened so far in the UK. In fact, the onus is not on the patient, but the service, to improve. All that does happen is that weaker-performing hospitals get better. Individual consumers learn to be more demanding of their local hospitals – and everybody benefits. Florence Nightingale would probably have approved too. ■

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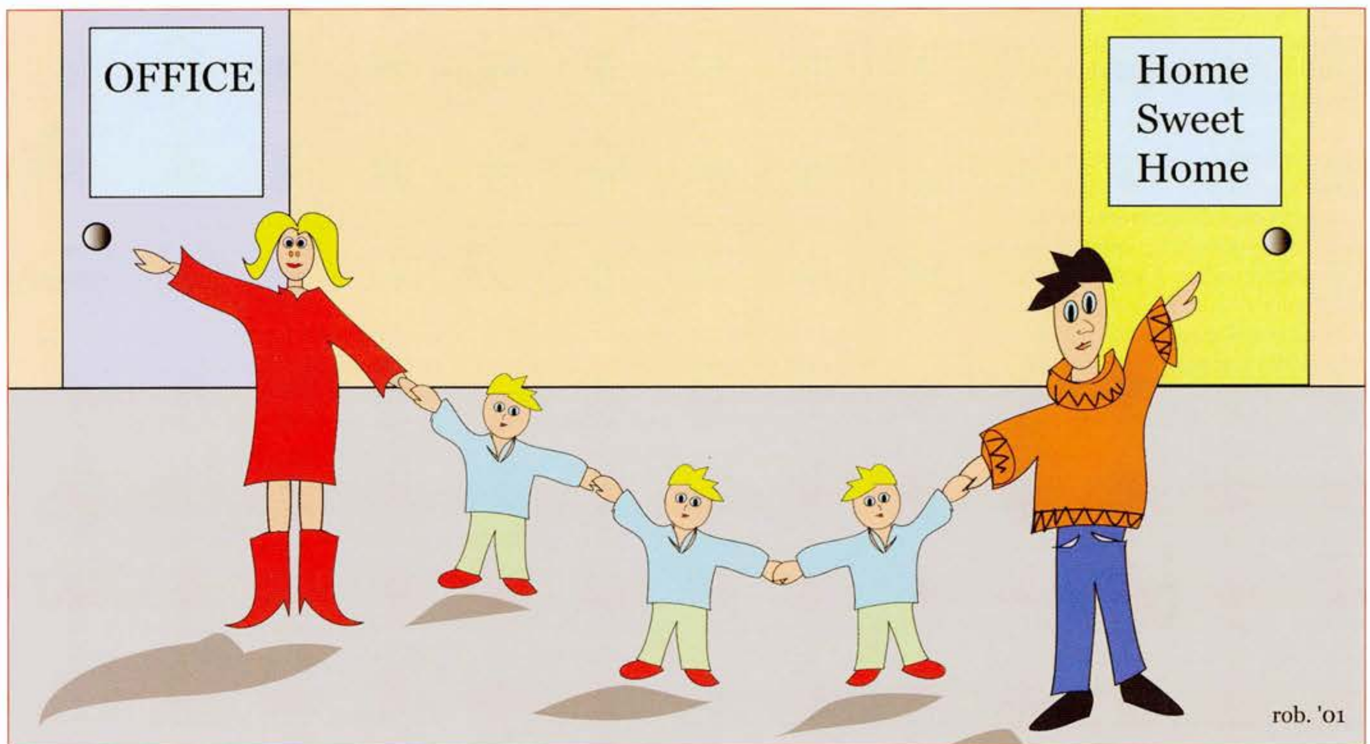
Can governments influence population growth?

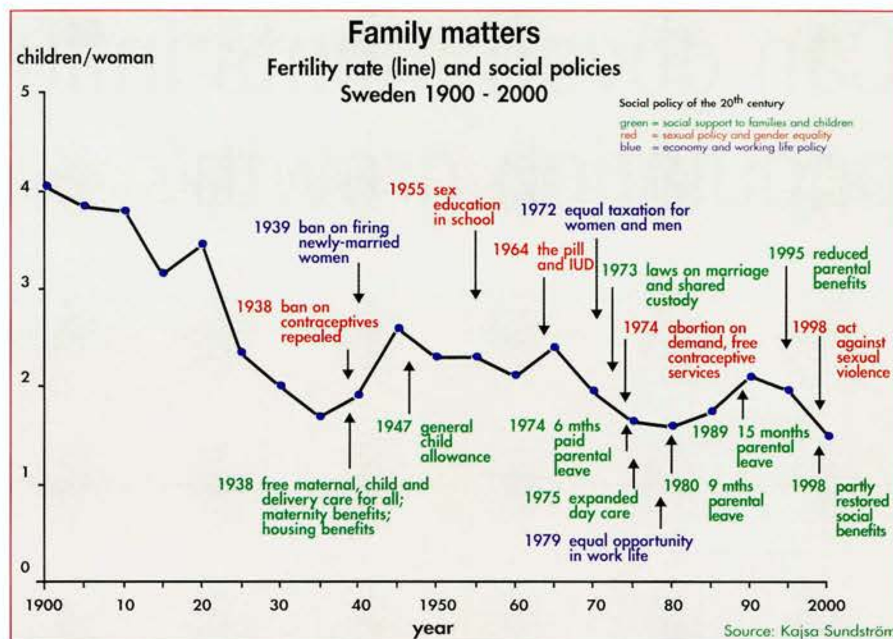
Kajsa Sundström, Division of International Health, Karolinska Institute, Stockholm, and Q Web*



Fertility levels – the number of children being born to assure the next generation – are generally low in OECD countries. This is a cause of primary concern to governments because it contributes to ageing societies and means fewer taxpayers to fund pensions, health services and so on. Yet, almost a century of policies to encourage larger families has failed to boost birth rates. The case of Sweden may help explain why.

When many governments introduced their social welfare programmes during the economic depression of the 1930s and 1940s, they did so mainly to combat widespread poverty, unemployment and poor housing conditions. But in Sweden's case, there was less of a concern about these problems than about population. Influential Swedish economists, Alva and Gunnar Myrdal, argued in their 1934 book, *Crisis in the Population Question*, that Sweden must raise its birth rate; at the time the rate was below two children per woman, down from four at the turn of the century. The way to reverse this trend, they said, was by social reform that would support the family. Their proposals placed the responsibility for population targets in the hands of government and included maternal and child healthcare, free delivery, maternity and housing benefits, and general child allowances. Changes in social and welfare systems and marked reforms in the spheres of sexuality and reproduction saw the birth rate for most of the past half-century fluctuate at around two children per woman. It peaked at around 2.5 in the mid-1940s, when the general child allowance was introduced following the end of the Second World War, but never recovered its turn-of-the-century level.

A recent sharp fall has brought the birth rate to its lowest ever – 1.5 children per woman. Again, government is increasing support to parents and benefits to families with children, hoping to reverse the trend.



Some changes over the past 60 years have clearly affected the birth rate, though not always in predictable ways. A law in 1939 preventing employers from dismissing women because of marriage, pregnancy or childbirth helped push up the birth rate, as more women became able to marry, have children and keep earning money. Indeed, since that time, most Swedish women have sought to combine family life and a career.

The next breakthrough for women on the labour market came in the 1960s, when rapid economic development led to increased opportunities for schooling and higher education, and well-paid jobs. Employers were crying out for staff (male or female); sexual equality and gender roles were under discussion; and women's economic freedom increased. Many women also took advantage of the new sexual freedom provided by the contraceptive pill and the IUD. Although contraceptive methods – chiefly condoms and diaphragms – had been part of sex education in school (introduced on a voluntary basis in 1942 and made compulsory in 1955), views on sexual relations had remained strict. Abstinence before marriage was all schools could recommend. The introduction of the pill as a reliable and simple contraceptive for women, helped change attitudes, allowing young people to live together without marriage.

Women without a foothold in the labour market or on very low incomes, whether due to unemployment or studies, have the lowest birth rate of all.

The economic expansion of the 1960s fuelled optimism about the future, and the birth rate rose to more than 2.5, if only temporarily. Many women found themselves struggling to balance a full-time job with taking care of the home and children due to inadequate childcare facilities. They had won the right to work full-time, but men were not clamouring to help share the responsibilities at home. As a result, many women remember these days of "progress" for their hard work and a constant feeling of inadequacy.

A need for effective birth control had become obvious. The pill was a help, but still expensive and restricted, especially for young, single women. Then, in 1974 the government introduced a law allowing abortion on demand. In order to ensure abortion was seen as a last resort, the government saw it as an obligation to make contraceptives equally accessible. Family planning services, provided by trained midwives, were soon created at health centres all over the country.

Women juggling work and family were at last able to plan their childbearing. Indeed, since the early 1970s it has become common and socially acceptable for young people to live in stable relationships without having children. Most young women want to finish their education and find a job before starting a family. In 1975, the mean age for a first-time mother was 24; by 1998 it was 28.

Population paradox

This trend of having fewer children caused the birth rate to fall in the 1970s to 1.6, a new low. This was the decade when public day-care facilities became widespread and men were officially encouraged to share the responsibilities of childcare, with six months' paternity leave at 90% of their salary. But at the same time, women became full economic equals with men through a new law on individual taxation which made all adults responsible for earning their own living and providing for themselves. One indirect result of all these changes was an increasing number of divorces, as no woman felt obliged to stay in a miserable relationship for either economic or conventional reasons.

The early 1980s brought more economic expansion. The participation rate of women in the labour force was high; 86% of women aged 20 to 64 and 90% of men of the same age group were gainfully employed, one of the highest in the OECD area. Most men worked full-time, while a third of women had reduced working hours. Still, the birth rate increased to 2.1, while other European countries such as Italy, Germany and Hungary reported rates of 1.3 to 1.5 children per woman.

The reasons behind Sweden's high fertility level, despite its high female employment rate, were generous parental benefits and improved childcare conditions, allowing working women to have a third child. By 1989, combined maternity and paternity leave had been extended to 12 months at 90% of salary and three months with

minimum pay. Moreover, either parent became entitled to up to 60 days paid leave a year to look after a sick child.

But a shift from economic boom to deep recession and high unemployment in the 1990s put an end to these reforms. Efforts to restore the economy to health led to cuts in almost every area of the welfare system, including parental benefits. The birth rate fell back to 1.5 children per woman at the end of the 1990s, the lowest ever recorded.

The last few years of the decade were economically buoyant, and child allowances and parental leave benefits were increased. Female unemployment remained high and fewer women wanted to start a family, as they felt uneasy about their economic future. Women without a foothold in the labour market or on very low incomes, whether due to unemployment or studies, have the lowest birth rate of all. What is more, there is no evidence of young women choosing to have children instead of seeking work or furthering their education. This is a break with previous trends in Sweden and differs from several other OECD countries, e.g. the US and the UK.

Meanwhile, the population continues to age. But any new social reform plans to solve this demographic crisis will have to take into account the fact that both women and men in Sweden want first and foremost to work and earn an income of their own before raising a family. ■

* Qweb is a global network on women's health and empowerment, www.qweb.kvinnoforum.se

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Ethics, medicine, economics and power

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Today's doctors face a bewildering array of choices and constraints, from technological discovery to increasing budget pressures. Their dilemmas go beyond diagnosis and treatment to weighing the benefits of new discoveries and whether society is willing to pay for them.

The health world has undergone a number of profound changes in recent years, from population ageing and the fact that people are increasingly well informed, to industrialisation of healthcare, squeezed budgets and the biotech revolution. These changes have raised serious questions for all those involved in healthcare. Is there a code of ethics regarding choices? And if so, how does it compare with the criteria on which the philosophy of medical practice has been built from antiquity to today?

In fact, it is the very purpose of the medical profession and the doctor's role that is at stake today. Time and again doctors are forced to question the purpose of their actions and accept the limited extent of their knowledge in the face of the dizzying array of new discoveries in molecular biology and genomic sciences. At the same time they must weigh their sense of compassion and altruism as they help the sick who entrust their lives to them, against the pressure to use community resources responsibly.

Increasing legal complications and the media spotlight do not help either. All of this has been compounded by the gradual breakdown of traditional social structures, and the doctor's diminished status in society.

In the midst of all these changes, what is a doctor, really? A learning machine supposed to know everything? An economic player whose sole job is to control the costs of treatment? A practitioner who must protect his livelihood from legal attack by practising a defensive form of medicine? Or is a doctor simply an illusory buffer against the suffering, anguish and solitude of his fellow human beings?

More than 80% of people nowadays die in hospital, far away from the places where they have spent their lives.

The answer would be easy if medicine were a science. But unfortunately (or perhaps fortunately), it is only an art. That is to say, a permanent quest for a philosophical absolute: Health, Well-being or perhaps even to some degree, Happiness.

And the problem does not stop with doctors. Hospitals are faced with an identity

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crisis of their own. How can they cope with the impossible task of providing an excellent, efficient service while remaining local, familiar and human?

We should not forget that it was to the hospitals that thousands of homeless turned at the height of the last economic crisis in the early 1990s, appearing in casualty departments in search of human contact or simply a bowl of food. They were not thinking about the high financial cost of appealing for help in this way. In 2000, 49% of the 80 billion euros spent on the French health system went on hospitals. A hospital like the one where I practise costs nearly FF 5 000 (760 euros) a minute to run, or almost a month's minimum wage.

And families turn more and more to hospitals to look after their loved ones at the end of their lives, so that they can be as free as possible from suffering. But this means dying as far away as possible from the places where people have spent their lives – more than 80% of people nowadays die in hospital.

But these crises and contradictions are only on the surface, for it is in the outstretched hand, in the bowl of soup and in the silent support for the terminally ill that the essential meaning of the practice of medicine really lies. Just being there and showing compassion as life slips away is still a form of medical treatment.

Science alone cannot provide a definition of medical practice. It is just a tool. Indeed, the whole purpose of medicine would probably be lost, if in considering the illness the doctor were to forget the patient, or if in considering the pain he were to forget the suffering, or the hope. Another issue that is going to crop up increasingly in the future is the question of power.

Medical power was at its apogee after the Second World War, as symbolised in the relationship between an upright, healthy, clean and well-dressed doctor and an innocent, uneducated and silent patient confined to bed.

The doctor was all-powerful in his hospital world, at once terrifying and unintelligible. This status was underpinned by an absence of laws on ethics or respect for people subjected to biomedical research. There were no patients' associations capable of standing up for the legitimate and inalienable rights of individuals entering hospital or putting their lives in the hands of a doctor.

Fortunately, the vast majority of doctors used their power wisely, with the sole object of helping their patients. However, we have seen the perverse effects that unbridled, inappropriate and inadequate use of such power and authority can have.

So where does the era of the Internet, lobbies and the media leave us? Doctors are seen by many as primarily those responsible for running up social security deficits and higher social charges, and as a heartless and incompetent lot.

This grotesquely inaccurate picture of the medical profession may conceal an underlying desire to destroy the origins of medical power at source. But it offers no concrete proposals for establishing a system capable of promoting health, eradicating suffering and respecting the life, value and dignity of all human beings.

France spends 10% of its GDP on health, but are the French satisfied with their health system? It is questionable whether they agree with spending so much on what seems to them to be a fairly remote asset, especially if they are of an age that does not actually need its services.

Nor can it be said that the French health system itself is happy with the resources it has, when 50 000 of its 800 000 staff end their careers early, and 3 000 of the 39 000 jobs for hospital doctors remain vacant. Can we say that we have answered the legitimate hopes of young people in terms of equity and compassion when we tacitly accept that people with AIDS or cancer in Europe will be cured whereas if they were African or Asian, poor and submissive, they would be left to die uncared for?

Economics, whether national or global, cannot be a substitute for ethics. Economics imposes choices and ethics helps us to make them.

Answers will have to be found to such questions. Otherwise our health systems risk collapsing under the cumulative burden of budget squeezes, a crisis of conscience among doctors and the emergence of a patients' lobby that is filling the void left by medical power.

Yet despite the difficulties of a world in the throes of far-reaching change, there is no reason to be pessimistic. Other values are helping us find answers to the pressing challenges facing a system that no longer knows which way to go. For in reality, power and purpose can only make sense through sharing.

Sharing means the individual, unique and privileged relationship between doctor and patient, it means respect for others, the right for all to equal access to quality care, the right to share knowledge, the patient's right to dignity and hope.

Through sharing patients and doctors, administrators and economists, businesspeople and researchers can forge an unbreakable alliance and at last create the conditions needed for a health system that lives up to everyone's hopes and makes proper use of scientific achievements and potential. As a result, all can be sure that every effort will be made, within the limits of available resources, to ensure that human beings live fulfilling, happy and healthy lives.

Each country and each region will of course have to define its own health priorities by democratic means, taking account both of requirements and resources.

In the same way, it is vital that overall "governance" of these issues involves sharing between North and South. Lastly, encouragement must be given to schemes to back the right of young people to become involved in health-related charities.

Economics, whether national or global, cannot be a substitute for ethics. Economics imposes choices and ethics helps us to make them.

We need a renewed code of ethics, based on choice, shared power and an efficient health system open to all. Everyone can then assume his or her share of that power with one principle in mind: that everybody in the world should have the same rights and the same opportunities in the face of sickness, suffering and adversity. ■

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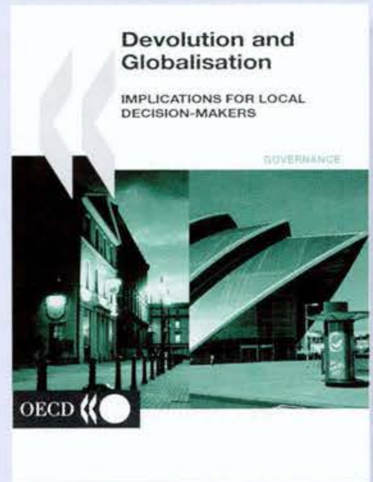

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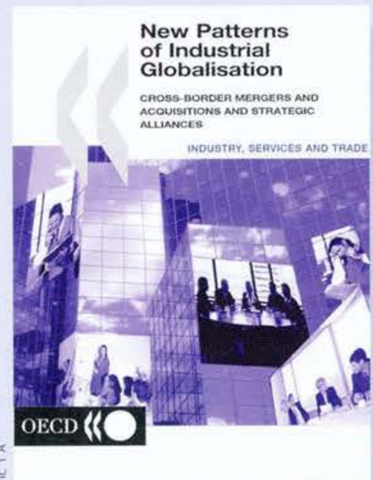

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OECD

In the eye of the storm

Brett Parris, Economic Policy Officer, World Vision International

The future performance of OECD health systems will depend on how healthcare is progressing globally. A greater effort, including investment, is needed to improve health systems in other (particularly poorer) countries.

Those of us brought up in wealthy OECD countries since the Second World War have been lulled into a false sense of security by our modern health systems and medicines. We too easily forget the power and virulence of unconquered disease. We forget the "Black Death" of the 1300s in which one-third of Europe's population perished. We forget that Spain's conquest of Mexico received more than a little help from the smallpox brought by a single infected slave; Mexico's population plummeted from around 20 million in 1520 to just 1.6 million by 1618.

And we forget that an estimated 95% of the population of the New World was wiped out by diseases the native Americans had never encountered – influenza, measles, smallpox, typhus and tuberculosis. Similar tragedies were played out in Australia, Fiji, Hawaii, Southern Africa and elsewhere.

All this is just ancient history. Or is it? The biggest natural disaster of the last century was not fire or flood, earthquake or drought, but the influenza epidemic of 1918-1919 that killed 25 million people. Now, AIDS is well on the way to surpassing that figure. In the 20 years since it was first reported, AIDS has infected 58 million people and killed 22 million of them, according to UNAIDS.

We, in wealthy OECD countries, have grown up in an unusually fortunate age, where our antibiotics and vaccines have been able to hold many diseases at bay. Smallpox has been vanquished. Polio likewise is within range. But anti-microbial resistance is spreading. Tuberculosis is making a comeback in major cities in the United States and Europe. The West Nile virus arrived in North America in 1999, infecting 69 people in New York and killing seven. Malaria is still endemic in tropical zones, killing millions.

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In the last couple of years, following the rampant spread of AIDS, the international community seems to have finally woken up to the health crisis facing the world's poorest countries. Several new initiatives have been launched in the last few years. They include Stop TB (www.stoptb.org), Roll Back Malaria (www.RBM.who.int), the International AIDS Vaccine Initiative (www.iavi.org), the Multilateral Initiative for Malaria (www.nih.gov/fic), the International Partnership for AIDS in Africa (www.unaids.org/africapartnership), and the World Health Organisation's Commission on Macroeconomics and Health (www.cmhealth.org).

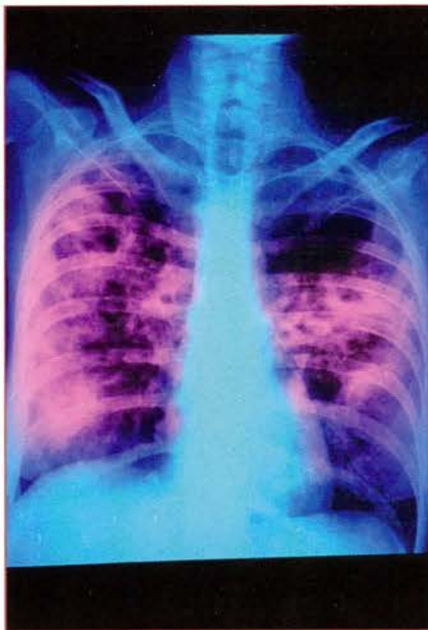
In May 2001, the UN secretary-general, Kofi Annan, launched a "Global AIDS and Health Fund", aiming to raise US$7-10 billion to fight HIV/AIDS, malaria and tuberculosis. But by August only about US$1.4 billion had been raised and Mr Annan has had to weather criticism from irritated donors that he raised expectations too high.

The trouble is, the UN secretary-general's figure may be just what is needed. Without an assault of that scale, the problem will hardly be dented and the consequences will be unimaginable. Mr Annan is supported by the strong vocal support of a widely respected Harvard economist, Jeffrey Sachs.

Representatives and organisations from around the world want the new Fund to become operational by the end of 2001. UNAIDS executive director, Peter Piot, told a meeting in June that half of the amount Mr Annan aimed to raise to fight AIDS would be needed for sub-Saharan Africa alone. Current spending in developing countries to fight the disease is estimated at just $1.8 billion.

Yet around 36.1 million people are living with HIV/AIDS, most of them in sub-Saharan Africa, where 3.8 million people became newly infected last year. Of the more than 10.4 million AIDS orphans world-wide, over 90% live in sub-Saharan Africa and it is predicted that by 2010, the 19 worst affected African countries will have produced about 40 million orphans.

But AIDS is not the only problem. There were some 8.4 million new tuberculosis cases in 1999, up from 8 million in 1997. The rise was largely due to a 20% increase in African countries most affected by HIV/AIDS, according to WHO. Alarmingly high rates of multi-drug-resistant TB are



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TB, as seen in an an x-ray. The pale pink area shows extensive fibrosis in both lungs, called primary pulmonary tuberculosis. In the post-primary stage cavitation may occur.

occurring not only in Africa, but in Argentina, Estonia, Latvia and Russia. With modern jet travel, the resistant strains can spread quickly. In the early 1990s the US spent nearly $1 billion treating just 350 cases of multi-drug-resistant TB in New York, from a strain that had migrated from Russia and Asia.

Drug-resistance thrives under poor drug control regimes, caused principally by under-resourced health systems – if patients do not complete a course of treatment, or are given inappropriate antibiotics, the bacteria can develop resistance to the drugs.

Malaria also kills over a million people each year – mainly children – and severely erodes national incomes. According to WHO, it has reduced sub-Saharan Africa's GDP over the past 30 years by around US$100 billion. There is no vaccine, and again, resistance to current drugs is growing. Some epidemiological models predict that with global warming, by the end of next century, malaria's range will have increased from the current 45% to around 60% of the world's population. It has already returned to parts of the US, Korea, southern Europe and the former Soviet Union. Even scientists in the UK are preparing risk assessments, to determine whether this "marsh fever", rife from the 16th to 18th centuries, could return.

Can OECD countries afford to ignore these problems? No – and not just for moral reasons. Costs on OECD health systems will come under pressure as diseases and drug-resistance spread. In fact, the evidence points to a stark but simple choice facing OECD countries: invest several billion dollars now, strategically and carefully, in helping developing countries solve their current health crises, or pay hundreds of billions in future years to deal with international humanitarian disasters, collapsing economies (and OECD export markets), waves of stricken refugees and outbreaks of virulent drug-resistant diseases.

The Global Health Fund is an important initiative but is fraught with potential problems, not least the need to ensure that the planning and administrative burdens on developing countries are simplified, not increased. A lack of co-ordination by donors forces developing countries to tie up more of their scarce financial and administrative resources in the red tape of compliance required by their donors. Reform is needed here.

Similarly, control of the new fund requires careful thought: in particular, will it be another donor-driven exercise, or will developing countries and poor people themselves be at least full partners, if not taking the lead in the decision-making processes?

A further matter to be resolved is that of drug prices. The World Trade Organisation's TRIPS agreement on intellectual property rights needs to be revised in a pro-public health way. Yes, incentives for research are vital, but these might well be better provided by an international fund guaranteeing purchase of successful drugs, viewing health as a global public good, rather than an individual luxury commodity available to those who can afford it. For all its trumpeted importance, the current patent system has resulted in AIDS drugs that have been unaffordable to most of those in need, and has led to virtually no new drugs for tuberculosis and malaria being developed in the past 30 years.

Finally, national health systems in developing countries must be strengthened. This will require significantly more aid, less debt repayments and sustained capacity building and technical assistance. In 1999 the global donor effort for all health programmes in sub-Saharan Africa totalled just $1.30 per person, a figure Jeffrey Sachs described as "tragically insufficient".

In the early 1990s the US spent nearly $1 billion treating just 350 cases of multi-drug-resistant TB in New York.

Health security strategies can no longer be formulated purely nationally. They must be considered in a global context. An OECD country's health services and public health strategies will be ultimately ineffective if they ignore the interdependency of global health challenges. Today we understand the importance and gravity of these challenges better than ever. We have an historic opportunity to meet them. Will we invest now, or pay later? ■

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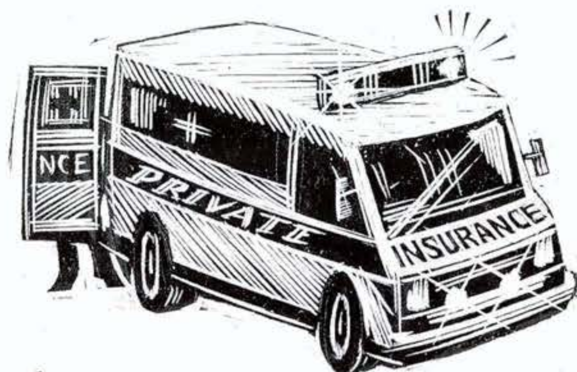
Private insurance, public health

Nicole Tapay, OECD Directorate for Financial, Fiscal and Enterprise Affairs



Health is a public service almost by definition, though private insurance is expected to play a greater financing role. Finding the right balance between public and private health coverage and building the appropriate regulatory framework is an ongoing policy challenge.

The mere mention of the words "private health insurance" can stir up strong feelings across the political and ideological spectrum. Many people view it as an important aspect of consumer choice, offering the possibility of access to different types of providers or services in many countries. Private insurance can also help consumers meet the additional costs that may not be paid for by some public systems, so that individuals' use of health services is fully covered. However, there are concerns in government and among consumer, provider and other organisations, that a private market might threaten valued universal entitlements to health services. Some countries have had bad experiences with private insurance, others simply distrust the idea of the private market in the healthcare system.

Should it be so? Our role at OECD is not to come down on one side or another or promote a particular "ideal" role for private health insurance within a national health system. But we are ideally placed to collect and analyse the experience of many OECD member countries in this area, so that governments and other health providers can make informed policy choices. This is one of the key aims of this component of the OECD's health project: to evaluate and examine over the next two years and beyond, the role of private health insurance in OECD countries, as well as the interdependence and relationship between public and private health coverage. The outcome, we hope, will be useful and practical guidance for governments and policymakers as they try to promote an efficient, equitable and properly regulated health insurance market.

There are concerns in government and among consumer, provider and other organisations, that a private market might threaten valued universal entitlements to health services.

There are some "messages" that we can put forward. One broad, though essential one is that private health insurance does require regulations – and the project will try to identify those that appear to have been particularly useful.

The role of private health insurance varies significantly across countries and it is difficult to identify a single "trend" in this area. What seems certain is that private insurance will play at least some role in financing many countries' health systems in the years to come, including in countries where private health insurance is relatively rare.

Take Poland, for instance. It enacted legislation in 1999 permitting the entry of private health insurance into its health system in 2002; this legislation also included broader reforms. Yet, at the end of 2000, ongoing discussions and debates regarding health reforms and uncertainty regarding the desired role for such insurance delayed implementation.

In Turkey, the current system, based on a range of mostly public institutions, does not provide the entire population with health coverage and 30% of the population is uninsured. There is some interest in the potential role of private insurance to help fill that gap.

Policy debates continue strong even in countries where private insurance is more common. Australia, for instance, has a universal public insurance system and private insurance coverage is only permitted to cover services not funded by the public Medicare system. Nonetheless, a significant share of overall health financing – a third or so according to some estimates – in Australia comes from the private sector.

Since 1995, three major reforms have been implemented, addressing aspects of the private health insurance market: selective

contracting (allowing health plans to enter into selective contracts with hospitals and physicians); government subsidies for health insurance through a 30% rebate for private health insurance and a move away from pure community rating – a regulatory scheme which prevents premiums from varying according to factors like age, gender or health status – to a modified system of community rating (sometimes referred to as "lifetime community rating") which provides incentives for purchasing private insurance at a younger age.

In the United States, private financing accounts for about 55% of health spending, according to recent government figures. One of several ongoing health policy discussions in the US involves how to incorporate the services of private health plans into Medicare, a federal health programme for those aged 65 and older, as well as for certain disabled individuals. Legislation enacted in 1997 enhanced the ability of Medicare beneficiaries to opt to receive their benefits through private health insurers; these plans sometimes offered additional benefits, such as additional prescription drug coverage.

However, this transition has caused some concern. For example, private insurers claim that reimbursement levels are insufficient. In fact, several have discontinued offering this type of cover. So, while private insurance is important within US healthcare, certain related policy issues continue to be debated by the state and federal governments.

Another country with recent changes affecting private health coverage is Switzerland. The enactment of compulsory basic insurance in 1996 resulted in changes in the voluntary supplemental coverage market as well. Basic cover can be offered by state-approved health funds or private insurers (although no private insurers are currently involved in operating this compulsory health insurance); in this case, health funds and private insurers are both subject to the Health Insurance Law and the supervision of the Federal Social Insurance Office. In addition, voluntary supplemental coverage can be offered by health funds or private insurers.

Unlike the situation before the recent reforms, the premiums for voluntary supplemental health insurance offered by the health funds are now calculated according to risks, using criteria such as age and gender (and already had been calculated in this manner by private insurers), in contrast to the premiums for basic compulsory insurance. These changes have raised concerns about how best to assure access to supplemental cover for all.

Supplementary insurance is currently not the subject of any targeted provisions of Swiss insurance law and proposals have been under discussion regarding gender-neutral premiums for voluntary supplemental insurance, as well as the calculation of these premiums based on the purchaser's age when the contract is first issued.

As OECD tries to draw the strands of these different experiences and discussions together, we see some difficult questions emerging. For instance, what are the best practices in this area and to what key social,

economic, financial and regulatory principles should a public/private system of healthcare funding and management conform? What are the main advantages and drawbacks of private health insurance – with particular focus on financial security, social adequacy, individual choice, risks from both the financial and health management perspectives – and how can it best be used to complement public schemes?

A central challenge will be to examine the right balances that can be struck between public or private health insurance, mandatory and voluntary health insurance. From the point of view of equity, it would clearly be desirable to avoid the creation of a system with two classes of service. But from the point of view of efficiency, this balance also should promote an optimal use of resources without creating moral hazard incentives, such as any policies that might encourage persons to wait until they expect medical expenses before purchasing health insurance.

Apart from looking at policy incentives, policy also has to aim at appropriate regulatory frameworks for private health insurance, taking into account key concerns like competition, information access, consumer protection, portability – the ability to change health insurance policies or insurers without repeatedly incurring penalties – and so on.

The OECD's work in these areas is ongoing. It will involve the collective effort of all expertise available in our member countries to get it right. ■

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The Dutch model
Self-regulation versus integration

Niek Klazinga, **Diana Delnoij** and **Isik Kulu Glasgow**, Academic Medical Centre of the University of Amsterdam

With medical professionals and institutions responsible for devising their own separate quality systems, achieving a coherent quality framework for the Netherlands is proving a harder job than many had bargained for.

A report by the World Health Organisation in 2000 ranked the Netherlands 17th in the world for the quality of its health services. The OECD too has scrutinised the Dutch healthcare system and several reports comparing the Dutch situation with other countries have been produced in the Netherlands. All of them have sparked much debate in the Dutch press and among academic circles.

There is no doubt that benchmarking has put the question of performance indicators for health systems on the Dutch political agenda. But the indicators these studies have used, like disability-adjusted life expectancy or fairness in financial contribution, do not really address the acutely felt problems in the Dutch healthcare system, such as waiting times and labour shortages. So while interesting, these international indicators lack a strong link with national policy and decision-making frameworks in the Netherlands.

More energy should be channelled into filling these gaps, for when it comes to developing such indicators, the Netherlands is lagging behind countries like the US, Canada and Australia. One reason is the different approaches the Netherlands has chosen for monitoring its healthcare system, which can be characterised as a self-regulating system within which public and private elements are intertwined.

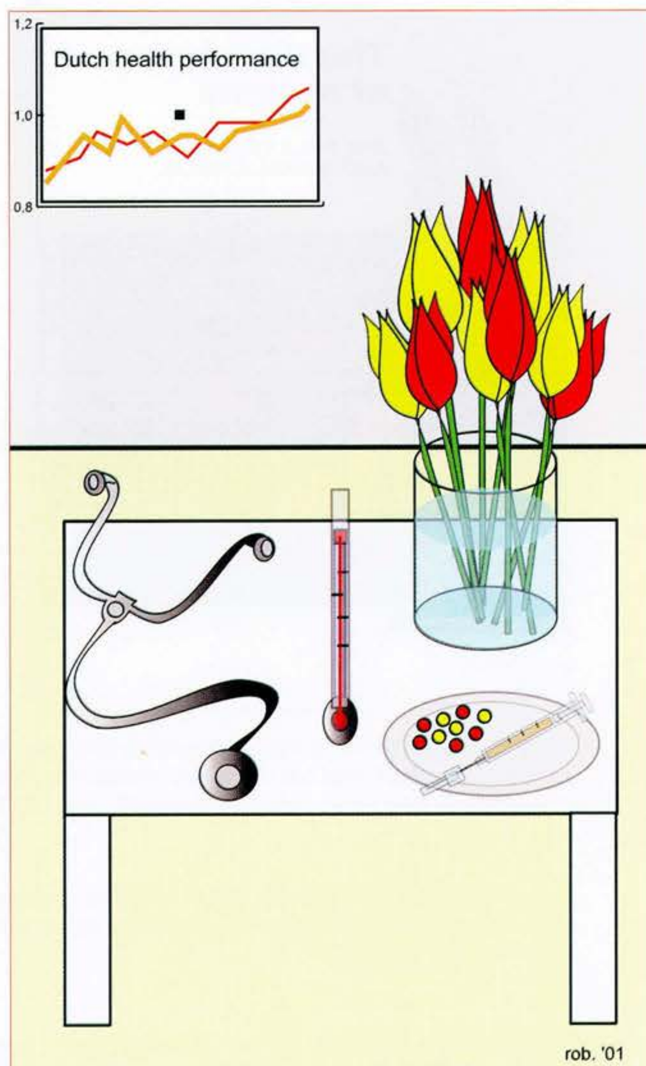
After a decade of planning regulations, like health manpower and budgets, healthcare policy shifted towards a regulated market in the second half of the 1980s. A nationwide emphasis was placed on the quality of care.

Over a decade ago, in 1989, the first national broad-based conference on quality in healthcare was held. Participants agreed that healthcare professionals – doctors, nurses and other personnel – and institutions such as hospitals and nursing homes, should each develop "quality systems" of their own. They agreed these systems would be used to achieve improvements in quality as well as external accountability; that patient organisations and financiers (municipalities, public and private insurers) would be involved in devising the quality system; and that the government would enforce these policies, with the inspectorate of health exerting control.

Health services and professionals have to become more community oriented. But this will be difficult to achieve since financial and legislative incentives work against it.

Legislation followed in 1991 and in the last decade many initiatives were taken to enforce already existing quality assurance mechanisms, or to introduce new ones. The drive to develop quality systems among professionals comes from both internal and external pressures. Work includes formalised training programmes, accreditation of courses, and the introduction of obligatory re-licensing for the medical professions (since 1989). It also includes plans to introduce national practice guideline programmes for medical specialists, general practitioners and nursing professions; peer review and audit programmes for these groups and others, like nursing home physicians and specialists in social medicine; and to develop clinical registries by scientific societies.

Healthcare institutions, on the other hand, have been more active in applying new systems, like the European Foundation for Quality Management (EFQM) model, the International Organization for Standardization (ISO) model and the North American Accreditation model. In 2000, two-thirds of the institutional healthcare providers were involved in project-based quality improvement. A third were preparing for the implementation of a comprehensive, coherent quality system.



A conference on quality in 2000 endorsed the principle of self-regulation, but saw the danger of a divide emerging between professionals and institutions instead of more integrated care arrangements. Present legislation and financing structures reinforce this divide, treating prevention, cure and social care as separate entities. Yet the need for integrated care is recognised. For instance, Dutch healthcare is financed through a mix of private and public insurance schemes. The public schemes are regulated through the Sick Fund Law (ZWF), covering most of the treatment (or curative) sector (e.g. hospitals, physicians) and prescription drugs, and the Catastrophic Illness Act (AWBZ), covering most of the care (e.g. nursing homes, homes for the elderly, home care). Now there are proposals to merge the AWBZ and ZWF under one basic insurance package for treatment and care.

In terms of monitoring by means of performance indicators, one of the major challenges ahead will be to link public health data with the performance data of individual services in a meaningful way. A prerequisite is that health services and professionals become more community oriented. But this will be difficult to achieve under the self-regulation model where financial and legislative incentives work in opposite directions. Governments must therefore provide guidance towards the overall goals of healthcare, take initiatives to safeguard coherence in the system and assure that it is population-based, instead of service-based.

Linking public health data with performance data on health services and professions begs several questions: for instance, do we provide the optimal mix of services to our population and are these services provided effectively, efficiently, in a client-oriented manner?

We have to develop performance indicators for healthcare institutes and professions that are community-based. These national performance indicators have to be placed in a quality system framework. In other words, for national indicators to be meaningful for policy and management, they will have to be part and parcel of a quality system for healthcare as a whole. The WHO 2000 report helped to reorient the focus of the Dutch healthcare system. It is now time to take the next step and develop an integrated, policy-friendly, national performance framework. ■

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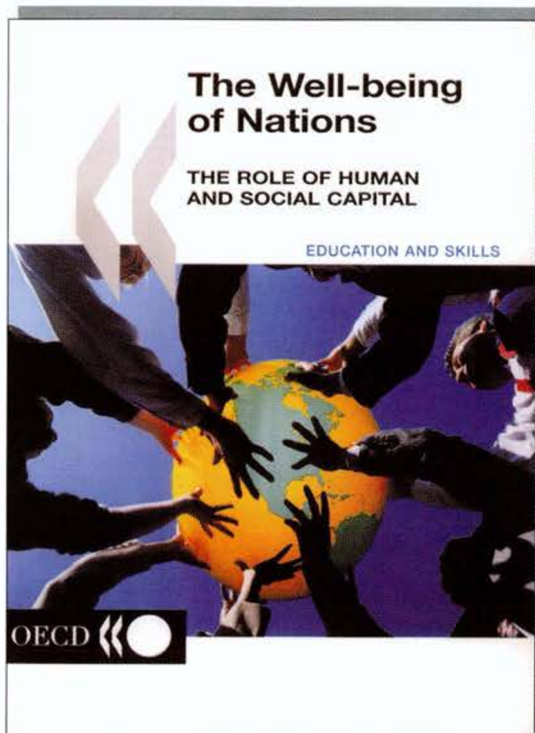
Bestseller



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Trade in the global economy

Julia Nielson, OECD Trade Directorate

When you buy a business service online, the salesperson may be half a block or half a world away. But do the same trade rules apply as when you buy a piece of solid merchandise, and who decides?

Services are a relative newcomer to the multilateral trading system, having been famously defined only as "anything you can't drop on your foot". Most trade negotiations over the years have focused on trade in goods, so while barriers on say, shoes or televisions, have been tumbling, services are only now beginning to be freed up. One reason that these "intangibles" were long ignored in an international trade context is that many types of service, such as business advice, were not easily exported, being rather local or national in reach.

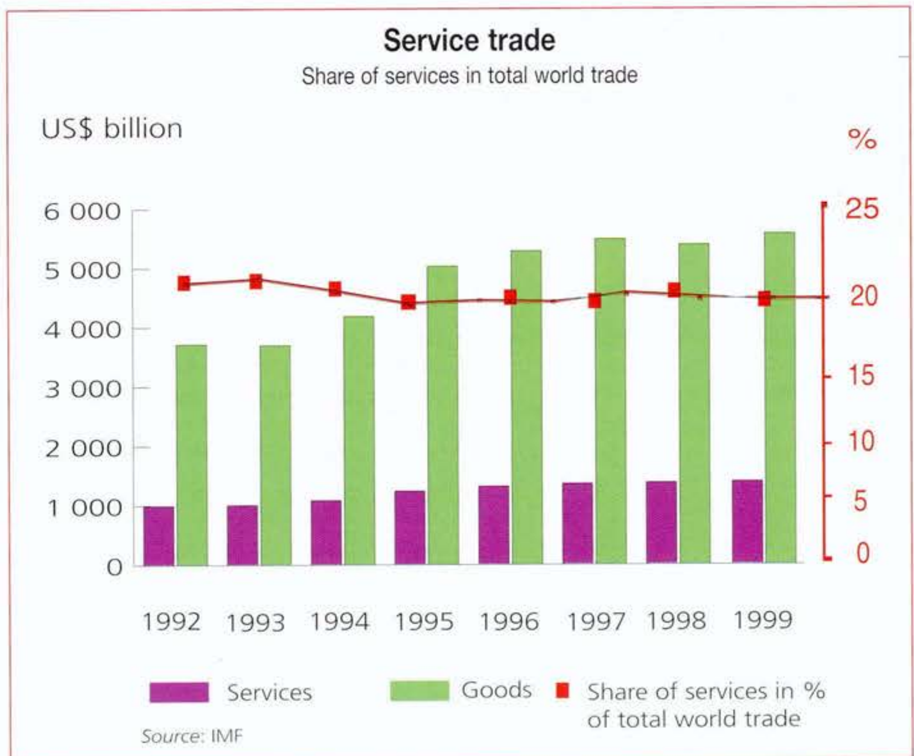
That picture has changed enormously. Technological advance, privatisation and liberalisation have seen global trade in services rise to an estimated US$2.1 trillion annually. Even business services have spread their wings across borders, thanks to modern telecommunications. And the break-up of former state monopolies has created new cross-border opportunities for areas like telecommunications and energy. This trade is not simply for and among developed countries: the share of services in total trade has also increased in developing countries, with services accounting for approximately 30% of all world trade.

Services are a key indicator of economic development, accounting for 50-70% of economic activity, more than half of all civilian employment in most OECD countries, and underpinning many other sectors, including manufacturing. Countries at all levels of development have recognised that an inefficient services infrastructure can act as a tax on the entire economy, affecting efficiency and competitiveness, as well as physical trade.

Hard talks

It is hardly surprising that services should become the subject of multilateral trade talks. The trouble is that trying to remove barriers to services trade is as complex as services themselves, a point clearly demonstrated by the international negotiations under the WTO General Agreement on Trade in Services (GATS), which began on 1 January, 2000.

Technological change – sometimes blurring the differences between goods and services – the wide range of state and private sector suppliers, monopolies and markets,



unilateral liberalisation in some state-owned monopolies, like telecoms: all of this makes for a complex global marketplace and an equally fast-changing regulatory landscape.

The GATS provides a framework of rules for global trade in services and a structure for multilateral commitments to liberalise. But the GATS has yet to deliver real market opening – most countries' GATS commitments represented the status quo at the time of the Uruguay Round a decade ago. Meanwhile, thanks to technological change and unilateral liberalisation, most countries' markets are in fact significantly more open than their GATS requirements indicate. Translating this into multilateral commitments is a major challenge of the current negotiations.

Progress in the GATS negotiations will not be easy, not least because of the sheer number of issues involved. Market access negotiations in services cover sectors as diverse as energy and telecommunications, transport and computer services. Already more than 90 negotiating proposals have been received from some 40 WTO members, with more to come. Some

Progress in the GATS negotiations will not be easy; already more than 90 negotiating proposals have been received from some 40 WTO members, with more to come.

particularly sensitive sectors where little progress has been made so far – maritime transport, audio-visual services (with its cultural dimension reflected in some countries' desire to protect their own language) and the movement of service suppliers (so-called "mode 4" of the GATS) – remain firmly on the table. Expectations of progress on mode 4 in particular are running high, with some developing countries indicating that their willingness to deepen commitments under other modes (such as mode 3 on commercial presence) may lessen if they do not receive increased access for their service suppliers.

In addition to market access negotiations, there is a significant agenda of rules issues left over from the Uruguay Round, covering rules on subsidies, government procurement, qualification requirements, technical standards, licensing and the like. One question stands out – that of a possible emergency safeguard mechanism to allow members to temporarily suspend a commitment where a surge of imports is causing unforeseen damage to domestic industry.

But the terms "damage", "domestic industry" and even "imports" are much more difficult to define for services than for goods. Some major developed countries query the feasibility and desirability of a safeguard, but some developing countries may refuse to make significant market access commitments without one. The deadline for these negotiations has recently been extended to March 2002.

Broader negotiations

Apart from the technical difficulties, there are the politics. After the failure at Seattle to launch a broad trade round, only negotiations on agriculture and services already agreed under the "built-in agenda" were allowed to proceed.

While these two negotiations are formally separate, politically they are linked as some agricultural exporting countries in particular are reluctant to deliver liberalisation on services without an indication of similar progress in, say, market access for food. Most WTO members see little prospect of real results from the services negotiations in the absence of a broader negotiating agenda to provide the trade-offs and gains that allow multilateral trade deals to be struck.

In the meantime, services negotiations are taking place against the backdrop of concern about liberalisation and globalisation. Some people are anxious about the provision of public services like health and education and wonder about their governments' ability to pursue national policy objectives within a global environment. While services supplied in the exercise of governmental authority are excluded from the GATS, most countries now have a mix of private and public sector provision, in health and education for instance. Services liberalisation also presents new challenges for regulation.

Contrary to some critics' suggestion, "liberalisation" and "deregulation" are not synonyms. Indeed, services liberalisation often necessitates regulation or re-regulation, as governments try to achieve a range of policy objectives within new market structures. After all, governments still have to ensure competitive markets, safeguard consumer interests, improve environmental protection and, in areas like health and education, ensure universal provision.

Services might not drop on your foot, but failing to achieve progress multilaterally could leave some service-starved countries limping.

Dialogue and debate are needed on these important issues. The OECD will contribute to this dialogue via its forthcoming study, Open Services Markets Matter, which addresses these concerns and balances the costs and benefits of liberalising services.

The road ahead for the services negotiations will be long and difficult. True, unilateral and regional liberalisation will probably continue and the global market will grow. But multilateral progress will be vital to spread the benefits of better, more efficient services to all consumers.

Services might not drop on your foot, but failing to achieve progress multilaterally could leave some service-starved countries limping on the sidelines of regional and bilateral deals and struggling in the global economy. ■

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Why agricultural trade liberalisation matters

Jonathan Brooks and **Carmel Cahill**, OECD Agriculture, Food and Fisheries Directorate

Farmers' incomes still rely too heavily on subsidies, which distort markets, put exporters from developing countries at a disadvantage and cost taxpayers hundreds of billions of dollars a year. Agricultural reform and reductions in trade barriers could help farmers both in the industrial and developing worlds get a better deal in a more cost-effective way.

Agricultural policies in OECD countries cost consumers and taxpayers more than US$330 billion a year. On average, more than a third of farm receipts come from government programmes, although this share varies widely among OECD members, from almost zero to nearly three-quarters of farm receipts.

To put this spending in perspective, total agricultural support accounts for 1.3% of GDP across the OECD area, yet agriculture accounts for less than 5% of national income in most member countries. The value of support is more than five times higher than official spending on overseas development assistance and twice the value of agricultural exports from all developing countries.

Given this scale of intervention, it is important to ask whether the money is being well spent. In general, the answer is no. Current policies typically reduce economic efficiency and disrupt international markets – often at the expense of developing countries. The current policies also fail to target low-income farmers and in many cases do more harm than good to the environment. OECD ministers have recognised the need for fundamental reform. Substantial reductions in support and protection would ease the burden on consumers and taxpayers. The resources released would also allow for more targeted assistance to farmers and a clearer focus on environmental and other domestic objectives. Such changes would be consistent with Article 20 of the Uruguay Round Agreement on Agriculture (URAA), which calls for a continuation of the reform process to build a fair and market-oriented agricultural trading system, while taking account of non-trade concerns, such as food security and the environment.

Given the scale of intervention, it is important to ask whether the money is being well spent. In general, the answer is no. The fact is that, despite the reforms to date, overall support remains very high.

As a new round of trade negotiations approaches, it is important to note that the starting point is very different from 1986 when the Uruguay Round was launched. The URAA was a watershed, in that agriculture was finally subjected to multilateral rules and disciplines. Specific reform requirements were mandated in three areas: market access, export subsidies and domestic support. WTO members will be approaching the forthcoming WTO ministerial with proposals in mind for how the rulings agreed in 1994 should be revised and extended.

The main achievement of the market access discipline was "tariffication" – a process whereby import bans, quotas and other restrictive import measures were converted into tariffs. But the price of this reform was that some of the new tariffs were set at extremely high levels. Six years on, with Uruguay Round implementation in agriculture completed for the developed countries, tariffs remain very high. Average agricultural tariffs are in the region of 60% of the price of imports, whereas industrial tariffs are rarely above 10%.

Market opening measures in the form of tariff-rate-quotas (a quantity of imports allowed at a lower tariff) have not been fully successful, with a large number remaining unfilled. Not surprisingly, the growth in world agricultural trade has remained much slower than in other sectors, and developing countries have been unable to increase their share of world markets. Significant improvements in market access will require much deeper cuts in tariffs, or big increases in the volumes admitted at lower tariffs, and preferably both.

The disciplines on export subsidies were the most effective part of the URAA, with countries less able to resort to export subsidies when world markets weakened.

Export subsidies disrupt world markets and prevent efficient producers from competing. The lower prices they imply may benefit some developing country importers, but in many more cases they undermine local markets and hinder agricultural development. Further reforms could have significant impacts in some markets, notably for dairy products, and would prevent countries returning to export subsidisation in the event of weaker world markets.

An innovative feature of the URAA was the domestic support disciplines, which recognised that domestic policies can have strong effects on trade and trade policies. Countries agreed to reduce the value of support for the most trade-distorting policy measures (such as output-related price supports), but not for the less-distorting ones (such as direct income payments). But more has to be done. For a start, these commitments did not significantly constrain WTO members, since countries agreed to make reductions from a base period of unusually high support, rather than from the actual levels at the time of the agreement in 1994. Moreover, while several countries have since shifted to less-distorting support measures, these still keep additional resources in farming and continue to distort trade as a result. The fact is that, despite the reforms to date, overall support remains very high. Exempting policies on the basis that they do not affect farmers' production decisions at the margin may fail to address the cumulative impact that the whole range of support policies has on production and trade.

In order to consolidate the reform process, there is a need for stronger disciplines and simpler legal requirements. Less complicated provisions would undoubtedly ease developing countries' concerns about the need for a "fair" and "balanced" agreement. A number of other difficult issues may also have to be addressed. These include the tendency for tariffs to escalate according to the degree of processing undertaken, the potential for state trading enterprises to distort trade, the growing use of anti-dumping duties, and the possible misuse of food aid and export credits.

Some countries would also like to see "non-trade" concerns specifically acknowledged and integrated into a new agreement. A number of countries with high animal welfare standards argue that they should not have to accept competition from countries with lower standards. A wide range of issues related to production processes and methods – in particular concerning food quality and safety – has also been raised. The Agreement on Sanitary and Phytosanitary Measures and the Agreement on Technical Barriers to Trade cover many of these issues. Yet while the framework created by the Uruguay Round should facilitate further reform, it is unlikely to be sufficient to address all countries' concerns.

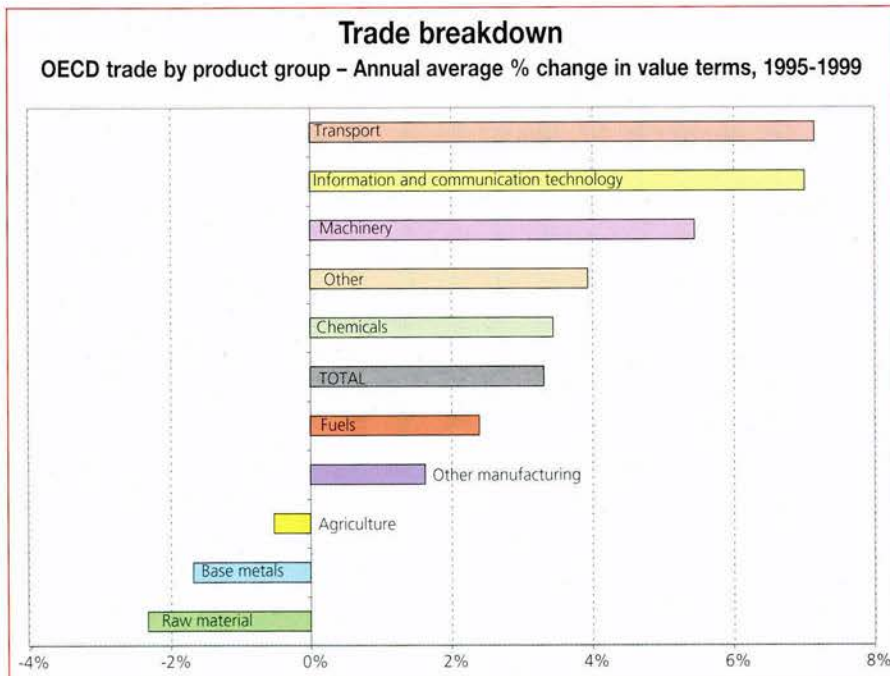
A consolidation of the URAA promises efficiency gains that should translate into stronger economic growth. But it is important to recognise that while trade reform promises aggregate gains, it does not guarantee that everyone will be better off. Within and among countries, there will be both winners and losers, although the losers may benefit in the long term from stronger growth and higher returns in other activities. In particular, the burden imposed on net food importing countries, and on specialised exporters that depend on one or two key commodities, may need to be addressed.

While such problems do not alter the case for further trade reform, they nevertheless imply that trade cannot be viewed in isolation. In those OECD countries where the agricultural sector benefits from high support and protection, adjustment assistance, compensation and income safety nets may be required. In developing countries, there may also be a need for export capacity building and renewed efforts to reduce dependence on one or two key commodities or export markets. Development assistance clearly has a role to play here.

A new agreement with deeper reforms would reduce the burden on consumers and taxpayers in OECD countries. It would also be of overall benefit to developing countries, many of which have lost out from limited market access opportunities and the difficulties of competing with subsidised exports from more developed countries. ■

Trade breakdown

OECD trade by product group – Annual average % change in value terms, 1995-1999



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Market access
A priority for development

Douglas Lippoldt, OECD Trade Directorate

Increased trade plays an important role in integrating developing countries into the world economy. But many complain that current global rules make it difficult for them to compete for much-needed markets. Developed countries counter that the list of developing countries is too long for them to make an exception for everyone. How best can these differing interests be met?

Market access to OECD countries: this is one of the most important trade questions between OECD and non-OECD countries as a new round of trade talks gets under way. Although the multilateral trading system, under the auspices of the World Trade Organization (WTO), provides for "special and differential" treatment for developing countries, many continue to face substantial constraints in access to export markets. They can point to relatively high tariffs, quantitative restrictions, subsidies and other measures that undermine their exports in key areas. Improving trade possibilities for manufactured and agricultural products of interest to developing countries has to be a central objective if we are to have a mutually beneficial "development round" of trade talks. Experience to date indicates that through trade-offs in negotiations, progress should be possible.

Since the end of the Second World War, eight rounds of multilateral trade negotiations have succeeded in lowering the average trade-weighted most-favoured-nation tariff rates on industrial goods from roughly 40% to 4%. The most recent rounds have also helped to address some important non-tariff barriers associated with technical standards, import licensing, transparency and other areas. Estimates indicate that once the Uruguay Round agreements are fully implemented, the proportion of imports from non-OECD countries affected by OECD members' non-tariff barriers will drop from around 18% to 5%. In addition, the Uruguay Round yielded progress in areas such as trade in services.

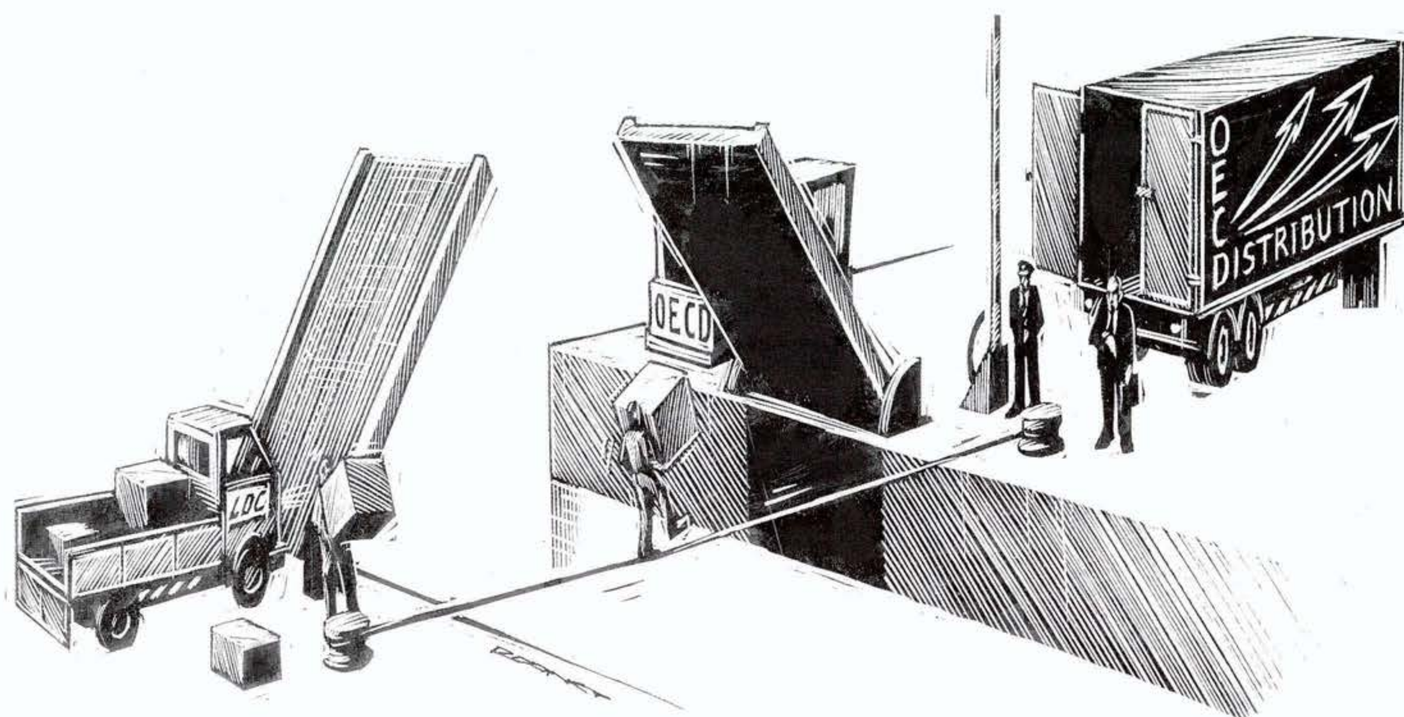
Nevertheless, despite this broadly improved framework, market access issues still arise concerning products of particular interest to developing countries. In the case of apparel industries, for example, even after the Multi-Fibre Arrangement-related quotas have been phased out (set to be completed by 2005), relatively high tariffs will remain in place on many products. Some sensitive sectors, like leather, remain subject to escalating tariffs that increase according to the degree of processing, which limits developing countries' export prospects for higher value-added products. Agricultural producers in developing countries, meanwhile, encounter high tariffs, quotas and subsidised exports. And liberalisation in the service sector remains limited in areas such as the temporary entry of service providers, like consultants.

More than two-thirds of the WTO's 142 members are considered to be developing countries by virtue of their self-designation to that status. While WTO agreements make extensive references to special provisions, rights and obligations for developing countries, there is no official definition of what constitutes such a country. Certain groups of developing countries qualify for more generous treatment under some of the existing provisions. These include net food importing countries, least developed countries and countries with a per capita income of less than US$1 000 per year.

The remedies for Singapore with per capita income of US$26 600 in 1998 are probably different from those appropriate to Ghana with a per capita income of US$400. Yet both classify themselves as developing.

Overall, the developing countries could potentially benefit from 145 special and differential treatment provisions operating within the WTO system. These deal with such issues as: trade opportunities; safeguarding developing country interests; flexibility of commitments; transitional time periods; and technical assistance.

Some developing countries have expressed dissatisfaction with the actual operation of these provisions, however,



saying they are inadequate instruments to help them integrate more fully into the multilateral trading system. On the other hand, developed countries increasingly take the view that no single approach can address the needs of such a diverse group of countries. After all, the remedies appropriate to a country like Singapore with per capita income of US$26 600 in 1998 are probably different from those appropriate to a country like Ghana with a per capita income of US$400, and yet, both classify themselves as developing. And even if the remedies were the same, their capacities to adopt them would probably differ.

The WTO operates on a consensus basis, so any progress in trade talks will involve trade-offs between the interests of OECD countries and developing countries. As a result, increased market access and other measures to recognise the special situation of developing countries will need to be balanced against calls for the more advanced developing nations to accept increased responsibilities under the multilateral trading system.

Economic success in non-OECD countries is generally associated with integration into the world economy. But liberalisation is only one side of the coin.

Given that there already is some differentiation among developing countries – least-developed status for instance – it may be possible to further extend the practice of targeting more benefits to a select group of countries facing particular disadvantages. Alternatively, the more advanced developing countries could be promoted from the developing country group, either on a self-initiated basis or using objective criteria, including economic indicators such as per capita income.

Economic success in non-OECD countries is generally associated with integration into the world economy. But liberalisation is only one side of the coin. To succeed, it must be accompanied by appropriate domestic policies in areas such as institutional capacity building, social cohesion, human capital development and infrastructure improvements. These require investment and assistance. But they should not hide the fact, that while additional work is needed, improving market access to OECD markets is the *sine qua non* of world development. While undertaking multilateral trade negotiations is a tremendous task, it is well worth the global effort by OECD and non-OECD countries alike. ■

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Better business behaviour

Barbara Fliess, OECD Trade Directorate

World trade and globalisation depend on responsible business practices, if they are to win public confidence and deliver global prosperity. That is where codes of conduct come in, whether towards the environment, labour or other ethical rules. Almost all of the world's 100 largest multinational enterprises have issued environmental codes or policy statements on health and safety. The majority of them have also issued statements addressing labour practices. But do these codes work?

Codes of conduct are a well-established tradition in the private sector. They are also becoming more common as ways to better match changing public attitudes and expectations from their stakeholders about their role in society. In many professions there has been a long tradition of regulating the behaviour of members through voluntary codes. Virtually every company has developed guidelines for staff on how to behave when confronted with dilemmas such as conflict of interests, gifts, theft, insider trading, pay-offs and bribery.

But codes are now being used to establish rules of good behaviour in relation to a host of other issues. Respect for labour rights, a clean environment and preservation of natural resources, and personal and political freedoms for citizens – these are some of the areas where corporate performance has come under close scrutiny from stakeholders and where private initiatives have emerged as a major force in corporate ethics programmes.

A close look at these codes shows that OECD companies are making a strong effort on environmental and labour issues. In fact, almost all of the world's 100 largest multinational enterprises (MNEs) have issued environmental codes or EHS (Environment, Health and Safety) policy statements. The majority of them have also issued statements addressing labour practices. Other codes demonstrate a commitment to areas such as advertising ethics, consumer protection, genetic engineering and animal rights. Which companies do what largely depends on the industry they are in.

Mining, forestry and paper, for example, focus, though not exclusively, on rules of behaviour for environmental management, health and safety standards. Labour provisions are particularly common in the garment, footwear, rug and sporting goods sectors, where dismal working conditions, low wages and child labour have been well documented. Often, companies, whatever the sector, make some commitments in both areas and many codes contain provisions relating to health and safety in the workplace.

Apart from individual companies, business organisations also promote standards of business conduct. Well-known initiatives include the Business Charter for Sustainable Development drawn up by the International Chamber of Commerce, the Responsible Care Initiative of the chemical industry to improve its environmental, health and safety performance, and the Charter for Good Corporate Behaviour drawn up by Keidanren in Japan. Non-governmental organisations (NGOs), too, have issued sets of global principles, such as the Consumer Charter for Global Business developed by Consumers International, which links 200 consumer groups in more than 80 countries, or the Clean Clothes Campaign, a European initiative directed at the textile industry.

Moreover, it is commonplace to find labour unions, NGOs and other private groups participating in code initiatives with the private sector. The Ethical Trading Initiative in the UK is an example.

The standards which companies pledge to observe do not stop at the gate of corporate headquarters but are intended for all their operations in all countries. Many companies apply standards to their supply chain management, clearly expecting other business partners they work with to uphold their codes.

A decision by Reebok not to sell footballs made with child labour was swiftly followed by similar commitments from other companies. This is happening despite the (short-term) costs such commitments entail. Still, good corporate practices bring commercial benefits too.

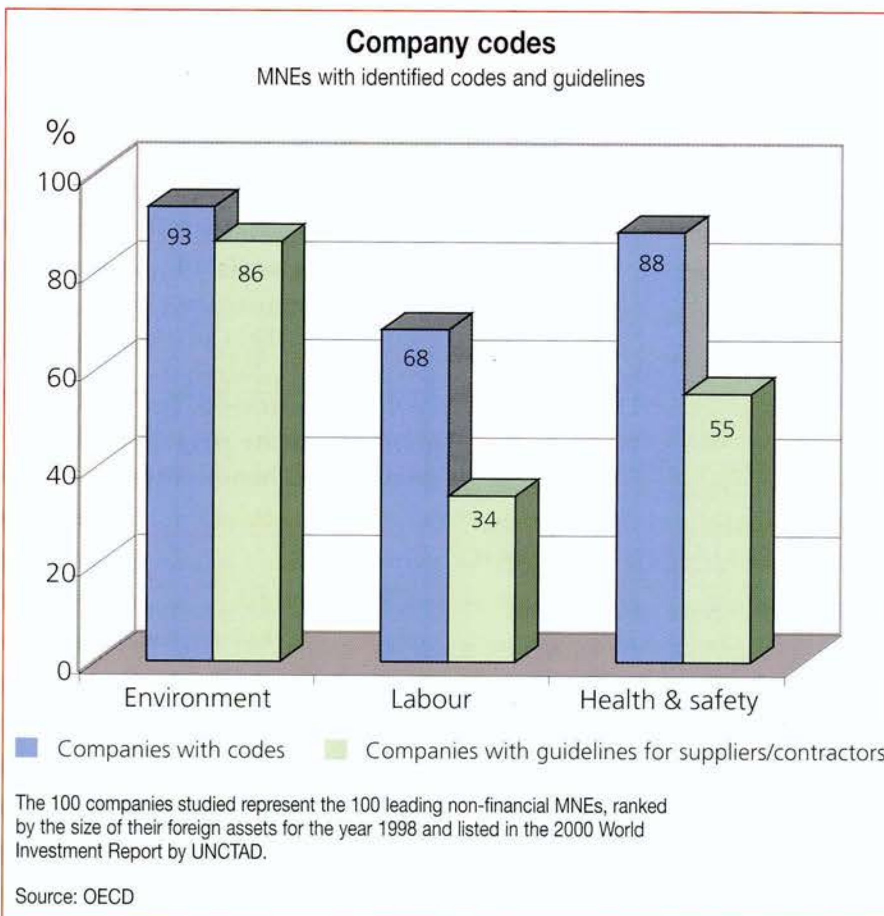
Supplier codes of this type are particularly prevalent in the retail and textile industries. Here, prospective suppliers and contractors are often screened for child labour abuse and may be asked to sign up to a code as part of any contractual arrangement. Chemical firms in the Responsible Care Initiative factor

environmental principles into their procurement decisions. Indeed, their suppliers must provide safety, health and environmental information on their products.

The economic weight of large companies helps them to shape the terms of employment, the quality of jobs and rights of workers, the quality of goods and services, health and the environment in many countries and regions around the world. Royal Dutch/Shell Group operates in more than 130 countries, General Electric manufactures in 100 and the mining activities of Rio Tinto cover all continents. If outsourcing policies are taken into account, their influence becomes more considerable still; in the automobile industry, materials and component suppliers account for more than 60% of the cost of the goods sold in most cases, and up to 90% for some companies in the electronics and electrical equipment industry.

The question is, are these codes worth more than the paper they are written on? Will voluntary initiatives lead to the types of changes needed to contribute to a cleaner environment and better working conditions, for instance? Some stakeholders are sceptical. First, whatever goals a company pledges to reach or standards to obey, like fair working conditions, they must have a specific, practical application. Without this, codes will set only the overall groundrules for corporate conduct. Turning intentions into action requires commitment from top management down.

A comparison of codes reveals discrepancies. One code may focus on a single labour issue (for example, a commitment not to use child labour, or a commitment to contribute to the elimination of its use as a long-term goal) while another contains a full set of core labour standards. And these standards can differ too. Some pledge to comply with local law, others commit to exceed legal requirements and others make explicit references to ILO conventions and other internationally recognised standards. This can confuse suppliers, putting them under pressure to meet often competing standards. It highlights a need for devising more consistent policy.



The 100 companies studied represent the 100 leading non-financial MNEs, ranked by the size of their foreign assets for the year 1998 and listed in the 2000 World Investment Report by UNCTAD.

Source: OECD

The toughest part about a code is implementation and enforcement. Its administration is a formidable task at the best of times. Nor is company behaviour always transparent and easy to monitor. In fact, many companies prefer to monitor compliance themselves rather than use independent inspection services. The trouble with that is, when companies come under pressure from consumers and the media to rectify violations, their credibility takes a knock.

But management practices are evolving. A number of organisations, ranging from global accounting and audit firms such as KPMG, Price Waterhouse Coopers, to more specialised monitoring firms like Bureau Véritas, and NGOs, now provide external verification services. Also, auditing and monitoring standards are being developed. A large and growing number of internationally active companies are engaged in the process of adopting standardised and certifiable ISO 14001 or EU environmental management systems. They also disclose information about their performance through health, safety and environmental reports. For labour issues, similar standardised management systems are under development, e.g. Social Accountability 8000; Global Reporting Initiative (see *OECD Observer* No. 226-227 or www.oecdobserver.org/GRI/).

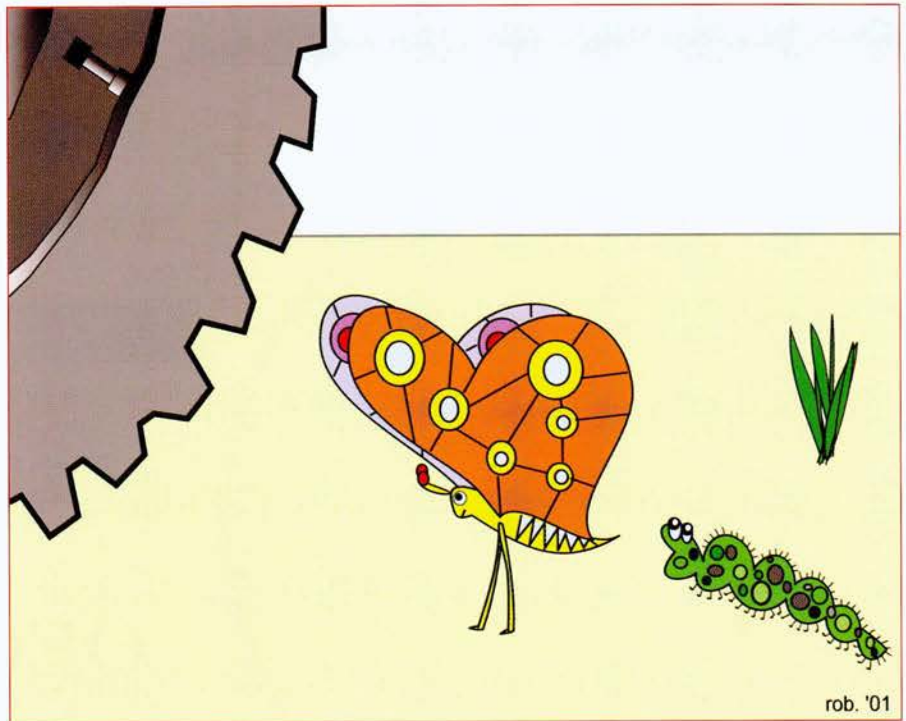
Another trend that appears to be increasing is dialogue and stakeholder participation. More and more companies are engaged in discussions with labour unions, environmental groups and other relevant stakeholders on various aspects of making voluntary initiatives effective. NGOs have provided expert advice, for example to retailers as they developed their approach to the problem of child labour in Pakistan's soccer-ball producing sector. They have participated in the

drafting of various model codes of conduct that can serve as general guidance for every company, regardless of sector (for example, CERES principles, SA8000). NGOs will continue to monitor and sponsor public relations campaigns against the activities of particular corporations, but direct stakeholder involvement may provide the best safeguard of proper implementation of and compliance with private codes and can help build up trust between companies and society.

There is also extensive government involvement in "voluntary" initiatives for corporate responsibility, both at the national level and through international organisations. The types of involvement include legal and regulatory incentives, tax expenditures, contribution to compliance expertise and so on. International norms and guidelines provide benchmarks which governments and businesses agree to, the Universal Declaration on Human Rights, the various protocols drawn up by the ILO and the OECD Guidelines for Multinational Enterprises being some examples.

Making a code fully operational takes years. Management systems are still in their infancy, which makes it hard to assess the effectiveness of these private initiatives. Clearly, the intense code activity of recent years has kept a spotlight on undesirable practices. There is some evidence that codes have reduced the number of children working in the Caribbean garment export industry. Also, it has been estimated that Responsible Care has reduced releases of toxic chemicals to the environment by almost 50%. At various times, companies have stopped doing business with overseas contractors who disregarded their standards and pulled out of countries where forced prison labour or violation of other fundamental human rights have been well documented.

However, such punitive measures can be counterproductive economically for the local communities (children may even be displaced to more hazardous industries) and do not help spread better practices. Remaining engaged with local contractors and working with them to improve their performance may in many cases be a better approach, as it reduces the risk of disruption and spurs development.



Codes were once largely a defensive response to accidents and scandals, like Bhopal in India, various oil spills and repeated discoveries of sweatshops in Asia. Often companies lead the way to improvement. A decision by Reebok not to sell footballs made with child labour was swiftly followed by similar commitments from other companies. This is happening despite the (short-term) costs such commitments entail.

Still, good corporate practices bring commercial benefits too. They help firms achieve a variety of goals – protecting corporate reputation, improving employee morale, enhancing consumer and client loyalty, and avoiding costly criminal and civil proceedings. Nike or The Body Shop brand themselves on their better practices (and even so, they have their detractors). Companies can strengthen their position on capital markets, for example, by being recognised by ethical investment funds, and even mainstream investors are now paying more attention.

So while some stakeholders feel that many companies just pay lip service to standards, these codes do in fact have "bite". Companies who do not practice what they pledge risk adverse publicity and losing customers, even black-listing. Codes used as marketing tools but not backed by action can have legal consequences. But we are still a long way from a level playing field in business codes which could ensure a fair deal for companies as well as for the people and environment of the host countries where they operate. ■

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Prepare for the global e-campus

Donald Hirsch, Policy consultant to the OECD Centre for Educational Research and Innovation

There has been much talk but precious little action about the coming of "virtual learning". This might be about to change, although challenges remain.

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Where's the teacher?

Log on to www.cardean.edu from anywhere in the world, and you can enrol in a business, management or accounting course from a university partnered by a consortium of prestigious institutions from Stanford to the London School of Economics. In the course of your studies, you will not have to leave your desk – because all of Cardean University's courses are fully online. This is the most respectable-looking of a new breed of virtual universities, whose prospectuses and student bodies are modest so far, but whose potential as multinational purveyors of learning is mind-boggling. Will we soon all be taking our degrees on the web? And does this mean that, 24 centuries after Plato's Academy, the days of the physical campus are numbered?

The 1990s witnessed plenty of talk and relatively little action, both about the coming of "virtual learning" and about the export of educational services. Many existing higher education institutions started to use electronic media to support their programmes, without changing their underlying structure. Truly virtual courses tended to be experimental, small scale or of dubious quality.

But representatives of OECD governments meeting with e-learning experts in Tokyo recently noted that in the past two years virtual learning has started to take off. It seems that three trends are converging to bring a global virtual education economy closer to reality.

First, the technical possibilities of the Internet and related technologies now make it possible to deliver high quality courses, largely or even entirely, online. Education observers have been impressed by the very high quality of the platform created by Cardean, albeit at enormous cost.

Second, radical changes in who participates in higher education, and why, have created pressure for equally radical change in what is provided, and how. Gone are the days when students were primarily a minority of the population in their late teens and early 20s, studying full-time for bachelor degrees. Universities in many countries have expanded part-time study, created new modes of off-site learning, often in partnership with business, and introduced more flexible forms of credit transfer. Yet existing universities still tend to be oriented around their long-established features: the campus, the faculty, the term or semester, the annual admission of a fresh batch of young undergraduates. The founding of entirely new institutions without recognisable campuses could herald a more fundamental shake-up.

Third, some countries are belatedly realising that international trade in educational services could become a significant force. The biggest component of such trade to date has been study overseas; now e-learning opens up new prospects of consumers who stay in their own countries and import a wide range of services from foreign suppliers. The US has placed the removal of trade restrictions in education on the table in the GATS negotiations on liberalisation of trade in services.

This intersection of technological, educational and trading developments is still a long way

Some 24 centuries after Plato's Academy, might the days of the physical campus be numbered?

from creating a serious threat to national education systems, even if each element of the mix is growing fast. Take e-learning. A survey last year found that 57% of Canadian universities already offer online courses, with 3 000 offered in total. In other countries only a minority do, but growth is rapid: only one in four Dutch universities currently provide electronic learning environments, but 90% say they have plans to do so.

The physical link between campus and student is already being broken. One in seven students enrolled at Australian universities are described as "external": attendance is incidental or voluntary. On the trade front, education is at least the fifth largest sector of internationally traded service in the US, yet most trade in educational services still involves physical travel by foreign students, while most e-learning remains domestic. The multinational virtual university remains a dream, of which Cardean is so far only a prototype.

Many national government representatives meeting in Tokyo were nevertheless worried about what lies ahead. The US is well positioned to export educational services – its student-testing industry, for example, has already become a serious international business – and there is little prospect of a threat to its own domestic provision from outside. But smaller countries fear cultural domination and loss of control over a service that governments regard as a crucial tool in influencing how their societies develop. Even the US has agreed that primary and secondary education will be off limits in GATS, but some countries worry too about foreign intrusion into degree or diploma courses at colleges and universities.

Looking ahead, several key issues would need to be resolved for exported e-learning to take off in a big way. Quality control and accreditation is crucial. Students need to know not just the intrinsic worth of the course they are buying, but also how it will be regarded, particularly by employers. Countries already accredit domestic institutions, and recognised national qualifications ensure that student learning is recognised and valued by others. All this becomes a lot harder when it comes to overseas providers, particularly those that have no physical presence in a country. International accreditation is in its infancy – one of the more prominent bodies with this mission, the Global Alliance for Transnational Education, has so far recognised only four institutions.

Another closely-related issue is protectionism. The GATS negotiations will need to confront a range of measures taken by countries to keep out education imports, including direct legislation and policy, refusal to recognise foreign credentials, telecommunications laws, and restrictions on movement of people. This means confronting a fundamental motivation: the desire to keep control of one's own education system.

Governments need to become clearer about exactly what public objectives they wish to retain for education systems, and recognise the huge scope for private services to be provided beyond this, whether from home or foreign suppliers.

A basic question about e-learning has to be answered before it can compete seriously with face-to-face study. Is it good value for money? Initially it was assumed that teaching thousands of people via intelligent software was bound to bring huge savings over using real teachers in classrooms. Today, it is widely recognised that study can only be effective if it includes some level of human interaction – whether by email or at least some direct contact between student and teacher. Moreover, the fixed cost of setting up a really high quality e-learning platform can be huge – Cardean's set-up costs were in the hundreds of millions of dollars. Therefore, the winners will be those who can sell services on a truly global scale. The need initially to tap premium revenue sources with courses such as MBAs and corporate management training may delay the day that virtual universities start to compete seriously with other provision for undergraduates.

Finally, issues of intellectual property are coming ever more to the fore. When in April 2001, MIT announced that it will be putting all of its course materials on the Internet, its stated aim was to counter a trend towards privatising knowledge. It also said that the materials were not in themselves courses; but those who do try to sell courses online may find it hard to protect their products from some forms of piracy. At best, this may help keep out products that simply dump materials on students without giving individualised support. But at worst it could limit the willingness of leading academics to sell their wisdom to online providers, fearing that endless duplication might devalue the currency of their own intellectual contribution, as well as that of the prestigious institutions where they teach.

Some 57% of Canadian universities already offer online courses. In other countries only a minority do, but growth is rapid.

The OECD's Tokyo meeting heard important warnings against "cyperbole": the tendency to exaggerate the degree to which electronic communications will change the world. E-learning is as far today from challenging campus education as educational imports are from threatening the far greater volume of within-border learning. Yet there is no doubt that both these phenomena exist and are growing rapidly. Education ministers are keen to keep a close eye on them: meeting in Paris earlier this year, they requested that the OECD monitor developments and report back. The eyes of many governments will be watching this space, whether with excitement or with trepidation. Cyperbole may have its merits: at least the issue is now seriously on the agenda. ■

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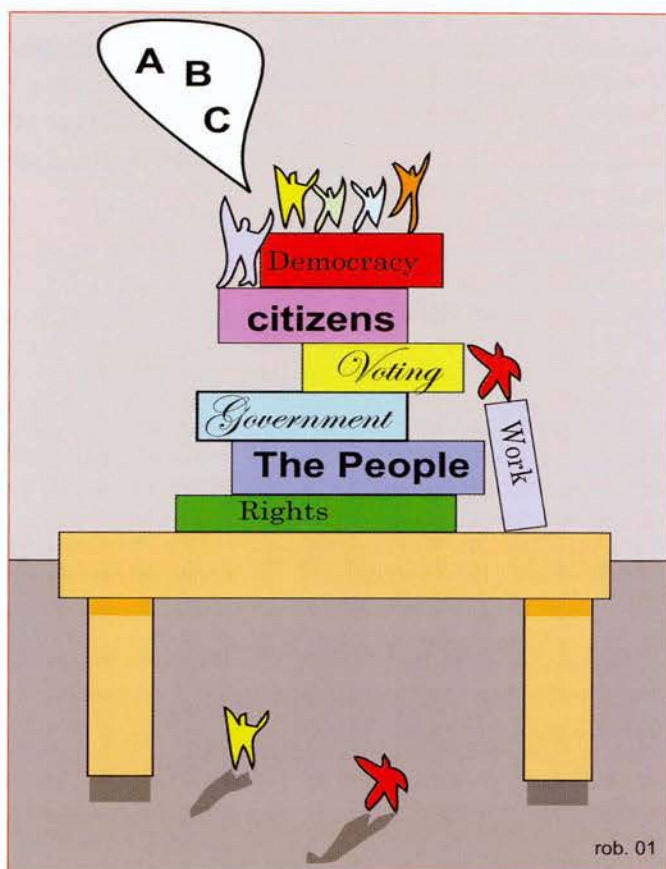
Why citizens are central to good governance

Joanne Caddy,
OECD Public Management Service (PUMA)

Participatory government, consultation and transparency are today's public policy buzzwords. It is time they became more than that.



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Strengthening the relationship between a government and its citizens might seem to be such an obvious priority for democracies that it hardly needs spelling out. Yet governments everywhere have been criticised for being remote from the people, not listening enough and not seeking participation. Street protests from Seattle to Genoa may have grabbed most of the headlines, but less spectacular developments have included a steady erosion of voter turnout in elections, falling membership in political parties in virtually every OECD country and declining confidence in key public institutions. In 2001, fewer than three in five people bothered to vote in the British general elections – fewer still turned out for a referendum on the French presidency. Calls for greater government transparency and accountability have grown as public and media scrutiny of government action increases. At the same time, new forms of representation and participation in the public sphere are emerging in all OECD countries.

The pressure is now on to spread consultation and participation to all areas of government, from budgeting to foreign policy.

Not that consultation and participation never happen, they do. But these efforts are too often focused on specific issues where public interest is already high, such as the environment or consumer protection, and have not been imitated enough throughout government as an integral part of the whole democratic and law-making process. Healthcare is another area where consultation and public participation appear to work well in several countries, for instance, with France's scrutinising public "juries", Canada's National Forum on Health and Denmark's patient advocacy groups. The pressure is now on to spread this type of consultation and participation to all areas of government, from budgeting to foreign policy. These new demands are emerging against the backdrop of a fast-moving, globalised world increasingly characterised by networks rather than hierarchy. Internet has opened up new frontiers in the independent production and exchange of information while providing a powerful tool for co-ordination among players on opposite sides of the globe. Businesses have been among the first to capitalise on this new reality, while international civil society has not been far behind. Governments have, in contrast, been slow to reap the benefits of a network approach to good governance and are only now discovering the advantages of engaging citizens and civil society organisations in shaping and implementing public policy.

Citizens as partners

Engaging citizens in policy-making allows governments to tap new sources of ideas, information and resources when making decisions. All fine in theory, but where to start in practice? While not having all the answers, a new OECD book, *Citizens as Partners*, has closely scrutinised the issues, a range of country experiences and throws some light on the way forward.

The current difficult political and economic climate has led to talk about the return of government. But it would be no good returning to old models of large, impenetrable institutions. Transparency and participation are more important than ever for democracy and stability.

The starting point is clear. To engage people effectively in policymaking, governments must invest adequate time and resources in building robust legal, policy and institutional frameworks. They must develop and use appropriate tools, ranging from traditional opinion polls of the population at large to consensus conferences with small groups of laypersons. Experience has shown, however, that without leadership and commitment throughout the public administration, even the best policies will have little practical effect.

The key ingredients for success in engaging citizens in policymaking are close to hand, including information, consultation and public participation. Information provided has to be objective, complete, relevant, easy to find and easy to understand. And there has to be equal treatment when it comes to obtaining information and participating in policymaking. This means, among other things, governments doing all they can to cater for the special needs of linguistic minorities or the disabled. Several OECD countries, including Canada, Finland and Switzerland, have laws ensuring that information is provided in all of the country's official languages.

The scope, quantity and quality of government information provided to the public has increased greatly over the past 20 years and legal rights to information are widespread among OECD countries. In 1980 only 20% of OECD countries had legislation on access to information, by 1990 the figure had doubled to over 40% and by the end of 2000 it had doubled again to reach 80%. But six OECD countries – Germany, Luxembourg, Mexico, Poland, Switzerland and Turkey – do not as yet have freedom of information laws.

Legal rights to consultation and active participation are less common. In some countries, such as Canada, Finland and Japan, the government is required to consult with citizens to assess the impact of new regulations. But it is not enough to inform in advance; if governments want people to invest their time in consultation, they must account for the use of that input in policymaking and explain their decisions afterwards.

But once these rights are in place, what then? Timing in public consultation is essential. Indeed, it should be as early as possible in the policy process. After all, people may well be more angry and frustrated at being asked for input when a decision has already been taken than if they had not been consulted at all. Early on in preparing its Freedom of Information Act, passed in 2000, the UK government conducted extensive public consultation and parliament received 2 248 comments on the draft bill. The UK is the latest among the OECD countries to introduce such an act.

Today, there are widespread efforts to put more government information online and open up arenas for online consultation, like the America Speaks citizens' electronic forum in the US, the UK's discussion and information portal, Citizen's Space, or Finland's Share Your Views With Us. All laudable initiatives, but they have their limits (not everyone is online for a start), so when it comes to feeding citizens' suggestions into policymaking, Internet is not enough on its own.

Clear roles

The respective roles and responsibilities of the government (making a decision for which it is held accountable and on which its performance may be judged) and the citizen (providing input for the decision-making process) must be clear too. Citizens are not government, they elect it and want to be served by it. But if they are to participate more than just via the ballot box, then they need proper access to information, meaningful consultation and opportunities to take an active part in policymaking.

The government must be clear from the start about its objectives in seeking the public's views, as well as being careful not to raise unrealistic expectations. As the questionnaire received from New Zealand noted, one of the most common reasons cited for a consultation failing is that it was "carried out for its own sake rather than to genuinely shape policy". Asking people vague questions about, say environmental quality, rather than asking the public to comment on the specific policy options available, like choosing between new railways or roads, only leads to public disillusionment. But people tend to accept the outcome of a fair process, even if it is not the solution they would have chosen. There is of course a danger that seeking public input too often may lead to consultation fatigue. By recognising that the time and effort citizens invest in being consulted by government is a precious resource, steps can be taken to improve co-ordination and avoid duplication across government units.

Building democracy

The current difficult political and economic climate has led to talk about the return of government, not just as regulator and arbiter, but as a key partner in free-market economies, as well as provider of security, emergency services and defence. But its role in promoting political and social cohesion in our civilisation has not been emphasised enough. In the present turmoil, the point should not be forgotten that the strength of democracy lies in having active and informed citizens. Governments can no longer afford to provide incomplete information or just ask the public its opinions on matters that are fait accompli.

And while reaffirming government's role is welcome, it would be no good returning to old models of large, impenetrable, secretive public institutions. Transparency, public consultation and participation are more important than ever to improve policy and reinforce democracy and stability. Promoting open and transparent government, while guaranteeing security, privacy and civil liberties, is a major challenge of our times. ■

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- A policy brief and practical handbook will be available free of charge on http://www.oecd.org/puma/citizens
- For more information on PUMA's work on government-citizen relations contact: joanne.caddy@oecd.org

Going to the source –

"An invaluable electronic resource for academic and research libraries", is how the American Library Association described **SourceOECD**, the new online platform for OECD publications and statistics, in its annual government publications awards in 2001. SourceOECD is indeed linking its way on to more and more library networks.

What is it? Well, broadly speaking, it is an online library. For a single annual fee, subscribers to SourceOECD can get unlimited access to all OECD published information on this internet portal, including 26 statistical databases.

Alternatively, subscribers can sign up to access individual periodicals, such as the twice-yearly *OECD Economic Outlook* and the monthly *Main Economic Indicators* database. The technology allows subscribers to sign up for everything or combinations of their choosing. The system is hosted by ingenta, a leading online aggregator (http://www.ingenta.com/), where OECD online publications can also be accessed.

The OECD is the first intergovernmental organisation to create such an integrated information portal to include its published periodicals, reports and databases.

SourceOECD has attracted more than 1 200 subscribers in 57 countries from around the world since its launch in January 2001. And new subscribers are even getting together to sign up. A Canadian consortium of eight francophone universities in Quebec has recently subscribed, and a similar venture is under negotiation in Scandinavia. "The take-up rate has exceeded our most optimistic projections," said Toby Green, the OECD's head of marketing. ■

For more information, please e-mail sourceoecd@oecd.org.
Visit www.sourceoecd.org

– as new main site launched –

Think of a theme, from ageing to trade, and the new OECD website will take you on a tour of the subject. The second-generation website offers thematic access to subjects and issues dealt with at the OECD as well as a new statistics portal, revamped newsroom, and improved search engine. And to keep you up to date there is MyOECD: just pick the subjects that interest you and you will receive free e-mail alerts to new information and publications on those themes. "The OECD's knowledge base and expertise are now fully accessible to the international community thanks to this new portal," says the OECD's secretary-general, Donald Johnston. "We are making strides towards our objectives of transparency, timeliness of information and customised service".

"The new OECD statistics portal provides a one-stop-shop for statistics and indicators that gives governments, institutions and citizens a unique facility for analysing key policy issues using reliable data sets," says the organisation's chief statistician, Enrico Giovannini. ■

The new website is at www.oecd.org

– and *OECD Observer* reaches new heights

OECD Observer online has consolidated its position in cyberspace. Since the start of 2000 it has been in the top 10 of Yahoo's popular business and economy magazines list and has been ranked second on the more scholarly Google economic journals list. Traffic has been rising by about 15% per month since 1999. Visits come from all over the world. The biggest single community of visitors has been US-based businesses, followed by educational institutions and government. After the US, Australia was the source of most visits in October, followed by the UK, Canada, Japan and Germany. Most non-OECD visits to the site came from Singapore, Malaysia, South Africa, Saudi Arabia, Brazil and Russia. ■

Visit www.oecdobserver.org

Number crunching

Keeping up to date with developments on the statistics front has been made easier by the new *OECD Statistics Newsletter*, bringing together statistical information from across the OECD. The new newsletter aims to offer statisticians, economists and other analysts interested in data a way to find and exchange relevant information, know more about current activities and future plans and reinforce co-operation between statistical agencies.

Each issue features articles on statistical developments, and highlights a database of the month with information on the content of a particular OECD database and advice on how to get the best out of it. The latest issue features the OECD health database and explains how the transition to the euro is being treated in OECD statistics. ■

Register for the *Statistics Newsletter* at: www.oecd.org/oecddirect or e-mail: std.statnews@oecd.org

Calendar of forthcoming events

Please note that many of the meetings mentioned are not open to the public and are listed as a guide only. All meetings are in Paris unless otherwise stated. For further information, consult the OECD website at http://www.oecd.org/media/upcoming.htm, which is updated weekly.

OCTOBER – Some highlights

15 **Biotechnology and Sustainable Development: Voices of the South and the North,** international conference sponsored by the Egyptian government. Cairo, Egypt.

17 **World Knowledge Forum in Seoul, South Korea.** An annual gathering of "new economy" thinkers. As knowledge is becoming the most powerful source for competitiveness, this year's topic is the digital divide.

17-18 **Global Forum on Competition,** organised by the Directorate for Financial, Fiscal and Enterprise Affairs (DAF). Top competition authorities of OECD member countries in dialogue with competition authorities of non-member economies.

25 **Tourism and Air Transport Roundtable,** organised by the Directorate for Science, Technology and Industry (STI).

25-26 **Regulation of Private Pensions in China,** workshop organised by the China Programme of the Centre for Co-operation with Non-Members (CCNM) and DAF. Beijing, China.

27-28 **Policies for Economic and Social Transition in the 21st Century,** forum organised by the OECD International Futures Programme.

29-30 **Electronic Commerce Business Impacts Project,** workshop co-organised by STI and the Italian Statistical Institute with the support of the Italian Banking Association.

29-30 **Money Laundering. Extraordinary plenary meeting of the Financial Action Task Force** to discuss further work on money laundering and terrorist activities. Washington, DC.

NOVEMBER

5-7 **Measuring Up: Improving Health Systems Performance in OECD Countries,** international high-level conference hosted by the Canadian government and organised by the Directorate for Education, Employment, Labour and Social Affairs (ELS). Ottawa, Canada.

6-7 **Modernising Government,** global forum on public governance organised by CCNM and the Public Management Service (PUMA).

9-13 **World Trade Organization ministerial meeting.**

10-13 **Competitiveness and New Technologies in Latin America and the Caribbean,** international forum on Latin American perspectives, organised by the Development Centre in co-operation with the Inter-American Development Bank. Madrid, Spain on 10 and 12 Oct. Paris on 13 Oct.

20 **OECD Economic Outlook No. 70,** publication of preliminary version. A twice-yearly analysis of the major trends that will mark the next two years, providing in-depth coverage of the economic policy measures required to foster high and sustainable growth in each member country.

20 **Aid Review of Germany.** The Development Assistance Committee (DAC) "peer reviews" monitor the efforts in OECD countries of development co-operation.

22-23 **Devolving Power to More Autonomous Public Bodies and Controlling Them: the Governance of Public Agencies and Authorities,** high-level conference organised by the Public Management Service (PUMA) and hosted by the Slovak Republic. Bratislava, Slovak Republic.

22-23 **Improving Governance for Sustainable Development,** seminar organised by PUMA. The focus is on policy integration, improving citizens' involvement and improving longer-term management for sustainable development.

26-27 **New Horizons and Challenges for Foreign Direct Investment in the 21st Century,** forum on international investment co-organised by the Mexico government and DAF. Mexico City, Mexico.

28-30 **The Environmental Impacts of Living Modified Organisms,** conference hosted by the US government and organised by the Environment Directorate (ENV) biotechnology programme. Raleigh, NC, USA.

28-30 **The Economics of Pesticide Risk Reduction in Agriculture,** workshop organised by ENV. Copenhagen, Denmark.

29-30 **Investment Promotion,** investor's seminar organised by CCNM/DAF, the Hellenic Centre for Investment, and the Croatian Ministry of Economy. Athens, Greece.

DECEMBER

3-4 **Institutional Responses to Changing Student Expectations: Europe and North America,** seminar organised by CERI.

5-6 **Ensuring Accountability and Transparency in the Public and Private Sectors,** Global Forum on Governance meeting organised by CCNM/PUMA. Brasilia, Brazil.

5-7 **Continuous Reporting System on Migration (SOPEMI),** annual meeting organised by ELS, to analyse recent trends in migration movements and policies in OECD countries as well as in certain non-member countries.

5-7 **Adult Learning Policy,** international conference organised by ELS and the Korean Research Institute for Vocational Education & Training. Seoul, Korea.

12 **Development Assistance Committee,** high-level meeting.

17-18 **The Steel Industry,** special high-level meeting organised by STI to address long-term issues and objectives, following up from a meeting between government and industry officials in October.

JANUARY 2002

21-22 **Telecommunications Policy for the Digital Economy,** conference organised by STI. The conference participants will discuss market opening and competition in providing telecom infrastructure and services. Dubai, United Arab Emirates.

24-25 **Genetic Inventions, Intellectual Property Rights and Licensing Practices,** meeting organised by STI and hosted by the German Ministry of Education and Research. Berlin, Germany.

28-30 **Territorial Development,** high-level conference organised by TDS, DATAR (Délégation à l'aménagement du territoire et à l'action régionale), and the Caisse des dépôts. Cité des Sciences et de l'industrie, Paris.

30 **The Inland Waterways of Tomorrow in Europe,** seminar organised by the European Conference of Ministers of Transport (ECMT).

31-5 Feb **World Economic Forum,** gathering of business and political leaders to address key economic, political and social issues. Davos, Switzerland.

FEBRUARY

7-8 **Foreign Direct Investment and Environment in the Mining and Forestry Sectors,** conference organised by ENV and DAF.

11-12 **Quality of Public Expenditure: Implementing Results-Focussed Management and Budgeting,** meeting organised by PUMA.

MAY

13-15 **OECD Forum 2002,** a public gathering of senior figures from governments, business, academia and civil society.

15-16 **OECD Council Meeting at Ministerial Level,** annual meeting of foreign affairs, finance, economy and trade ministers.

On their best environmental behaviour

Environmentally Related Taxes in OECD Countries: Issues and Strategies

There are a number of ways to influence environmental good conduct – one is to make sound practices profitable, another is to make bad practices taxable. This OECD report by environmental experts and fiscal specialists shows how.

Environmentally related taxes reinforce the "polluter pays principle", by which the costs of pollution are reflected in the price and output of goods and services that pollute. For instance, the US levies a "gas-guzzler" tax on cars that pollute heavily, varying between US$1 000 and 7 700 on the sale of energy-inefficient vehicles. Taxes on non-refillable beverage containers encourage recycling and reduce waste.

Over the past decade, most OECD countries have integrated environmentally related taxes into environmental policy, for several reasons. They are relatively easy to administer and may help tackle global warming, because they can provide incentives for both technological innovation and further reductions in polluting emissions. They also feed government coffers: revenue from environmentally related taxes averages roughly 2% of GDP in OECD countries, and 6% of total tax revenues.

Still, there are problems to overcome. Industry has been coddled with exemptions and rebates, for fear that the burden of extra fees and charges will drive companies to relocate to green-tax "havens". The result is that households and transport take the burden of most of these taxes.

Yet business should not be frightened by environmentally related taxes, and the report suggests several options for imposing them more effectively without reducing competitiveness. For instance, a two-tier rate structure, rather than the use of full exemptions, could be used, with lower rates for the more internationally exposed sectors.

In any case, while some businesses may become less competitive with a burden of green taxes, others, more benign, could be made more competitive. Ecological accountability can eventually be made profitable, so that industry is less taxing on the environment. ■

Visit the environment tax database at: www.oecd.org/env/tax-database
See also: http://www.oecdobserver.org/news/fullstory.php/aid/497.html

Sizing up red tape

Businesses' Views on Red Tape: Administrative and Regulatory Burdens on Small and Medium-sized Enterprises

Filling in government forms, filing official documents and sorting out red tape can be confusing, tedious and time-consuming. But imagine being asked to fill in a form about the administrators, rule-enforcers and bureaucrats themselves. This was the task set to the managers of 8 000 small and medium-sized businesses (SMEs) in 11 OECD countries, and their feedback is not merely paperwork.

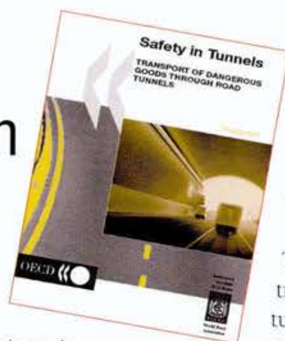
The survey asked businesses how easy or difficult it was to comply with employment, tax and environmental regulations and how much it cost them. It also questioned the efficiency of administrative decision-making, right down to personal contact, with true/false responses to statements such as: "Officials do not give definite answers"; "It is not clear who is responsible for decisions"; "One does not get the same view no matter who one contacts".

The findings confirm that government regulations and bureaucratic formalities have a significant impact on small and medium-sized businesses. SMES surveyed spend on average US$27 500 per year complying with administrative requirements. This equates to an average cost of US$4 100 per employee, or around 4% of the annual turnover of companies. And the smaller the firm is, the greater the hassle. The smallest companies – those with less than 20 employees – endured more than five times the administrative burden per employee than larger firms did. Small SMEs spend an average of US$4 600 per employee on paperwork, whereas SMEs with over 50 employees spend around US$900. Furthermore, small SMEs made eight times more requests for authorisations or decisions each year than larger SMEs.

Not surprisingly, around 80% of SMEs believed that compliance with employment regulations was bad for business. Many felt that employment regulations increased non-wage labour costs, and increased the difficulty of hiring and firing staff.

The point of the survey was to clarify for governments where its red tape was poorly designed or applied, whether it was inefficient or outdated, and whether it impeded innovation, trade and investment. Clearly, regulations are needed, not just to protect public interests but to allow markets to work properly too. But, as this reports shows, red tape may need to be less costly, streamlined and more transparent. ■

Improving tunnel vision



Safety in Tunnels: Transport of Dangerous Goods through Road Tunnels

Tunnel safety has been a major issue in recent years, with serious incidents at Mont Blanc and in Austria, not to mention the Channel tunnel fire. With advances in tunnelling technology and greater use of tunnels for road construction, the question is: how do we make our tunnels safer?

Take the transport of dangerous goods. A serious incident involving, say, explosive or toxic chemicals in a tunnel can be extremely costly in terms of loss of human lives, environmental degradation, tunnel damage and transport disruption. On the other hand, a blanket ban on carrying dangerous goods through all tunnels is unthinkable, since it may create unjustified economic costs. Moreover, bans can force operators to use more dangerous routes, such as those through towns and other populated centres.

The rules and regulations for the transport of dangerous goods in tunnels vary considerably among countries and even within countries. This contrasts with the transport of dangerous goods by open road, which are consistently regulated, often based on international model regulations. For tunnels, the definition of regulations, decision-taking, responsibility and enforcement are often left to local or provincial authorities, the tunnel owners, or "expert" opinions. The lack of general rules or regulations that are applicable to all road tunnels at the national level limits the capacity to assess risks and take action.

The OECD and the World Road Association have addressed these problems in this new study, which covers both regulatory and technical issues. For instance, a relatively simple system of grouping dangerous loads has been devised, which transporters could refer to when planning their route. Currently, transport operators have to refer to extensive lists of goods and quantities which are banned from individual tunnels. A quantitative risk assessment model has been developed to compare the risks involved in transporting dangerous goods through a tunnel, with the risks taken on alternative routes. In addition, extensive work was done to study the effectiveness of risk-reducing measures such as drainage, ventilation or fire detection systems.

One encouraging message is that, with the right management, tunnels have a good future. Improving incident prevention and construction techniques means they are increasingly safe and cost-effective for crossing difficult terrain, and also for traversing urban areas, reducing local environmental impact from roads and traffic. Road traffic using these tunnels (heavy goods in particular) is increasing, though, which makes the arrival of this new study all the more welcome. ■

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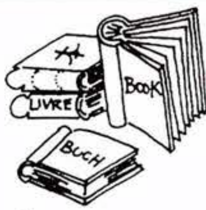

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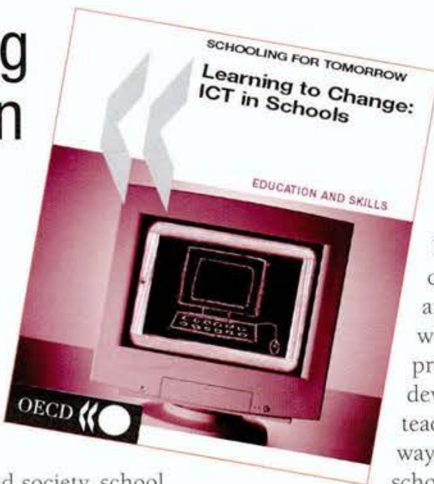
Rebooting education

Learning to Change: ICT in Schools



Learning your ABC is no longer enough; you can now add a D for digital, as well as an E for electronic. But while information technology has changed society, school has changed hardly at all.

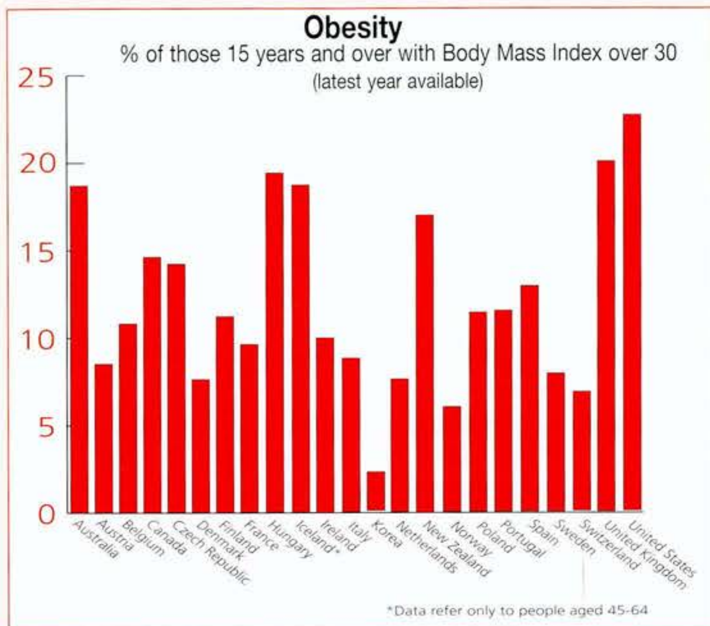
A US study showed that while 68% of teachers used the Internet to find resources for use in lessons, only 29% of students used the Internet in school. As schools stock up on computers and invest in Internet connections, how can teachers best use information and communications technology?

A starting point is classroom use of quality software and digital materials such as CD-ROM encyclopaedias and educational games. New forms of curriculum and testing are also called for, as well as updated professional development for teachers, and even new ways of organising schools.

Access to the Internet provides a richness and variety of resources that a conventional school library cannot hope to keep up with. Apart from straightforward research, NASA, for example, offers a suite of interactive projects allowing students to direct a telescope or chat with an astronaut or astronomer.

Access to the Internet provides a richness and variety of resources that a conventional school library cannot hope to keep up with.

On a Swedish site, "Science, Technics and Ethics", students plan a simulated island environment and see the consequences of their decisions. ICT is changing the professional role of teachers. A number of countries expect beginning teachers to have developed both ICT skills and pedagogical competence. In the Netherlands, teachers are required to obtain the European version of the International Computer Driving Licence. When the students they teach have grown up, this test will be obsolete. Today's children are the most computer-literate generation, but educators need to learn to tap into those skills and teach the "digital learner". ■



Weight of evidence

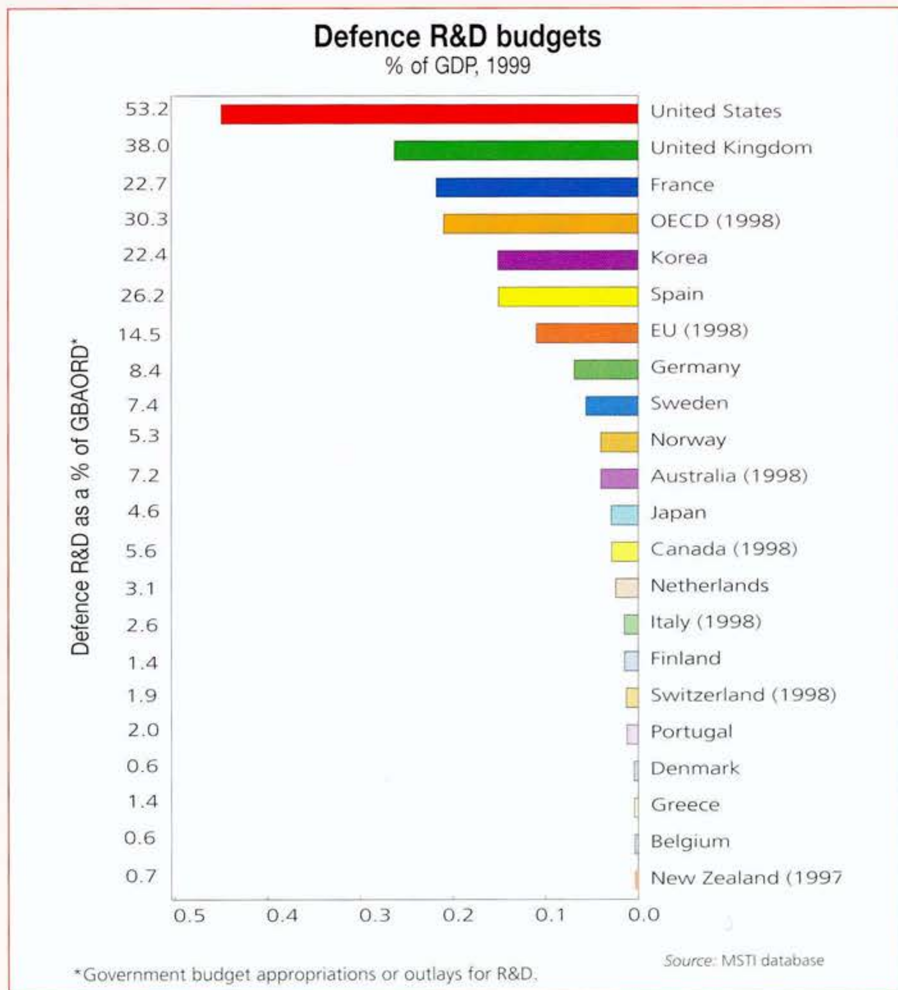
General health in OECD countries may be improving in many areas, but not when it comes to obesity, which is rising fast almost everywhere. But levels vary enormously, from 25.1% of women classified as obese in the United States at the top of the list to just 1.6% of Korean men at the other end of the scale. Obesity levels have risen sharply in recent years, particularly in countries such as Australia, where 7.1% of those over 15 were obese in 1980 and 18.7% in 1995, and the UK, where the level rose from 7% in 1980 to 20% in 1999. Obesity is more common among women than among men in two-thirds of OECD countries, and such problems also tend to be more common in lower socio-economic groups. ■

Health at a Glance, OECD, 2001.

Research spending

Cell phones, satellite tracking and high-resolution cameras are not cheap to come by, but happily for the industries that use them, costs for their development have been partly picked up by defence budgets. More than half of the US government budget for research and development is spent on defence. The UK defence R&D budget is more than a third of total government spending on research, and for France and Spain, this spending is around a quarter of the total. In 1999, US spending on defence R&D was 0.45% of GDP, and the UK and France were the next in rank, at 0.26% and 0.22% respectively. In 1998, these three countries accounted for almost 90% of total OECD-area spending in defence R&D. The US accounted for almost 80%, and France and the UK accounted for 6% each, with Korea and Spain not far behind. That said, for the last decade military spending in OECD countries has been steadily declining. Research and development followed this trend, with the biggest decreases in Sweden by 0.23%, the US by 0.21%, and France by 0.20%. ■

Science, Technology and Industry Scoreboard: Towards a Knowledge-Based Economy, OECD, 2001.



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			previous period	previous year			current period	same period last year
Australia	Gross domestic product	Q2 01	0.9	1.4	Current balance	Q2 01	-1.79	-4.44
	Leading indicator	Aug. 01	1.5	4.2	Unemployment rate	Aug. 01	6.8	6.1
	Consumer price index	Q2 01	0.8	6.0	Interest rate	Aug. 01	4.95	6.49
Austria	Gross domestic product	Q2 01	-0.5	0.9	Current balance	July 01	-1.40	-0.99
	Leading indicator	Aug. 01	-0.2	-3.5	Unemployment rate	Aug. 01	3.9	3.6
	Consumer price index	Aug. 01	-0.2	2.5	Interest rate*		. .	. .
Belgium	Gross domestic product	Q1 01	0.5	2.5	Current balance	Q1 01	3.29	3.84
	Leading indicator	Aug. 01	0.5	-5.8	Unemployment rate	Aug. 01	6.8	6.9
	Consumer price index	Sep. 01	0.3	2.3	Interest rate*		. .	. .
Canada	Gross domestic product	Q2 01	0.0	2.1	Current balance	Q2 01	5.58	3.35
	Leading indicator	Aug. 01	0.1	-5.9	Unemployment rate	Aug. 01	7.2	7.1
	Consumer price index	Aug. 01	0.0	2.8	Interest rate	Sep. 01	3.49	5.84
Czech Rep.	Gross domestic product	Q2 01	. .	3.9	Current balance	Q2 01	-0.55	-0.36
	Leading indicator		. .	. .	Unemployment rate	Q2 01	8.2	9.0
	Consumer price index	Aug. 01	-0.1	5.6	Interest rate	Sep. 01	5.41	5.34
Denmark	Gross domestic product	Q2 01	0.6	1.3	Current balance	July 01	0.35	0.43
	Leading indicator	Aug. 01	0.8	-1.6	Unemployment rate	Aug. 01	4.3	4.6
	Consumer price index	Aug. 01	0.0	2.5	Interest rate	Aug. 01	4.57	5.65
Finland	Gross domestic product	Q2 01	-1.7	0.4	Current balance	July 01	0.79	0.94
	Leading indicator	Apr. 01	-1.4	-17.0	Unemployment rate	July 01	9.0	9.6
	Consumer price index	Aug. 01	0.1	2.4	Interest rate*		. .	. .
France	Gross domestic product	Q2 01	0.3	2.3	Current balance	June 01	3.36	3.32
	Leading indicator	Aug. 01	-0.9	-6.5	Unemployment rate	Aug. 01	8.5	9.3
	Consumer price index	Aug. 01	0.0	1.9	Interest rate*		. .	. .
Germany	Gross domestic product	Q2 01	0.0	0.6	Current balance	July 01	-2.68	-2.52
	Leading indicator	Aug. 01	-0.1	-5.4	Unemployment rate	Aug. 01	7.9	7.8
	Consumer price index	Aug. 01	-0.2	2.6	Interest rate*		. .	. .
Greece	Gross domestic product	1999	. .	3.4	Current balance	June 01	-0.63	-0.69
	Leading indicator	July 01	0.7	1.0	Unemployment rate		. .	. .
	Consumer price index	Aug. 01	0.1	3.8	Interest rate*		. .	. .
Hungary	Gross domestic product	1999	. .	4.2	Current balance	July 01	0.16	0.01
	Leading indicator		. .	. .	Unemployment rate	Q1 01	5.8	6.5
	Consumer price index	Aug. 01	-0.2	8.7	Interest rate	Aug. 01	10.76	10.60
Iceland	Gross domestic product	1999	. .	4.3	Current balance	Q2 01	-0.12	-0.26
	Leading indicator		. .	. .	Unemployment rate	July 01	1.2	1.3
	Consumer price index	Aug. 01	0.3	8.0	Interest rate	July 01	10.95	11.40
Ireland	Gross domestic product	2000	. .	11.5	Current balance	Q1 01	-0.78	-0.07
	Leading indicator	July 01	-1.6	-9.7	Unemployment rate	Aug. 01	3.8	4.1
	Consumer price index	Aug. 01	0.3	4.6	Interest rate*		. .	. .
Italy	Gross domestic product	Q2 01	0.0	2.1	Current balance	June 01	0.52	-1.84
	Leading indicator	Aug. 01	0.1	-0.8	Unemployment rate	July 01	9.4	10.4
	Consumer price index	Sep. 01	0.0	2.6	Interest rate*		. .	. .
Japan	Gross domestic product	Q2 01	-0.8	-0.7	Current balance	July 01	6.22	10.00
	Leading indicator	Aug. 01	-0.5	-2.6	Unemployment rate	Aug. 01	5.0	4.6
	Consumer price index	Aug. 01	0.4	-0.7	Interest rate	Sep. 01	0.03	0.35
Korea	Gross domestic product	Q2 01	0.5	2.7	Current balance	Aug. 01	-0.11	0.89
	Leading indicator		. .	. .	Unemployment rate	Aug. 01	3.6	3.9
	Consumer price index	Sep. 01	0.0	3.2	Interest rate	Aug. 01	4.90	7.00

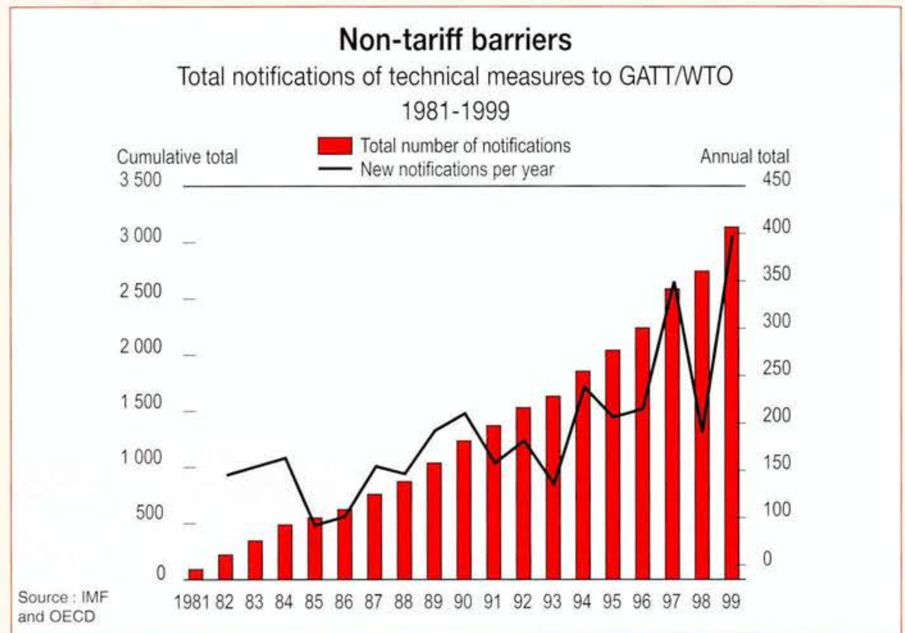
			% change from:				level:	
			previous period	previous year			current period	same period last year
Luxembourg	Gross domestic product	2000	. .	8.5	Current balance		. .	. .
	Leading indicator	Aug. 01	0.4	-7.5	Unemployment rate	Aug. 01	2.5	2.5
	Consumer price index	Aug. 01	1.2	2.8	Interest rate*		. .	. .
Mexico	Gross domestic product	Q2 01	0.1	0.0	Current balance	Q2 01	-3.37	-3.56
	Leading indicator	Aug. 01	4.3	4.6	Unemployment rate	Aug. 01	2.3	2.2
	Consumer price index	Aug. 01	0.6	5.9	Interest rate	Aug. 01	8.54	15.71
Netherlands	Gross domestic product	Q2 01	0.4	1.5	Current balance	Q2 01	3.88	4.12
	Leading indicator	July 01	0.2	-2.0	Unemployment rate	July 01	2.2	2.9
	Consumer price index	Aug. 01	0.3	4.7	Interest rate*		. .	. .
New Zealand	Gross domestic product	Q2 01	1.9	2.9	Current balance	Q2 01	-0.12	-0.60
	Leading indicator		. .	. .	Unemployment rate	Q2 01	5.2	6.1
	Consumer price index	Q2 01	0.9	3.2	Interest rate	Sep. 01	5.57	6.66
Norway	Gross domestic product	Q2 01	0.1	1.4	Current balance	Q2 01	5.85	4.59
	Leading indicator	July 01	-0.7	-1.9	Unemployment rate	Q2 01	3.4	3.2
	Consumer price index	Aug. 01	-0.1	2.7	Interest rate	Sep. 01	7.14	7.33
Poland	Gross domestic product	2000	. .	4.0	Current balance	May 01	-0.74	-0.41
	Leading indicator		. .	. .	Unemployment rate	July 01	16.1	14.3
	Consumer price index	Aug. 01	-0.3	5.0	Interest rate	Sep. 01	13.77	17.65
Portugal	Gross domestic product	Q1 01	-0.1	2.2	Current balance	Q2 01	-2.71	-3.15
	Leading indicator	July 01	-0.5	1.5	Unemployment rate	Aug. 01	4.4	4.2
	Consumer price index	Aug. 01	-0.2	4.0	Interest rate*		. .	. .
Slovak Republic	Gross domestic product	Q2 01	..	2.8	Current balance	June 01	-0.20	-0.05
	Leading indicator		..	..	Unemployment rate	Q1 01	19.3	18.9
	Consumer price index	Aug. 01	-0.1	7.8	Interest rate	July 01	8.80	10.80
Spain	Gross domestic product	Q2 01	0.5	2.9	Current balance	June 01	-2.32	-1.01
	Leading indicator	July 01	-0.5	0.1	Unemployment rate	Aug. 01	13.0	13.9
	Consumer price index	Aug. 01	0.2	3.7	Interest rate*		. .	. .
Sweden	Gross domestic product	Q1 01	0.5	2.2	Current balance	July 01	0.20	0.65
	Leading indicator	July 01	-0.8	-5.3	Unemployment rate	Aug. 01	4.7	5.8
	Consumer price index	Aug. 01	0.3	2.8	Interest rate	Sep. 01	4.01	3.94
Switzerland	Gross domestic product	Q2 01	0.4	2.1	Current balance	Q2 01	6.11	7.44
	Leading indicator	Aug. 01	-1.5	-3.1	Unemployment rate	Aug. 01	1.8	1.9
	Consumer price index	Aug. 01	-0.6	1.1	Interest rate	Aug. 01	3.10	3.38
Turkey	Gross domestic product	Q2 01	. .	-9.3	Current balance	Q2 01	1.07	-3.27
	Leading indicator		. .	. .	Unemployment rate	Q2 01	6.9	6.2
	Consumer price index	Aug. 01	2.9	57.5	Interest rate	Sep. 01	59.03	47.44
United Kingdom	Gross domestic product	Q2 01	0.4	2.3	Current balance	Q2 01	-5.54	-10.00
	Leading indicator	Aug. 01	0.0	-0.1	Unemployment rate	June 01	5.1	5.4
	Consumer price index	Aug. 01	0.4	2.1	Interest rate	Aug. 01	4.92	6.13
United States	Gross domestic product	Q2 01	0.1	1.2	Current balance	Q2 01	-106.50	-108.13
	Leading indicator	Aug. 01	-1.1	-5.7	Unemployment rate	Aug. 01	4.9	4.1
	Consumer price index	Aug. 01	0.0	2.7	Interest rate	Sep. 01	2.87	6.60
Euro zone	Gross domestic product	Q2 01	0.1	1.7	Current balance	July 01	-3.53	-2.35
	Leading indicator	Aug. 01	-0.2	-4.0	Unemployment rate	Aug. 01	8.3	8.8
	Consumer price index	Aug. 01	0.1	2.8	Interest rate	Sep. 01	3.98	4.85

Definitions and notes

Gross domestic product: Volume series, seasonally adjusted except for Czech Republic, Slovak Republic and Turkey; ***Leading indicator:*** A composite indicator, based on other indicators of economic activity (employment, sales, income, etc.), which signals cyclical movements in industrial production from six to nine months in advance; ***Consumer price index:*** Measures changes in average retail prices of a fixed basket of goods and services; ***Current balance:*** $ billion; not seasonally adjusted except for Australia, the United Kingdom and the United States; ***Unemployment rate:*** % of civilian labour force – standardised unemployment rate; national definitions for Iceland, Korea, Mexico, Poland, Switzerland and Turkey; seasonally adjusted apart from Slovak Republic and Turkey; ***Interest rate:*** Three months, except for Turkey (overnight interbank rate); . . not available; *Refer to Euro zone. **Source:** ***Main Economic Indicators***, OECD Publications, Paris, October 2001; Quarterly National Accounts database.

Invisible barriers

Non-tariff measures are an increasingly thorny issue in agricultural trade. The key question is when a non-tariff measure – quotas or anti-dumping measures, for example – is a legitimate action and when it is an attempt at protectionism in disguise. One thing is clear: the number of non-tariff measures applied by GATT/WTO members has risen steeply in the past 20 years, with new notifications rising from less than 200 in 1995 to about 400 in 1999, after countries began to implement their Uruguay Round commitments. But at least some of this increase is due to more transparency because of more extensive rules on the notification of new non-tariff measures. High-income countries notified the largest number of new technical measures over 1995-1999, although they account for a relatively small proportion of total WTO membership. ■

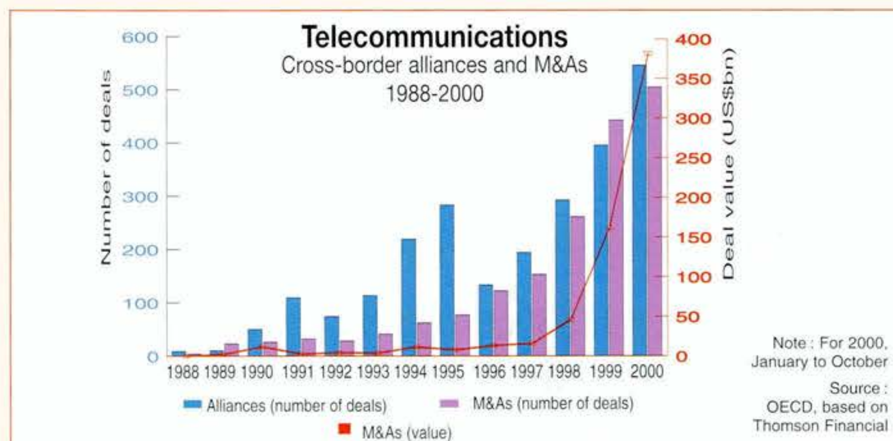


Agricultural Policies in Emerging and Transition Economies: Special Focus on Non-Tariff Measures, OECD, 2001.

Making connections

The telecommunications sector is the best example of how rapid technological developments, in combination with regulatory reform, both enable and force companies to seek new partners across national and technical borders. As deregulation has opened up national telecom markets to foreign competitors and as technological advances have made possible even global communication services, large telecom operators, many of them former national monopolies, have become global operators by acquiring and forming alliances with local (regional) telecom companies. Many telecom operators have pursued dual strategies: intra-regional (full) mergers as a way to enter neighbouring markets and inter-regional alliances to enter the markets in other regions, where they know less.

As a consequence, both cross-border alliances and M&As have continued to rise since the middle of the 1990s, and especially the latter has accelerated in recent years. While the 1 300 international alliances in the latter half of the 1990s were only twice the number in the first half, the 1 055 cross-border M&As in the second half of the decade were more than five times the number in the first half. The deal value of M&As in the latter half of the 1990s (US$244.3 bn) is more than seven times that of the first half (US$34.1 bn). Telecom carriers' recent focus is on wireless communications: acquisitions of regional mobile telecom operators have been prominent, for example, France Telecom's US$45.9 bn takeover of Orange PLC (UK) in August 2000. ■



New Patterns of Industrial Globalisation: Cross-border Mergers and Acquisitions and Strategic Alliances, OECD, 2001.

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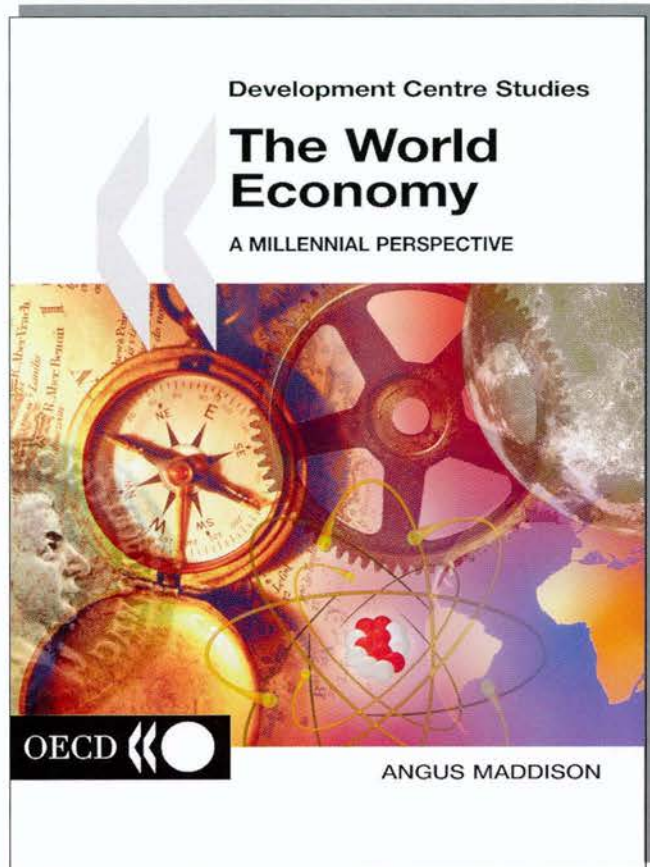

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