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Labour/Management Programme

ACCESS TO HEALTH CARE IN AN AGEING SOCIETY

Report on a meeting of management experts held under the OECD Labour/Management Programme

Paris, 18 September 2002

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OECD LABOUR/MANAGEMENT PROGRAMME

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Report on a meeting of management experts
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(Paris, 18 September 2002)

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FOREWORD

Under the OECD Labour/Management Programme for 2002, a meeting of management experts on "Access to Health Care in an Ageing Society" was held in Paris on 18 September 2002. The meeting was prepared in collaboration with the Business and Industry Advisory Committee to the OECD (BIAC).

Below, you will find the Agenda of this meeting, along with the Discussion Paper and the overall report of the discussions of the meeting of experts, which were both prepared by Mr. Paal Frisvold, designated as General Rapporteur for this activity.

**THE OPINIONS EXPRESSED AND ARGUMENTS EMPLOYED IN THIS REPORT
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AGENDA

I- Introduction

- *Carlo Castellano* - Opening by the Chair of the meeting
- *Paulette Guinchard-Kunstler*, Vice President, French National Assembly
- *Orio Giarini*, The Geneva Association

II- Ageing societies & health-related innovation

- Ageing-related diseases
- Overview of the OECD project on ageing-related diseases
- *Stéphane Jacobzone*, *OECD DELSA*

BIAC perspective :

- *Helena Brus*, Chair, USCIB Health Care Policy Working Group
- *Daniel Whitaker*, *N/E/R/A*

Discussion

III- Related innovation: products, hospital services, processes

- Overview of the OECD Project on New and Emerging Health-Related Technologies
- *Kees Vangool* (OECD DSTI)

BIAC perspective:

- *Machiel Nuyten*, Confederation of Netherlands Industry and Employers VNO-NCW
- *Alain Sommer*, Chair of the BIAC Task Force on Health Care Policy
- *Stefano Olgiati*, Gruppo Ospedaliero San Donato

Discussion

IV- Directions in long term-care policy and reform

- Overview of the OECD project on long-term care
- *Manfred Huber* (OECD DELSA)

Health insurance & new solutions to financing

- Overview of OECD project on private health insurance
- *Nicole Tapay* (OECD DAFPE)

New solutions to financing:

- *Jim Rice*, International Health Summit
- *Floris Goyens*, BVVO – UPEA

DISCUSSION PAPER

by
Paal Frisvold, Managing Director of the Brussels Office, SPRL
(Belgium)

I. INTRODUCTION

1. The health sector is of vital importance to the OECD economies. In recognition of this pivotal role and in order to better understand the interdisciplinary nature of the various actors involved, the OECD has created a horizontal three-year Health Project combining the work of DEELSA, DSTI, DAFFE, and ECO. As part of the Health Project, these directorates have undertaken a number of projects that are at various stages of completion. This LMP-meeting will briefly present three examples of work from these Directorates:

- Ageing-related diseases project by DEELSA
- Impact of new and emerging health-related technologies by DSTI
- Private health insurance component by DAFFE, in co-operation with DEELSA

2. When looking at these projects one must bear in mind the unique role of the OECD to provide advice to its Member governments based on sophisticated economic analyses. The special recognition of the need to study the role of the health care sector in the economies of the OECD countries requires the development of new concepts in comparative analysis and statistics. These new concepts in turn would permit a more integrated view of how to reconcile the societal need for justice and security of health care provision for all with the need to support and stimulate innovation that often is health care related.

3. Collecting data and information is a vital and indeed a prerequisite for presenting objective and knowledge-based guidance to decision-makers. This task is even more complex when information is to be produced in a form that allows the OECD (and increasingly non-member governments) to compare and to draw conclusions that transcend any one country or region and acknowledge that we face a global nature of innovation even though it has to be adapted to local needs and based on local cultural terms.

4. The goal of this LMP meeting is to provide the business and industry perspective to the specific projects included in the exercise of the OECD Health Project. Members of BIAC are particularly well-placed to partner with the governments and through the OECD in the reforms needed to assure both the health care societal goals and the financial and industrial capabilities to sustain them. As large employers, BIAC members are vitally concerned about the efficient functioning of the health insurance systems so that they would be faced with health and productive labour force. As taxpayers and/or insurance contributors, they also bear the costs of the total bill for health care. Yet as producers of health-related products, services and medical knowledge, business and industry provide the engine of economic growth of the OECD economies based on the innovative output.

5. One of the most important questions is how could the OECD break through the existing impasse on the matters concerning the future of health and social systems and the economies that both need and sustain them in view of demographic and social changes? Does the fragmentation of comparable data prevent us from drawing much awaited policy conclusions? If so, what research methods can be used to produce advice on political

trade-offs with vast implications for the functioning of the health care systems and beyond?

6. It has become a cliché to claim that "ageing" society obviously represents a strain on the welfare economy as older people tend to demand more health care services than the young. However, it is the contention of our distinguished introductory speaker, Dr. Giarini, that viewing average calendar age as a criterion of "workforce" estimation is flawed and unhelpful. Perhaps not all, but many individuals beyond the traditional "retirement" age will and should be counted on as workers supporting those who are young or prematurely disabled. It also means that more people will be able to extend their professional career. Being professionally active is good for a person's well being. It can also provide governments with much needed additional contributors to financing health care system. But it is unlikely that these changes can be achieved through the "one-fit-all" policy measures concentrated in labour market measures or retirement or health care only. Is the social policy, health and retirement schemes designed to allow the individuals who are older to remain professionally active as long as they wish?

7. One of the primary reasons why the society is ageing is the continued economic advancement and the progress in medical science leading to life-prolonging and life-enhancing innovation. Given that older people would not be just idle retirees, this medical progress is good. However, our statistical tools have lagged behind our intuitive notion that health improvements are constantly registered not only in the OECD, but also in the non-OECD countries.

8. What we seem to measure is health care expenditure of its various industrial segments such as pharmaceuticals, diagnostics, hospitals, physician and nursing care. In response to public concerns in different countries, there are outcries about increasing prices of these components where they impact the general public. This could take a form of the new tax as in the UK, or in higher insurance premiums, or the high payment for a new item such as a drug or a test that is not covered by health insurance. There is increasingly a need for the government and the general public to understand whether the rising costs are purely inflationary or whether there are some structural changes in the expenditure on health care that reflects a better way of doing things, as measured ultimately by the recipients themselves. The OECD is perhaps the only economic think-tank that could lead the way in seeking this better understanding of the current phenomena and advising the governments based on facts.

II. AGEING SOCIETIES AND HEALTH-RELATED INNOVATION

i) DEELSA's Ageing-Related Diseases Project

9. Do governments currently have sufficient basis to judge the effects of medical innovation on health? Could "best practices" with respect to major ills of the OECD populations be developed by the OECD based on the current knowledge and comparative statistics?

10. Based on the ARD project, could the OECD recommend a more disaggregated conceptual approach to the analysis of total health care expenditure? Would a look at the major disease areas help us discern what has gone into treatment of major diseases by distinguishing what was done from how much it all cost?

ii) Health-related innovation: products, hospitals services, processes

11. What are the emerging new technologies in health care and what is their nature (global, products, services?). How do they stack against the need to equip people according to their health and work needs and regardless of their calendar age?

What are the greatest barriers to diffusion of the emerging innovation? What are the new elements,

unknown in the 80's and the 90's? Do we have the tools to cope?

Given the experience with the economic evaluation methods of pharmaceuticals and diagnostics, what additional drawbacks can be foreseen in the future for more individualised medical products and services?

How can the OECD data account better for the innovative effort in health-related areas while accounting for the outcome improvements?

How could incentives be provided for research on the neglected markets: either large or poor populations with enormous medical needs of social import or small affluent OECD populations with rare diseases (such as children across the developed world, e.g. orphan drugs).

III. HEALTH INSURANCE AND NEW SOLUTIONS TO FINANCING

12. Financing of health care was designed in a different demographic context – at a time with considerably fewer products at lower cost as well as fewer diseases. Today, despite higher incomes, under the traditional retirement cut-off point, there are clearly fewer people to finance a much larger demand combined with a substantially higher number of novel products at a higher price.

13. Both the 'solidarity' system of Europe and the 'private insurance based' model in the US are experiencing strains because of rising expectations and continuing budget constraints. It is suggested that part of the solution is for governments to act more as catalysts and regulators rather than providers of services. This poses a number of questions:

- What do we mean by integrating public and private providers of health care services?
- What are the policies needed to allow private and public health insurers compete on equal terms? How would such a scheme function in practice?
- What are the possible social costs involved in this? How can policies be designed to allow for an equal participation of private insurers without copying the undesirable effects of the US?

14. However, for insurance to work hand-in-hand with the needs of a new "mature" society, the insurance product needs to be far more individualised and far more integrated with the ability of a given person to continue productive activity regardless of calendar age.

15. Should the governments re-examine the social purpose of health insurance under the new demography? Is the insurance efficient in redistributing funds during the life cycle of a person? Is European "solidarity" too much based on the uniform approach to age as a cut-off point? Is the American system too unconcerned about stability? What incentives could be created that would maintain the stability and redistribution but would encourage good health and long productive lives?

FINAL REPORT ON THE MEETING

by
Paal Frisvold, Managing Director of the Brussels Office, SPRL
(Belgium)

I. INTRODUCTION

1. The health sector is of vital importance to OECD economies. In recognition of this pivotal role and the multidisciplinary nature of the policy challenges, the OECD launched a three-year Health Project involving the Directorate for Employment, Labour and Social Affairs (ELS), the Directorate for Science, Technology and Industry (STI), the Directorate for Fiscal, Financial and Enterprise Affairs (DAF) and the Economics Department (ECO). This meeting included presentations of three elements of this work: ageing-related diseases project by ELS; impact of new and emerging health-related technologies by STI; and private health insurance by DAF, in cooperation with ELS.
2. The OECD has a unique role in providing advice to its Member governments based on multidisciplinary economic analysis. The health care sector in the economies of the OECD countries requires the development of new concepts in comparative analysis and statistics. These new concepts in turn would permit a more integrated view of how to reconcile the societal need for justice and security of health care provision for all, with the need to support and stimulate innovation that is indispensable to the satisfaction of the health care needs.
3. Collecting data and information is vital and indeed a prerequisite for presenting objective and fact-based guidance to decision-makers. This task is even more complex when information is to be produced in a form that allows the OECD (and increasingly non-member) governments to compare and to draw conclusions that acknowledge the global nature of innovation, which must at the same time be adapted to local needs in a local cultural context.
4. The Chairman of this meeting, **Dr. Carlo Castellano**, defined the meeting's goal as to provide the business and industry perspective on several of the specific projects of the OECD Health Project. BIAC members can provide sound practical advice on the reforms needed to assure both health care societal goals, and the financial and industrial capabilities to sustain them. Strengthened dialogue between policy-makers and market actors can help identify policy tools that can provide better incentives for efficient delivery and innovation, with the organisation of appropriate insurance coverage.

II. AGEING SOCIETIES AND HEALTH-RELATED INNOVATION

5. One of the most important questions is the challenges for the future of health and social systems in view of prospective demographic and social changes. Does the fragmentation of comparable data prevent us from drawing the necessary policy conclusions? If so, how can we produce policy recommendations on the political trade-offs which have vast implications for the functioning of the health care systems and beyond?

6. It has become a cliché to claim that ageing societies represent a strain on the welfare economy as older people tend to demand more health care services than the young. However, according to **Dr. Giarini**, many individuals beyond the traditional retirement age are capable of working and “supporting” retirees. With increasing life expectancy and improving health conditions, more people will be able to extend their professional career. Being professionally active can also be good for a person’s well-being. It can provide governments with much-needed additional contributors for financing health care systems. But it is unlikely that the policy changes to enable people to work longer can be achieved through “one-size-fits-all” policy measures in the labour market or retirement or health care areas. How can social policy, health and retirement schemes be designed to allow older workers to remain professionally active as long as they wish?

7. As Dr. Giarini put it in his “Letter to everyone who is or will turn 65”, treating ageing societies as one of the major problems of our time is like attempting to drive a car with your eyes glued to the rear-view mirror. Conventional thinking in this area is looking at the problem from the wrong angle. Ageing societies can in fact be part of the solution, rather than the problem, in the view of **Ms. Guinchard-Kunstler**, former French State Secretary of Health and current Vice President of the French National Assembly. She argued that old age represented an opportunity for economic activity and employment. She said it was time that society also looked at the ageing as an unexplored market. Using her home region of Franche-Comté as an example, Ms. Guinchard-Kunstler testified that by using innovative practices, her region had already created 40 000 new jobs by providing new services for the elderly. More importantly, 25% of those dependent on public welfare support had returned to an active professional life. Another 15% of the disabled had regained complete physical autonomy. Not only did she speak of innovative market opportunities, but also of the need to change our attitudes, our minds, and our ways of perceiving people over a certain age. The services created stimulated the economy in the Franche-Comté region as a whole and the elderly had gone from being seen as part of the problem, to becoming part of the solution.

8. The experience shared by Ms. Guinchard-Kunstler was supported by Dr. Giarini’s view that ageing was a relative term. According to the French Economic and Social Council, the concept of “ageing” should be restricted to “the age at which the population begins to suffer real incapacities”. Obviously, this point varies according to the individual – but while men in their 60s were considered old in the 1930s, today’s studies show that our genome is programmed to live 120 years. Dying before that should be considered premature.

9. Evidence also shows that increasing life expectancy not only means living longer as healthy and active individuals, but also results in a decrease in the number of years lived in disability or illness. Dr. Giarini calls it “compression of morbidity” the years of disability are reduced and the years in good health prolonged.

10. Thus, health cannot be simply measured in terms of specific illnesses. One must also consider the human ability to function and live. Dr. Giarini spoke of adding a new dimension to managing the health sector – that is, working and remaining active as a way to improve each person’s health and thus diminish health expenditures. The ability to function in older age should be actively promoted. Policies must be designed to allow for such participation, including reintegrating those who have temporarily left the labour market. In

conclusion, a key policy objective should be to make possible and even stimulate working after the age of 60 or 65.

11. One of the primary reasons why our societies are ageing is the continued economic prosperity and progress in medical science leading to life-prolonging and life-enhancing innovations. However, as noted by **Ms. Brus**, the statistical tools have lagged behind our intuitive sense that health improvements are constantly registered not only in the OECD, but also in the non-OECD countries.

12. Rather than measuring the output of health care - accounting for the improvements in the quality, given spending on different inputs – what we seem to debate is the level of health care expenditure on the various categories of the individual inputs such as pharmaceuticals, diagnostics, hospitals, physician and nursing care. In response to public concerns in different countries, there are outcries about increasing prices of these expenditure components. This can lead to a form of new tax as in the UK, or to higher insurance premiums, or the high payment for a new item such as a drug or a test that is not covered by health insurance.

13. As pointed out by several BIAC delegates, there is an increasing need for the government and the general public to understand that rising health costs reflect improving health services rather than pure inflation. Participants noted that the OECD was perhaps the only international organisation that helps governments and societies gain a better understanding of trends in the health sector.

14. **Stéphane Jacobzone (ELS)** provided an overview of the OECD project on ageing-related diseases and raised the question of how countries receive value for money by looking at new technologies and the growth in health care expenditures. He underlined the need for the OECD to continue its work in order to enable governments to measure productivity gains in the health care sector in comparison with those of the overall economy. He concluded that economic constraints facing health systems have multiple and convergent implications and that trends are going towards “ambulatory/non invasive care” consistent across diseases. Emphasis was made on the need to interpret with caution the outcomes with regard to prevention, treatment as well as non-controlled variables. The goal is to establish a performance measurement framework that can give governments sufficient basis to judge the effects of medical innovation on health. The OECD Secretariat is therefore looking at whether “best practices” with respect to major illnesses of OECD populations could be developed by the OECD, based on current knowledge and comparative statistics.

17. In his comments on the age-related disease study, **Mr. Whitaker** complimented the OECD on the approach taken and emphasized the need for comparative focus that recognises the effect of incentives under the different health care systems. At the same time, he indicated several limitations and weaknesses in the OECD study, such as no clinical, ambulatory or patient perspectives, measurement of demand solely in terms of mortality, inadequate measurement of outcomes, and other problems. He suggested possible improvements in future studies of age-related diseases, such as better estimates of true demand and outcomes, separating out long-term care and terminal costs, and recommended a look at the role of technology across diseases.

18. Based on the Age Related Disease project, **Ms. Brus** recommended a more disaggregated conceptual approach to the analysis of total health care expenditure. While noting the unique position of OECD to assemble and process information about these issues, she also pointed out the need to involve government experts from industry and R&D ministries, since looking solely at data on social affairs expenditures could be misleading. The meeting recommended that OECD should invite industry and R&D officials to their meetings on health care expenditures.

III. HEALTH-RELATED INNOVATION: PRODUCTS, HOSPITALS SERVICES AND PROCESSES

19. What are the emerging new technologies in health care and what is their nature? Are they global? Are they new products? Are they new services? How do they stack up against the need to equip people according to their health and work needs and regardless of their calendar age?

- What are the greatest barriers to diffusion of the emerging innovation? What are the new elements, unknown in the 80s and the 90s? Do we have the tools?
- Given experience with the economic evaluation methods of pharmaceuticals and diagnostics, what additional drawbacks can be foreseen in the future for more individualised medical products and services?
- How can OECD data better account for innovative efforts in health-related areas while also accounting for the outcome improvements?
- How could incentives be provided for research on neglected markets: either large or poor populations with enormous medical needs of social importance or numerically small OECD populations suffering from “orphan” diseases?

20. The key issues of the OECD work address the difficulties in acceptance of Health Technology Assessment (HTA) decisions and the limitations of cost-effectiveness analysis (CEA), as well as the uncertainty and risk in decision-making. OECD work also looks at how to assess the implications and opportunities from advances in genetics and biotechnology. The aim is to gather evidence on how HTA can facilitate the allocation of health-related technology resources in accordance with the goals of the health care policy-makers. In addressing this, a work plan encompassing three phases has been elaborated: i) to develop an analytical framework by which to measure HTA performance, ii) to collate appropriate and representative case studies that elucidate HTA factors that have worked particularly well and from which we could learn, and iii) to identify key underpinning principles of good practice in using HTA.

21. **Messrs. Nuyten and Sommer** presented lessons learned from the 1990s – a decade of great innovations in health services – and formulated some recommendations for improvement in the development and the diffusion of these innovations. They presented the most important trends in health services: i) innovative services for elderly, ii) integration of the care process, iii) the search for gains in productivity, iv) improvement in quality service. They stressed the role of the 5 pillars used by these innovations: i) process re-engineering, ii) development of information technologies, iii) changes in individual and collective behaviour, iv) new business models, v) private initiative.

22. Questions were asked whether the innovations in the case of the “medical internet” had met its promoters’ and users’ expectations. Until now, the overall answer seems to be negative. Concerning innovative health services, their development is endangered by a series of obstacles, although the process re-engineering technique fully met the expectation of its promoters and became a standard of management technique.

23. Messrs. Nuyten and Sommer showed that lessons learned by this decade of development should help improve significantly the chances of success in innovative health services. They concluded that some obstacles were now well identified such as i) the importance of the diffusion speed and the harmful role of some regulatory barriers, ii) the lack of answers from the regulatory authorities to new questions raised by these innovations, iii) the lack of responsiveness of the public or private health-insurers, iv) some specific mistakes in

the management of these innovations, v) the lack of trained human resources. This calls for further development of innovation and experimentation in order to meet the ever evolving needs of ageing societies. Regulatory authorities in health care were encouraged to invest in harmonisation of information technology systems, to prepare the field by addressing the ethical and legal issues, and to learn how to assess the characteristics of the innovative health services by thinking beyond the simplistic scheme of cost efficiency analysis. On this precise point they were called to learn from the private sector the crucial role of “creating a capability to cure” through comprehensive investments in techniques, skills and processes. For instance, traditional structures in hospitals would have to be broken down in order to allow for the uptake of new technology and management practices. Finally, Messrs. Nuyten and Sommer made a plea for the renewal of the concepts in use in the public health sector traditionally influenced by public management techniques and concepts.

24. Governments should guarantee and provide standard information about the benefits, costs and risks of the various alternatives, as it is already done in the securities and insurance sectors. **Mr. Olgiati** pointed out that in countries where governments are direct players, in terms of providers of health services, they should foster competition between private and public providers and payers. In the opposite case, where governments are not active players, they should assume a less regulatory stance and fall back to licensing and control. In other words, consumers of health care services must be free to choose what they would like to spend their money on. For that, governments must create a health care market that is responsive to the needs and wants of consumers and patients.

25. **Mr. Huber** reported on the OECD project on long-term care where already extensive co-operation between public and private service providers exists. Key concepts here were access to the market, finance, choice and quality of care. Evidence from member countries’ experience will be gathered to investigate the hypothesis that long-term care is an area where technological progress could clearly have both cost-saving effects and lead to improvements in the quality of care.

IV. HEALTH INSURANCE AND NEW SOLUTIONS TO FINANCING

26. Financing of health care was designed in a different demographic context – at a time with considerable fewer products at lower cost, as well as fewer diseases. Today, despite higher incomes, under the traditional retirement cut-off point, there are clearly fewer people to finance a much larger demand for health services, combined with a substantially higher number of novel products and services at a higher price.

27. Both the “solidarity” system of Europe and the “private insurance based” model in the US are experiencing strains because of rising expectations and continuing budget constraints. It is suggested that a part of the solution is for governments to act more as catalysts and regulators rather than as providers of services. This poses a number of questions:

- What do we mean by integrating public and private providers of health care services?
- What are the policies needed to allow private and public health insurers to compete on equal terms? How would such schemes function in practice?
- What are the possible social costs involved? How can policies be designed to allow for equal participation of private insurers without copying the undesirable effects of the US?

28. However, for insurance to work hand-in-hand with the needs of a new "mature" society, insurance products need to be far more individualised and far more integrated with the ability of a given person to continue productive activity regardless of calendar age.

29. Should governments re-examine the social purpose of health insurance under the new demography? Is insurance efficient in redistributing funds during the life cycle of a person? Is European "solidarity" too much based on the uniform approach to age as a cut-off point? Is the American system too unconcerned about stability? What incentives could be created that would maintain the stability and redistribution but would encourage good health and long productive lives?

30. The OECD work looking at the private health insurance component established that there were significant variations amongst OECD countries with regard to what were the insurable risks versus the social risks as well as the public/private mix of health financing. Moreover, **Ms. Tapay (DAF)**, who presented this OECD work, explained that an investigation would be made into the extent to which private insurance alleviates some of the financial burden on governments. Key to this is the identification of government interventions and regulatory practices. Extensive private health insurance statistical and regulatory information is being collected through surveys sent to all OECD country governments. Case studies of private health insurance's role in five countries are being undertaken during 2002-2003. A clear definition of the division of labour between private and public insurance has been developed.

31. Attention was drawn to elaborations made by Dr. Giarini, as well as other BIAC delegates, on the redefinition of division of labour into i) social adequacy: where all individuals must have access to insurance under all circumstances, though care must be taken that the insurance system does not accidentally become a wealth-redistribution mechanism, ii) efficiency: where insurance schemes must allow individuals to maximize the return on their disposable resources, without dispersing efficiency gains in administrative costs, and without adversely affecting work incentives, iii) flexibility: where changing economic circumstances may mean that existing insurance arrangements require periodic overhaul, something much easier to do with private insurance products than with social insurance, and iv) transparency: where both public and private provision must attempt to minimize the complexity that often attends insurance contracts.

32. **Mr. Goyens** drew attention to how private health insurance could distribute the risks to individuals instead of enterprises. After governments had developed policies without adequate budgetary resources, new financial contributors had to be identified. The right blend of public and private insurance offers was identified as the key challenge.

33. The basic message submitted by **Mr. Rice** was the need for different kinds and degrees of insurance in order to meet future demands. The current market structure, with "insurance silos" was judged as inadequate to meet these challenges. New market actors, with new products were called for. Insurances need to move away from defined benefits to defined contributions in order to meet demands. The current "insurance silos" were clearly inadequate.

V. CONCLUSION:

34. BIAC delegates expressed the hope that the OECD work would make it possible to:

- develop truly effective and progressive policies for active ageing that would recognize the potential of older people.
- estimate the burden of the most important diseases of older people in such a way that the cost and the contribution of each component of the expenditure can be precisely assessed.
- encourage better dissemination of new health technologies, as current experience shows that some citizens have to wait several years for a technology that has already proved to be effective in other countries.
- understand and take into account the requirements of emerging new services in order to facilitate their diffusion and to increase their success.
- continue the review of the financial and insurance mechanisms in order to facilitate financial innovations that may respond to new demographic and economic needs.

ANNEX --LIST OF PARTICIPANTS

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