

THE NEXT GENERATION of HEALTH REFORMS

OECD Health Ministerial Meeting

17 January 2017



MINISTERIAL STATEMENT

1. We, the Health Ministers and Representatives of OECD Members and Argentina, Colombia, Costa Rica, Kazakhstan, Lithuania, Peru and South Africa met in Paris on 17 January 2017, under the chairmanship of Mr. Jeremy Hunt, the Secretary of State for Health of the United Kingdom. The Vice-Chairs of the meeting were Ms. Carmen Castillo Taucher, Minister of Health of Chile; Mr. Hermann Gröhe, Federal Minister of Health of Germany; and Mr. Alain Berset, Federal Councillor, Head of the Federal Department of Home Affairs of Switzerland. The meeting was preceded by a Policy Forum on *People at the Centre: The Future of Health*. The World Health Organization, the World Bank, the International Social Security Organization and the Council of Europe participated in the Policy Forum and Ministerial meeting, as well as representatives from the Business and Industry Advisory Committee (BIAC) and from the Trade Union Advisory Committee (TUAC) to the OECD.

2. The purpose of our meeting was to share views and options on how to design and implement the *Next Generation of Health Reforms*. Our discussion was framed by the ambition of the Sustainable Development Goals. We also welcomed the strong role that health plays in the Inclusive Growth Agenda of the OECD and in OECD strategic priorities.

3. Health for all is a source of well-being and inclusive growth. Furthermore, people who are in good physical and mental health can more easily invest in their human capital, can obtain better educational outcomes, and have access to more productive and rewarding jobs, thus contributing more actively to our societies. In addition, the health system, as a significant employer, contractor, investor and purchaser of medical goods and technologies, is itself a contributor to the economy and social cohesion.

4. The achievements of our health systems are already significant:

- Much progress has been made towards securing effective Universal Health Coverage, despite the tight financial conditions many of us face. Important lessons can be learnt from our respective experiences in both developed and emerging economies to build sustainable, responsive, people-centred, and data-driven health systems.
- Life expectancy has increased by more than ten years since 1970 in the OECD, and even more significant progress has been made in emerging economies.
- We have also made progress at delivering safe and effective care. For example, improved treatments and better illness prevention and lifestyles have led to a 50% reduction in mortality from cardio-vascular disease on average across OECD countries.
- We have made some progress in promoting healthier lifestyles. Smoking rates, for example, have reduced by a quarter since 2000; yet one in five adults still smokes regularly across the OECD, and prevalence of harmful use of alcohol, obesity and lack of physical exercise shows that much remains to be done.

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5. Despite these successes, our health systems are still facing important challenges, and a new vision for the future is needed. Inequalities in access to care and health outcomes still persist within and across our countries: for instance, across the OECD, life expectancy is up to ten years lower amongst individuals with lower levels of education, and outcomes are poorer for Indigenous peoples in some OECD countries. Addressing the social and economic determinants of health is necessary to reduce health inequalities and will help strengthen the nexus between productivity, growth and inclusiveness in a sustainable manner. Environmental risk factors – air, water, soil and climate change – are also a large and growing challenge in many regions.

6. Moreover, the rise in chronic disease and multiple morbidities; the changing needs of an ageing population; the need to consider the most effective uses of new health technologies; and the urgency of tackling global threats such as the rise in resistance to antimicrobials, are emerging issues. Faced with tighter budgets, we need to improve the efficiency of the delivery of high-quality care for all, while eliminating ineffective care. We need to address how to pay for effective health technologies, in particular for innovative medicines, so as to ensure that investment in health systems improves patient outcomes. We need to measure health system performance on the basis of what it delivers to people, and make a better use of health data. All of these challenges demand greater involvement of patients in care processes and better health system governance. There is a need to make health systems more people-centred.

7. We confirm our strong support for OECD policy analysis and advice to help us in these efforts, and in making our health policy more evidence-based and more people-centred. To address future challenges, we also need stronger dialogue among ourselves, and express our thanks to the OECD for providing us a platform for information collection, analysis and policy discussion.

Promoting high-value health systems for all

8. In many of our countries, tight public finances have led to cuts or significant slowdown in the growth in health spending. Most European countries report annual health spending growth per capita below the growth rates seen before the crisis. Outside of Europe, health spending has been growing at around 2.5% per year since 2010, but demand for further reforms to deliver improved access to care and value for money remains high.

9. We discussed policies that have successfully helped tackle low-value interventions and free resources for investment in the most effective health activities, and how to remove barriers to successful health reform. We recognised the opportunities to improve quality of life for all people by improving efficiency in health and long-term care systems. We expressed our concern for evidence showing that a significant fraction of health spending does not actually improve patient health. When waste occurs during clinical care, in the operation and organisation of the health system, and within health system administration, it takes resources away from improving patient care. The policies that we considered will help make our health systems more responsive to the needs of all people. For example:

- We shared experiences of how to improve patient safety by addressing preventable clinical errors and adverse patient events. Large geographic variations in medical practice within our countries are not always due to differences in need or preferences, and policies should promote clinical best practice.

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- As recognised in the 2016 UN General Assembly High-Level Meeting on Antimicrobial Resistance, the growing resistance to antimicrobials across our societies, and at the global level, is a threat to modern medicine and the health of our people that can undermine attainment of the 2030 Agenda on sustainable development. We are committed to further actions to address the growing challenge of antimicrobial resistance, including through the development of new antimicrobials, vaccines and other alternative treatments, rapid diagnostic tests and delivery systems for the development of such new technologies to combat the emergence and spread of antimicrobial resistance. We are committed to efforts to ensure that existing antimicrobials are used in rational ways in the human sector, and to co-operate with Ministers of Agriculture and the Environment to address the issue in the agriculture and veterinary sectors, according to a “One Health” approach. We also recognised the importance of preventive public health interventions, and welcomed the OECD’s work in this field.
- We recognised that we need to take advantage of opportunities to foster better care co-ordination across providers and across the health and social care sector, including by making more effective use of richer and better health data to provide a complete picture of what happens to people across the pathway of care.
- We shared information on promising initiatives to make better use of health professionals’ skills and encourage cheaper, equally effective, alternatives to costly treatments.
- Options to address fraud, abuse, and other integrity violations in health care, which concern different key stakeholders, were also part of our discussion.

10. Our guiding principle in re-orienting our health systems is to focus on patients and their continuity of care, and to promote people’s physical and mental good health. Chronic diseases and poor lifestyle choices can damage the ability of people to productively engage in the labour market, and put a burden on families and informal carers. These circumstances demand strong primary and community services. They also demand strategies to prevent illness, and the integration of measures to promote healthy living across government agencies and policies, and between government and non-governmental actors. We welcomed the Recommendation of the OECD Council on Integrated Mental Health, Skills and Work Policy adopted in 2015 and recognised the efforts countries are making to implement it.

Adapting health systems to new technologies and innovation

11. We recognise that health technologies contribute to improving the performance of health systems. They provide a wide range of treatment possibilities to improve people’s outcomes, allowing for health systems to be more centred on people’s needs. We welcomed the acceleration of technological developments in health: advances in genomics mean that treatment pathways are becoming tailored to individual patients; medical devices are employing digital communication tools that can deliver and receive data; digital innovations and big data are enabling people to manage their health more independently and are being used for clinical purposes and to improve health system governance.

12. These innovations can also create opportunities to tackle waste and improve the efficiency of health systems, raise clinical standards, facilitate surveillance and boost research, and improve patient

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outcomes. However, innovations can also pose novel challenges. Many countries are working towards achieving high-performing data and patient-record systems. At the same time, some effective and very costly new generation treatments change the treatment paradigm but have significant budget impact and wider implications for our health systems. Health technology assessments can be a key instrument to provide evidence-based information on the impact of new technologies, such as on therapeutic value, other benefits, and cost. We recognise the importance of ensuring access to effective health care treatments and protecting people's wellbeing and needs, while ensuring the sustainability of our health care systems and maintaining incentives for health innovation. We acknowledge that we need to explore how to encourage innovation where it is most needed, such as to address dementia and to develop new antimicrobials, vaccines, rapid diagnosis tests and other alternative treatments. And we recognise that the uniqueness of national systems for innovation and for health care offers a multitude of options to fund and facilitate good health innovations, for consideration by countries.

13. We reviewed our experiences and shared views on possible approaches to tackle these challenges:

- We recognised that we need to take advantage of opportunities to work more collaboratively among ourselves to improve knowledge and share experiences and in some cases reduce duplications in assessment mechanisms, and increase the transparency of these processes for patients, providers and payers.
- We concluded that we should work together to generate evidence on the effectiveness of treatments taking into consideration the real world, so that we can make informed decisions about the adoption and use of new technologies.
- We look forward to OECD work on sustainable access to innovative medicines. In line with the ambitions of the G7, this work can help us improve our understanding of ways to keep innovation robust, treatments accessible and health systems sustainable. We encourage ongoing reflection, supported by high-level expertise, and international co-operation in this area.
- Our experience suggests that, in line with specific national processes and approaches, constructive dialogue across governments, with industry, and with other key stakeholders including patients, providers, payers and academics, can help identify solutions to the challenges of using new technologies most effectively. We welcomed the OECD contributions, in collaboration with the WHO and other international organisations, to discussions on this issue at international fora.
- We spoke about the enormous potential health data offer for improving people's health and health systems' performance. We are aware that due consideration of potential benefits and risks involved is needed to make the most of the vast amount of clinical, administrative, and other types of data being generated in health systems. Ensuring populations trust in the confidentiality of their health data is of utmost importance for health systems, and requires that the right data protection measures are in place. We acknowledge that these notions are in line with the G7 leaders' commitment at the 2016 Ise-Shima Summit Meeting, which affirmed the importance of further enabling the use of health data while pointing out relevant issues for

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consideration. We, the OECD Health Ministers, welcome the new Recommendation of the Council on Health Data Governance (see Annex 1), which identifies core elements to strengthen the health data governance and thereby maximise the potential of using health data while protecting individuals' privacy.

Reorienting health systems to become more people-centred

14. We recognised that patients' expectations are rising, and that there is a need for a fundamental change in how people interact with health services and health professionals. Big data and the generation of vast amounts of new information are allowing people to have access to more information about health than ever before, and increasing the range of possible ways for people to manage their own health. To make sure patients are able to use this information effectively, efforts are needed to address barriers to health literacy of the population, and to facilitate people's access to their own medical records and health information. Yet, as the demand to become active participants in decision-making is becoming the new normal, people are still too often playing an insufficient role in deciding about their treatment.

15. Health systems need to maximise the effectiveness and efficiency of health services and long-term care; deliver seamless care across services and providers; they also need, fundamentally, to deliver improvements that matter to patients and their changing care needs. We share with our people and clinical leaders the view that "people-centred care" should better guide the course taken by health care in the future.

16. The shift from a health system that is centred on providers to one that is centred on people's individual needs and preferences has important implications for how we measure health system performance. The OECD has long played a leading role in benchmarking health system performance. Internationally comparable indicators have provided a powerful reference for countries seeking to understand the impact of policy reform. However, we recognise that data generated in health systems are still too often concentrated on health activities and inputs, limiting opportunities for gaining new insight into the impact of policies.

17. We need to invest in measures that will help us assess whether our health systems deliver what matters most to people. Too often, we only rely on measures of what health systems do, and how much they cost, rather than their effects on patients. We, the OECD Health Ministers, welcome the advice from the OECD High-level Reflection Group on Health Statistics to invest in better cross-country comparative measures of patients' own experience of medical care and health care outcomes, and we ask the OECD to further engage in the analysis and development of such comparative measures. They will help assessments of whether care is delivering comfort and quality of life, whether it enables people to be free of pain or to improve their ability to function and live independently. Measuring how care affects those outcomes that matter most to people and linking those with information already collected by the OECD, such as on expenditure, resources, safety and effectiveness of health care, will help us gain new knowledge on how to improve lives for all. Better measurement can also help deepen understanding of health needs, and how the impact of health reforms differs across income and other socio-economic groups.

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18. Making our health systems more people-centred also requires modernisation of delivery models. Primary care must become stronger, match people's needs and be co-ordinated with other services; prevention of disease must be at the heart of health systems. End of life care, too, must be a collaboration between patients and clinicians. The health and long-term care workforce also should be better centred on people's health needs. One in ten workers across the OECD today is employed in the health and social care sector, and the contribution of a productive health workforce to achieving the Sustainable Development Goals is undeniable. We need to equip these health professionals with the right skills, and adapt training and work models to deliver care that maximise patients' outcomes. We welcome the report from the UN Secretary General's Commission on Health Employment and Economic Development and ask the OECD to work with the World Health Organization (WHO) and the International Labour Organization (ILO) to contribute to its implementation.

19. We, the OECD Health Ministers, have thus identified several areas of further policy research that would be very useful to us in further developing health policies, and invited the OECD to pursue work on these issues (see Annex 2).

Encouraging dialogue and international co-operation

20. We recognise the importance of promoting an ongoing dialogue between governments, patient groups, the industry, health worker representatives, payers and other key stakeholders. However, the challenges we face for the future – particularly the need to make care more centred on people's needs – suggest that new ways of working with different stakeholders is required. We should strengthen co-operation across government Ministries and agencies (such as with those in charge of economy, technology and innovation), and define new ways for effective and transparent interaction with patient groups and industry.

21. We are committed to promoting dialogue and co-operation with governments of emerging and developing economies to address together global health issues and the common challenges our health systems face. We are committed to sharing our experiences with them as they seek to further strengthen their health systems and leap over some of the shortcomings that our health care systems have experienced. We are also committed to promoting international collaboration on key health issues, and encourage the OECD to continue working with other relevant international organisations in this field.

22. We look forward to further OECD work on health, to provide new insights on how to approach the next generations of health reforms in order to promote Universal Health Coverage, to maximise the contribution of health systems to productivity and more inclusive economies, and to help address common challenges.

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ANNEX 1. RECOMMENDATION OF THE COUNCIL ON HEALTH DATA GOVERNANCE

THE COUNCIL,

HAVING REGARD to Article 5 b) of the Convention on the Organisation for Economic Co-operation and Development of 14 December 1960;

HAVING REGARD to the Recommendation of the Council concerning Guidelines Governing the Protection of Privacy and Transborder Flows of Personal Data [C(80)58/FINAL as amended by [C\(2013\)79](#)], the Recommendation of the Council on Human Biobanks and Genetic Research Databases [C(2009)119] and the Recommendation of the Council on Digital Security Risk Management for Economic and Social Prosperity [C(2015)115];

NOTING the OECD report *Health Data Governance: Privacy, Monitoring and Research* (OECD, 2015);

RECOGNISING that access to, and the processing of, personal health data can serve health-related public interests and bring significant benefits to individuals and society;

RECOGNISING that health systems are increasingly affected by a growing volume of personal health data in electronic form, including electronic health and administrative records; that such data are often held in silos by the organisations that have collected them and by governmental authorities, such as health ministries and statistical agencies; and that when the secure transfer, linkage and analysis of health data occurs, then the value of the data to serve health-related public interest purposes increases significantly.

RECOGNISING that public trust and confidence in the protection of personal health data must be maintained if the benefits achievable through its processing are to be realised; and that governments have a role in fostering compliance with privacy laws and policies.

RECOGNISING that personal health data, being sensitive in nature and subject to ethical standards and the principle of medical confidentiality, require a particularly high level of protection and that technological developments can both enable the privacy protective use of personal health data and also introduce new risks to privacy and data security;

RECOGNISING that achieving these benefits requires the careful development and application of robust, context appropriate, privacy protective health data governance frameworks that require the identification and management of privacy and security risks;

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RECOGNISING that although Members and non-Members adhering to this Recommendation (hereafter the “Adherents”) are investing in health data infrastructure and that considerable progress is being made to achieve co-ordinated health data governance frameworks, the many differences in the availability of, access to and use of personal health data both within and across national borders must be addressed; and

CONSIDERING that, while there are differences in their domestic laws, effectively safeguarding the public interest is an important function of governments; that health data governance is not only the domain of central governments but that it encompasses all levels of government, where different mandates apply in different countries; and that this Recommendation is accordingly relevant to all levels of government.

On the proposal of the Health Committee and the Committee on Digital Economy Policy:

- I. **AGREES** that this Recommendation applies to the access to, and the processing of, personal health data for health-related public interest purposes, such as improving health care quality, safety and responsiveness; reducing public health risks; discovering and evaluating new diagnostic tools and treatments to improve health outcomes; managing health care resources efficiently; contributing to the progress of science and medicine; improving public policy planning and evaluation; and improving patients’ participation in and experiences of health care.
- II. **AGREES** that for the purpose of this Recommendation the following technical terms require a brief description to support a common understanding:
 - “Personal health data” means any information relating to an identified or identifiable individual that concerns their health, and includes any other associated personal data.
 - “Processing personal health data” means all data-related operations involving personal health data such as data collection, use, disclosure, storage, recording, editing, retrieval, transfer, sharing, linkage or combining, analysis, and erasure.
 - “De-identification” means a process by which a set of personal health data is altered, so that the resulting information cannot be readily associated with particular individuals. De-identified data are not anonymous data. “Re-identification” means a process by which information is attributed to de-identified data in order to identify the individual to whom the de-identified data relate.
- III. **RECOMMENDS** that governments establish and implement a national health data governance framework to encourage the availability and use of personal health data to serve health-related public interest purposes while promoting the protection of privacy, personal health data and data security. Such a health data governance framework should provide for:

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1. **Engagement and participation**, notably through public consultation, of a wide range of stakeholders with a view to ensuring that the processing of personal health data under the framework serves the public interest and is consistent with societal values and the reasonable expectations of individuals for both the protection of their data and the use of their data for health system management, research, statistics or other health-related purposes that serve the public interest.
2. **Co-ordination within government and promotion of cooperation among organisations processing personal health data, whether in the public or private sectors.** This cooperation should:
 - i. Encourage common data elements and formats; quality assurance; and data interoperability standards; and
 - ii. Encourage common policies and procedures that minimise barriers to sharing data for health system management, statistics, research and other health-related purposes that serve the public interest while protecting privacy and data security.
3. **Review of the capacity of public sector health data systems used to process personal health data to serve and protect the public interest.** Such review should include:
 - i. Data availability, quality, fitness for use, accessibility, as well as privacy and data security protections.
 - ii. Elements of data processing that are permitted for health system management, research, statistics or other health-related public interest purposes, subject to appropriate safeguards, particularly dataset transfers and the linkage of dataset records.
4. **Clear provision of information to individuals.** Such provision should ensure that:
 - i. Where personal health data are collected from individuals, information about the processing of their personal health data, including possible lawful access by third parties, the underlying objectives behind the processing, the benefits of the processing, and its legal basis is disclosed in clear, accurate, easily understandable and conspicuous terms.
 - ii. Individuals are notified in a timely manner of any significant data breach or other misuse of their personal health data. Where individual notification is not

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practicable then notification may be made by effective public communication.

5. Informed consent and appropriate alternatives.

- i.* Consent mechanisms should provide:
 - a. Clarity on whether individual consent to the processing of their personal health data is required, and, if so, the criteria used to make this determination; what constitutes valid consent and how consent can be withdrawn; and lawful alternatives and exemptions to requiring consent, including in circumstances where obtaining consent is impossible, impracticable or incompatible with the achievement of the health-related public interest purpose, and the processing is subject to safeguards consistent with this Recommendation.
 - b. That, where the processing of personal health data is based on consent, such consent should only be valid if it is informed and freely given, and if individuals are provided with clear, conspicuous and easy to use mechanisms to provide or withdraw consent for the future use of the data.
- ii.* Where the processing of personal health data is not based on consent, to the extent practicable, mechanisms should provide that:
 - a. Individuals should be able to express preferences regarding the processing of their personal health data, including not only the ability to object to processing under certain circumstances but also the ability to actively request that their personal health data be shared for research or other health-related public interest purposes.
 - b. If data processing objections or requests cannot be honoured, then individuals should be provided with the reasons why this is the case including the relevant legal basis.

6. Review and approval procedures, as appropriate, for the use of personal health data for research and other health-related public interest purposes. Such review and approval procedures should:

- i.* Involve an evidence-based assessment of whether the proposed use is in the public interest;

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- ii.* Be robust, objective and fair;
 - iii.* Operate in a manner that is timely and promotes consistency of outcomes;
 - iv.* Operate transparently whilst protecting legitimate interests; and
 - v.* Be supported by an independent multi-disciplinary review conducted by those with the expertise necessary to evaluate the benefits and risks for individuals and society of the processing, and risk mitigation.
- 7. Transparency, through public information mechanisms which do not compromise health data privacy and security protections or organisations' commercial or other legitimate interests.** Public information should include the following elements:
 - i.* The purposes for the processing of personal health data, and the health-related public interest purposes that it serves, as well as its legal basis.
 - ii.* The procedure and criteria used to approve the processing of personal health data, and a summary of the approval decisions taken, including a list of the categories of approved data recipients.
 - iii.* Information about the implementation of the health data governance framework and how effective it has been.
- 8. Maximising the potential and promoting the development of technology** as a means of enabling the availability, re-use and analysis of personal health data while, at the same time, protecting privacy and security and facilitating individuals' control of the uses of their own data.
- 9. Monitoring and evaluation mechanisms.** Such mechanisms should:
 - i.* Assess whether the uses of personal health data have met the intended health-related public interest purposes and brought the benefits expected from such uses and whether any negative consequences of such uses have occurred, including failures to comply with national requirements for the protection of privacy, personal health data and data security; data breaches and data misuses; and feed the results of such

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assessment into a process of continuous improvement, including through:

- a. Periodic review of developments in personal health data availability, the needs of health research and related activities, and public policy needs; and
 - b. Periodic assessment and updating of policies and practices to manage privacy, protection of personal health data and security risks relating to personal health data governance.
- ii. Encourage those processing personal health data to periodically review and assess the capabilities, reliability and vulnerabilities of the technologies they use.
10. **Establishment of appropriate training and skills development in privacy and security measures for those processing personal health data**, that are in line with prevailing standards and data processing techniques.
11. **Implementation of controls and safeguards.** These should:
 - i. Provide clear and robust lines of accountability for personal health data processing, accompanied by appropriate mechanisms for audit.
 - ii. Establish requirements that personal health data can only be processed by, or be the responsibility of, organisations with appropriate data privacy and security training for all staff members, commensurate with their roles and responsibilities in relation to processing personal health data and consistent with any applicable professional codes of conduct.
 - iii. Encourage organisations processing personal health data to designate an employee or employees to coordinate and be accountable for the organisation's information security programme, including informing the organisation and its employees of their legal obligations to protect privacy and data security.
 - iv. Include formal risk management processes, updated periodically that assess and treat risks, including unwanted data erasure, re-identification, breaches or other misuses, in particular when establishing new programmes or introducing novel practices.
 - v. Include technological, physical and organisational measures designed to protect privacy and security while maintaining, as far as practicable, the utility of personal health data for health-related public interest purposes. Such measures should include:
 - a. Mechanisms that limit the identification of individuals, including through the de-identification of their personal health data, and take into account the proposed use of the data, while also allowing re-identification where approved. Re-

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identification may be approved to conduct future data analysis for health system management, research, statistics, or for other health-related public interest purposes; or to inform an individual of a specific condition or research outcome, where appropriate.

- b. Agreements, when sharing personal health data with third parties for processing that help to maximise the benefits and manage the risks while maintaining the utility of personal health data. Such agreements should specify arrangements for the secure transfer of data and include appropriate means to effectively sanction non-compliance.
- c. Where practicable and appropriate, considering alternatives to data transfer to third parties, such as secure data access centres and remote data access facilities.
- d. Robust identity verification and authentication of individuals accessing personal health data.

- 12. Require organisations processing personal health data to demonstrate that they meet national expectations for health data governance.** This may include establishment of certification or accreditation of organisations processing personal health data, in so far as these certifications or accreditations help to implement standards for the processing of personal health data or demonstrate capacity to meet recognised governance standards.

IV. RECOMMENDS that governments support transborder co-operation in the processing of personal health data for health system management, research, statistics and other health-related purposes that serve the public interest subject to safeguards consistent with this Recommendation. To that effect, governments should:

- i.* Identify and remove barriers to effective cross-border cooperation in the processing of personal health data for health-related public interest purposes in a manner consistent with protecting privacy and data security, in light of all the circumstances.
- ii.* Facilitate the compatibility or interoperability of health data governance frameworks.
- iii.* Promote continuous improvement through the sharing of outcomes and best practices in the availability and use of personal health data for health system management, research, statistics and other health-related purposes that serve the public interest.

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V. RECOMMENDS that governments engage with relevant experts and organisations to develop mechanisms consistent with the principles of this Recommendation that enable the efficient exchange and interoperability of health data whilst protecting privacy, including, where appropriate, codes, standards and the standardisation of health data terminology.

VI. ENCOURAGES non-governmental organisations to follow this Recommendation when processing personal health data for health-related purposes that serve the public interest.

VII. INVITES the Secretary-General to disseminate this Recommendation.

VIII. INVITES Adherents to disseminate this Recommendation at all levels of government.

IX. INVITES non-Adherents to take account and to adhere to this Recommendation.

X. INSTRUCTS the Health Committee, in co-operation with the Committee on Digital Economy Policy, to:

- a) Serve as a forum to exchange information on progress and experiences with respect to the implementation of this Recommendation, and;
- b) Monitor the implementation of this Recommendation and report to the Council within five years of its adoption and thereafter as appropriate.

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ANNEX 2. FURTHER OECD WORK ON HEALTH

23. We, the OECD Health Ministers, would like OECD to continue to provide robust comparable measures of health systems performance, and tailored economic analysis of health policies that help us deliver sustainable, high-performing health systems and maximise the benefits for our economies.

24. We ask the OECD to help us assess how health policy reforms are implemented, drawing on robust health statistics, so as to generate a virtuous cycle of learning from the successful experiences in our countries. We ask the OECD to continue its work as a valuable partner to member, key partner and programme countries as they seek to implement health reforms, and to continue to support the strengthening of our health systems through targeted policy advice.

25. In addition, we invite the OECD to carry out further work to help us build the health systems of the future. In particular, we believe that progress towards people-centred health care will remain but a vague ambition unless we have metrics that help us understand whether health systems deliver good patient outcomes, and unless we are able to compare those to the resources invested. We therefore invite the OECD, in collaboration with other relevant bodies, to carry out work in the following areas, subject to resources and in line with the usual budgetary and approval processes of the Organisation:

Reorient health systems to be more knowledge-based

- ***New health statistics to measure and compare patient-reported experiences and outcomes in health care.*** We ask the OECD to develop specific statistical tools to assess in a comparable way the experience and outcomes of patients in our countries. In a context of rapid demographic changes, fiscal challenges, and ongoing technological progress, these patient reported indicator measures will better equip countries with data that reflect what matters for patients, helping to understand whether care, particularly for elderly patients, those with chronic disease and long-term conditions, and those experiencing mental ill-health, is well co-ordinated. Coupling such patient-reported outcome and experience measures with existing statistics on expenditure, clinical quality and processes of care will offer a powerful set of benchmarks to inform comprehensive policy advice for governments seeking to achieve high-performing health systems. We ask the Health Committee to review the development of these statistical tools and report back at the next Meeting of Health Ministers.
- ***Highlighting best practice.*** We ask the OECD to develop a system, based on existing data sources, to enable the compilation of tables of health outcomes at country level, and other key indicators of health and health system performance which identify relative strengths in order for all countries to share, and learn from, examples of best practice. We ask that this work is

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initially targeted at the main health issues – such as cancer, mental health and stroke. The work should include an assessment of effective country specific policies which might help others achieve better outcomes.

- **Knowledge-based health systems.** Building on the work on new technologies and big data, and the Recommendation of the Council on Health Data Governance, we ask the OECD to help us adapt our health systems to manage efficiently and effectively the vast amounts of clinical, administrative, and other types of data being generated on a daily basis, so that this information is used to improve health systems performance. This work should enable us to make our health policies more evidence-based and capable of responding to the pressures health systems are confronting. We also ask that the OECD continue to support member and partner countries to further develop their capacity.

Enhance the people-centred focus of health systems and policies and promote high-value care

- **Primary health care and public health.** To face the challenge of ageing populations with growing incidence of multiple chronic care needs, our primary care and public health systems will need to become stronger, better co-ordinated with the rest of the health system, and better integrated within the health sector and across other sectors of the economy. We ask the OECD to help us identify good practices for high-performing primary health care systems, so as to get greater value out of this sector. We also ask the OECD to continue its ongoing work to help improve our ability to tackle risk factors to health (such as obesity, harmful alcohol consumption, smoking), and new and rising threats (such as antimicrobial resistance), through economic analysis and stronger inter-sectoral linkages. And we ask OECD to help us understand options for optimising regulatory approaches, industry co-operation and respect of individual choices to facilitate healthy lifestyles. This work will help improve decision-making about how to ensure that health systems best meet people's needs and wishes, and help health systems become more efficient in addressing those needs.
- **Health inequalities.** A priority for our people is that our health systems strive for access to health care for all, are inclusive, and contribute to reducing health and broader socio-economic and geographical inequalities. However, people from low socio-economic groups are more likely to forgo medical treatments due to cost. Furthermore, the impact of health reforms may vary across different groups including by income and locations. We need better data and analysis about the contribution of health to inclusive economies and societies across an individual life span. Building on the results of the OECD work on *Generation Next: How to Prevent Ageing Unequally* and more broadly on the Inclusive Growth initiative, we look to OECD to help us develop better indicators of health inequality, explore the extent to which inequalities persist over the lifecycle, as well as the intergenerational transmission of inequalities in early life. This work will help us improve the quality of life and the outcomes of vulnerable patients, contributing to more equitable and inclusive societies.

THE NEXT GENERATION of HEALTH REFORMS

OECD Health Ministerial Meeting

17 January 2017



Modernise delivery models

- **New technologies.** Building on the work OECD has been conducting on new technologies and sustainable access to innovative medicines, and conscious of the fact that new treatments and technologies offer opportunities but may also pose significant governance and fiscal challenges, we ask the OECD to follow-up to the work initiated to help us explore how to optimise innovations in health care, so as to take best advantage of technological and digital developments, promote cost-effectiveness and transparency, and identify how best to leverage effective international cooperation to improve health system performance and patient care. We ask that the Health Committee draws on the work of the OECD's horizontal project on digitalisation to inform such reflection. We further ask the OECD to support efforts by the G7, the G20 and other global fora to address new and rising challenges to public health and health system performance, such as antimicrobial resistance and sustainable access to high-cost and innovative treatments.
- **The future of the health workforce.** We ask OECD to help us develop a transformative agenda for the health workforce, assessing health professional skills, remuneration and co-ordination, and how these skills and models of care need to adapt in light of digitalisation, wider technological changes, and the evolution of patients' needs. We note that the OECD's horizontal project on the Future of Work, as well as the work conducted in co-ordination with the WHO and the ILO, should hold important lessons for the health sector.

26. We look forward to reviewing progress on this work at the next Ministerial meeting in 5/6 years' time.