

# Health Statistics

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## Health Accounts

### Purpose

To provide policy relevant, comparative data and analysis on health expenditure and financing, and to facilitate harmonisation across national health accounting practices. To provide data sources for research and to make country-specific health accounts data and analysis more widely available.

### Objectives and outputs

The third Joint OECD, Eurostat and WHO System Health Accounts (SHA) data collection was successfully implemented in 2008. It has improved the availability and comparability of health expenditure data and also contributed to the improvement in health expenditure data published in OECD Health Data. A System of Health Accounts database has been developed as a component of the OECD Statistical Information System. National Health Accounts Experts and others interested in accessing health accounts data can now do so using OECD.Stat and SourceOECD.

Methodological developmental work has continued on a number of projects: Improving the Comparability and Availability of Private Health Expenditure; Development of Output based Health-Specific Purchasing Power Parities; Estimating Expenditure by Disease, Age and Gender; and Measurement of Health Volume Output. The consultation process for the revision of the SHA manual has commenced. The revision is a collaborative activity of the OECD, Eurostat and WHO.

### Non-member countries involved in the activity:

Croatia, Cyprus, Estonia, Latvia, Lithuania, Malta, Romania, Slovenia

### Databases

OECD Health Data (Expenditure and Financing)

System of Health Accounts Database

### Main Developments for 2009

#### General aspects:

In 2009, the fourth Joint OECD-Eurostat-WHO health accounts (SHA) data collection will take place. Previous improvements to the validation tools used both by the national compilers and the international organisations will continue to provide efficiency gains in the validation exercise and ultimately feed through to improved timeliness in dissemination of the data.

The 2009 questionnaire is unchanged from the previous year and it is envisaged that the questionnaire will continue to be based on the current version for at least the next few years with any changes kept to a minimum. As much as it is possible it is the aim to collect SHA Tables for preceding years (that is, from 2000 onwards).

In addition, an increasing number of OECD and non-OECD countries are expected to submit data to the 2009 collection which will improve overall coverage and data comparability. Combined with improved

linkages to the OECD Health Data database, this will also lead to an increase in the quality of the expenditure and financing data in OECD Health Data 2009.

The main developments in the OECD Health Data collection in relation to expenditure and financing (Parts 5 & 6) are continuing improvements in the consistency between the 3 tables for total, public and private health expenditure and increased harmonisation with the Joint SHA data collection so that data are fully comparable.

The consultation process for the revision of the SHA manual will continue in 2009. A draft of the SHA Manual Version 2.0 will be produced by the end of 2010, as a collaborative project of the OECD, Eurostat and WHO.

The methodological projects which commenced in 2007 such as Improving the Comparability and Availability of Private Health Expenditure; Development of Output based Health-Specific Purchasing Power Parities; Estimating Expenditure by Disease, Age and Gender; and Measurement of Health Volume Output will be further developed or completed in 2009. These projects as well as methodological work undertaken in the past such as Refinement of the SHA framework for health financing; Definitions and estimation of long-term care expenditure; and Incorporating Input, Output and Productivity Measurement into the SHA Framework will feed into the revision of the SHA manual. A new project on Improving Estimates of Imports and Exports of Health Care Goods and Services under the SHA will commence in 2009.

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## Health Care Quality Indicators

### Purpose

The purpose of the Health Care Quality Indicators (HCQI) Project is to develop a set of indicators that can be used to raise questions regarding quality of care across countries. They are reported as a regular chapter in Health at a Glance since 2007.

### Objectives and outputs

The HCQI Project goals in 2009 are to update the set of HCQI already published and in addition collect data on new indicators: 7 patient safety, 2 mental health care and 9 avoidable hospitalisations. The results of the data collection will be published as a chapter in Health at a Glance 2009.

### Non-member countries involved in the activity:

Singapore

### Databases

Health Care Quality Indicators

### Main Developments for 2009

#### General aspects:

No major changes.

#### Data collection:

Pilot data collection of fourteen patient safety and four mental health care indicators, and baseline data and information collection to explore the feasibility of new health promotion, prevention and primary care indicators.

#### Data management:

Plan 2008 - planning for any changes to the management of data for the Health Care Quality Indicators Project will be finalised by February 2008.

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## Health Data

### Purpose

To provide policy makers and health researchers with a wide range of statistics on health and health systems to allow comparative analysis of different aspects of the performance of health systems. The central parts of the database include data on health care resources, their utilisation, expenditure and financing. This is complemented by a broader range of data on health status, lifestyle, and other data on the socio-economic environment of health systems in OECD countries, in order to provide data on the context of health systems for policy analysis. Developmental work is also under way to obtain comparable data on disparities in health status and health care access and use, as well as on the quality of health care. Some of these data will be gradually included in OECD Health Data to fill important gaps in measuring the performance of health systems.

### Objectives and outputs

The activity is co-ordinated with Eurostat, WHO Geneva and WHO Europe to reduce the duplication of work and promote the harmonisation of international data collection and reporting. An agreement in principle was reached in April 2008 to explore the possibility of developing a new joint data collection with Eurostat and WHO in the area of non-monetary health care statistics. The main achievements of the 2008 release of OECD Health Data include more detailed information on the health workforce (related in particular to different categories of doctors and nurses) and a new chapter on long-term care resources and utilisation presenting data on the number of beds available in nursing homes and the number of people receiving long-term care in institutions or at home. Progress was achieved in reviewing the availability and comparability of selected measures of disparities in health status and in health care access and use, and to identify the next steps needed to improve the comparability of these data.

### Databases

OECD Health Data 2009

### Main Developments for 2009

#### General aspects:

Improving data on health employment and education, working in collaboration with other international organisations (the priorities will be to refine the current data collection on medical specialists and explore the possibility of introducing a new data collection on physicians-in-training). Introducing a new data collection on the long-term care workforce, including formal and informal care givers. Improving data on medical technologies, including both the supply and utilisation of selected diagnostic or therapeutic equipment. Assessing the feasibility of filling data gaps on the occurrence of selected chronic diseases, working in collaboration with other international organisations (the focus will be to try to gather incidence and prevalence data on diabetes, dementia, depression, ischemic heart disease, stroke and asthma, to complement the data currently reported on cancer and HIV/AIDS incidence). Collecting data on a selected set of indicators of disparities in health status and in health care access and use to begin to fill data gaps in this area.