ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

ORGANISATION DE COOPÉRATION ET DE DÉVELOPPEMENT ÉCONOMIQUES

OECD Health Data 2020 Questionnaire
Definitions for all indicators

HEALTH_STAT - Health Status

Life expectancy at birth and at various ages (40, 60, 65, 80)

Life expectancy at birth and ages 40, 60, 65 and 80 is the average number of years that a person at that age can be expected to live, assuming that age-specific mortality levels remain constant.

❗**Note: Life expectancy at birth for the total population is estimated by the OECD Secretariat for all countries, using the unweighted average of life expectancy of men and women.**

Life expectancy by education level

Females at birth, at age 30, at age 65: Low education (ISCED 0 to 2), Medium education (ISCED 3 and 4) and High education (ISCED 5 to 8)
Males at birth, at age 30, at age 65: Low education (ISCED 0 to 2), Medium education (ISCED 3 and 4) and High education (ISCED 5 to 8)
Total population at birth, at age 30, at age 65: Low education (ISCED 0 to 2), Medium education (ISCED 3 and 4) and High education (ISCED 5 to 8)

Education level is based on the International Standard Classification of Education, ISCED-2011.

Definitions

Life expectancy at birth, at age 30 and at age 65 is the average number of years that a person at that age can expect to live, assuming that age-specific mortality levels remain constant.

Education level is expressed by the highest completed level of education, defined according to the latest International Standard Classification of Education (ISCED-2011):

Low education (ISCED 0 to 2)
Early childhood education (ISCED 0)
Primary education (ISCED 1)
Lower secondary education (ISCED 2)

Medium education (ISCED 3 and 4)
Upper secondary education (ISCED 3)
Post-secondary non-tertiary education (ISCED 4)

High education (ISCED 5 to 8)
Short-cycle tertiary education (ISCED 5)
Bachelor's or equivalent level (ISCED 6)
Master's or equivalent level (ISCED 7)
Doctoral or equivalent level (ISCED 8)

For details about each category, please refer to OECD (2015), "What are the benefits of ISCED 2011 classification for indicators on education?", Education Indicators in Focus, No. 36, OECD Publishing, Paris, http://dx.doi.org/10.1787/5jrqgdw9k1lr-en.

Sources and Methods

The **Eurostat database** (dataset Life expectancy by age, sex and educational attainment level [demo_mlexpecedu] accessed in June 2019) is the data source for 14 European countries (Czech Republic, Denmark, Estonia, Finland, Greece, Hungary, Italy, Norway, Poland, Portugal, Slovak Republic, Slovenia, Sweden and Turkey).
Further information: http://ec.europa.eu/eurostat/data/database?node_code=demo_mlexpecedu.

Life expectancy by education level at birth
Source: The **Eurostat database** (dataset Life expectancy by age, sex and educational attainment level [demo_mlexpecedu] accessed in June 2019) is the data source for 14 European countries.

Life expectancy by education level at age 30
Sources:
- The **Eurostat database** (dataset Life expectancy by age, sex and educational attainment level [demo_mlexpecedu] accessed in June 2019) is the data source for 14 European countries.
- Data from **national surveys** provided in response to the OECD Health Data questionnaire for the following six countries: Austria (2006 only), Canada (2006 only), Iceland, Israel, Mexico, Netherlands and Switzerland.
- Data available from the **OECD Statistics Directorate project** (data extracted in December 2016) for the following 11 countries: Australia (2011), Austria (2012), Belgium (2011), Canada (2010), Chile (2004), France (2012), Latvia (2011), New Zealand (2006), Turkey (2013), United Kingdom (2011) and United States (2011).

Life expectancy by education level at age 65
Sources:
- The **Eurostat database** (dataset Life expectancy by age, sex and educational attainment level [demo_mlexpecedu] accessed in June 2019) is the data source for 14 European countries
- Data from **national surveys** provided in response to the OECD Health Data questionnaire for the following two countries: Israel and the Netherlands.
- Data available from the **OECD Statistics Directorate project** (data extracted in December 2016) for the following 12 countries: Australia (2011), Austria (2012), Belgium (2011), Canada (2010), Chile (2004), France (2012), Latvia (2011), Mexico (2010), New Zealand (2006), Turkey (2013), United Kingdom (2011) and United States (2011).

Further information on the **sources and methods** is available:
- From Eurostat: Corsini, V. (2010), "Highly Educated Men and Women Likely to Live Longer", Eurostat Statistics in Focus 24/2010, Eurostat, Luxembourg, available at

http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/publication?p_product_code=KS-SF-10-024.
- From the OECD: "Inequalities in longevity by education in OECD countries: Insights from new OECD estimates". Authors: Fabrice Murtin, Johan Mackenbach, Domantas Jasilionis, Marco Mira d'Ercole. January 2017. http://www.oecd-ilibrary.org/social-issues-migration-health/inequalities-in-longevity-by-education-in-oecd-countries_6b64d9cf-en.

Infant mortality

The number of deaths of children aged under one year of age that occurred in a given year, expressed per 1000 live births.

Notes:
- The first measure is not based on any minimum threshold in gestation period or birthweight for the registration of a live birth.
- The second measure is based on a minimum threshold of 22 weeks of gestation (or 500 grams birthweight).

Neonatal mortality

The number of deaths of children under 28 days of age in a given year, expressed per 1000 live births.

Notes:
- The first measure is not based on any minimum threshold in gestation period or birthweight for the registration of a live birth.
- The second measure is based on a minimum threshold of 22 weeks of gestation (or 500 grams birthweight).

Perinatal mortality

The ratio of deaths of children within one week of birth (early neonatal deaths) plus foetal deaths of minimum gestation period 28 weeks or minimum foetal weight of 1000g, expressed per 1000 births.

Note that some variations exist in the definitions for some countries, particularly with regard to foetal deaths, and as such, care should be exercised when making comparisons between countries.

Maternal mortality

Number of maternal deaths, all causes, per 100 000 live births (ICD-10 codes O00-O99).

Note: The maternal mortality series records very small numbers so there may be large annual fluctuations, particularly in countries with low population levels.

Perceived health status

Good/very good health, females aged 15+
Fair (not good, not bad) health, females aged 15+
Bad/very bad health, females aged 15+
Good/very good health, males aged 15+
Fair (not good, not bad) health, males aged 15+
Bad/very bad health, males aged 15+
Good/very good health, total aged 15+

Fair (not good, not bad) health, total aged 15+
Bad/very bad health, total aged 15+

Percentage of the population, aged 15 years old and over who report their health to be 'good/very good' (or excellent) (all positive response categories), 'fair' (not good, not bad), 'bad/very bad' (all negative response categories)**.**

There is not yet full standardisation of the measurement of perceived health status across OECD countries. In Europe, a standard health interview survey instrument has been recommended to measure this variable. The recommendation is described in the publication: "Health Interview Surveys: Towards International Harmonization of Methods and Instruments," WHO Regional Office for Europe, 1996, and is as follows:
How is your health in general?
* Very good
* Good
* Fair
* Bad
* Very bad

Not all countries have adopted this standardised instrument. Differences in the questions and response categories used in national health surveys from this standardised instrument are listed in the *Sources and Methods*.

Perceived health status by age and gender

Good/very good health, females, 15-24
Good/very good health, females, 25-44
Good/very good health, females, 45-64
Good/very good health, females, 65+
Good/very good health, females aged 15+
Good/very good health, males, 15-24
Good/very good health, males, 25-44
Good/very good health, males, 45-64
Good/very good health, males, 65+
Good/very good health, males aged 15+
Good/very good health, total, 15-24
Good/very good health, total, 25-44
Good/very good health, total, 45-64
Good/very good health, total, 65+
Good/very good health, total aged 15+

Percentage of the population, aged 15 years old and over who report their health to be 'good/very good' (or excellent)**.**

There is not yet full standardisation of the measurement of perceived health status across OECD countries. In Europe, a standard health interview survey instrument has been recommended to measure this variable. The recommendation is described in detail in the publication: "Health Interview Surveys: Towards International Harmonization of Methods and Instruments," WHO Regional Office for Europe, 1996, and is as follows:
How is your health in general?
* Very good
* Good
* Fair
* Bad
* Very bad

Not all countries have adopted this standardised instrument. Differences in the questions and response categories used in national health surveys from this standardised instrument are listed in the *Sources and Methods*.

Perceived health status by socio-economic status

Good/very good health, total aged 15+, Income quintile 1 (lowest)
Good/very good health, total aged 15+, Income quintile 5 (highest)
Good/very good health, females, males and total population, aged 15+, Low education (ISCED 0 to 2)
Good/very good health, females, males and total population, aged 15+, Medium education (ISCED 3 and 4)
Good/very good health, females, males and total population, aged 15+, High education (ISCED 5 to 8)

1. Perceived health status by income quintile

This indicator is the proportion of persons aged 15 years old and over within the highest and lowest income quintiles who report their health to be 'good/very good' (or excellent). The data sources are generally health or household surveys.

Income quintiles

- **Quintile 1   Lowest 20% of income group**
- **Quintile 5   Highest 20% of income group**

Individual versus household income

- **If data come from <u>health surveys</u> and relate to individual income: the individuals' income will be used to assign them to income quintiles.**
- **If data come from <u>household surveys</u> and relate to household income: equivalisation of income for persons within households should take place. A common method divides household income by the square root of the household size. *Example*: a household of 2 adults and 3 children has an income of 50,000. The equivalised income for this household is 50,000 divided by the square root of 5 = 22,361. This equivalised income is then applied to each member of the household.**

More information on equivalence scales at http://www.oecd.org/eco/growth/OECD-Note-EquivalenceScales.pdf.

Gross versus net disposable income

If possible, net disposable income (after tax and transfers) should be used. If this is not possible, gross income can be used.

Appropriate sources and methods should explain the methodology used.

2. Perceived health status by education level
This indicator is the proportion of persons aged 15 years old and over by level of education who report their health to be "good" or "better".

Education level is expressed by the highest completed level of education, defined according to the latest International Standard Classification of Education, ISCED-2011:

Low education (ISCED 0 to 2)
Early childhood education (ISCED 0)
Primary education (ISCED 1)
Lower secondary education (ISCED 2)

Medium education (ISCED 3 and 4)
Upper secondary education (ISCED 3)
Post-secondary non-tertiary education (ISCED 4)

High education (ISCED 5 to 8)
Short-cycle tertiary education (ISCED 5)
Bachelor's or equivalent level (ISCED 6)
Master's or equivalent level (ISCED 7)
Doctoral or equivalent level (ISCED 8)

For details about each category, please refer to OECD (2015), "What are the benefits of ISCED 2011 classification for indicators on education?", Education Indicators in Focus, No. 36, OECD Publishing, Paris, http://dx.doi.org/10.1787/5jrqgdw9k1lr-en.

Low birthweight

Number of live births weighing less than 2500 grams as a percentage of total number of live births.

Acquired Immunodeficiency Syndrome (AIDS)

Number of AIDS cases and incidence rates per 100 000 population at year of diagnosis.

Please note that data are provisional due to reporting delays which sometimes can be for several years depending on the country.

For the OECD European countries, data up to 2017 are taken from the **"HIV/AIDS surveillance in Europe 2018 – 2017 data"** report (https://ecdc.europa.eu/sites/portal/files/documents/hiv-aids-surveillance-europe-2018.pdf) published by the **European Centre for Disease Prevention and Control** (ECDC, http://ecdc.europa.eu) and the **WHO Regional Office for Europe** (http://www.euro.who.int). Previous editions of the report are available via http://ecdc.europa.eu/en/publications/surveillance_reports/HIV_STI_and_blood_borne_viruses/Pages/hiv_aids_surveillance_in_Europe.aspx.

Incidence of pertussis, Incidence of measles, Incidence of hepatitis B

Rate of reported cases per 100 000 population (only <u>acute cases</u> are taken into account).

The **ECDC Surveillance Atlas of Infectious Diseases** (accessed on 24 June 2019) has been used as the source for all European countries, except Switzerland and Turkey.
Database available at http://atlas.ecdc.europa.eu/public/index.aspx.
- Pertussis: All cases, notification rates. Data updated from 1998 onwards.
- Measles: All cases, notification rates. Data updated from 1999 onwards.
- Hepatitis B: Acute cases, notification rates. Data updated from 2006 onwards.
Methodology: Cases presented in ECDC outputs are possible, probable, confirmed cases as per EU 2012 case definitions. ICD-codes are not used. See EU case definitions at https://ecdc.europa.eu/en/infectious-diseases-public-health/surveillance-and-disease-data/eu-case-definitions.

Injuries in road traffic accidents

Number of people injured in road traffic accidents per million population.

The United Nations Economic Commission for Europe (UNECE), *Statistics of Road Traffic Accidents in Europe and North America* (several issues), has been used as a source for several OECD countries (see detailed list below).
Database available at http://w3.unece.org/PXWeb2015/pxweb/en/STAT/STAT__40-TRTRANS__01-TRACCIDENTS (data extracted 17 June 2019).
Other countries have supplied data directly.

The following definitions are used in this report:
Road traffic accident:
An accident which occurred or originated on a way or street open to public traffic; resulted in one or more persons being killed or injured, and at least one moving vehicle was involved. These accidents therefore include collisions between vehicles, between vehicles and pedestrians and between vehicles and animals or fixed obstacles. **Single vehicle accidents** in which one vehicle alone (and no other road user) was involved are included. **Multi-vehicle collisions** are counted only as one accident provided that the successive collisions happened at very short intervals
Injured:
Any person who was not killed but sustained one or more serious or slight injuries as a result of the accident.
Serious injuries:
Fractures, concussions, internal lesions, crushing, severe cuts and laceration, severe general shock requiring medical treatment and any other serious lesions entailing detention in hospital.
Slight injuries:
Secondary injuries such as sprains or bruises. Persons complaining of shock, but who have not sustained other injuries, should not be considered in the statistics as having been injured unless they show very clear symptoms of shock and have received medical treatment or appeared to require medical attention.

⭕ **Please note that some countries include people killed in road traffic accidents. Differences in definition are noted in the country-specific *Sources and Methods*.**

Self-reported absence from work due to illness

The number of self-reported work days lost per year due to illness per employed person. It excludes maternity leave.

Sources and Methods
Labour force, general social or health surveys.

Compensated absence from work due to illness

The number of compensated work days lost per year due to illness per employed person. It excludes maternity leave.

Sources and Methods
Administrative sources responsible for compensating absence from work due to illness (e.g., social security, public or private insurance agencies).

⭕ **Please note that differences in the coverage of the working population and in reporting systems limit the comparability of data across countries.**

HEALTH_LVNG - Non-Medical Determinants of Health

Tobacco consumption in grams per capita (age 15+)

Annual consumption of tobacco items (e.g. cigarettes, cigars) in grams per person aged 15 years old or more.

Note: The methodology to convert tobacco items into grams may differ across countries. Typically a cigarette weighs approximately 1 gram of which the tobacco content can vary between 65-100% depending on the type of cigarette; a cigar weighs approximately 2 grams and contains a similar proportion of tobacco as a cigarette.

Average number of cigarettes per smoker per day (age 15+)

The average number of cigarettes per smoker per day.

Daily smokers (age 15+)

Daily smokers is defined as the percentage of the population aged 15 years old or over who report that they are daily smokers.

Note: International comparability is limited due to the lack of standardisation in the measurement of smoking habits in health interview surveys across OECD countries. There is variation in the wording of the question, the response categories and the related administrative methods.

A standard health interview survey instrument to measure smoking habits in a population has been recommended by the World Health Organization Regional Office for Europe. The recommendation is described in detail in the publication: "Health Interview Surveys: Towards International Harmonization of Methods and Instruments" WHO Regional Office for Europe, 1996.

The instrument comprises the following questions:
1. Do you smoke?
-Yes, daily
-Yes, occasionally (go to question 3)
-No (go to question 4)
2. How many cigarettes do you usually smoke on average each day?
- Does not smoke cigarettes
- Fewer than 20
- 20 or more (heavy smokers)

Use of vaping products New

Vapers, percentage of adults (total, females and males aged 15+) and young adults (total, females and males aged 15-24 years old), who are regular users.
Regular users are defined as using vaping devices at least monthly, i.e. daily, weekly or monthly.

Notes:
- Caution should be used when interpreting the data, due to small sample sizes leading to great variations from one year to another for some countries.
- Age groups may also differ from one country to another.
- Any deviation from the OECD definition is indicated with a D in the OECD.Stat dataset and in the information available below.

Vapour devices are distinguished from traditional combustible tobacco products by their production of vapour through a process of heating rather than the burning associated with the consumption of cigarettes, cigars, cigarillos or smoking tobacco. In their current form, vapour devices usually include electronic circuitry and a power source supplying energy to the heating mechanism (Source: Euromonitor International).

All Electronic Nicotine Delivery Systems and Electronic Non-Nicotine Delivery Systems (ENDS/ENNDS) heat a solution (e-liquid) to create an aerosol which frequently contains flavourants, usually dissolved into Propylene Glycol or/and Glycerin. All ENDS (but not ENNDS) contain nicotine. Although generally considered a single product class, these products constitute a diverse group with potentially significant differences in the production of toxicants and delivery of nicotine. There are several coexisting types of devices on the market: first-generation or so-called cigalikes, second-generation tank systems and even larger third-generation or personal vaporizers. Others classify these devices into closed and open systems depending mainly on the degree of control that users have over the e-liquid used and the voltage and resistance applied to heating the e-liquid and ventilation features (Source: WHO).

Vapour products include the following types of products:

- **Closed Vaping Systems:** Closed system e-cigarettes use ready-made refills, which screw directly on to the e-cigarette's battery.
- **Open Vaping Systems:** In an open system, the liquid that is vapourised can be refilled manually by the user. There is also a removable mouthpiece.
- **Heated Tobacco Products:** Heated tobacco products are tobacco products that produce aerosols containing nicotine and other chemicals, which are inhaled by users, through the mouth. They contain the highly addictive substance nicotine (contained in the tobacco), which makes HTPs addictive. They also contain non-tobacco additives, and are often flavoured. HTPs mimic the behaviour of smoking conventional cigarettes, and some make use of specifically designed cigarettes to contain the tobacco for heating.

Alcohol consumption in litres per capita (age 15+)

Annual consumption of pure alcohol in litres, per person, aged 15 years old and over.

Notes:
🛑 **Most countries typically provide sales data as a proxy for consumption, as indicated in the methodology provided below. Caution should thus be used in interpreting the data.**
- The methodology to convert alcoholic drinks to pure alcohol may differ across countries. Typically beer is weighted as 4-5%, wine as 11-16% and spirits as 40% of pure alcohol equivalent.

The **WHO Global Information System on Alcohol and Health (GISAH)** (accessed on 22 May 2018, with data updated from 2000 onwards) has been used as a source for several OECD countries (see detailed list below). Database available at http://www.who.int/gho/alcohol/en/. Other countries have supplied data directly.
WHO GISAH methodology:
- Recorded alcohol per capita (15+) consumption of pure alcohol is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits, other) from different sources. The first priority in the decision tree is given to government statistics; second are country-specific alcohol industry statistics in the public domain (Canadean, IWSR-International Wine and Spirit Research, OIV-International Organisation of Vine and Wine, Wine Institute, historically World Drink Trends); and third is the Food and Agriculture Organization of the United Nations' statistical database (FAOSTAT).
- In order to make the conversion into litres of pure alcohol, the alcohol content (% alcohol by volume) is considered to be as follows: Beer (barley beer 5%), Wine (grape wine 12%; must of grape 9%, vermouth 16%), Spirits (distilled spirits 40%; spirit-like 30%), and Other (sorghum, millet, maize beers 5%; cider 5%; fortified wine 17% and 18%; fermented wheat and fermented rice 9%; other fermented beverages 9%).
Further information: http://www.who.int/gho/alcohol/en/.

Consumption of vegetables and fruits – Survey data

Proportion of the population aged 15+ eating vegetables (excluding potatoes and juice) at least once per day.
Proportion of the population aged 15+ eating fruits (excluding juice) at least once per day.

The main data sources are national health surveys. A number of European countries have implemented the relevant module recommended in the European Health Interview Survey.
Although most countries ask questions of the type "How often do you eat fruits/vegetables", which provide information on frequency of consumption, some countries (such as Australia, Korea and New Zealand) ask question of the type "How many serves of fruit/vegetables do you usually eat each day", which provide information on quantity of consumption. Data derived from quantity-type questions are indicated as "d".

Overweight or obese population - Self-reported data (age 15+)

The Body Mass Index (BMI) is a single number that evaluates an individual's weight status in relation to height (weight/height^2) with weight in kilograms and height in meters.

- Overweight (but not obese) **is defined as a BMI between 25 and 30 kg/m^2 (25≤ BMI <30 kg/m²).**
- Obesity is defined as a BMI of 30 kg/m² or more (BMI ≥30 kg/m²).
- Overweight or obese population is the sum of the population with a BMI over 25 kg/m² (BMI ≥25 kg/m²).
For further details on the BMI classification, see http://www.who.int/bmi/index.jsp?introPage=intro_3.html.

Overweight or obese population - Measured data (age 15+)

The Body Mass Index (BMI) is a single number that evaluates an individual's weight status in relation to height (weight/height^2) with weight in kilograms and height in meters.

- Overweight (but not obese) **is defined as a BMI between 25 and 30 kg/m^2 (25≤ BMI <30 kg/m²).**
- Obesity is defined as a BMI of 30 kg/m² or more (BMI ≥30 kg/m²).
- Overweight or obese population is the sum of the population with a BMI over 25 kg/m² (BMI ≥25 kg/m²).
For further details on the BMI classification, see http://www.who.int/bmi/index.jsp?introPage=intro_3.html.

HEALTH_REAC - Health Care Resources: Remuneration

Remuneration of general practitioners

Remuneration is defined as the average gross annual income, including social security contributions and income taxes payable by the employee.
General Practice: General practice includes fully-qualified general practitioners (GPs). Physicians in training should normally be excluded.

Note: To the extent possible, average annual income should refer to physicians working full-time.

Salaried: Physicians who are employees and who receive most of their income via a salary.

Self-employed: Physicians who are primarily non-salaried. That is, they are either self-employed, or operate independently, usually receiving (mainly) either capitation or fee-for-service reimbursement.

For physicians who are both salaried and operate in a self-employed or independent capacity, they are presented in the category under which they receive the majority of their compensation.

Inclusion:
- the values of any social contributions, (income) taxes, etc. payable by the employee even if they are actually withheld by the employer and paid directly to social insurance schemes, tax authorities, etc. on behalf of the employee
- all gratuities, bonuses, overtime compensation and "thirteenth month payments"
- any supplementary income (income from private practices for salaried physicians or salaried work for self-employed physicians).

Exclusion:
- for salaried physicians, social contributions payable by the employer
- for self-employed physicians, practice expenses.

Remuneration of specialists

Remuneration is defined as the average <u>gross</u> annual income, including social security contributions and income taxes payable by the employee.

Specialists: Fully-qualified physicians who have specialised and work primarily in areas other than general practice. Physicians in training should normally be excluded.

Note: To the extent possible, average annual income should refer to physicians working full-time.

Salaried: Physicians who are employees and who receive most of their income via a salary.

Self-employed: Physicians who are primarily non-salaried. That is, they are either self-employed, or operate independently, usually receiving (mainly) either capitation or fee-for-service reimbursement.

For physicians who are both salaried and operate in a self-employed or independent capacity, they are presented in the category under which they receive the majority of their compensation.

Inclusion:
- the values of any social contributions, (income) taxes, etc. payable by the employee even if they are actually withheld by the employer and paid directly to social insurance schemes, tax authorities, etc. on behalf of the employee
- all gratuities, bonuses, overtime compensation and "thirteenth month payments"
- any supplementary income (income from private practices for salaried physicians or salaried work for self-employed physicians).

Exclusion:
- for salaried physicians, social contributions payable by the employer
- for self-employed physicians, practice expenses.

Remuneration of hospital nurses

Remuneration is defined as the average <u>gross</u> annual income, including social security contributions and income taxes payable by the employee.

Salaried hospital nurses: Certified/registered nurses actively practising in public and private hospitals and who receive most of their income via a salary, including fully-qualified nurses (with post-secondary education in nursing) and associate/practical/vocational nurses (with a lower level of nursing skills but also usually registered).

<u>The following categories of nurses should normally be excluded</u>:

- Nursing aids/assistants and care workers who do not have any recognised qualification/certification in nursing
- Nurses in training
- Midwives (however registered nurses working part-time as midwives should be included)
- Nurse managers.

Note: To the extent possible, average annual income should refer to nurses working full-time.

Average annual income:
Inclusion:
- the values of any social contributions, (income) taxes, etc. payable by the employee even if they are actually withheld by the employer and paid directly to social insurance schemes, tax authorities, etc. on behalf of the employee
- all gratuities, bonuses, overtime compensation and "thirteenth month payments".

Exclusion:
- social contributions payable by the employer.

HEALTH_PROC - Health Care Utilisation: Waiting times

Waiting times for selected elective surgeries

Measurement approaches and units:
Waiting times from specialist assessment to treatment: Mean (days)
Waiting times from specialist assessment to treatment: Median (days)
Waiting times from specialist assessment to treatment: % of all patients waiting more than 3 months
Waiting times of patients on the list: Mean (days)
Waiting times of patients on the list: Median (days)
Waiting times of patients on the list: % of all patients waiting more than 3 months

Selected procedures (non-emergency/elective):
Cataract surgery - ICD-9-CM (1996): 13.1--13.8
Percutaneous transluminal coronary angioplasty (PTCA) - ICD-9-CM (1996): 36.01, 36.02, 36.05
Coronary bypass - ICD-9-CM (1996): 36.1
Prostatectomy - ICD-9-CM (1996): 60.2, 60.3--60.6
Hysterectomy - ICD-9-CM (1996): 68.3--68.7; 68.9
Hip replacement (total and partial, including the revision of hip replacement) - ICD-9-CM (1996): 81.51--81.53
Knee replacement (including the revision of knee replacement) - ICD-9-CM (1996): 81.54--81.55

Definitions

Waiting times from specialist assessment to treatment includes the time elapsed for patients on the non-emergency (elective) surgery waiting list from the date they were added to the waiting list for the procedure (following specialist assessment) to the date they were admitted for treatment.

Inclusion
- All publicly-funded patients (including patients who have received the treatment either by publicly- or privately-owned providers).

  [Note: If the data coverage also includes patients whose treatment has been completely privately-funded, please indicate this in the *Sources and Methods*]

Exclusion
- The time elapsed from the date of referral of the general practitioner to the date of specialist assessment (in some countries, this is referred to as 'outpatient waiting time').

Waiting times of patients on the list includes the time elapsed for patients on the non-emergency (elective) surgery waiting list from the date they were added to the waiting list for the procedure (following specialist assessment) to a designated census date.

Exclusion
- The time elapsed from the date of referral of the general practitioner to the date of specialist assessment (in some countries, this is referred to as 'outpatient waiting time')

Measurement units

Mean (days): The mean (average) number of days that patients have been waiting for each procedure.

Median (days): The median is the number of days separating evenly the higher half of patients who have waited the most from the other half who have waited the least. (Compared with the mean, the median reduces the influence of outliers, that is, patients who have been waiting for a very long time).
Percentage of all patients waiting more than three months: The number of patients waiting more than three months divided by all patients (treated or on the waiting list).

HEALTH_PHMC - Pharmaceutical Market

Pharmaceutical consumption by DDDs

Pharmaceutical consumption according to the Anatomic Therapeutic Chemical Classification (ATC)/Defined Daily Dose (DDD) system, created by the WHO Collaborating Centre for Drug Statistics Methodology.

The Anatomic Therapeutic Chemical Classification system divides drugs into different groups according to the organ system on which they act and/or therapeutical, pharmacological and chemical characteristics. The main principles for the classification of medicinal substances according to the ATC is presented in the publication "Guidelines for ATC classification and DDD assignment", WHO Collaborating Centre for Drug Statistics Methodology, Oslo. The publication "ATC Index with DDDs" lists all assigned ATC codes and DDD values. Both these publications are updated annually.

The ATC codes below are based on the 2020 version of the ATC Index.
All alterations implemented from January 2020 are available on the WHO Collaborating Centre for Drug Statistics Methodology website at http://www.whocc.no/atc/lists_of_new_atc_ddds_and_altera/alterations_in_atc_ddd/.

The unit of measurement is Defined Daily Dose (DDD), defined as the assumed average maintenance dose per day for a drug used on its main indication in adults.

Main groups / groups based on three levels	Codes (2020 Index)
A-Alimentary tract and metabolism	**A**
Antacids	A02A
Drugs for peptic ulcer and gastro-oesophageal reflux diseases (GORD)	A02B
Drugs used in diabetes	A10
B-Blood and blood forming organs	**B**
C-Cardiovascular system	**C**

Cardiac glycosides	C01A
Antiarrhythmics, Class I and III	C01B
Antihypertensives	C02
Diuretics	C03
Beta blocking agents	C07
Calcium channel blockers	C08
Agents acting on the Renin-Angiotensin system	C09
Lipid modifying agents	C10
G-Genito urinary system and sex hormones	**G**
Sex hormones and modulators of the genital system	G03
H-Systemic hormonal preparations, excluding sex hormones and insulins	**H**
J-Antiinfectives for systemic use	**J**
Antibacterials for systemic use	J01
M-Musculo-skeletal system	**M**
Antiinflammatory and antirheumatic products non-steroids	M01A
N-Nervous system	**N**
Analgesics	N02
Anxiolytics	N05B
Hypnotics and sedatives	N05C
Antidepressants	N06A
R-Respiratory system	**R**
Drugs for obstructive airway diseases	R03

Pharmaceutical sales

Sales of pharmaceutical products on the domestic market, in total and by selected Anatomic Therapeutic Chemical (ATC) groups, based on retail prices (which means the final price paid by the customer).

The ATC codes below are based on the 2020 version of the ATC Index.
All alterations implemented from January 2020 are available on the WHO Collaborating Centre for Drug Statistics Methodology website at
http://www.whocc.no/atc/lists_of_new_atc_ddds_and_altera/alterations_in_atc_ddd/.

Note: There are at least three possible sources of under-reporting of drug sales in different countries: 1) sales data may only cover those drugs that are reimbursed by public insurance schemes; 2) they may be based on ex-factory or wholesale prices rather than retail prices; and 3) sales data may exclude drug consumption in hospitals.

Please also note that depending on the allocation of pharmaceutical products with more than one use, differences in reporting of specific drugs may occur across countries, thereby affecting the relative size of specific ATC groups.

Main groups / groups based on three levels	**Codes (2020 Index)**
Total pharmaceutical sales	-
A-Alimentary tract and metabolism	**A**
Antacids	A02A
Drugs for peptic ulcer and gastro-oesophageal reflux diseases (GORD)	A02B
Drugs used in diabetes	A10
B-Blood and blood forming organs	**B**
C-Cardiovascular system	**C**
Cardiac glycosides	C01A
Antiarrhythmics, Class I and III	C01B
Antihypertensives	C02

Diuretics	C03
Beta blocking agents	C07
Calcium channel blockers	C08
Agents acting on the Renin-Angiotensin system	C09
Lipid modifying agents	C10
G-Genito urinary system and sex hormones	**G**
Sex hormones and modulators of the genital system	G03
H-Systemic hormonal preparations, excluding sex hormones and insulins	**H**
J-Antiinfectives for systemic use	**J**
Antibacterials for systemic use	J01
M-Musculo-skeletal system	**M**
Antiinflammatory and antirheumatic products non-steroids	M01A
N-Nervous system	**N**
Analgesics	N02
Anxiolytics	N05B
Hypnotics and sedatives	N05C
Antidepressants	N06A
R-Respiratory system	**R**
Drugs for obstructive airway diseases	R03
Products not elsewhere classified	-

Generic drug market

Definitions
Source: Glossary developed by the WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, available at http://whocc.goeg.at/Glossary/Search.

Generic
A pharmaceutical product which has the same qualitative and quantitative composition in active substances and the same pharmaceutical form as the reference medicinal product, and whose bioequivalence with the reference medicinal product has been demonstrated by appropriate bioavailability studies.
Generics can be classified in branded generics (generics with a specific trade name) and unbranded generics (which use the international non-proprietary name and the name of the company).

Reimbursement market
The reimbursement market is the sub-market which includes medicines whose expenses covered by a third party payer.

Community pharmacy
Health care facility dispensing medicines (prescription-only medicines, i.e. POM, and OTC, reimbursable and non-reimbursable medicines) to out-patients.
Pharmacies are subject to pharmacy legislation (e.g. national legislation regarding establishment and ownership of pharmacies). In many countries, community pharmacies are private facilities, but public pharmacies (i.e. in public ownership) also exist. Pharmaceutical provision for inpatients is provided for by hospital pharmacies or pharmaceutical depots; in some cases hospital pharmacies also act as community pharmacies.

Hospital
See SHA definition for H.P.1.

Value
Data are collected as a share expressed in value. Values can for instance be the turnover of pharmaceutical companies, the amount paid for pharmaceuticals by third-party payers, or the

amount paid all payers (third-party and consumers). Market value are most often at ex-factory prices, while amounts paid by third-party payers (and consumers) are in general at retails prices.

Volume
Data are collected as a share expressed in volume. Volumes can be expressed in DDDs or as a number of packages/boxes or standard units.

HEALTH_LTCR - Long-Term Care Resources and Utilisation

Definition of long-term care

Long-term care (health and social) consists of a range of medical, personal care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health status for people with a degree of long-term dependency, assisting them with their personal care (through help for activities of daily living, ADL, such as eating, washing and dressing) and assisting them to live independently (through help for instrumental activities of daily living, IADL, such as cooking, shopping and managing finances).
[Note: This definition is consistent with the definition of long-term care (health and social) under the System of Health Accounts 2011 – HC.3 for the health component and HCR.1 for the social component].

Long-term care workers: formal sector (Head counts and FTE)

Long-term care workers are individuals who provide care to long-term care recipients.

Formal LTC workers include the following occupations and categories:
1) Nurses, as defined by the ISCO-08 classification (2221 ISCO code for professional nurses and 3221 ISCO code for associate professional nurses, providing long-term care at home or in LTC institutions (other than hospitals)).
Inclusion:
i) Persons who have completed their studies/education in nursing and who are licensed to practice (including both professional nurses and associate/practical/vocational nurses);
ii) Salaried and self-employed nurses delivering services at home or in LTC institutions (other than hospitals);
iii) Foreign nurses licensed to practice and actively practising in the country;
iv) Nurses providing long-term care to patients affected by dementia and/or Alzheimer's disease.

Exclusion:
i) Students who have not yet graduated;
ii) Nursing aids/assistants and care workers who do not have any recognised qualification/certification as a licensed nurse;
iii) Nurses working in administration, research, and in other posts that exclude direct contact with the patients;
iv) Unemployed nurses and retired nurses;
v) Nurses working abroad;
vi) Nurses providing social services;
vii) Psychiatric nurses.

2) Personal care workers (caregivers) include formal workers providing LTC services at home or in institutions (other than hospitals) and who are not qualified or certified as nurses. As per the draft definition in the ISCO-08 classification, personal care workers are defined as people providing routine personal care, such as bathing, dressing, or grooming, to elderly, convalescent,

or disabled persons in their own homes or in institutions.

Inclusion:
i) Nursing aids/assistants and care workers providing LTC services, who do not have any recognised qualification/certification in nursing;
ii) Family members, neighbours or friends employed (i.e., under a formal contractual obligation and/or declared to social security systems as caregiver) by the care recipient, or person/agency representing the care recipient, and/or by public care services and private care service companies, to provide the care services to the person in need for care.

Exclusion:
i) Informal caregivers receiving income support or other cash payments from the care recipient as part of cash programmes and/or consumer-choice programmes, but who are not formally employed, or paid for, by the care recipient (or person/agency representing the care recipient, including providers/organisations, such as public social care services and private care service companies);
ii) Unemployed and retired caregivers;
iii) Caregivers working abroad;
iv) Caregivers in assessment teams employed to evaluate care needs and other persons employed in administrative positions;
vi) Social workers/community workers.

Long-term care settings
- Long-term care at home is provided to people with functional restrictions who mainly reside at their own home. It also applies to the use of institutions on a temporary basis to support continued living at home - such as in the case of community care and day care centres and in the case of respite care. Home care also includes specially designed or adapted living arrangements (for instance, sheltered house) for persons who require help on a regular basis while guaranteeing a high degree of autonomy and self-control, and supportive living arrangements.

- Long-term care institutions herein refer to nursing and residential care facilities (HP.2) which provide accommodation and long-term care as a package. They refer to specially designed institutions or hospital-like settings where the predominant service component is long-term care and the services are provided for people with moderate to severe functional restrictions.

Inclusion (for LTC institutions):
- Nurses and personal carers providing LTC services in nursing and residential care facilities (HP.2) dedicated to long-term nursing care (HC.3).

Exclusion (for LTC institutions):
- Nurses and personal carers providing LTC services in institutions used on a temporary basis to support continued living at home - such as community care, day care centres and respite care
- Nurses and personal carers providing LTC services in specially designed or adapted living arrangements for persons who require help on a regular basis while guaranteeing a high degree of autonomy and self-control (defined as home).
- Nurses and personal carers providing LTC services in hospitals (HP.1).

🛑 **Full-time equivalent data are usually calculated on the basis of the standard or normal working time in the country.**

Long-term care recipients in institutions (other than hospitals)

People receiving formal (paid) long-term care in institutions (other than hospitals).

Note: The services received by long-term care recipients can be publicly or privately financed.

Long-term care institutions refer to nursing and residential care facilities (**HP.2**) which provide accommodation and long-term care as a package. They include specially designed institutions or hospital-like settings where the predominant service component is long-term care and the services are provided for people with moderate to severe functional restrictions.

Inclusion:
- Persons who receive long-term care by paid long-term care providers, including non-professionals receiving cash payments under a social programme
- Recipients of cash benefits such as consumer-choice programmes, care allowances or other social benefits which are granted with the primary goal of supporting individuals with long-term care needs based on an assessment of needs.

Exclusion:
- Persons receiving long-term care in hospitals (HP.1)
- Disabled persons of working age who receive income benefits or benefits for labour market integration without long-term care services
- Persons who need help only with instrumental activities of daily living (IADL), that is, receiving only long-term social care as defined under the Health Accounts questionnaire (HC.R.6-type services).

Long-term care recipients at home

People receiving formal (paid) long-term care at home.
[Please refer to definition of formal long-term care in the long-term care (LTC) workers section]

Note: The services received by long-term care recipients can be publicly or privately financed.

Long-term care at home is provided to people with functional restrictions who mainly reside at their own home. It also applies to the use of institutions on a temporary basis to support continued living at home - such as in the case of community care and day care centres and in the case of respite care. Home care also includes specially designed or adapted living arrangements for persons who require help on a regular basis while guaranteeing a high degree of autonomy and self-control.

Inclusion:
- Persons who receive long-term care by paid long-term care providers, including non-professionals receiving cash payments under a social programme
- Recipients of cash benefits such as consumer-choice programmes, care allowances or other social benefits which are granted with the primary goal of supporting individuals with long-term care needs based on an assessment of needs.

Exclusion:
- Disabled persons of working age who receive income benefits or benefits for labour market integration without long-term care services
- Persons who need help only with instrumental activities of daily living (IADL), that is, receiving only long-term social care as defined under the Health Accounts questionnaire (HC.R.6-type services).

HEALTH_PROT - Social Protection

Government/social health insurance

Total health care
In-patient and acute care
Out-patient medical care
Pharmaceutical goods

Share of population eligible for a defined set of health care goods and services under public programmes.

This series refers to the share of the population eligible to health care goods and services that are included in total public health expenditure. Coverage in this sense is independent of the scope of cost-sharing.

Most social security arrangements link entitlement to labour force participation and therefore, employment surveys are an important source of data. In these cases, the construction of a coverage index requires a calculation of each group of the labour force (private sector blue and white collars, public sector employees, the self-employed, farmhands, farmers, clergymen), plus the non-active population entitled to medical benefits.

Private health insurance

Private health insurance comprises insurance schemes financed through private health premiums, i.e., payments that a policyholder agrees to make for coverage under a given insurance policy, where an insurance policy generally consists of a contract that is issued by an insurer to a covered person. Take up of private health insurance is often, but not always, voluntary (it may also be compulsory for employees as part of their working conditions). Premiums are non-income-related, although the purchase of PHI by a specific population group or by the population at large can be subsidised by the government. The pool of financing is not channelled nor administered through the government, even when the insurer is government-owned.

Private health insurance <u>includes</u>:
- Employer self-insured health benefits, whereby an employer self-insures health coverage instead of purchasing cover from an insurance company. The employer acts as an insurer in that it assumes insurance risk and is thereby often subject to the same regulatory requirements as other health insurers.
- Special schemes for government employees, where the government, in its role as employers, pays part or the whole premiums of private health insurance cover subscribed for its employees.

For the purpose of this data collection, private health insurance <u>excludes</u> the following schemes:
- Travel insurance covering the risk of illness or accidents incurred abroad;
- Employers or corporation health programmes for their employees that do not imply insurance (for example, direct supply of health services or reimbursement of certain health-related costs);
- Medical savings accounts, health savings accounts or similar schemes which offer pre-payment but do not imply risk sharing or pooling across individuals;
- Life and long-term care insurance schemes which include a health element, such as disease specific, lump sum, critical illness, income replacement, cash products, temporary or permanent disability, and long-term care insurance.

<u>Data reporting</u>:
Total PHI coverage: Total PHI coverage is a head count of all individuals covered by at least one PHI policy (including both individuals covered in their own name and dependents). To avoid duplications, it should not refer to the number of PHI policies sold in the country, as individuals may be covered by more than one PHI product. Similarly, total population coverage is not necessarily the sum of PHI coverage by different types, as an individual may hold more than one PHI policy.

Breakdown by type of PHI: Where possible, data has been broken down by private health insurance type. Where data could not be broken down by type or main role, they were reported only in the category "total", or under the category that best represents the characteristics of PHI coverage in the country.

Primary PHI: private health insurance that represents the only available access to health coverage

because i) there is no government/social coverage or individuals are not eligible to coverage under government/social programmes (principal); ii) individuals are entitled to government/social coverage but have chosen to opt out of such coverage (substitute).

Duplicate PHI: private health insurance that offers coverage for health services already included under government health insurance, while also offering access to different providers (e.g., private hospitals) or levels of service (e.g., faster access to care). It does not exempt individuals from contributing to government health coverage programmes.

Complementary PHI: private health insurance that complements coverage of government/social insured services by covering all or part of the residual costs not otherwise reimbursed (e.g., cost-sharing, co-payments).

Supplementary PHI: private health insurance that provides coverage for additional health services not at all covered by the government/social scheme.