Health Accounts Experts

SUMMARY RECORD OF THE 10th MEETING OF HEALTH ACCOUNTS EXPERTS
OECD Conference Centre, 2 rue André-Pascal, 75016 Paris, France

8-9 October 2008

Contact: Mr Luca LORENZONI, Administrator (Health Accounts)
Tel: + 33 (0)1 45 24 76 21; e-mail: luca.lorenzoni@oecd.org
TABLE OF CONTENTS

Item 1. Opening and adoption of the agenda................................................................. 3
Item 2. Evaluation of the 2008 OECD, EUROSTAT and WHO Joint Health Accounts Questionnaire Data Collection................................................................. 3
Item 3. Proposal for the 2009 OECD, EUROSTAT and WHO Joint Health Accounts Questionnaire ...... 3
Item 4. Report on project for the development of guidelines for expenditure by disease, age and gender. 6
Item 5. Report on project for the development of guidelines for private expenditures...................... 6
Item 6: Revision process for the System of Health Accounts manual: summary of the current state of the play................................................................................................................................. 6
Item 7: SHA revision unit 1: purposes and principles of the SHA ........................................ 7
Item 8: SHA revision unit 2: global boundaries of health care .............................................. 8
Item 9: SHA revision unit 5: types of health accounts.......................................................... 9
Item 10: SHA revision unit 7: ICHC-HC Functional Classification of Health Care ....................... 10
Item 11: SHA revision unit 9: Classification of Financial Sources.......................................... 11
Item 12: SHA revision unit 10: Classification of Financing Schemes....................................... 12
Item 13: Overview of activities on health at the OECD.......................................................... 13
Item 14: Development of Purchasing Power Parities (PPPs) in the health sector......................... 13
Item 15: Health care quality indicators (HCQI) project: progress and next steps........................ 14
Item 16: Measuring disparities in health status and in access and use of health care: progress and next steps................................................................................................................................. 15
Item 17: Proposed framework for data collection on long-term care........................................ 15
Item 18: Brief update on development of dissemination systems for OECD health statistics........ 16

ANNEX: PARTICIPANTS LIST/LISTE DES PARTICIPANTS ...................................................... 17
Item 1. Opening and adoption of the agenda
1. Delegates were welcomed to the 10th Meeting of Health Accounts Experts by the Secretariat. The importance of the meeting with regard to the revision of the SHA manual was stressed, in that it provided an opportunity for country delegates to discuss the initial proposal for units in the first waves of the process.

2. Ms. Cathy Cowan of the United States Centre for Medicare and Medicaid Services was nominated and accepted to chair the meeting. The agenda of the meeting was duly adopted.

3. The first part of the meeting was devoted to discussions of current health accounts data collections and reports on ongoing projects related to the System of Health Accounts.

Item 2. Evaluation of the 2008 OECD, EUROSTAT and WHO Joint Health Accounts Questionnaire Data Collection
4. The OECD Secretariat (Mr. David Morgan) presented, on behalf of the International Health Accounts Team (IHAT), an evaluation of the 2008 OECD, Eurostat and WHO Joint Health Accounts Data Collection [DELSA/HEA/HA(2008)1]. The significant progress in the number of countries submitting the questionnaire and hence the improvement in health expenditure comparability was highlighted. At the same time, it was noted that further effort was needed to improve data availability and comparability on some specific policy-important areas (such as over-the-counter medical goods and cost-sharing).

Item 3. Proposal for the 2009 OECD, EUROSTAT and WHO Joint Health Accounts Questionnaire
5. The OECD Secretariat (Mr. Roberto Astolfi) then presented, also on behalf of IHAT, the proposal for the 2009 joint data collection [DELSA/HEA/HA(2008)2], stressing the intention to maintain the stability of the questionnaire by introducing no changes to the data tables. It was proposed to clarify the notes regarding financing sources and capital formation to improve the reporting in these two areas.

6. Following these two presentations, there was a ‘tour de table’ allowing each country to share its experiences and plans in reporting on the joint questionnaire. The main points made by country delegates were as follows:

- **Australia:** Will submit according to their own timetable with delivery of tables up to the financial year 2007/08 in September/October 2009.

- **Austria:** Provided SHA tables (for 2004) under the joint questionnaire for the first time and expect to provide tables for 2005 and 2006 under the 2009 collection. Also working on regional accounts (at a local government level), and a project on expenditure by age and gender should see results published in 2010.

- **Belgium:** No particular changes to the process for the 2009 collection; main unknown will be the timeliness of the submission because of the availability of data.

- **Canada:** Expect no problems with meeting the deadlines in 2009. Regarding the FSxHF table, they plan to undertake a feasibility study to collect information over the coming years.

- **Czech Republic:** Expect to provide the 3 main tables on time. Problems continue with information on private cost sharing. Information sources had been identified regarding non-profit institutions for 2003-07 and the Ministry of Health was working on clarifying the data on LTC. Next year they will continue to provide some information on RC but not on FS.
Denmark: New team in place including Statistics Denmark and had led to better data quality. Tables for 2003 to 2005 had been revised. Although some difficulty in meeting the deadlines for the 3 main tables in 2008 they foresee no problems for 2009.

Finland: SHA tables produced back to 1995 to a good level of detail. Certain challenges remain – such as capital formation. Hope to provide the FSxHF and RCxHP tables and see no problem with the timetable.

France: Expect to provide 3 main tables as for the 2008 questionnaire with the FSxHF later. Regarding the latter, seek clarification issues regarding taxes by households and the handling of deficits/surpluses.

Germany: No problems with 2008 reporting but would keep the same timetable in 2009, i.e. submitting data around 6 weeks after the deadline of end of March. No additional tables can be expected in 2009. The main area of work in 2008 had been the German Cost of Illness accounts.

Hungary: Some delays experienced in submitting the tables this year. The main issues related to the private sector with some data gaps. The proposed deadline appears tight for them with some background data not becoming available until end March.

Iceland: Reported SHA tables for the period 2003-06. Next year they plan to revise 2006 and submit the new tables by the March deadline. This year’s work had been included in their national health report and was accompanied by a news release and a webpage.

Ireland: Feasibility study ongoing with the three main tables planned with 2006 data which they hope to report. The main issues relate to availability of data on private expenditure while the public health expenditure data are generally good. A decision would then be made on the institutionalisation of SHA in Ireland.

Italy: SHA implementation study in progress, coordinated by the Ministry of Health. Hope to complete the 2009 questionnaire according to the minimum requirements.

Japan: Implemented some minor changes to the data this year and because of the deadline they would only be submitting preliminary 2006 data in October.

Korea: Submission to the joint collection now stable - report main tables and FSxHF. Hope to enlarge reporting to include RCxHP table and provide a better breakdown of public health and prevention categories. The end-March deadline is rather early regarding the availability of some data sources.

Luxembourg: Resource issues meant that they were unable to submit the questionnaire in 2008 but hope to be able to complete the 2009 questionnaire for the period 2003-07. Continuing problems with data coherence and the quality of data regarding private expenditure.

Netherlands: No problems regarding the timetable for 2009; expect to provide the FSxHF and RCxHP tables. The level of detail (of the functional classification) is still seen as a lower priority. Work to be undertaken to provide long time series back to 1972.

New Zealand: Completed the 2008 joint questionnaire with tables from 2004 to 2006. Expect to also submit the 2009 questionnaire.
Norway: No plans for any change to their submission practice and expect to submit the tables by the March deadline with preliminary data for 2008 via the Health Data questionnaire.

Poland: Will supply the three main tables according to the deadline. Continue to face some data problems.

Portugal: A different dissemination calendar means that that there will be a revision of 2006 in November (new benchmark for the year 2006) and first estimates for 2007 in December. Will concentrate on providing the FSxHF and RCxHP tables but continue to have no data on OTC and cost-sharing.

Spain: Apologies for the absence of the correspondent from the Spanish Ministry due to an organised forum in Spain. Ongoing statistical work with the autonomous regions and the concentration on private spending estimates.

Sweden: SHA implementation resulted in tables being produced for the period 2001-06. Next year definitive tables for 2006 and preliminary tables for 2007 with some more detail by function.

Switzerland: Delay due to change in personnel but hope to be on track for 2009 questionnaire. Some issues remain regarding provisional sources data and the distinction between ‘non-available’ and ‘non-existent’ data and the consistency between countries on reporting current and total health expenditures.

Turkey: Working on a study to improve estimates of out of pocket payments next year.

United Kingdom: Currently the Office for National Statistics is not allocating any resources to SHA – however, they hope this position might change. In committing such resources they are looking for consistency and stability and are interested in stressing the policy uses of health accounts. Some work done on prevention and public health expenditures according to the SHA and a draft paper on this was available.

United States: Expect to submit the 2009 questionnaire on time. Some improvements in the data and expect more data on cost-sharing to be available. Produce projections rather than preliminary estimates are produced and that there could be a discussion on how these could be incorporated.

Russian Federation: Main task was to work towards the requirements set out by the OECD and look towards harmonising existing reporting systems with these.

Romania: Completed the questionnaire this year and hope to improve some aspects of their submission next year.

Slovenia: Provided the 3 main tables for 2003-06 plus FSxHF; the revision and submission now part of their normal statistical production. Hope to be able to provide the RCxHP table and improve on timeliness next year.

7. Finally, Dr Ravi Rannan-Eliya representing the Asian-Pacific National Health Accounts network (APNHAN) reported that the JHAQ had been used on a trial basis twice with the network with valuable experience learned from it.

8. On behalf of the IHAT, the OECD Secretariat (Mr. David Morgan) thanked all delegates for the feedback and update of current activities related to national health accounts.
Item 4. Report on project for the development of guidelines for expenditure by disease, age and gender

9. The OECD Secretariat (Mr. David Morgan) presented an overview of the ongoing project of Estimating Expenditure by Disease, Age and Gender under the SHA framework [DELSA/HEA/HA(2008)3], including the main discussions from the previous day’s workshop. The draft guidelines drawn up in the first phase of the project and presented at last year’s expert meeting were in the process of being tested by six participating countries. Their feedback and recommendations will feed into the final project report and proposed guidelines, with an additional module to collect such data possibly incorporated into the 2010 JHAQ. The initial data results from the country studies are likely to form a Health Working Paper in 2009.

10. Sweden, one of the countries in the study, clarified the position regarding the different methodologies used and the difference in the overall estimates obtained. France pointed out that their experience of their own previous study had been that such work was resource intensive, and were interested in finding out the level of resources countries had committed and the frequency of such data request in the JHAQ. Both Finland and Portugal expressed an interest in the studies and looked forward to seeing more information on methodologies, particularly with regard to outpatient and private spending.

Item 5. Report on project for the development of guidelines for private expenditures

11. The OECD Secretariat (Ms. Sandra Hopkins) provided an update on the project to improve estimates of private expenditure [DELSA/HEA/HA(2008)4], outlining the guidelines produced by Dr Ravi Rannan-Eliya and the steps in testing the feasibility.

12. A number of countries welcomed the guidelines and noted the importance of the work and the progress made. Spain confirmed its participation in the testing of the guidelines and Ireland expressed an interest in providing feedback for what they saw as important for their ongoing SHA project. Korea commented on the proposed ranking of sources and methods, noting that the country-specific quality of data sources may affect such a ranking (e.g. with regards to the use of the Household Budget Survey (HBS). Both Switzerland and France also welcomed the document – the latter adding that the need for a direct calculation of total household payments was better suited to the French situation.

Item 6: Revision process for the System of Health Accounts manual: summary of the current state of the play

13. The discussion on the SHA revision commenced with a presentation from the OECD Secretariat (Ms. Sandra Hopkins), on behalf of the IHAT, on the current state of play. Initial proposals on six units of the revision were to be presented at the meeting, four in the first wave and two in the second wave. It was emphasised that all units presented should be considered as work-in-progress, and that the discussion at the meeting would help to refine these initial proposals leading to a first formal draft on each item in the coming months. It was also noted that, although the units would be discussed separately during the meeting, they do not stand alone and more coordination between the units will be required in the next phase. Some of the key challenges in moving forward on the programme of work for the SHA revision were reiterated, including the need to ensure a wide consultation process allowing sufficient time for debate and reconciliation of different views, and the need to ensure “backward comparability of data” to maintain time series. Delegates were reminded that a website (www.oecd.org/health/sha/revision) is dedicated to the SHA revision process, and that contributions can also be made on the SHA revision Electronic Discussion Group (EDG).
Item 7: SHA revision unit 1: purposes and principles of the SHA

14. Mr. Jens Wilkens (WHO) presented an outline of SHA revision unit 1 related to the purposes and principles of the SHA. He started by commenting on how SHA-based health expenditure data have been used for research and policy. Then, he suggested that the revised SHA manual should be a tool for a comprehensive description of the health system from the expenditure perspective and provide data that are more responsive to needs in health policy analysis. He presented a framework to analyse the functions and objectives of the health system based on the WHR 2000 health system framework. Finally, he presented the proposed main purposes of the SHA 2 as a checklist to be used throughout the revision process.

15. The discussant for unit 1, Mr. Mitsutake (Institute for Health Economics and Policy, Japan), commented on the policy relevance of SHA in Japan and emphasised that the SHA should reflect the evolution of health care delivery, in particular in the area of long-term care and prevention. He also proposed that the unit should find a balance between current purposes and future issues, and also include an introduction for countries compiling health accounts for first time users.

16. The United States said that it is important to keep in mind that the objective is not to measure the health status of the individuals but the total health expenditure.

17. Ireland said that the SHA data can only really describe the functional side of health systems. In order to measure the instrumental and ultimate objectives of health systems, one also needs non-expenditure data (e.g. health outcomes as a result of treatment, changes in health behaviors as a result of public health information campaigns). Korea, while welcoming the paper, also reminded delegates that the expenditure side is only one part of the health system.

18. Reflecting on the proposed framework to analyse the performance of health systems, France wondered why figure 1 in the proposed WHO framework does not include the determinants of health that are not related to health systems, as these should also expected to determine health status.

19. The delegate from Portugal said that the draft proposal was useful, but argued that the SHA should be viewed as a satellite account to the System of National Accounts (as proposed in the European National Accounts). She also suggested that it may not be advisable to finalise this chapter early in the process, since it will be influenced by other decisions taken for other units.

20. Denmark supported the idea of describing health care system through an input-output approach, and added that it is not necessary to build a new classification system, but rather to improve the SHA only where needed.

21. In responding to the comments, Mr Wilkens agreed that unit 1 is indeed broad and comprehensive in nature; thus it is not envisaged to finalise it before the links to other units have been properly considered. Moreover, he said that there is a conceptual difference between costs and expenditure, e.g. informal care. Finally, he stated that expenditure data are useful for analytical purposes and to measure the attainment of health policy objectives and this is far more ambitious as compared to description.

22. Tessa Tan-Torres (WHO) reiterated that an important consideration in revising the SHA will be the ability to link SHA1 and SHA2 for the purpose of trend analysis.

23. The OECD Secretariat (Ms. Sandra Hopkins) clarified that the end-of-October deadline for submitting written comments would not mean the end of the revision process for this and other units. She added that the first draft of this unit should be available for comments early in 2009.
Item 8: SHA revision unit 2: global boundaries of health care

24. Cor van Mosseveld (Eurostat) presented an initial proposal to unit 2 related to the boundaries of the health care sector. The proposal distinguishes between a core health accounting framework – including components on function, financing, and provision – and an extended accounting framework with additional components. He then discussed the main boundary issues: current expenditure versus total expenditure; consumption versus provision approach; household production (for own final use); medical good production versus final use of medical goods; nursing care versus long-term social care.

25. The discussant for unit 2 of the SHA revision, Mr. John Goss (Australia), emphasised the importance of including a rule about “principal” purpose in the definition of health boundaries, in order to have a non-overlapping classification system. He then discussed the different options that relate to long-term health and social care. Mr. Goss’ proposal was to limit long-term health care to pure medical and nursing activities, as initially proposed in the first version of the SHA manual.

26. Sweden added that they provided an input paper for this unit with a proposal of reporting LTC in three separate sub-groups: Long-term health care excluding ADL (LTHC); Long-term nursing care including ADL (LTNC); Long-term social care (LTSC). LTHC should be classified as HC.3 (only medical procedures) and the others as HC.R.6 (all activities related to ADL and IADL should be grouped together as a health-related activities). This proposal is supported by the revision of SNA according to NACE. As a possible approach in drawing the borderline between LTHC and LTSC, Sweden recommends the option "Professional qualification of providers" as the guiding principle and as a second best solution "Types of institutions".

27. Japan said that it is difficult to set boundaries and that they support the Australian view presented by John Goss on LTC. Korea said that the ‘core’ accounting framework should be for functional classification, as it is ‘clumsy’ for financing or providers and restated the importance of separating LTHC from LTSC.

28. Switzerland also said that the distinction between ADL and IADL is not adequate from the point of view of provision. Responding to the point made by Australia, Switzerland suggested that the idea of principal activity was not a satisfactory criterion because of the different organisational arrangements between countries regarding health care and overall there is the need to find a solution that improves comparability across countries.

29. The Netherlands said that LTC is a different dimension as compared to nursing functions such as curative and rehabilitative care. It is not to be included in the health care related functions but should be considered as a whole as in the Dutch Health and Social Accounts approach with no need to split between health and social.

30. On the other hand, Germany said that they do not agree to exclude ADL from health expenditure as it is a health component (without help with ADL, the health status of the persons would deteriorate).

31. Denmark agreed that ADL care should be considered as health. They expressed their concern, however, that many of the boundary issues presented in the paper (Table 1) could broaden the concept of health and a restrictive approach would be welcome.

32. Dr Ravi Rannan-Eliya said that there are clear implications for comparability across countries linked to the ADL/IADL split. He said that there are 2 processes taking place in the delivery of health and LTC services: increase in medicalisation and increase in institutionalisation of services that used to be provided “informally” by families. Given that a growing amount of money is spent on LTC in developed countries due to population ageing (1-2% of GDP), the extent to which LTC spending is included in health
spending will have a growing impact on the overall level of health spending reported by each country and will also affect the comparability of data, if the coverage of LTC spending varies across countries. He suggested, therefore, that it may be wise to use a conservative approach in including LTC spending under health care spending.

33. To the question of LTC, Portugal also agreed with the current definition proposed in the JHAQ, and that data were available for her country. On the other boundary issues, Portugal said that it is important to distinguish between current expenditure and total health expenditure. She proposed to keep gross capital formation separate from current expenditure. In their opinion, the consumption versus production approach was not an issue for unit 2, for it has to deal only with the compilation issue of estimating final consumption expenditure. Finally, she suggested including the pharmaceutical industry in the medical goods expenditure.

34. In response to the comments, Eurostat replied that, although a lot of discussion has already taken place on the definition of LTC, further discussion is needed to try to reach a broader consensus and final decision. The distinction between LT nursing care and LT medical care, as proposed by Sweden could make sense as a ‘conservative approach’. Cor van Mosseveld said that it is useful to keep the distinction between consumption and provision. Finally, an addendum to the question of separation of current and capital expenditure, the SNA revision would probably reclassify R&D as an investment for the future (although this itself is not a boundary issue).

Item 9: SHA revision unit 5: types of health accounts

35. The OECD Secretariat (Mr Roberto Astolfi) presented unit 5 on the types of health accounts. He said that the basic idea of the initial proposal is to borrow some of the methodology from the SNA and apply it to SHA, with the boundaries determined by SHA. The advantages of the proposal include an increase in the analytical power of SHA and the spelling out of the relationship to SNA. He stated that the two representations – SNA and SHA – complement each other rather than being in competition. He also stated that using the SNA sequence of accounts to represent the health system could provide the users of SHA with a richer set of information and that the full explicit use of SNA accounting rules might enable the solution of some problems in the revision of SHA.

36. The first discussant, Isabel Quintela (Portugal), welcomed the introduction of additional tables, such as supply and use tables, and institutional sector accounts to meet the data requirement. However, she pointed out that sector accounts cannot simply “borrow” from the SNA. She noticed that the complete sequence of accounts can only be compiled for institutional units, while for establishment only the production and generation of income accounts can be compiled. Ms Quintela also said that it is not necessary to define new transactions as the existing ones with the appropriate contextualisation are correct. Her main conclusion was that SHA should use standards of the SNA for comparability, harmonization, completeness and consistency reasons. She said that the concepts should be clearly explained in the respective chapters to which they refer. She proposed that the sequence of accounts be compiled on a voluntary basis and that if a sector account is used, financing sources are not needed.

37. The second discussant, Michael Müller (Germany), said that if the scope of analysis of SHA were to be extended, then the sequence of accounts might be one possibility. He indicated that the creation of sequence of accounts will be difficult for countries whose NHA are only loosely linked to NA. Thus he proposed that the sequence of accounts compilation must remain voluntary depending on national needs. He affirmed that the top priority of the SHA revision should not be on requesting additional information for SHA but on the clarification on the definition of total health expenditure and on the harmonization of the methodology. The main objective should be to increase the comparability of the data.
38. France supported this view that the priority should be to improve the comparability of existing data, not asking for additional information through the SHA. France does not oppose the principle of linking NA to SHA, but expressed concerns that while SHA1.0 focuses on consumption, SHA2.0 seems to focus on production. They do not consider this to be the right development path. France also said that there are limitations to the information that might be expected from the SHA, and SHA data alone should not be expected to measure productivity or efficiency. He also said that the production tables were not easy to fill out, and this could be eventually done only for public hospitals. France added that stock variations were of minor policy importance as compared to total expenditures. In conclusion, his suggestion was the sequence of accounts tables should be a proposal and filled out only on a voluntary basis, and that in order to avoid the development of concepts that put at risk the consistency of other parts of the manual, the existing tables should be completed first.

39. Sweden said that to define boundaries, a production perspective is needed. She added that net lending was not a useful concept in Sweden as responsibility lay with local governments, their accounts include also other sectors, and taxes were not earmarked.

40. Australia asked if it was possible to derive information on establishment units by their parent units (i.e. institutional units). Ms Quintela responded that this was not the case.

41. The delegate from Belgium said that the discussion was central to the SHA revision. He said that SHA should continue to focus on the consumption side, and that NA is measuring production, not consumption. He asked what we wanted to measure through SHA, as production is not equal to consumption. Belgium affirmed that moving towards production was not feasible, and he agreed with Germany and France that the main objective of the SHA revision was to consolidate the current concepts to improve comparability, and not to extend the scope of the SHA.

42. The delegate from Switzerland supported the view that the link to NA should not be a priority; the only link that is important is consistency at the total health expenditure level. On a separate matter, he suggested including in the SHA manual a set of questions which could be answered by using data collected through the JHAQ. As an example, he said that financing and sustainability could be analysed using the data currently collected with SHA, while performance could not.

43. In his reply, the OECD Secretariat (Roberto Astolfi) reminded the delegates that the proposal for unit 5 is currently only an initial methodological proposal. It should be kept in mind that the life span of the new manual is anticipated to be at least 10 years and data availability and technology for data collection and assembling will evolve over the next 10 years to the point where the development of greater links between SHA and SNA will be easier and increasingly desirable. In addition, the inclusion of new elements would enhance the quality of aggregates currently included in the JHAQ. For example, estimation of capital stock is required to estimate the consumption of fixed capital, which is an essential component of the non-market output.

44. Both Australia and Korea expressed their support for the methodology in unit 5 and its ongoing development.

**Item 10: SHA revision unit 7: ICHC-HC Functional Classification of Health Care**

45. Dr Riccardo Valadarres Cardrona (WHO Consultant) presented an initial proposal of SHA revision unit 7 related to the functional classification. The proposal had been based on a wide consultation process with the overriding principles to link to the purpose of final use and reflect the health care characteristic of continuum of care. The main classes of Care & Treatment, Public Health & Prevention and Stewardship & Governance were presented.
Dr Jeong (Korea), as the discussant for unit 7, commented that although it was excellent in conceptualisation, it would be difficult to implement and report to in practice. Dr Jeong raised potential data availability problems with the classification at the 2 and 3 digit level in relation, for instance, to governance, and care and treatment (e.g. the split between acute vs. chronic). He added that the WHO proposal had carefully tried to avoid mixing up functions with modes of production, but the inpatient and outpatient split is considered to be crucial and of policy relevance for some countries to understand changes in hospital activities. This view was also expressed by Australia, Japan and Portugal in the subsequent discussion. Dr Jeong also noted some problems with the nomenclature of the HC.2 Public Health and Prevention. Finally, from a policy point of view, the total sum of pharmaceutical expenditure is important, but in the proposed classification, pharmaceuticals are recorded according to their function.

Australia, Denmark and Japan supported the view that some of the proposed changes would be difficult to implement and emphasised the importance of ensuring that there is a clear link between the compilation of functional classification in SHA1.0 and SHA 2.0. This is important for data consistency over time. Australia and Portugal both raised possible data compilation issues with the split between acute and chronic care.

Australia also pointed out a problem of using governance as it could be considered to be an intermediate good not a final good. Finally, many countries appreciated the attempt to clarify prevention and public health by including a classification for individual prevention activities and a separate one for public health activities.

WHO concluded that the comments from countries were consistent in acknowledging the reasons behind the proposed changes in the classification but acknowledged the concerns about the feasibility of the implementation and how the important information concerning the mode of production would be maintained. The further issue related to the compilation of data in some areas and the need to ensure consistency with the current classification would be taken into account.

Item 11: SHA revision unit 9: Classification of Financial Sources

The OECD Secretariat (Ms Eva Orosz) presented an introduction to unit 9 and unit 10 in which she highlighted the 2 possible options for revising the classification of financing sources as a classification of schemes or institutional units, and the types of information provided by the alternative interpretations, i.e. transactions (e.g. taxes) versus actors (e.g. Ministries of Health).

Mrs Cathy Cowan (United States) presented an outline of SHA revision unit 9: Classification of Financial Sources, prepared at the request of OECD [DELSA/HEA/HAM(2008)6]. The proposed revision of unit 9 is built around a classification of actors that is consistent with the current classification in the Joint Health Accounts Questionnaire. Mrs Cowan did not propose using the terminology public and private, but using the basic headings of government, business, households and other private. A set of T-accounts which display combined information on both actors and transactions was proposed.

The discussant for unit 9 of the SHA revision, Mr Joe Kutzin (WHO, European regional office), emphasised the importance of using a classification of financial sources to measure who pays for the health system and what are the public, private and rest of the world shares. The critical distinction from a policy perspective is the contribution mechanism (e.g. general public revenues, earmarked taxes) or the transactions. He also emphasised that it is useful to have a distinction between compulsory and voluntary contributions. The framework also has to be relevant for a wide range of countries.

The general discussion focused on issues of how various taxes should be classified, and the distinction between public vs. private financing and compulsory vs. non compulsory insurance schemes.
Mr. Kutzin strongly objected to the assignment of dedicated taxes for public health insurance to households as this makes one kind of tax public and another kind private. Peter Scherer (OECD) supported this view by pointing out that any attempt to sort out the incidence of taxes and the contribution mechanism may mean that tax policy and health policy becomes confused. The basic premise should be that all government revenues come from households, businesses or the rest of the world.

54. Some participants spoke in favour of the usefulness of using the public vs. private terminology. The discussion indicated a need for better clarification on the classification of public and private corporations.

55. The delegate from Portugal commented that the financial sources table under the current JHAQ is not a priority for her country. She added that the proposal on financial sources was flawed in the sense that it does not follow the principle of mutual exclusivity. She would prefer to see the classification follow more closely the breakdowns provided by SNA.

Item 12: SHA revision unit 10: Classification of Financing Schemes

56. The OECD Secretariat (Ms Eva Orosz) presented an outline of SHA revision unit 10: Classification of Financing Schemes. The presentation gave the background to the development of the unit and emphasised the importance of defining ICHA-HF as a classification of financing schemes rather than institutional units. The main problems with the current classification are that it does not reflect adequately the complex and changing systems of health financing in countries such as the Netherlands. Two options were put forward to create the two main groups (HF.1 and HF.2). Under Option A, HF.1 would include only schemes which meet both the criteria of mandatory participation and inter-personal redistribution. Under Option B, the mandatory criterion would be used as the only main characteristic to differentiate between HF.1 and HF.2, regardless of whether inter-personal redistribution is involved. The presentation also highlighted the advantages of defining ICHA-HF as financing schemes over defining it as “establishment unit”. Finally, the presentation laid out the work-in-progress on the unit to develop a set of possible tools for analysing financing schemes and the links between financial sources and financing schemes.

57. The discussant for unit 10, Mr Joe Kutzin (WHO, European regional office), noted first that the initial proposal challenged his initial conceptions and made a good case for using financing schemes rather than agents (as in the current classification). He commented that a classification of schemes would need to be sufficiently flexible and generic to capture the growing diversity of arrangements. In addition, he felt that more attention needs to be paid to the classification of government programs to ensure conceptual consistency. In this regard, he noted in particular that the classification of schemes should accommodate differences in links between contributions and entitlements.

58. In the general discussion, France, the Netherlands, Korea indicated a preference for option A, with some European countries noting that Option A was more consistent with ESSPROS. On the other hand, Mr Kutzin commented that Option B (that is to include all compulsory schemes under HF.1) may be more consistent with a health policy framework. The Netherlands and Portugal raised a concern about the differences in social insurance terminology used between SHA and SNA. Switzerland liked that the proposed classification for financing schemes does away with the public vs. private distinction. Korea, on the other hand, noted that the public vs. private distinction is politically important.

59. In responding to comments on units 9 and 10, the Chair and the OECD Secretariat noted that further reflection and modifications on these and other units of the SHA revision will be needed as expected, and encouraged countries to send any additional written comments on the initial proposal regarding the six units discussed during the meeting by email before 31 October 2008.
Item 13: Overview of activities on health at the OECD

1. The Secretariat (Peter Scherer, Head of the Health Division) provided an overview of recent and upcoming activities on health at the OECD, including the Draft Programme of Work in 2009-2010 related to monitoring the performance of health systems and achieving high-performing health systems.

2. Regarding work to monitor the performance of health systems, the OECD Health Committee has given high priority to work on Health Accounts, OECD Health Data and the Health Care Quality Indicators project. The Draft Programme of Work envisages greater linkages between the different streams of data work, to enable performance analysis at different levels (system-wide, subsector and disease-based).

3. In the area of analytical projects, the joint work with the Economics Department to examine the links between the institutional characteristics of health systems and their performance was noted. In order to develop an information base on health system institutional characteristics, the Secretariat will launch in October 2008 a survey to collect qualitative information on health financing and coverage, health care provision, and governance and resource allocation issues. This will complement existing quantitative information collected through the OECD Health Data questionnaire and the Joint Health Accounts Questionnaire. This survey will not be directed at Health Data Correspondents or Health Accounts Experts.

4. The release of two recent OECD publications was announced: The Looming Crisis in the Health Workforce: How can OECD Countries Respond? and Pharmaceutical Pricing Policies in a Global Market.

5. The next meeting of the Health Committee, scheduled for 10-11 December 2008, will discuss plans for an OECD Meeting at the Ministerial Level in 2010. The meeting will also review progress on other current OECD activities, including work on health statistics and indicators, long-term care, the adoption of information and communication technologies in the health sector, and a draft final report from the project on the economics of prevention.

Item 14: Development of Purchasing Power Parities (PPPs) in the health sector

6. The OECD Secretariat (Ms. Francette Koechlin) reported on the preparation of the 2008 OECD-Eurostat PPPs questionnaire. This is administered every three years, for the purpose of estimating economy-wide PPPs for international comparisons of GDP in volume. She described the current survey which will be conducted in November-December 2008 in 55 countries, and focused on the current methodology used to collect price information for health goods and outpatient services. There is a need for more interaction between health experts and PPPs experts at the national level, to improve the availability and reliability of the data submitted on the health component of the questionnaire. The Chairperson supported this recommendation. The list of national correspondents for the OECD-Eurostat PPPs questionnaire was made available to facilitate interaction.

7. In the second presentation, the OECD Secretariat (Mr. Luca Lorenzoni) reported on next steps to improve the methodology for developing output-based PPPs in the health sector, with a particular focus on the hospital sector. The new methodology is currently being tested in six pilot countries – Australia, Canada, France, Korea, Norway, and the United States. It aims at comparing across countries the unit average cost of a representative set of hospital products. He also presented the results of the questionnaire to assess data availability at the hospital level that was sent out to all OECD and Eurostat countries (as well as other countries participating in the PPP programme of work) in June 2008. Due to the postponement of
the Health Committee, the dates of the 3rd Health PPPs Task Force meeting have been moved to 8-9 December 2008.

8. The delegate from Portugal said that for consistency, it was important to compare the methodologies used by countries to estimate a cost by product. It is also important to evaluate whether all relevant resource items are included in the unit cost measurement. The United States agreed on the approach proposed and suggested to rank the case types according to homogeneity and representativity of products. Australia said that they were satisfied with the pilot work thus far, and they will produce an interim report on the result of the feasibility study in their country.

**Item 15: Health care quality indicators (HCQI) project: progress and next steps**

9. The Secretariat (Niek Klazinga and Sandra Garcia-Armesto) outlined the progress and future priorities of the OECD Health Care Quality Indicators (HCQI) project. The aim of the project is to develop an indicator set to explore and raise questions about the quality of health care across OECD countries. Following the conceptual framework that was adopted for the project a few years ago, two streams of activities are currently being pursued:

1) a regular data collection of indicators of quality of care that have been assessed by the HCQI Expert Group as being suitable for international comparisons; and

2) the development of new indicators in a number of priority areas.

10. Several indicators are already collected through the OECD Health Data questionnaire. For those remaining, data will be collected through a questionnaire to be administered to the HCQI Experts group in November 2008, in parallel with the Health Data collection. The HCQI data collection will benefit from ongoing methodological work to improve the quality and comparability of these indicators. The results from this data collection will be reported in an expanded chapter on Quality of Care in the 2009 edition of *Health at a Glance*.

11. With respect to indicator development, progress has been made in 2008 in a number of priority areas, including:

i. **Patient safety**: A Manual on *Facilitating Cross-National Comparisons of Indicators of Patient Safety at the Health System Level in OECD countries* has been released as OECD Health Technical Paper No. 19. Following testing, a number of indicators on patient safety will move from a pilot data collection to the regular data collection. Developmental work in the area of patient safety is being carried out in close collaboration with international organisations specialising in quality and patient safety, including WHO’s Global Alliance on Patient Safety, DG SANCO Working Party on Patient Safety and the European Commission-sponsored EuroNetPas and SImPatIE projects.

ii. **Mental health care**: The Secretariat has also released OECD Health Technical Paper No. 20, reviewing the *Information Availability for Measuring and Comparing Quality of Mental Health Care across OECD Countries*. The mental health expert subgroup has proposed that two indicators related to unplanned hospital readmissions be included in the regular HCQI data collection.

---

1 All HCQI Technical Papers are available at [www.oecd.org/els/health/technicalpapers](http://www.oecd.org/els/health/technicalpapers) or on the HCQI website at [www.oecd.org/health/hcqi](http://www.oecd.org/health/hcqi).
iii. **Primary care**: Developmental work has identified a set of indicators related to avoidable hospital admissions, which will also be included in the regular HCQI data collection.

iv. **Responsiveness/patient experiences**: Work has begun to develop a core set of questions for use in population-based surveys and to promote the standardisation of patient-based surveys.

12. The next meeting of the HCQI Expert Group will be held on 23-24 October 2008. The main purpose of the meeting will be to review progress on activities and to discuss proposed priorities for further data development and analytical work.

**Item 16: Measuring disparities in health status and in access and use of health care: progress and next steps**

13. The Secretariat (Michael de Looper) presented work-in-progress to assess the availability and comparability of indicators of equity and disparity in health by socioeconomic status (SES), with a view to including a suitable selection in *OECD Health Data*. The presentation was drawn from a draft paper that had been presented to the May 2008 Health Committee meeting [DELSA/HEA/HD(2008)1].

14. Indicators of health status (mortality, morbidity and summary health measures), as well as health care access and use (health insurance, health service use, unmet health care needs, and out-of-pocket expenditure) are being assessed. The selection of indicators is constrained by a number of factors, including data availability, the requirement for linkage between different health data sets, and the harmonisation of definitions and survey instruments.

15. Initial indicators flagged for routine collection in *OECD Health Data* include self-rated health by income or education group, self-rated disability by income or education group, and unmet health care need by income group.

16. The work was received with interest. A number of correspondents questioned how different ways of measurement across countries can be reconciled. The United States saw disparities by socioeconomic status as important, as well as inequalities by race or ethnicity. The United Kingdom highlighted research that had been done to measure dispersion in age at death, and suggested its use as an indicator.

17. Several correspondents pointed out that cultural differences could complicate using self-rated health and disability by SES. The Secretariat responded that the interest is not in comparing the absolute level of inequality across countries, but in comparing relative levels within countries.

18. Comments on the proposed approach were welcomed by the Secretariat. The paper is due to be completed by the fourth quarter of 2008.

**Item 17: Proposed framework for data collection on long-term care**

19. The Secretariat (Francesca Colombo) presented a framework for future data collection on non-monetary indicators of long-term care (LTC). The results of the 2008 data collections on LTC beds and recipients (based on the regular 2008 *OECD Health Data* collection) and on the LTC workforce (based on a pilot questionnaire sent in March 2008) were evaluated in terms of data coverage, comprehensiveness, quality, and consistency in the definitions used. A proposal for the next round of LTC data collections was then put forward, including options related to:

i. the process of data collection and reporting;

ii. refinements in the definitions used; and
iii. the data specifications requested [DELSA/HEA/HD(2008)2]

20. Several correspondents (Norway, Finland, the Netherlands, Japan, Switzerland and the United States) expressed general support for data collection on LTC resources and utilisation, which they consider important from a policy perspective. There was also general agreement not to expand data collection on LTC resources and utilisation before data quality and comparability on a core set of indicators and specifications are improved. Switzerland did not support the collection of data on LTC workers by country of origin, and several countries (including Germany and Italy) mentioned in written comments after the meeting that data on LTC workers by country of origin and education level are not available.

21. Regarding data collection, one country (Norway) favoured the idea of setting up a dedicated network of LTC experts, while the Netherlands and the United States suggested relying on the existing network of OECD Health Data National Correspondents. In written comments received by the Secretariat after the meeting, this latter view was also supported by Germany, Iceland and Finland, while Italy indicated a preference for the establishment of a dedicated network and the Czech Republic suggested that a network could be used on a temporary basis until data collection, particularly on LTC workers, becomes regular.

22. Some countries (the Netherlands and Switzerland) supported the idea of collecting data on the LTC workforce once every two years. This view was supported by Germany and Finland in written comments following the meeting. However, the Czech Republic suggested that at least in the initial phases, the data collection on LTC workforce should take place annually.

23. Two countries mentioned limits in data availability: Finland, for data on the LTC workforce which are not regularly collected; and Japan, for data on LTC recipients at young age groups (i.e. below 40 years old). Japan also explained that the increase in the number of LTC beds over recent years is due not so much to the introduction of their LTC system, but to a change in the definition of the institutions included in the data collection.

Item 18: Brief update on development of dissemination systems for OECD health statistics

24. The Secretariat (Marie-Clémence Canaud) provided a brief update on the growing number of tools used by the OECD to disseminate the health statistics collected from National Correspondents. The database OECD Health Data is available online (http://www.ecosante.org/oecd.htm) and on CD-ROM. Selected data series and all Sources and Methods are available free of charge on the OECD Health Data website (www.oecd.org/health/healthdata). Key indicators are also presented every two years in the publication Health at a Glance.

25. Additionally, all official delegates connecting to OLIS now have access to the online database. Further dissemination is also planned in OECD.Stat, which already includes the key data series disseminated free-of-charge on the OECD Health Data website. OECD.Stat also includes a separate SHA database, containing the data from the Joint Health Accounts Questionnaire.

26. Correspondents are invited to contact the Secretariat if they have any questions concerning access to the database.
ANNEX: PARTICIPANTS LIST/LISTE DES PARTICIPANTS

Chairperson/Président(e)  Ms. Cathy COWAN
National Health Statistics Group, Office of the Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard Room: N3-02-13
21244-1850 Baltimore, MD
United States
Tel: (1 410) 786 4880
Email: cathy.cowan@cms.hhs.gov

Australia/Australie  Mr. John GOSS
Expenditure and Economics Unit
Australian Institute of Health and Welfare
GPO Box 570
ACT 2601 Canberra
Australia
Tel: +61 2 62441151
Email: john.goss@aihw.gov.au

Austria/Autriche  Ms. Herta Maria RACK
IV/3 - Quality and Health Economy
Federal Ministry for Health, Family and Youth
Radetzkystrasse 2
A-1030 Vienna
Austria
Tel: +43 1 71100-4221
Fax: + 43 1 7134404-1269
Email: herta.rack@bmgfj.gv.at

Mr. Christian HALPER
Macro-Economic Statistics
Statistics Austria
Guglgasse 13
A-1110 Vienna
Austria
Tel: +43 1 71128-7662
Fax: +43 1 714 62 52
Email: christian.halper@statistik.gv.at
Ms. Elisabeth SAMMER
Macro-Economic Statistics
Statistics Austria
Guglgasse 13
A-1110 Vienna
Austria
Tel: +43 1 71128-8119
Fax: +43 1 714 62 52
Email: elisabeth.sammer@statistik.gv.at

Belgium/Belgique
Mr. Dirk MOENS
Attaché
Direction générale Politique Sociale
Service public fédéral de la sécurité sociale
Eurostation II
Place Victor Horta 40 boîte 20
1060 Brussels
Belgium
Tel: +32 2 528 63 26
Fax: +32 2 528 69 71
Email: Dirk.Moens@minsoc.fed.be

M. Koenraad LENAERTS
Représentant Permanent adjoint
Délégation Permanente
14, rue Octave Feuillet
75116 Paris
France
Tel: +33 1 56 75 34 54
Fax: +33 1 56 75 34 70
Email: koenraad.lenaerts@diplobel.fed.be

Canada/Canada
Mr. Christopher KUCHCIAK
Manager, Health Expenditures
Canadian Institute for Health Information
495 Richmond Road, Suite 600
K2A 4H6 Ottawa
Canada
Tel: +1 613 694 6984
Email: ckuchciak@cihi.ca
Czech Republic/République Tchèque

Mr. Jakub HRKAL
Statistical Analyst
Institute of Health Information and Statistics of the Czech Republic
Palackeho nam. 4
12801 Praha 2
Czech Republic

Tel: +420 224 972 112
Fax: +420 224 972 659
Email: hrkal@uzis.cz

Mr. Tomas ROUBAL

Email: roubal.tom@gmail.com

Ms. Lia VENEROVA
Expert
Czech Statistical Office
Na Padesatem 81
100 82 Praha
Czech Republic

Tel: +420 274 054 121
Email: lia.venerova@czso.cz

Denmark/Danemark

Mr. Christian HARSLOF
Ministry of Health and Prevention
Slotsholmsgade 10-12
1216 KBH Copenhagen
Denmark

Email: cha@sum.dk

Finland/Finlande

Dr. Nina KNAPE
Development Manager
National Research and Development Centre for Welfare and Health
STAKES
P.O. Box 220
FIN-00531 Helsinki
Finland

Tel: +358 9 3967 2683
Fax: +358 9 3967 2459
Email: nina.knapa@stakes.fi
France/Allemagne

M. Michel DUEE
Chef du bureau Comptes et Prévisions d'Ensemble
Direction de la recherche, des études, de l'évaluation et des statistiques
Ministère de la Santé, de la Jeunesse et des Sports
14, Avenue Duquesne
75350 PARIS 07 SP
France

Tel: +33 1 40 56 81 41
Fax : +33 1 40 56 88 00
Email: michel.duee@sante.gouv.fr

Mme Annie FENINA
Chargée des comptes de la santé
Direction de la recherche, des études, de l'évaluation et des statistiques
Ministère de la Santé, de la Jeunesse et des Sports
11, place des-5-martyrs-du-Lycée-Buffon
75696 Paris cedex 14
France

Tel: +33 1 40 56 81 72
Fax: +33 1 40 56 88 00
Email: annie.fenina@sante.gouv.fr

Mme Marie-Anne LE GARREC
Chargée des comptes de la santé
Direction de la recherche, des études, de l'évaluation et des statistiques
Ministère de la Santé, de la Jeunesse et des Sports
11, place des 5-martyrs-du-Lycée-Buffon
75696 Paris cedex 14

Tel: +33 1 40 56 81 38
Fax: +33 1 40 56 88 00
Email: marie-anne.legarrec@sante.gouv.fr

Mr. Michael CORDES
Head of Unit
Federal Statistical Office (Statistisches Bundesamt)
Graurheindorfer Strasse 198
D-53117 BONN
Germany

Tel: +49 611 75-8116
Fax: +49 611 75-8996
Email: michael.cordes@destatis.de
Mr. Michael MUELLER
Federal Statistical Office (Statistisches Bundesamt)
Graurheindorfer Strasse 198
D-53117 BONN
Germany

Tel: +49 611 75-8161
Fax: +49 611 75-8996
Email: michael.mueller@destatis.de

Hungary/Hongrie
Mr. Szilard Anatol PALL
Social Services Statistics
Hungarian Central Statistical Office
Keleti Varoly u. 5-7
Budapest
Hungary

Tel: 36-1-3406730
Email: szilard.pall@ksh.hu

Mr. Szabolcs SZIGETI
OEP
Váci út 73/A
1139 Budapest
Hungary

Email: szigeti.sz@t-online.hu

Iceland/Islande
Ms. Guðrún EGGERTSDOTTIR
Pjöðhagsreikningar/National accounts
Hagstofa Íslands/Statistics Iceland
Borgartúni 21a
150 Reykjavik
Iceland

Tel: +354 528 1135
Fax: +354 528 1299
Email: gudrun.eggertsdottir@hagstofa.is

Ireland/Irlande
Ms. Ciara O'SHEA
Statistician, Government Accounts
Central Statistics Office
Ardee Road
Rathmines
Dublin 6
Ireland

Tel: +353 1 498 4312
Email: Ciara.M.OShea@cso.ie
Italy/Italie

Mrs. Paola COLITTI
Commercial Attaché
Permanent Delegation
50, rue de Varenne
75007 Paris
France

Tel: +33 1 44 39 21 66
Fax: +33 1 42 84 08 59
Email: paola.colitti@esteri.it

Ms. Deborah GUERRUCCI
DCCN - DRE/C
ISTAT
Via Agostino Depretis 74b
00184 Roma
Italy

Tel: (39 6) 4673 3127
Fax: (39 6) 4673 3134
Email: guerruc@istat.it

Mrs. Cristina TAMBURINI
Head of Unit - Office of Statistics
D.G. of Information System
Ministry of Welfare, Health and Social Policies
via Ribotta 5
00144 Rome

Tel: +39 06 5994 2964
Fax: +39 06 5994 2873
Email: c.tamburini@sanita.it

Japan/Japon

Mr. Yasuhiro HIMENO
First Secretary
Health & Social Affairs
Permanent Delegation
11, avenue Hoche
75008 Paris
France

Tel: +33 1 53 76 61 32
Fax: +33 1 45 63 05 44
Email: himeno@deljp-ocde.fr
Ms Rachel HANSON  
Assistant  
Japanese Delegation to the OECD  
11, avenue Hoche  
75 008 Paris  

Tel: +33 1 53 76 61 34  
Email: rachel.hanson@deljp-ocde.fr  

Mr. Yojiro ISHIBASHI  
Senior Research Fellow  
Institute for Health Economics and Policy  

Email: ishibashi@ihep.jp  

Mr. Naohiro MITSUTAKE  
Senior Researcher/Associate Director  
Research Department  
Institute for Health Economics and Policy  
No. 11, TokyoOkaiji Bldg  
1-5-11, Nishi-Shinbashi, Minato-ku  
105-0003 Tokyo  
Japan  

Tel: +81-3-3506-8529  
Fax: +81-3-3506-8528  
Email: mitsutake@ihep.jp  

Korea/Corée  

Mr. Sinchul JANG  
Counsellor  
ELSAC, LEED  
Permanent Delegation  
4 Place de la Porte de Passy  
75016 Paris  
France  

Tel: + 33 (1) 44 05 21 90  
Fax: + 33 (1) 47 04 07 39  
Email: marathonjang@hanmail.net  

Mr. Young-Sik CHANG  
Director, Centre for Health and Social Statistics  
Korea Institute for Health & Social Affairs  
San 42-14  
Bulgwang-dong, Eunpyeong-gu  
Seoul 122-705  
Korea  

Email: changpsw@hanafos.com
Ms. Eunji HAN  
3rd Secretary  
Ministry of Foreign Affairs and Trade  
Email: ejhan07@mofat.go.kr

Mr. Young-Nam HYUN  
Ministry for Health, Welfare and Family Affairs  
Email: hyn0117@mw.go.kr

M. Hyoung-Sun JEONG  
Associate professor  
Department of Health Administration  
Yonsei University  
Maeji-ri. #234  
Hungob-Myon, Wonju-si  
Kangwon-do  
Korea  
Email: jeonghs@yonsei.ac.kr

Ms. Young-Sook KIM  
Research Fellow  
Institute for National Health Insurance  
National Health Insurance Corporation  
Seoul  
Korea  
Email: yskim@nhic.or.kr

Luxembourg/Luxembourg  
Mme Marianne SCHOLL  
Inspection Générale de la Sécurité Sociale  
B.P. 1308  
L-1013  
Luxembourg  
Tel: (352) 2478 6362  
Fax: (352) 2478 6225  
Email: marianne.scholl@igss.etat.lu

Mme Laurence WEBER  
Chargée d’études, STAPS  
IGSS  
B.P. 1308  
L-1013 Luxembourg  
Tel: +352 2478 6342  
Fax: +352 2478 6225  
Email: laurence.weber@igss.etat.lu
Mexico/Mexique
Mr. Carlos SOSA
Ministry of Health
Reforma 450, 4° piso
Col. Juarez
Delegacion Cuauhtémoc
06600 DISTRITO FEDERAL
Mexico

Email: csosam@salud.gob.mx

Dr. Gabriela VILLARREAL
Ministry of Health
Reforma 450, 11° piso
Col. Juárez
Delegación Cuauhtémoc
06600 DISTRITO FEDERAL
Mexico

Email: gvillarreal@salud.gob.mx

Netherlands/Pays-Bas
Mr. Vincent VAN POLANEN PETEL
Senior Statistician
Division of Social and Spatial Statistics
Statistics Netherlands
Room B 6017
PO Box 24500
2490 HA The Hague
Netherlands

Tel: +31 70 337 4364
Email: vpln@cbs.nl

New Zealand/Nouvelle-Zélande
Mr. Bruce CARLSON
Sector Accountability and Funding
Ministry of Health
1-3 The Terrace
PO Box 5013
Wellington
New Zealand

Tel: +6448162658
Fax: +6444962191
Email: Bruce_Carlson@MOH.GOVT.NZ
Ms. Bridget HESKETH
Sector Accountability & Funding
Ministry of Health
1-3 THE TERRACE
PO BOX 5013
WELLINGTON
New Zealand

Tel: +64 4 4962409
Fax: +64 4 4962191
Email: Bridget_Hesketh@moh.govt.nz

Mr. Stephen SALZANO
Principal Technical Specialist
System Performance
Ministry of Health
1 - 3 Terrace
PO Box 5013
Wellington
New Zealand

Tel: +04 816 2967
Email: Stephen_Salzano@moh.govt.nz

Norway/Norvège
Ms. Ann-Kristin BRAENDVANG
Adviser
Department of Economic Statistics, Division for National Accounts
Statistics Norway/SSB
Kongens gt. 6
P.B. 8131 Dep
0033 OSLO
Norway

Tel: +47 21 09 48 59
Fax: +47 21 09 49 96
Email: akb@ssb.no

Ms. Marit Getz WOLD
Senior Adviser
Division for Health Statistics
Statistics Norway
PO Box 8131 Dep
0033 Oslo

Email: mgw@ssb.no
Poland/Pologne

Mme Agnieszka CHOCHOROWSKA
Central Statistical Office
Al. Niepodleglosci 208
00-925 Warsaw
Poland

Fax: +48(22) 608 38 72
Email: a.chochorowska@stat.gov.pl

Izabela WILKINSKA
Chief Specialist
Central Statistical Office
Al. Niepodleglosci 208
00-925 Warsaw
Poland

Tel: +48(22) 608 32 94
Fax: +48(22) 608 38 72
Email: i.wilkinska@stat.gov.pl

Ms. Malgorzata ZYRA
Consultant
Social Surveys Division
Central Statistics Office
Al. Niepodleglosci 208
00-925 Warsaw
Poland

Tel: (48 22) 608 3240
Email: m.zyra@stat.gov.pl

Portugal/Portugal

Mrs. Maria Isabel QUINTELA
Chef du Service de l'unité des Comptes Sattelites
National Accounts Department
Institut National de Statistiques (INE)
Av. António José de Almeida, nº5
Lisboa
Portugal

Tel: +351 21 844 04 87
Fax: +351 21 842 63 66
Email: isabel.quintela@ine.pt
Mr. Gabriel BASTOS
Conseiller Technique
Comité de l’Education
Permanent Delegation
10 Bis rue Edouard Fournier
75116 Paris
Portugal

Tel: +33 1 45 03 34 61
Fax: +33 1 45 03 22 03
Email: gabriel.bastos@ocde-portugal.com

Slovak Republic/République slovaque
Ms. Marcela HANUSOVA
Third Secretary
Permanent Delegation
28, avenue d'Eylau
Paris
France

Tel: +33 1 56 26 50 97
Fax: +33 1 56 26 50 92
Email: hanusova@oecd-sr.com

Ms. Renáta LENHARCÍKOVÁ
Statistician
Department of international cooperation
National Health Information Center
Lazaretská 26
811 09 Bratislava
Slovak Republic

Tel: + 421 2 57 26 93 08
Fax: + 421 2 52 63 54 90
Email: renata.lenharcikova@nczisk.sk

Spain/Espagne
Ms Milagros CASALS ARQUIMBAU
Déléguée Santé
Bureau du Travail
Délégation Permanente de l'Espagne auprès de l'OCDE
22, avenue Marceau
75008 Paris
France

Tel: +33 1 53 70 05 23
Fax: +33 1 53 70 05 30
Email: mcasalsa@mtas.es
Sweden/Suède

Ms. Christina LIWENDAHL
Responsible for National Health Accounts
Statistics Sweden
SCB, Box 24300
104 51 STOCKHOLM
Sweden

Tel: (46) 8 506 94 543
Fax: (46) 8 506 94 296
Email: christina.liwendahl@scb.se

Ms. Ingalill PAULSSON LÜTZ
Statistics Coordinator
Centre for Epidemiology
The National Board of Health and Welfare
Rålambsvägen 3
S-106 30 Stockholm
Sweden

Tel: +46 75 247 31 15
Fax: +46 75 247 33 27
Email: ingalill.lutz@socialstyrelsen.se

Ms. Anna SKYGGE
National Accounts
Statistics Sweden
Box 24 300
104 51 Stockholm
Sweden

Tel: 46 8-506 944 42
Fax: 46 8-506 942 96
Email: anna.skygge@scb.se

Mrs. Kristina STIG
Economist
Office of Health and Welfare Economics
The National Board of Health and Welfare
Rålambsvägen 3
106 30 Stockholm
Sweden

Tel: +46 8 75 247 3536
Fax: +46 8 75 247 3346
Email: kristina.stig@socialstyrelsen.se
Switzerland/Suisse

M. Raymond ROSSEL
Département fédéral de l'intérieur, Section Santé
Office Fédéral de la Statistique
10, Espace de l'Europe
CH-2010 Neuchâtel
Switzerland

Tel: +41 32 713 67 77
Fax: +41 32 713 61 07
Email: raymond.rossel@bfs.admin.ch

M. Christian SCHERRER
Conseiller d'ambassade
Délégation Permanente
28, rue de Martignac
75007 Paris
France

Tel: +33 1 49 55 74 61
Fax: +33 1 45 51 01 49
Email: christian.scherrer@eda.admin.ch

Mr. Mario MORGER
Département fédéral de l'intérieur
Office fédéral de la statistique, Section Santé
10, Espace de l'Europe
CH 2010 Neuchâtel
Switzerland

Tel: +41 32 713 65 14
Fax: +41 32 713 61 07
Email: mario.morger@bfs.admin.ch

Turkey/Turquie

Mr. Hakan Oguz ARI
Msc in Healthcare Management
School of Public Health
The Ministry of Health of Turkey
Rüzgarlı Ibrahim Müteferrika Sok.
No:5 Kat:6
Ulus/ANKARA
Turkey

Tel: +90 312 3091224 / 1603
Email: hakan.ari@hm.saglik.gov.tr
Mr. Mehmet OKYAR  
Head of Department  
Department of Strategic Development  
Ministry of Health  
Mithatpasa cad. No:3  
Sihhiye  
06434 Ankara  
Turkey  
Tel: +90 312 458 5143  
Fax: +90 312 458 53 20  
Email: mehmet.okyar@saglik.gov.tr

Mr. Erdogan YILMAZ  
Head of Department  
Performance and Quality Development Department  
The Ministry of Health of Turkey  
Urnut 19  
Kolej-ANKARA  
Turkey  
Tel: +90 312 458 5041

**United Kingdom/Royaume-Uni**  
Mr. John HENDERSON  
Economist  
Health Protection & International Healthcare  
3rd Floor (329), Wellington House  
133-155 Waterloo Road  
SE1 8UG LONDON  
United Kingdom  
Tel: +44 20 7972 1204  
Email: john.henderson@dh.gsi.gov.uk

**United States/États-Unis**  
Mr. John HOFF  
Health and Social Policy Advisor  
HHS  
Permanent Delegation  
EEST  
12 Avenue Raphael  
75016 Paris  
France  
Tel: +33 1 45 24 74 99  
Email: hoffjsx@state.gov
Mr. Jonathan CYLUS  
Health Systems 20/20 Team  
USAID  
310 West 30th Street  
21211 Baltimore  
United States  
Tel: 410-786-7897  
Email: jonathan.cylus@cms.hhs.gov

Mr. Sam NOTZON  
Director, International Statistics Programme  
National Center for Health Statistics  
3311 Toledo Road  
Rm 2425  
20782 Hyattsville  
United States  
Tel: +1 301 458 4402  
Fax: +1 301 458 4043  
Email: snotzon@cdc.gov

EC/CE  
Mr. Hartmut BUCHOW  
Health and Food Safety Statistics  
Eurostat  
European Commission  
BECH Building D2/708  
Luxembourg  
Luxembourg  
Tel: +352 4301 34990  
Fax: +352 4301 35399  
Email: hartmut.buchow@ec.europa.eu

Mr. Cor VAN MOSSEVELD  
Eurostat F5, Health and Food Safety Statistics  
Commission Européenne - Eurostat  
Bech B2/411  
Bâtiment Jean Monnet  
rue Alcide de Gasperi  
L-2920  
Luxembourg  
Tel: +352 4301 34837  
Fax: +352 4301 35399  
Email: Cornelis.VAN-MOSSEVELD@ec.europa.eu
Estonia/Estonie
Ms. Aljona KARLOSEVA
Analyst
Department of Health Statistics
National Institute for Health Development
Hiiu Str 42
11619
Email: aljona.karloseva@tai.ee

Romania/Roumanie
Ms. Vasilica Rodica DOBRA
Consilier superior
Ministry of Health, Romania
Intr. Cristian Popisteanu
nr. 1-3, sector 1, cod 010024 Bucharest
Romania
Email: ionvasilicadobra@yahoo.com

Ms. Oana MAVLEA
National Institute of Statistics, Romania
Email: oana.mavleva@insse.ro

Russian Federation/Fédération de Russie
Mrs. Oxana GUSEVO
Senior Specialist-Expert
Department of Medical Help and Healthcare Organisation
Ministry of Healthcare and Social Development
3/25 Rakmanovsky per.
127994 Moscow
Tel: +7 495 627 29 15
Email: Gusevo.OI@rosminzdrav.ru

Mr. Valery STEPHANETS
International Cooperation Department
Ministry of Health and Social Development
3/25 Rakhmanovsky per.
127994 Moscow
Russian Federation
Tel: +7 495 627 29 61
Fax: +7 495 694 02 12
Email: stephanetsVI@rosminzdrav.ru
Slovenia/Slovénie

Ms. Ana BOZIC
Advisor, health statistics
Statistical Office of the Republic of Slovenia
Parmova 33
SI-1000 Ljubljana

Tel: + 386 1 2340 876
Fax: + 386 1 2415 344
Email: ana.bozic@gov.si

Mr. Stane MARN
Statistical Office of the Republic of Slovenia
Vozarski pot 12
1000 LJUBLJANA
Slovenia

Tel: +386 1 2340 732
Fax: +386 1 2415-344
Email: stane.marn@gov.si

Business and Industry Advisory Committee (BIAC)/Comité consultatif économique et industriel (BIAC)

Ms. Helena BRUS
Vice Chairman of the BIAC Committee on Technology
Director, Global Health Policy
Merck & Co. Inc.
WS2A-65A, 1 Merck Drive
08889-0100 Whitehouse Station
United States

Tel: +1 908 423 4217
Fax: +1 908 735 12 58
Email: helena_brus@merck.com

Mr. Machel NUYTEN
Vice Chairman of the BIAC task Force on Health Care Policy
Health Care Policy
Confederation of Netherlands Industry and Employers VNO-NCW
P.O. Box 93002
NL-2509 AA THE HAGUE
Netherlands

Tel: +31 70 349 0211
Fax: +31 70 349 0235
Email: Nuyten@vno-ncw.nl
Observer/Observateur

Dr. Ravindra RANNAN-ELIYA
Director
Institute for Health Policy
72 Park Street
Colombo 2
Sri Lanka

Tel: +94 11 231 4041 / 2 / 3
Fax: +94 11 231 4040
Email: ravi@ihp.lk

World Health Organization (WHO)/Organisation mondiale de la santé (OMS)

Dr. Charu C. GARG
Health Economist
Health System Financing
World Health Organisation
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

Tel: +41 22 791 2579
Fax: +41 22 791 328
Email: gargc@who.int

Ms. Patricia HERNANDEZ
Health Economist, National Health Accounts
World Health Organization
Office 3058
20 Avenue Appia
CH 1211 GENEVA 27
Switzerland

Tel: +41 22 791 2328
Fax: +41 22 791 4328
Email: hernandezp@who.int

Mr. Joseph KUTZIN
Regional Adviser
Regional Office for Europe
World Health Organization (WHO)
Health Systems Financing
Scherfigsvej 8
DK-2100 Copenhagen
Denmark

Tel: +45 39 17 12 57
Fax: +45 39 17 18 99
Email: jku@euro.who.int
Dr. Enrique LOYOLA
Epidemiologist/Statistician
Health Intelligence Service
WHO
Regional Office for Europe
Health Systems Financing
8 Scherfigsvej
DK-2100 Copenhagen
Denmark
Tel: +1 202 974 3130
Fax: +1 202 974 3674
Email: ENL@euro.who.int

Dr. Tessa TAN-TORRES EDEJER
Coordinator
Health systems financing
World Health Organization (WHO)
20 Avenue Appia
CH-1211 Geneva
Switzerland
Tel: +41 22 791 3497
Fax: +41 22 791 4328
Email: tantorrest@who.int

Mlle. Nathalie VAN DE MAELE
Economiste/statisticien
OMS
20 avenue Appia
1211 Geneva
Switzerland
Tel: 41 22 791 12 56
Email: vandemaelen@who.int

Mr. Jens WILKENS
Technical Officer
World Health Organization (WHO)
Email: wilkensj@who.int
Mr. Luca LORENZONI  
Administrator (Health Accounts)  
ELS/HD  
OECD  
Annexe Monaco 405  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 76 21  
Email: Luca.LORENZONI@oecd.org

Mr. David MORGAN  
Statistician (Health Accounts/Health at a Glance)  
ELS/HD  
OECD  
Annexe Monaco 404  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 76 09  
Email: David.MORGAN@oecd.org

Ms. Eva OROSZ  
Administrator (Health Accounts)  
ELS/HD  
OECD  
Annexe Monaco 401  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 89 95  
Email: Eva.OROSZ@oecd.org

Mr. Peter A. SCHERER  
Head of Division  
ELS/HD  
OECD  
Annexe Monaco 110  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 91 98  
Fax: +33 1 45 24 90 98  
Email: Peter.SCHERER@oecd.org
Other/Autre

Dr. Philippe AUTIER
International Agency for Research on Cancer
150 Cours Albert Thomas
69372 Cedex 08 Lyon
France

Email: autierp@iarc.fr

Ms. Sally BULLOCK
Population Health Unit
Australian Institute of Health and Welfare
GPO Box 570
ACT 2601 Canberra
Australia

Tel: +61 2 6244 1008
Fax: +61 2 6244 1299
Email: sally.bullock@aihw.gov.au

Mr. Manfred HUBER
Director of Health and Care
European Centre for Social Welfare Policy and Research
Berggasse 17
A-1090 Vienna
Austria

Tel: +43-1-319 45 05-35
Fax: +43-1-319 45 05-19
Email: huber@euro.centre.org

Ms. Magdalena RATHE
Fundacion Plenitud

Email: mrathe@fundacionplenitud.org

Ms. Liis ROOVÄLI
Head of Department
Health Information and Analysis Department
Ministry of Social Affairs of Estonia
Gonsiori 29
15027 Tallinn
Estonia

Tel: +372 626 9158
Fax: +372 699 2209
Email: Liis.Roovali@sm.ee
Dr. Markus SCHNEIDER
Director
BASYS
Reisingersstrasse 25
86159 AUGSBURG
Germany

Tel: +49 821 257940
Fax: +49 821 579341
Email: ms@basys.de

Mr. Ricardo VALLADARES-CARDONA

Email: ricardo.valladares.consulting@gmail.com