OECD Health Data National Correspondents

SUMMARY RECORD OF THE OECD HEALTH DATA NATIONAL CORRESPONDENTS MEETING

9-10 October 2008

Contact: Mr Gaetan LAFORTUNE
Tel. + 33 1 45 24 92 67; e-mail: gaetan.lafortune@oecd.org
TABLE OF CONTENTS

SUMMARY RECORD OF THE OECD HEALTH DATA NATIONAL CORRESPONDENTS MEETING, 9-10 OCTOBER 2008................................................................................................................. 3
ITEM 1: OVERVIEW OF ACTIVITIES ON HEALTH AT THE OECD.......................................................... 3
ITEM 2: DEVELOPMENT OF PURCHASING POWER PARITY (PPP) IN THE HEALTH SECTOR 3
ITEM 3: HEALTH CARE QUALITY INDICATORS (HCQI) PROJECT: PROGRESS AND NEXT STEPS ......................................................................................................................................................... 4
ITEM 4: MEASURING DISPARITIES IN HEALTH STATUS AND IN ACCESS AND USE OF HEALTH CARE: PROGRESS AND NEXT STEPS .................................................................................................................. 5
ITEM 5: PROPOSED FRAMEWORK FOR DATA COLLECTION ON LONG-TERM CARE ............ 6
ITEM 6: BRIEF UPDATE ON DEVELOPMENT OF DISSEMINATION SYSTEMS FOR OECD HEALTH STATISTICS.......................................................................................................................... 6
ITEM 7: OPENING OF OECD HEALTH DATA NATIONAL CORRESPONDENTS MEETING AND ADOPTION OF THE AGENDA................................................................................................................. 7
ITEM 8: REPORT ON EXPERIENCE WITH OECD HEALTH DATA 2008, AND PROPOSED PRIORITIES FOR THE 2009 DATA COLLECTION.......................................................................................................................... 7
ITEM 9: STRENGTHENING COLLABORATION WITH OTHER INTERNATIONAL ORGANISATIONS ON NON-MONETARY HEALTH CARE STATISTICS ................................................................. 9
ITEM 10: PROGRESS REPORT FROM THE HOSPITAL DATA PROJECT 2 ON A PROPOSED SELECTED LIST OF PROCEDURES FOR INTERNATIONAL DATA COLLECTION .................... 11
ITEM 11: ASSESSING THE AVAILABILITY AND COMPARABILITY OF DATA ON THE USE OF SELECTED MEDICAL EQUIPMENT: REPORT ON A PROJECT FROM THE CANADIAN INSTITUTE FOR HEALTH INFORMATION......................................................................................... 12
ITEM 12: CHILDREN’S HEALTH AND HEALTH SERVICES .................................................................................. 12
ITEM 13: CHRONIC DISEASES .................................................................................................................. 14
ITEM 14: OTHER BUSINESS .................................................................................................................. 15
PARTICIPANTS LIST FOR MEETING OF OECD HEALTH DATA NATIONAL CORRESPONDENTS, 9-10 OCTOBER 2008 ............................................................................................................................. 16
ITEM 1: 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 2: DEVELOPMENT OF PURCHASING POWER PARITY (PPP) 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 focussed 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 3: HEALTH CARE QUALITY INDICATORS (HCQI) PROJECT: PROGRESS AND NEXT STEPS

9. The Secretariat (Nick 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

---

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).
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.

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 4: 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 5: 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 list 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 6: 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.

ITEM 7: OPENING OF OECD HEALTH DATA NATIONAL CORRESPONDENTS MEETING AND ADOPTION OF THE AGENDA

27. Participants adopted the draft agenda, and Mr Sam Notzon, the representative from the United States, was nominated as the Chairperson for the meeting.

ITEM 8: REPORT ON EXPERIENCE WITH OECD HEALTH DATA 2008, AND PROPOSED PRIORITIES FOR THE 2009 DATA COLLECTION

28. The Secretariat reviewed progress with OECD Health Data 2008 (both in terms of content and dissemination), with a particular focus on issues related to new variables in the 2008 data collection. It then outlined the priorities in 2009 in terms of data development, the timelines for the data collection, and the preparation of the 2009 edition of Health at a Glance [DELSA/HEA/HD(2008)3].

i) Evaluation of the 2008 data collection

29. The database was released in June 2008, and the Secretariat (Marie-Clémence Canaud) noted a significant increase in access to data tables—more than 30,000 tables were created using the online version between June to September 2008.

30. Ms Canaud reviewed the various tools made available to countries in order to help them update the data. These include: the user’s manual Guidelines; the hyperlinks in the Excel data files which provide direct access to the corresponding Definitions, the Sources and Methods; and the automatic checking tools within the Excel spreadsheets which help Correspondents identify possible data inconsistencies.

31. The delegate from the United States asked the Secretariat whether additional action could be taken to encourage greater use of the Sources and Methods.

32. The Secretariat (Gaetan Lafortune) then assessed the new variables on health employment introduced in 2008, notably the finer data collection on nurses and the collection on foreign-trained doctors.

33. As agreed at the 2007 meeting of OECD Health Data Correspondents, the 2008 data collection introduced a breakdown between two levels of nurses – qualified (professional) nurses and associate nurses. This is consistent with the Eurostat data collection. Two-thirds of OECD countries were able to report data, although there were some inconsistencies in data submissions. Some were due to countries misunderstanding the meaning of ‘qualified nurses’ (with some countries interpreting ‘qualified nurses’ as all nurses licensed to practice, including non-practising nurses). In order to improve the data collection in 2009, both OECD and Eurostat have agreed to use the new ISCO-08 designation and definitions on these two categories of nurses.

34. Correspondents welcomed the use of the ISCO definitions. The delegate from Norway mentioned that the data on nurses generated a lot of discussion in her country, and the accuracy of the data submitted will be verified. The Czech Republic proposed a possible extension of the data collection to also include
“nursing aides” (or personal care providers), as this category of workers may complement (or substitute for) nurses in certain countries. Turkey mentioned that they have combined two different categories of workers (nurses and “sanitarians”), since these two categories do the same type of work. Switzerland noted that the work of National Correspondents in responding to international data collections on topics such as nurses should not be under-estimated, given the differences between national and international categories. The Secretariat thanked Correspondents for their effort to meet the definitions used for international data collection, and added that it is important for Correspondents to document the decisions they have made in the Sources and Methods.

35. Regarding the new data collection on foreign-trained doctors, the Secretariat reported that data is available for half of OECD countries, meaning that there remain data gaps for the other half. The experience from the 2008 data collection will be used to refine the definition, so as to provide clearer guidance. The delegate from the Czech Republic mentioned that it is only possible for them for the time being to submit data on the annual “flow” of foreign-trained doctors, although data on the (cumulative) “stock” might become available. Germany said that they collect data only by country of citizenship, not by country of training. The Netherlands asked whether foreign-trained doctors working in the country, but living in a neighboring country, should be included. The Secretariat responded that they should be included since the aim of this data collection is to provide evidence on the number and share of foreign-trained doctors working in a given country.

ii) Proposed priorities for data development in 2009, and timelines for data collection and preparation for Health at a Glance

36. Referring to the OECD Health Committee’s Draft Programme of Work in 2009-2010, the Secretariat noted that the priorities to improve the content of the database in 2009 are to:

1. continue improving data on health employment and education, with a focus on doctors and nurses;
2. assess the feasibility to include selected indicators of disparities in health status, and health care access and use;
3. improve data on medical technologies and on procedures;
4. fill data gaps on the occurrence of selected chronic diseases and mental health problems (in cooperation with other international organisations); and
5. assess the possibility of improving data on children health and health services.

37. The Secretariat noted that the agenda for the meeting includes a more detailed discussion on all of these items.

38. The schedule for the production of the 2009 edition of OECD Health Data will remain the same as in previous years: the questionnaire will be sent out by the end of November 2008, and countries will have until mid-February 2009 to return it, with the aim of releasing the database by the end of June 2009. The Secretariat emphasized the importance of the mid-February deadline, and for Correspondents to pay particular attention to the quality and completeness of data and metadata submissions, as this will allow the preparation of Health at a Glance to begin as early as possible.

39. The draft table of contents of the 2009 edition of Health at a Glance was presented, with the new feature being a chapter dedicated to the health workforce. The chapter on Quality of Care may also be expanded, following discussions at the HCQI Experts meeting on 23-24 October. The schedule for the
production of *Health at a Glance 2009* will also remain the same as for previous editions: the Secretariat will prepare the draft publication in May and June 2009, then send it to Health Data Correspondents and Health Accounts Experts for comments, with the aim of incorporating these at the end of July and sending it to production in early August, so that it can be released in November 2009.

40. Some Correspondents (Norway and Finland) mentioned that the timing for sending the draft publication to countries for comments was not ideal, since it conflicts with holiday periods in their country. The Secretariat recognized that the timeframe may not be ideal for all countries, and explained the constraints around the preparation of the publication. This does not leave any choice but to seek comments from countries in June and July, if it is to be released in November.

**ITEM 9: STRENGTHENING COLLABORATION WITH OTHER INTERNATIONAL ORGANISATIONS ON NON-MONETARY HEALTH CARE STATISTICS**

41. The two main objectives of this agenda item were:

1. to review progress in harmonizing the structure and definitions of the regular data collection by OECD, Eurostat and WHO-Europe on selected non-expenditure health care statistics; and

2. to discuss the possibility of moving towards a joint data collection in the area of non-monetary health care statistics, building on the experience with the Joint OECD/Eurostat/WHO Health Accounts Questionnaire.

42. The Secretariat (Gaetan Lafortune) noted that these two topics were discussed at a coordination meeting between the OECD, Eurostat and WHO-Europe held in April 2008 and at a follow up meeting at the end of September 2008, which also included WHO-Headquarters.

**i) Progress in harmonisation of data collection on selected non-expenditure health care statistics**

43. The discussion addressed current efforts to improve and harmonise international data collection on different categories of doctors as well as on different types of medical equipment.

44. Regarding doctors, the discussion focussed on introducing a new data collection on physicians-in-training and improving the data collection on medical specialists. Some countries (such as Australia, Japan and Korea) mentioned that they would be able to respond to a new data collection on physicians-in-training, although the data sources might vary across countries. The ability to distinguish people who are training to become GPs from those who are specialising in other fields may also be problematic. There was broad agreement that a clear definition would be needed to guide any new data collection on physicians-in-training. The delegate from Switzerland noted that collecting data on physicians-in-training is challenging, since this is a mobile group.

45. International organisations also face challenges in collecting comparable data on medical specialists. The revisions to ISCO-08 cannot be expected to provide much support, as they will not go beyond the basic breakdown between general and specialist practitioners. Collection is particularly difficult for broad categories of specialties, such as “internal medicine” and “surgeons”. The Secretariat noted that two different approaches are presently used by international organisations: 1) Eurostat and OECD seek to collect data on a selected list of medical specialties, without any attempt to group them; and 2) WHO-Europe is grouping a number of specialties in two broad groups (“medical” and “surgical”) in an attempt to reduce the data collection effort and to achieve greater consistency in national data.

---

2 The selected list of medical specialties used by the OECD is a subgroup of a longer list used by Eurostat.
submissions. In the discussion, it was recognised that there are both advantages and disadvantages in using these two approaches. While some delegates supported the second approach, other delegates wondered about the appropriateness of grouping certain categories of specialists together (e.g. anaesthetists and surgeons) and others raised the issue that it may be difficult for countries to classify certain specialties in one group or another.

46. There was agreement that the Secretariat should carry out further developmental work, in collaboration with Eurostat and WHO, prior to implementing any changes in the data collection on both physicians-in-training and medical specialists.

47. Regarding medical equipment, the Secretariat proposed harmonising the shortlist of medical equipment collected by the OECD with that of Eurostat. This would mean adding three types of medical equipment (PET scanners, gamma cameras and angiography units). Several Correspondents mentioned that they would be able to supply data, and the proposal was therefore accepted. Some Correspondents added that it would be useful to complement such data with utilisation rates. This topic was discussed in more detail under item 11.

ii) Proposal to explore feasibility of joint data collection on non-expenditure health care statistics

48. The Secretariat reported on initial discussions between the OECD, Eurostat and WHO-Europe to explore the possibility of developing of a joint data collection in the area of non-monetary health care statistics, and sought agreement in principle from OECD Health Data National Correspondents to pursue these discussions further. As for the Joint Health Accounts Questionnaire, the main aims of a joint data collection on non-monetary health care statistics would be to reduce the data collection burden on National Correspondents, to promote the use of international standards and definitions, and to improve the comparability and consistency of data reported at the international level. The development of such a joint data collection would be based on three key principles:

1. the need to use international standards as much as possible (such as ICD-10, ISCO-08 and ICHA);

2. the need for sufficient flexibility to respond efficiently to the information needs of the different international organisations; and

3. the need for a transparent process, which would allow National Correspondents to be kept informed and consulted throughout the process.

49. Many Correspondents welcomed the effort to move towards a joint data collection, and several asked when such a collection might be implemented. Noting that the timing of the current OECD, Eurostat and WHO-Europe data collections vary, the delegate from the Netherlands added that a joint data collection would also involve agreeing on the annual data requests sent out to countries and the return of data submissions. While it was agreed that the experience in developing and implementing the Joint Health Accounts Questionnaire should be used as much as possible, the delegate from the Czech Republic noted that the development of a joint data collection on non-monetary health care statistics would be more difficult, given that the three international organisations have used for many years a separate questionnaire. The Secretariat responded that the three organisations are aiming to introduce such a joint questionnaire for the 2010 data collection, although the exact timing of the annual data request has not been decided yet. The Secretariat added that the precise scope of a joint data collection has not been determined yet, with options ranging from a fairly limited scope (e.g. covering only certain variables related to health care resources) to

---

3 WHO-Europe does not presently collect data on these types of medical equipment.
a broader scope (e.g. covering variables related to both health care resources and activities). The next steps in the process will involve a further review of the three existing questionnaires to identify similarities and differences, with a view to agreement on a common set of variables that might be collected jointly by the three organisations. Approval from OECD Health Data National Correspondents will be sought before any joint data collection is implemented.

ITEM 10: PROGRESS REPORT FROM THE HOSPITAL DATA PROJECT 2 ON A PROPOSED SELECTED LIST OF PROCEDURES FOR INTERNATIONAL DATA COLLECTION

50. Gerrie Lierens (Manager of the HDP2 project) provided a progress report on the work of the EU-funded Hospital Data Project (HDP2) to develop a selected list of hospital procedures to be used for international data collections and comparisons [DELSA/HEA/HD(2008)5]. The main aim of the presentation was to seek comments from OECD Health Data National Correspondents on whether the OECD should adopt this list for its data collection.4

51. Mr Lierens reported that in 2007 the expert group initially proposed 30 procedures along with 6 subgroups, based on criteria such as the volume of procedures, continuity with existing international lists, changing medical techniques, potentiality for day surgery, specialty coverage, cost and public health importance. The feasibility of collecting data for the selected list was pilot tested in 17 European countries in 2007 and 2008. The results indicate that it is possible to collect data for most of the selected procedures from most countries. One of the lessons learned from the pilot data collection is that it is difficult to collect data for certain procedures either because existing national classification systems do not have specific codes for them, or because the procedures are largely performed in hospital out-patient departments or outside hospitals (e.g. cataract surgery, bronchoscopy, colonoscopy, knee arthroscopy).5 Nonetheless, the HDP2 project recommends that international organisations should pursue a regular data collection based on the selected list of 30 procedures and 6 subgroups, but with certain caveats for some of these procedures. Another recommendation is that it is useful to collect data by specific age groups and sex, as this helps explain differences in activity rates across countries.

52. The delegate from Iceland mentioned that it would be helpful to have a consensus on one shortlist of procedures for international data collection, while the delegate from Luxembourg said that they would have no difficulty if the OECD were to add to its data collection the new procedures proposed by the HDP2 project. The delegate from the Czech Republic mentioned that as a participant in the HDP2 project, it proved to be difficult for them to send reliable data on a number of procedures, including laparoscopic procedures, brain surgeries and some of the cardiovascular procedures. At the same time, he suggested that it would be useful to add certain procedures related to cancer treatment (such as pulmectomy and colectomy) to the shortlist of procedures under the OECD data collection.

53. There was also some discussion on the difficulty of collecting complete data on these procedures, including day surgery carried outside hospitals in the ambulatory care sector. The delegate from the United States noted that it is no longer possible for his country to submit reliable data on procedure activities outside hospitals, because the ambulatory care survey was discontinued some years ago. He added that even for hospital-based activities, low-volume procedures may not be reliable.

54. The Secretariat noted that the current OECD data collection on procedures includes both in-patient and day cases, and that “day cases” should include, where possible, not only day care in hospitals, but also the activities of out-patient departments in hospital and in the ambulatory sector (e.g. clinics and doctor’s offices). Regarding the selected list of procedures, further discussion is needed among

---

4 WHO-Europe does not presently collect data on procedures.

5 In theory, the data collection under the HDP-2 project was limited to in-patients and day cases in hospitals.
international organisations to harmonise the existing lists, building as much as possible on the rigorous developmental work and pilot data collection carried out under the HDP2 project.

ITEM 11: ASSESSING THE AVAILABILITY AND COMPARABILITY OF DATA ON THE USE OF SELECTED MEDICAL EQUIPMENT: REPORT ON A PROJECT FROM THE CANADIAN INSTITUTE FOR HEALTH INFORMATION

55. The purpose of this agenda item was to assess the feasibility of complementing the current data collection on medical equipment with certain indicators related to their actual use. The delegate from Canada (Chris Kuchciak) was invited to present the main results of recent work carried out by the Canadian Institute of Health Information (CIHI) to collect data on the use of selected medical equipment in Canada as well as in other OECD countries [DELSA/HEA/HD(2008)6]. The work thus far has focussed on the use of MRI and CT scanners, with the main indicator of utilisation being the number of exams either per scanner or per capita. Besides the data available in Canada (from a National Survey of Selected Medical Imaging Equipment), reasonably comparable data were also identified and reported by CIHI for six other OECD countries (Belgium, Denmark, Spain, Sweden, the United Kingdom/England, and the United States).

56. In response to a question on the policy relevance of collecting data on the utilisation of equipment, Mr. Kuchciak responded that this effort in Canada is being carried out in a context of increasing government investments in medical imaging equipment, raising questions on whether the increased supply of these medical equipment has been accompanied by a proportional increase in their utilisation rates and a reduction in waiting times, and how utilisation rates in Canada compare internationally. The Secretariat added that this item had been put on the agenda in response to comments by some delegates in previous meetings that it was not sufficient to have indicators of the supply of equipment, and that these should be complemented by indicators on their use. The Secretariat concluded the discussion by saying that it would be useful to carry out some further work to review data availability on some of the leading indicators in this area, starting with the number of MRI and CT exams, with the aim of including a few additional indicators to fill this gap in OECD Health Data.

ITEM 12: CHILDREN’S HEALTH AND HEALTH SERVICES

i) Proposed priorities and approach to improve indicators on children’s health and health services

57. The 2009–2010 draft work programme includes work to improve indicators of children’s health and health services in OECD Health Data. The Secretariat (Michael de Looper) presented a short paper outlining the first steps in this process [DELSA/HEA/HD(2008)7].

58. Possible additional indicators were identified through reviewing national policy and programme documents, as well as leading child health reports. The criteria for selection include that the indicators have high priority in national programmes, and that data collection should already be in place (or recommended to be undertaken soon). Eight indicator development areas were identified—overweight and obesity, physical activity, diet and nutrition, smoking, harmful alcohol use, teenaged births, asthma prevalence and injuries mortality rate.

59. A review paper on progress will be presented to the December 2009 meeting of the Health Committee. Pending approval, the new child health indicators will be progressively introduced into OECD Health Data and Health at a Glance from 2009 onwards.

60. Correspondents supported the move to improve children’s health indicators. Italy suggested that the scope of the indicator on teenaged births be widened to include all of pregnancy, and include, for example, information on abortion. The Czech Republic pointed out that gathering comparable information
on child health risk factors will pose most problems. Clarification on what age group ‘children’s health’ encompasses was also requested.

**ii) Development and implementation of new international classification on childhood obesity**

61. To complement the work to develop child health indicators, the Secretariat invited Ms Trudy Wijnhoven (Non-communicable Diseases and Environment Unit, WHO Regional Office for Europe) to speak on WHO’s efforts to develop and implement classifications of childhood obesity.

62. Ms Wijnhoven presented the WHO child growth standards for children aged 0–5, and child growth references for children and adolescents aged 5–19, as well as the proposed semantics to accompany the different cut-off points. WHO classifications of overweight and obesity for different age groups were outlined, as was the WHO European Childhood Obesity Surveillance Initiative. This initiative will aim to measure trends in overweight and obesity in primary school children at two-yearly intervals, based on actual measures of height and weight.

63. The Secretariat noted that this work holds great promise for producing validated and comparable data on overweight and obesity in children. The United Kingdom pointed out that a complementary initiative in their country already measures the height and weight of almost 1 million primary school children. The U.S. delegate commented on the lack of reliability of self-reported data by parents concerning the height and weight of their children at younger ages, and mentioned that data based on actual measures are available in the United States and in Mexico. The U.S. delegate also noted that work by WHO in producing growth charts will complement those of the Center for Disease Control and Prevention. The Secretariat underlined the importance of data sharing, and in using measured data to generate BMI estimates.

**iii) Health Behaviour in School-aged Children (HBSC) study: a review of scope, approach and selected results**

64. Professor Candace Currie (Child and Adolescent Health Research Unit, University of Edinburgh) gave a presentation on the Health Behaviour in School-aged Children (HBSC) study. This international study gathers data from young people about their health and wellbeing in a social and developmental context. HBSC has had success in expanding its country coverage to include 25 OECD countries in the 2005–06 survey wave (the only five OECD countries that have not participated in the latest wave of the survey are Australia, New Zealand, Japan, Korea and Mexico).

65. The surveys are conducted every 4 years in participating countries, using a common standardised survey. Data are collected on nationally representative samples of 11, 13 and 15 year old schoolchildren in each country, with an approximate sample size of 1,550 per age group. The scope of the survey includes measures on physical, emotional and social health and well-being. It measures a comprehensive range of health risk and health promoting behaviours. It also includes measures of social context known to be of importance to young people's health including indicators of the socioeconomic, family, peer and school environments. The most recent report from the survey focuses on inequalities in young people’s health.

66. Correspondents welcomed the comprehensiveness of the HBSC results, and requested more information such as the length of time taken to complete the survey. Professor Currie replied that the questionnaire takes about 40 minutes to complete, and that children are asked to fill it in a classroom environment.

67. The Secretariat noted that the HBSC study provides a valuable source of comparable data across most OECD countries on several of the child health risk factors that have been identified as priority areas. The HBSC survey covers age groups that are often hard to reach in regular national health surveys.
Following a proposal made by Professor Currie, the Secretariat will explore the possibility of using the study results to fill current data gaps in its publications. It also supports and encourages the further extension of the survey to countries that have not yet participated.

ITEM 13: CHRONIC DISEASES

i) General introduction on proposed priorities and approach to fill data gaps on selected chronic diseases

68. The 2009–2010 draft work programme seeks to fill data gaps on the occurrence of selected chronic diseases and mental health problems. The Secretariat (Michael de Looper) presented a paper providing a general introduction to the proposed priorities and approach to fill these data gaps [DELSA/HEA/HD(2008)8].

69. The chronic diseases contributing to WHO’s leading burden of disease in high income countries provided guidance in selecting 6 chronic diseases for further development. In addition to continuing to report data on cancer incidence, the focus in 2009–2010 will be to improve incidence and prevalence data on diabetes, dementia, depression, ischaemic heart disease, stroke and asthma.

70. The proposed approach suggests building on past experience, and partnering with international organisations and initiatives.

71. Correspondents saw this work as important, but challenging. Sourcing incidence or prevalence data for several of the diseases, including stroke and ischaemic heart disease, will be particularly problematic. Australia queried whether data for chronic obstructive pulmonary disease (COPD) and alcohol use disorders should also be developed. Data for these might be available through linking hospital data sets, and through household surveys.

ii) Cancer incidence and screening: overview of activities of the International Agency for Research on Cancer (IARC)

72. Incidence data on cancer already exists in OECD Health Data, and is sourced from the International Agency for Research on Cancer (IARC). Dr Philippe Autier (Coordinator, Biostatistics and Epidemiology, IARC) gave a presentation on IARC’s cancer databases and spoke on their activities in collecting data on cancer incidence, screening and mortality.

73. Dr Autier explained the process of sourcing data from national registries, validating these data and making them publically available through the Cancer Incidence in Five Continents publication, and online through Globocan. He stressed the importance of these data for monitoring and descriptive oncology.

74. The Secretariat was appreciative in being able to use IARC data. The Secretariat asked whether data might be made more frequently available than the current 5 yearly publication cycle of Cancer Incidence in Five Continents. Dr Autier replied that IARC is seeking to publish data on the web on an annual basis.

75. Correspondents noted that it can take several years to provide complete incidence data. It was commented that these data are important in measuring health system efficiency, through using disease-specific expenditure data as an input, and the decline in cancer mortality and increase in 5-year survival rates as an output.
iii) Measuring diabetes prevalence: the experience of the International Diabetes Federation (IDF)

76. Diabetes is one of the chronic diseases for which data are sought for inclusion in OECD Health Data. The International Diabetes Federation (IDF) has produced national estimates of diabetes prevalence for most countries covering a number of years. These data are published in a Diabetes Atlas, now in its 3rd edition, and also on the web.

77. Professor Nigel Unwin (Institute of Health and Society, Newcastle University) is joint Chair of the IDF Atlas Committee. He gave a presentation on the experience of the IDF in measuring diabetes prevalence.

78. Professor Unwin began with a definition and description of diabetes. He covered the diagnostic cut points for diabetes, outlined the incidence and prevalence of diabetes in children and adults, and spoke about diabetes complications and mortality. He explained the sources and methods that were used to produce the 2007 prevalence estimates and projections [these are also summarised in DELSA/HEA/HD(2008)9]. A 4th edition of the Atlas, containing 2010 estimates, will be published in October 2009. These data will contribute to the 2005 Global Burden of Disease estimates.

79. Correspondents welcomed the work of IDF in providing estimates of diabetes prevalence. Correspondents asked additional questions about some of the methods used, and specifically how data are adjusted.

80. The Secretariat will seek to use IDF data in OECD Health Data and in other publications, with appropriate citation.

ITEM 14: OTHER BUSINESS

81. The Secretariat announced the dates for next year’s meetings:

- 7-8 October 2009 (Health Accounts Experts meeting)
- 8-9 October 2009 (Health Data Correspondents meeting)
PARTICIPANTS LIST FOR MEETING OF OECD HEALTH DATA NATIONAL CORRESPONDENTS, 9-10 OCTOBER 2008

Chairperson/Président(e)

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

Australia/Australie

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. John GOSS
Expenditure and Economics Unit
Australian Institute of Health and Welfare
GPO Box 570
ACT 2601 Canberra
Australia

Tel: +61 2 6244 1151
Email: john.goss@aihw.gov.au

Mr. Robert LONG
Health data analyst
Population Health Unit
Australian Institute of Health and Welfare

Email: robert.long@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@czo.cz
Denmark/Danemark
Mr. Carsten Rodseth BARSOE
National Board of Health
Email: CRB@sst.dk

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.knape@stakes.fi

France/France
Mme Martine BROIDO
IRDES
10, rue Vauvenargues
75018 Paris
France
Tel: +33 1 53 93 43 45
Fax: +33 1 53 93 43 50
Email: broido@irdes.fr

Mme Amélie SCHMITT
Ministère de la Santé, de la Jeunesse et des Sports
8, Avenue de Ségur
75700 PARIS
France
Tel: +33 1 01 40 56 78 22
Email: amelie.schmitt@sante.gouv.fr
Germany/Allemagne
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

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

Iceland/Islande
Ms. Guðrún EGGERTSDOTTIR
Þjóðhagsreikningar/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. Carla CECCOLINI  
Ministry of Health  
Via Giorgio Ribotta, 5  
00144 Rome  
Italy

Tel: +39 06 5994 2836  
Email: c.ceccolini@sanita.it

Ms. Marzia LOGHI  
Servizio Sanita e Assistenza  
ISTAT - NATIONAL INSTITUTE OF STATISTICS  
Viale Liegi 13  
00198 Rome  
Italy

**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. Aya YAMAZAKI
Statistics and Information Department
Ministry of Health, Labour and Welfare
1-2-2, Kasumigaseki
Chiyoda-ku
100-8916 Tokyo
Japan
Email: yamazaki-aya@mhlw.go.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
Professor Hyoung-Sun JEONG  
Department of Health Administration  
Yonsei University  
Email: tokyoparis@hanmail.net

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  
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, 4º 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. 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. Elisabetta VASSENDEN  
Head of Division  
Statistics Norway  
N-0033 OSLO  
Norway  
Tel: +47 21 09 42 59  
Fax: +47 21 09 44 04  
Email: elv@ssb.no

Poland/Pologne  
Mme Agnieszka CHOCHOROWSKA  
Office Statistique  
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, n°5
Lisboa
Portugal

Tel: +351 21 844 04 87
Fax: +351 21 842 63 66
Email: isabel.quintela@ine.pt

**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  
Mme 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. Cecilia DAHLGREN  
National Board of Health and Welfare  
Email: cecilia.dahlgren@socialstyrelsen.se

Mrs. INGALILL PAULSSON L  
Statistics Co-ordinator  
Centre for Epidemiology  
National Board of Health and Welfare  
Rålambsvägen 3  
S-106 30 Stockholm  
Sweden  
Tel: +46(8) 5555 3115  
Fax: +46(8) 5555 3327  
Email: ingalill.lutz@sos.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

Turkey/Turquie  
Ms. Handan KALAYCIOGLU  
Head of Department  
Ministry of Health  
T.C. Saglik Bakanligi  
Mithatpasa Cad. No :3 Sihhiye  
06434 Ankara
Ms. Claire COLLINS
Office for National Statistics (ONS)
1.276 Government Buildings
Cardiff Road
NP10 8XG Newport
United Kingdom

Tel: +44 1633 455 907
Email: claire.collins@ons.gsi.gov.uk

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

Mr. Sam WIDDOWFIELD
Higher Statistical Officer
NHS Information Centre
Trevelyan Square
LS1 6AE Leeds
United Kingdom

Tel: +44 113 25 47 133
Email: sam.widdowfield@ic.nhs.uk

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

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

Ms. Elodie CAYOTTE
Health and Food Safety Statistics
Eurostat
BECH - D2/706
L-2721 Luxembourg
Email: elodie.cayotte@ec.europa.eu

Ms. Gudrun GUDFINNSDOTTIR
DG Health and Consumers (SANCO)
Health Information Unit
HTC Building 00/079
Luxembourg
Email: gudrun.gudfinnsdottir@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. 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

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.Ol@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
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
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

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

Dr. Enrique LOYOLA
Epidemiologist/Statistician
Health Intelligence Service
WHO
Regional Office for Europe
8 Scherfigsvej
DK-2100 Copenhagen
Denmark

Tel: +1 202 974 3130
Fax: +1 202 974 3674
Email: ENL@euro.who.int

Mrs. Trudy WIJNHOVEN
Technical Officer, Nutrition Surveillance
Division of Health Programmes/NCE
World Health Organization
Regional Office for Europe
8 Scherfigsvej
DK-2100 Copenhagen
Denmark

Tel: +45 39 17 1248
Fax: +45 39 17 1818
Email: twi@euro.who.int
OECD/OCDE

Mlle. Gaëlle BALESTAT
Statistical Assistant (Health Data)
ELS/HD
OECD
Annexe Monaco 408
2 rue André-Pascal
75016 Paris
France

Tel: +(33-1) 45 24 17 45
Email: Gaelle.BALESTAT@oecd.org

Mlle. Marie-Clémence CANAUD
Coordinator, OECD Health Data Publications
ELS/HD
OECD
Annexe Monaco 406
2 rue André-Pascal
75016 Paris
France

Tel: +(33-1) 45 24 91 73
Email: Marie-Clemence.CANAUD@oecd.org

Mrs. Francesca COLOMBO
Principal Administrator (Asian Health and Social Policy Outreach)
ELS/HD
OECD
Annexe Monaco 116
2 rue André-Pascal
75016 Paris
France

Tel: +(33-1) 45 24 93 60
Email: Francesca.COLOMBO@oecd.org

Mr. Michael DE LOOPER
Administrator (Health Data)
ELS/HD
OECD
2 rue André-Pascal
75016 Paris
France

Tel: +(33-1) 45 24 76 41
Email: Michael.DELOOPER@oecd.org
Ms. Elizabeth DOCTEUR  
Deputy Head of Division  
ELS/HD  
OECD  
Annexe Monaco 128  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 76 03  
Email: Elizabeth.DOCTEUR@oecd.org

Ms. Rie FUJISAWA  
Administrator (Long-term Care, Remuneration of Health Professionals)  
ELS/HD  
OECD  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 14 09  
Email: Rie.FUJISAWA@oecd.org

Ms. Sandra GARCIA ARMESTO  
Administrator (Health Care Quality Indicators)  
ELS/HD  
OECD  
Annexe Monaco 425  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 82 45  
Email: Sandra.GARCIA-ARMESTO@oecd.org

M. Gaetan LAFORTUNE  
Principal Administrator (Health Data)  
ELS/HD  
OECD  
Annexe Monaco 129  
2 rue André-Pascal  
75016 Paris  
France  
Tel: +(33-1) 45 24 92 67  
Email: Gaetan.LAFORTUNE@oecd.org
Mme Christine LE THI  
Statistical Assistant  
ELS/HD  
OECD  
2 rue André-Pascal  
75016 Paris  
France  

Tel: +(33-1) 45 24 81 83  
Email: Christine.LETHI@oecd.org  

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  

Mrs. Annette PANZERA  
Consultant (Health Care Quality Indicators)  
ELS/HD  
OECD  
Annexe Monaco 407  
2 rue André-Pascal  
75016 Paris  
France  

Tel: +(33-1) 45 24 91 19  
Email: Annette.PANZERA@oecd.org
Mr. Peter A. SCHERER
Head of Division
ELS/HD
OECD
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

Professor Candace CURRIE
HBSC International Co-ordinator
The Moray House School of Education
University of Edinburgh
Holyrood Road
EH8 8AQ Edinburgh

Mr. Manfred HUBER
Director of Heath 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

Mr. Gerrie LIERENS
Prismant InformatieExpertise
Postbus 85200
3508 AE Utrecht
Netherlands

Email: gerrie.lierens@wxs.nl
Dr. Daša MORAVEC BERGER  
Slovenia  
Email: dasa.moravec@ivz-rs.si

Antony MORGAN  
Head, HBSC Policy Development  
The Moray House School of Education  
University of Edinburgh  
St Leonard's Land  
Holyrood Road  
Edinburgh EH8 8AQ  
Scotland, UK

Ms. Magdalena RATHE  
Fundacion Plenitud  
Email: mrathe@fundacionplenitud.org

Professor Nigel UNWIN  
Institute of Health and Society  
Newcastle University  
Leech Building  
The Medical School  
NE2 4HH Newcastle Upon Tyne  
United Kingdom