OECD HEALTH DATA QUESTIONNAIRE 2017

GUIDELINES FOR COMPLETING THE QUESTIONNAIRE

QUESTIONNAIRE SENT: 8 December 2016
DEADLINE TO RETURN THE INFORMATION: THURSDAY 16 FEBRUARY, 2017
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NOTE BY THE SECRETARIAT

1. These Guidelines aim to assist national correspondents in completing the OECD Health Data Questionnaire 2017. Besides these Guidelines, the questionnaire consists of the following files:

   - Seven Excel files with numerical data (in Excel 97-2003 format) to update country-specific segments of the corresponding datasets on Health Status, Non-Medical Determinants of Health, Remuneration of Health Professionals, Waiting Times, Pharmaceutical Market, Long-Term Care Resources and Utilisation, and Social Protection.

   - One DOC file with the documentation on Definitions, Sources and Methods to update country-specific methodology. The DOC file should be opened, edited, saved and returned as a Word document, using the track change mode.

   [Note: You can readily access the Definitions by clicking on the hyperlink in the first spreadsheet of the Excel files. All definitions are available online for information and for consultation at http://www.oecd.org/els/health-systems/OECD-Health-Data-2017-Questionnaire-DEFINITIONS.pdf. In case of any technical problems, please contact Marie-Clémence Canaud by e-mail or phone.]

   - In addition, national correspondents may receive a country-specific note, focusing on any pending issues related to the data collection.

2. The 2017 questionnaire reflects the discussions which took place at the meeting of OECD Health Data National Correspondents (October 13-14, 2016).

3. The deadline for returning the questionnaire is THURSDAY 16 FEBRUARY 2017.

4. Please return the questionnaire (updated Excel files for all parts of the database, and Sources and Methods in Word format) to Ms. Marie-Clémence CANAUD, OECD Health Division, at the following e-mail address: marie-clemence.canaud@oecd.org.
I. GENERAL INSTRUCTIONS FOR UPDATING THE DATA AND SOURCES AND METHODS

Chapters and variables contained in the questionnaire

5. Annex 1 presents the full list of variables collected through the OECD Health Data Questionnaire 2017. As indicated during the October 2016 meeting of OECD Health Data Correspondents, there is only one change in the 2017 data collection, in the Health Status dataset. The Secretariat is extending the data collection on life expectancy by education level, to collect data for women, men and the total population at birth and at age 65 (in addition to the current data collection at age 30 only). Data for several European countries have already been extracted from the Eurostat database for these two additional age groups.

6. Regarding European countries, Annex 2 provides the list of countries and variables that are directly imported from the Eurostat Database.

Update of data in the Excel spreadsheets

7. The questionnaire comprises seven Excel files, containing each several worksheets, one per sub-chapter, with the first worksheet displaying the complete list of variables for the given dataset. Note that the 2017 questionnaire follows the structure of the published database, and each file bears the full name of a dataset (i.e. Health Status), to be consistent with the content published in OECD.Stat.

8. Please fill/update only the cells of the time series, i.e. send back the Excel worksheets in exactly the same structure in which you receive them. It is essential that you do not change the format of the Excel files.

9. Please mark updates of data in BOLD or COLOUR in the Excel worksheets. This extra step is extremely useful for reviewing and processing the country’s submissions more efficiently and communicating changes in the data.

10. Please do not write any comments into the Excel worksheets and do not include any information on Sources and Methods in the texts of the e-mails you are sending us, but only in the Word documents provided for this matter. All comments should be supplied separately and/or inserted into the documentation of Sources and Methods (see below). The update of the database will rely exclusively on the electronic files received for the questionnaire.

Years included in the OECD Health Data Questionnaire 2017

11. Time series in the OECD Health Data Questionnaire 2017 should cover the period up to 2015. The questionnaire also includes the year 2016, for reporting final data or preliminary estimates. All countries are encouraged to report more timely data, making use of the P flag to indicate provisional data for 2016 (t-1) where needed (additionally to already-existing B, D and E control codes).

Updating the documentation of Sources and Methods

12. Please add and/or correct information directly into the body of the text of Sources and Methods. Please use TRACK CHANGES MODE in Word to highlight all changes to the Sources and Methods for your country. The electronic files to update the Sources and Methods are provided in DOC format, and should be opened, updated and then returned using WORD (or any text-processing software).
II. SPECIFIC FEATURES OF THE QUESTIONNAIRE

13. The questionnaire includes a tool to flag important issues related to data consistency and comparability. Correspondents will find in the Excel questionnaire additional columns, marked with a *, following every single data column, and are requested to do the following:

- **Include letters** to indicate specific new information. We would however like to urge for caution, as correspondents should **add letters only when necessary**. The Secretariat also reserves the right to modify the information provided by correspondents.

- If a letter already exists, please check it and **update the letter accordingly**: either leave it if it is still relevant, or remove it if it is no longer appropriate.

<table>
<thead>
<tr>
<th>Letters</th>
<th>Description</th>
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<tbody>
<tr>
<td>B</td>
<td>break in series</td>
</tr>
<tr>
<td>E</td>
<td>estimate/preliminary data</td>
</tr>
<tr>
<td>D</td>
<td>deviation from OECD definition</td>
</tr>
<tr>
<td>P</td>
<td>provisional value (to be used only for t-1 data, i.e. 2016) New</td>
</tr>
</tbody>
</table>

14. The questionnaire also includes tools which **check the internal consistency of data**. These checks concern the data for **overweight/obese population** in the dataset on Non-Medical Determinants of Health (sheet BODY in HEALTH_LVNG), and the data on **long-term care workers and recipients** in the dataset Long-Term Care Resources and Utilisation (HEALTH_LTCR). In these sheets, columns/rows with cells containing data checks have been added respectively on the right and at the bottom of the data tables.

These cells are highlighted in different ways:

- **shaded cell + red font**: signals an error that should be corrected or at least explained (however rounding errors eventually highlighted in this way do not require a correction);
- **red font**: signals a discrepancy that may need an explanation or may be solved;
- **“missing” in blue**: signals missing data;
- **black font**: data are correct.

15. For instance, in the sheet BODY (Body weight), the check highlights possible data inconsistency in the case that rates for females or males would be higher than for the total population for the respective categories (obese, overweight, overweight and obese), and also by gender (i.e. obese + overweight = overweight and obese). If this calculation is:

- **negative**, the difference will appear in red font in shaded cell (as the total cannot be inferior to the sum of females and males);
- **positive**, the difference will appear in red font in shaded cell (as the total cannot be superior to the sum of females and males);
- **between -1 and 1**, the difference will be in black font (there may be rounding errors but the data are correct).

- If data are missing, the word “**missing**” appears in blue in the cell.

16. Correspondents are invited to use these data checking tools and to correct any inconsistencies or to provide information in the Sources and Methods when the data do not add up.
III. GUIDELINES BY CHAPTER AND VARIABLE

HEALTH_STAT – Health Status

Mortality
- Life expectancy
- Life expectancy by education level, at birth, at age 30 and at age 65
- Causes of mortality
- Maternal and infant mortality
- Potential years of life lost

Morbidity
- Perceived health status (all response categories)
- Perceived health status by age and gender
- Perceived health status by socio-economic status
- Infant health
- Dental health
- Communicable diseases
- Cancer
- Injuries
- Absence from work due to illness

Life expectancy

17. The chapter on Life expectancy (by age and gender) will be directly imported from the Eurostat Statistical Database for the 26 European countries listed in Annex 2. Countries not listed in Annex 2 (Australia, Canada, Chile, Israel, Japan, Korea, Mexico, New Zealand, and the United States) are asked to supply data updates. As in previous years, life expectancy at birth for the total population will be calculated by the OECD Secretariat for all countries, using the unweighted average of life expectancy of men and women.

Life expectancy by education level

18. The OECD Health Data questionnaire has been collecting since 2010 data on Life expectancy by education level (LEED) at age 30, directly from countries but also with data extracted from the Eurostat database for a number of EU/EFTA countries. Following discussion at the October meeting, the 2017 questionnaire now includes an extension to this data collection, with data collected for life expectancy by education level at birth and at age 65 (for women, men and the total population), for three ISCED education groups, using the latest ISCED international classification (ISCED-2011): low education (ISCED levels 0 to 2), medium education (ISCED levels 3 and 4), and high education (ISCED levels 5 to 8). This extension will enable a better monitoring of health inequalities across socio-economic groups at different ages.

19. The OECD Secretariat has already extracted data for half of the 26 European countries listed in Annex 2 from the Eurostat Database (currently for 13 countries). It has also prefilled the questionnaire with data collected from an ad hoc OECD Statistics Directorate project (for 9 countries). Other European and non-European countries are asked to supply data and corresponding Sources and Methods.
Causes of mortality and PYLL

20. These data will be again collected directly from the WHO Mortality Database for all countries, and the Secretariat will calculate the standardised rates.

Maternal and infant mortality

21. Data on perinatal mortality will be imported from the Eurostat Statistical Database for the 26 European countries listed in Annex 2, unless these countries wish to provide their data directly to the OECD (in this case, they should also provide the corresponding Sources and Methods). Other countries are invited to update data on perinatal mortality as usual.

22. Building on the 2015 experience, the 2017 questionnaire still includes a minimum threshold of 22 weeks of gestation period (or 500 grams birthweight) for the registration of a live birth for the data collection on infant mortality and neonatal mortality. This is in addition to the traditional approach of not setting any minimum threshold for the registration of a live birth. The main purpose for having this minimum threshold is to improve the comparability of infant and neonatal mortality rates across countries. All countries (including European countries) are invited to submit data based on these two data collection specifications, where possible.

Perceived health status

23. The 2017 data collection on Perceived Health Status includes three separate chapters: 1) Perceived health status (PRHS), to collect data on the full range of responses available in surveys, i.e. including the response categories “good/very good”, “fair”, and “bad/very bad”; 2) Perceived health status by age and gender (SRHS), focusing on the age and gender breakdown for the “good/very good health” response category; and 3) Perceived health status by socio-economic status (SREC), which gathers data on perceived health status by income quintile and on perceived health status by education level based on the ISCED-2011 classification (see paragraph 18 for further details).

24. Data for all variables on perceived health status for all the 26 European countries listed in Annex 2 (except Turkey) will be extracted from the Eurostat Database (based on EU-SILC data). Turkey and non-European countries are asked to supply data and corresponding Sources and Methods.

Communicable diseases

25. Regarding AIDS incidence, data will be imported from the European Centre for Disease Prevention and the WHO Regional Office for Europe for all European countries including Turkey. Correspondents from non-European countries are invited to provide data updates and accompanying Sources and Methods.

Cancer

26. As in previous years, the Secretariat will collect data on cancer incidence from the International Agency for Research on Cancer (IARC) for all countries, to reduce the data collection burden and to promote greater consistency in cancer incidence data available at the international level.

Injuries (Injuries in road traffic accidents)

27. Data on injuries in road traffic accidents will be imported from the annual publication of the United Nations Economic Commission for Europe (UNECE), “Statistics of Road Traffic Accidents in Europe and North America”, for all the OECD countries covered in that report. For those countries not covered in the UNECE report (Australia, Chile, Israel, Japan, Korea, Mexico and New Zealand), correspondents are asked to provide data updates, along with accompanying Sources and Methods.
Absence from work due to illness

28. Correspondents are invited to provide data for both the variable “Self-reported absence from work due to illness” and the variable “Compensated absence from work due to illness”, along with corresponding information on Sources and Methods.

HEALTH_LVNG – Non-Medical Determinants of Health

Lifestyles and behaviour
- Tobacco consumption
- Alcohol consumption
- Food supply and consumption
- Body weight

Food supply and consumption

29. The data collection focuses on the proportion of the population aged 15+ eating vegetables (excluding potatoes and juice) at least once per day (FOODVEGE), and the proportion of the population aged 15+ eating fruit (excluding juice) at least once per day (FOODFRUT). Data should be reported by gender. The main data sources are national health surveys or the European Health Interview Surveys (EHIS).

Body weight

30. In order to clearly distinguish between self-reported and measured data, the data series continue to be split between these two data collection methods for the overweight population (BODYOVSR and BODYOVMS), the obese population (BODYOBSR and BODYOBMS), and the total number of overweight or obese population (BODYVBSR and BODYVBMS). All countries are invited to provide data for both self-reported and measured indicators, and update the corresponding information in the Sources and Methods.

HEALTH_REAC – Remuneration of Health Professionals

- Remuneration of general practitioners
- Remuneration of specialists
- Remuneration of hospital nurses

31. The data collection continues to focus on average annual income of general practitioners, specialists and hospital nurses. To the extent possible, countries are invited to supply data relating only to doctors and nurses working full-time. The data is collected for either salaried (unit prefix MT) or independent/self-employed (unit prefix MB) GPs or specialists.

HEALTH_PROC – Waiting Times

Waiting times
- Cataract surgery
- Percutaneous transluminal coronary angioplasty (PTCA)
- Coronary bypass
- Prostatectomy
- Hysterectomy
- Hip replacement (total and partial, including the revision of hip replacement)
- Knee replacement
32. The 2017 data collection continues to include a chapter on Waiting times (WAIT) for a selected set of surgical procedures, based on two measurement approaches: 1) waiting times from specialist assessment to treatment; and 2) waiting times of patients on the list (who have not received treatment yet). These two measurement approaches can be reported based on three units: mean (days), median (days), and the percentage of patients waiting more than 3 months.

33. **Waiting times from specialist assessment to treatment** is defined as the time elapsed for patients on the non-emergency (elective) surgery waiting list from the date they were added to the waiting list for the procedure (following specialist assessment) to the date they were admitted for treatment. **Waiting times of patients on the list** is defined as the time elapsed for patients on the non-emergency (elective) surgery waiting list from the date they were added to the waiting list for the procedure (following specialist assessment) to a designated census date. All countries are invited to provide data or data updates, along with the corresponding information in the Sources and Methods.

**HEALTH_PHMC – Pharmaceutical Market**

Pharmaceutical consumption
Pharmaceutical sales
Generic market

**Pharmaceutical consumption (volume of consumption of selected drugs)**

34. The data collection this year is based on the 2017 Anatomic Therapeutic Chemical Classification (ATC) Index. When updating the data series, correspondents should consider any ATC/DDD changes implemented from January 2017. The changes are available on the WHO Collaborating Centre for Drug Statistics Methodology website (see [http://www.whocc.no/atc/lists_of_new_atc_ddds_and_alterations_in_atc_ddd/](http://www.whocc.no/atc/lists_of_new_atc_ddds_and_alterations_in_atc_ddd/)). The Secretariat invites correspondents to clearly mention any deviation from the 2017 ATC Index (i.e. use of a national classification or an earlier ATC version).

35. Countries are invited to provide data for the total consumption of each pharmaceutical drug category, including consumption in hospitals where possible. Also, the data should include pharmaceutical consumption regardless of whether the drugs are reimbursed or not. Please make sure to clearly mention in the Sources and Methods the data coverage (i.e. total, out-patient only, reimbursed drugs only).

36. As was the case last year, all countries are invited to provide data for the category Antibacterials for systemic use (J01), including European countries for which these data used to be extracted from the European Surveillance of Antimicrobial Consumption Network (ESAC-Net) Database.

**Pharmaceutical sales (value of consumption of selected drugs)**

37. The data collection is also based on the 2017 Anatomic Therapeutic Chemical Classification (ATC) Index. When updating the data series, correspondents should consider any ATC/DDD changes implemented from January 2017. The changes are available on the WHO Collaborating Centre for Drug Statistics Methodology website (see [http://www.whocc.no/atc/lists_of_new_atc_ddds_and_alterations_in_atc_ddd/](http://www.whocc.no/atc/lists_of_new_atc_ddds_and_alterations_in_atc_ddd/)). Any deviation should be clearly noted in the Sources and Methods.

38. As for pharmaceutical consumption in volume, countries are invited to provide data for total sales of each drug category, including sales in hospitals where possible. Also, sales data should include all drugs regardless of whether they are reimbursed or not. Please make sure to clearly mention in the Sources and Methods the data coverage (i.e. total, out-patient only, reimbursed drugs only).
Generic market

39. The aim is to collect data on the Generic market share (PGEN) in value (TX) and in volume (PC) ideally for the total pharmaceutical market (PGENTOTM), but countries also have the possibility to report data for certain segments of the market including the reimbursed pharmaceutical market (PGENREIM), the community pharmacy market (PGENCOMP) and the hospital pharmaceutical market (PGENHOPH). The main objective for the 2017 data collection is again to further increase the number of countries reporting data on this important variable.

40. Given that the indicator is collected as the share of the generic market, there is flexibility in the measurement of values and volumes. Countries should indicate in the Sources and Methods what value and what volume they are reporting. Values can for instance be the turnover of pharmaceutical companies, the amount paid for pharmaceuticals by third-party payers, or the amount paid by all payers (third-party and consumers). Volumes can be expressed in DDDs or as a number of packages/boxes or standard units.

HEALTH_LTCR – Long-Term Care Resources and Utilisation

Long-term care workers

41. The chapter on Long-term care workers in the formal sector aims to collect data on formal caregivers. It includes 6 variables designed to collect data by Head count and FTE, for two occupational categories (nurses and personal carers), in two settings (at home and in institutions). Note that automatic checks have been added to this chapter, to check the internal consistency of data. Additional information is sought on the methodology used to calculate Full-Time Equivalent (FTE) for countries which can provide this information.

42. Following the decision taken at the October meeting, the data collection on informal LTC workers is discontinued in the 2017 questionnaire because of comparability limitations (the worksheet LTWI has been removed).

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

43. The data collection on LTC recipients in institutions (other than hospitals) includes a disaggregation by gender and selected age groups (0-64, 65+ and 80+). Note that automatic checks have been added to this chapter, to check the internal consistency of data.

44. Countries should follow as much as possible the proposed definitions and note any deviation from these proposed definitions in the Sources and Methods.

HEALTH_PROT – Social Protection

Private health insurance coverage

45. The format for data reporting on private health insurance is illustrated in the table below. Data should be reported as number of persons (thousands) and percentage of the population. If coverage is negligible (<1%) please indicate “0” (zero). If a given coverage type does not exist in the country, please mention this clearly in the Sources and Methods.
Table 2. Format for reporting of data on private health insurance coverage

<table>
<thead>
<tr>
<th>Country</th>
<th>Thousands of persons</th>
<th>% of population</th>
<th>TOTAL PHI coverage</th>
<th>Primary</th>
<th>Duplicate</th>
<th>Complementary</th>
<th>Supplementary</th>
</tr>
</thead>
</table>

Note: 1. Substitute or principal coverage.

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

47. **Breakdown by type of PHI:** Where possible, data should be broken down by private health insurance type. Where data cannot be broken down by type or main role, they should be reported only in the category “total”, or under the category that best represents the characteristics of PHI coverage in the country: primary, duplicate, complementary or supplementary PHI. Please refer to the Definitions, Sources and Methods for details on the definitions.

48. Countries are also asked to complete or revise the pre-filled information in relation to the table on “coverage categories” included in the Sources and Methods.
IV. RELATED DOCUMENTS

**OECD Health Statistics**

OECD Health Statistics 2016  
http://www.oecd.org/els/health-systems/health-data.htm

<table>
<thead>
<tr>
<th>Direct access to datasets in OECD.Stat</th>
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<tbody>
<tr>
<td>Health Expenditure and Financing</td>
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<tr>
<td>Health Status</td>
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<tr>
<td>Non-Medical Determinants of Health</td>
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<tr>
<td>Health Care Resources</td>
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<tr>
<td>Health Workforce Migration</td>
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<tr>
<td>Health Care Utilisation</td>
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<tr>
<td>Health Care Quality Indicators</td>
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<tr>
<td>Pharmaceutical Market</td>
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<tr>
<td>LTC Resources and Utilisation</td>
</tr>
<tr>
<td>Social Protection</td>
</tr>
<tr>
<td>Demographic References</td>
</tr>
<tr>
<td>Economic References</td>
</tr>
</tbody>
</table>

**Publications and related documents**

http://www.oecd.org/health/health-systems/health-at-a-glance-europe-23056088.htm


http://www.oecd.org/els/health-systems/health-at-a-glance.htm

*A System of Health Accounts*, OECD (2011) Paris  
http://www.oecd.org/els/health-systems/health-expenditure.htm

Health Working Papers  
http://www.oecd.org/els/health-systems/health-working-papers.htm

Health Division  
http://www.oecd.org/health/
ANNEX 1. LIST OF VARIABLES IN THE OECD HEALTH DATA 2017 QUESTIONNAIRE

49. This annex provides the draft list of variables collected through this questionnaire (or other sources). The final list of variables published will depend upon the availability and quality of data received from member countries.

50. The chapters for which data is imported from international sources are marked by their source (such as WHO, Eurostat Statistical Database, etc.). Please refer to the appropriate chapter in these Guidelines regarding the detailed list of countries when mentioned.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>ALTERNATIVE SOURCES</th>
<th>CHECK-LIST (for correspondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH_STAT – HEALTH STATUS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
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<tr>
<td>Life expectancy</td>
<td>Eurostat Database for European countries</td>
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<tr>
<td>Females at birth</td>
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<tr>
<td>Females at age 40</td>
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<td>Females at age 60</td>
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<td>Females at age 65</td>
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<td>Females at age 80</td>
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<td>Males at birth</td>
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<td>Males at age 40</td>
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<td>Males at age 65</td>
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<tr>
<td>Males at age 80</td>
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<tr>
<td>Total population at birth</td>
<td>Calculated by the Secretariat</td>
<td></td>
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<tr>
<td>Life expectancy by education level</td>
<td>Eurostat Database, OECD Statistics Directorate project, for selected countries</td>
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<tr>
<td>Females at birth, Low education (ISCED 0 to 2)</td>
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<tr>
<td>Females at birth, Medium education (ISCED 3 and 4)</td>
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<td>Females at birth, High education (ISCED 5 to 8)</td>
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<td>Males at birth, High education (ISCED 5 to 8)</td>
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<td>Total population at birth, Low education (ISCED 0 to 2)</td>
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<td>Total population at birth, Medium education (ISCED 3 and 4)</td>
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<td>Total population at birth, High education (ISCED 5 to 8)</td>
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<td>Females at age 30, Low education (ISCED 0 to 2)</td>
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<td>Females at age 30, Medium education (ISCED 3 and 4)</td>
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<tr>
<td>Females at age 30, High education (ISCED 5 to 8)</td>
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<td>Males at age 30, Low education (ISCED 0 to 2)</td>
<td>Total pop. at age 30, Low education (ISCED 0 to 2)</td>
<td></td>
</tr>
<tr>
<td>Males at age 30, Medium education (ISCED 3 and 4)</td>
<td>Total pop. at age 30, Medium education (ISCED 3 and 4)</td>
<td></td>
</tr>
<tr>
<td>Males at age 30, High education (ISCED 5 to 8)</td>
<td>Total pop. at age 30, High education (ISCED 5 to 8)</td>
<td></td>
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<tr>
<td>Total pop. at age 30, Low education (ISCED 0 to 2)</td>
<td>Total pop. at age 30, Medium education (ISCED 3 and 4)</td>
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<tr>
<td>Total pop. at age 30, High education (ISCED 5 to 8)</td>
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</table>

**Causes of mortality**

**Maternal and infant mortality**
- Infant mortality
- Neonatal mortality
- Perinatal mortality

**Maternal mortality**

**Potential years of life lost**

**Morbidity**

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

**Perceived health status by age and gender**
- Good/very good health, females 15-24
- Good/very good health, females, 25-44
- Good/very good health, females, 45-64
- Good/very good health, females 65+
- Good/very good health, females aged 15+
- Good/very good health, males 15-24
- Good/very good health, males 25-44
- Good/very good health, males 45-64

**WHO for all countries**

**Eurostat Database (unless these countries wish to provide data directly to the OECD)**

**WHO for all countries**

**Eurostat Database (for all European countries participating in EU-SILC Survey – not including Turkey)**

**Eurostat Database (for all European countries participating in EU-SILC Survey – not including Turkey)**
Good/very good health, males 65+
Good/very good health, males aged 15+
Good/very good health, total 15-24
Good/very good health, total 25-44
Good/very good health, total 45-64
Good/very good health, total 65+
Good/very good health, total aged 15+

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

**Infant health**
Low birthweight

**Dental health**
Decayed-missing-filled-teeth, DMFT

**Communicable diseases**
Acquired Immunodeficiency Syndrome (AIDS)

Incidence of pertussis
Incidence of measles
Incidence of hepatitis B

**Cancer**
Malignant neoplasms
Malignant neoplasms of colon
Malignant neoplasms of lung
Malignant neoplasms of female breast
Malignant neoplasms of cervix
Malignant neoplasms of prostate

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**Eurostat Database**
(for all European countries participating in EU-SILC Survey – not including Turkey)

**European Centre for Disease Prevention and WHO Regional Office for Europe**
(European Countries, refer to Guidelines)

**International Agency for Research on Cancer**
(for all countries)
Injuries
Injuries in road traffic accidents

Absence from work due to illness
Self-reported absence from work due to illness
Compensated absence from work due to illness

HEALTH_LVNG – NON-MEDICAL DETERMINANTS OF HEALTH

Life styles and behaviour

Tobacco consumption
Tobacco consumption

Alcohol consumption
Alcohol consumption

Food supply and consumption
Total fat supply  FAO (UN)
Total calories supply  FAO (UN)
Total protein supply  FAO (UN)
Sugar supply  FAO (UN)
Fruits and vegetables supply  FAO (UN)
Vegetables consumption (survey)
Fruits consumption (survey)

Body weight
Overweight, self-reported
Obese, self-reported
Overweight or obese, self-reported
Overweight, measured
Obese, measured
Overweight or obese, measured

HEALTH_REAC – REMUNERATION OF HEALTH PROFESSIONALS

Remuneration of health professionals
Remuneration of general practitioners
Remuneration of specialists
Remuneration of hospital nurses

HEALTH_PROC – WAITING TIMES

Waiting times
Cataract surgery
Percutaneous transluminal coronary angioplasty (PTCA)
Coronary bypass

UNECE for all countries except Australia, Chile, Israel, Japan, Korea, Mexico and New Zealand
Prostatectomy
Hysterectomy
Hip replacement (total and partial, including the revision of hip replacement)
Knee replacement

HEALTH_PHMC – PHARMACEUTICAL MARKET

Pharmaceutical consumption
A-Alimentary tract and metabolism
   A02A-Antacids
   A02B-Drugs for peptic ulcer & gastro-oesophageal reflux diseases
A10-Drugs used in diabetes
B-Blood and blood forming organs
C-Cardiovascular system
   C01A-Cardiac glycosides
   C01B-Antiarrhythmics, Class I and III
   C02-Antihypertensives
   C03-Diuretics
   C07-Beta blocking agents
   C08-Calcium channel blockers
   C09-Agents acting on the Renin-Angiotensin system
C10-Lipid modifying agents
G-Genito urinary system and sex hormones
   G03-Sex hormones and modulators of the genital system
H-Systemic hormonal preparations, excluding sex hormones & insulin
J-Antiinfectives for systemic use
   J01-Antibacterials for systemic use
M-Musculo-skeletal system
   M01A-Antinflammatory and antirheumatic products non-steroids
N-Nervous system
   N02-Analgescics
   N05B-Anxiolytics
   N05C-Hypnotics and sedatives
   NO6A-Antidepressants
R-Respiratory system
   R03-Drugs for obstructive airway diseases

Pharmaceutical sales
A-Alimentary tract and metabolism
   A02A-Antacids
   A02B-Drugs for peptic ulcer & gastro-oesophageal reflux diseases
A10-Drugs used in diabetes
B-Blood and blood forming organs
C-Cardiovascular system
   C01A-Cardiac glycosides
   C01B-Antiarrhythmics, Class I and III
   C02-Antihypertensives
C03 - Diuretics
C07 - Beta blocking agents
C08 - Calcium channel blockers
C09 - Agents acting on the Renin-Angiotensin system
C10 - Lipid modifying agents
G - Genito urinary system and sex hormones
   G03 - Sex hormones and modulators of the genital system
H - Systemic hormonal preparations, excluding sex hormones & insulin
J - Antiinfectives for systemic use
   J01 - Antibacterials for systemic use
M - Musculo-skeletal system
   M01A - Antiinflammatory and antirheumatic products non-steroids
N - Nervous system
   N02 - Analgesics
   N05B - Anxiolytics
   N05C - Hypnotics and sedatives
   NO6A - Antidepressants
R - Respiratory system
   R03 - Drugs for obstructive airway diseases

Generic market
Total pharmaceutical market
Reimbursed pharmaceutical market
Community pharmacy market
Hospital pharmaceutical market

HEALTH_LTCR – LONG-TERM CARE RESOURCES AND UTILISATION

Long-term care workers

Long-term care workers: formal sector
Formal LTC workers (Head counts)
Formal LTC workers at home (Head counts)
Formal LTC workers in institutions (Head counts)
Formal LTC workers (FTE)
Formal LTC workers at home (FTE)
Formal LTC workers in institutions (FTE)

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

HEALTH_PROT – SOCIAL PROTECTION

Health care coverage
Total public and primary private health insurance
Total public and primary private health insurance

Calculated by the Secretariat
<table>
<thead>
<tr>
<th>Government/social health insurance</th>
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<tbody>
<tr>
<td>Total health care</td>
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<tr>
<td>In-patient acute care</td>
<td></td>
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<tr>
<td>Out-patient medical care</td>
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<tr>
<td>Pharmaceutical goods</td>
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</table>

<table>
<thead>
<tr>
<th>Private health insurance</th>
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<tbody>
<tr>
<td>Total private health insurance coverage</td>
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<tr>
<td>Primary private health insurance coverage</td>
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<tr>
<td>Duplicate private health insurance coverage</td>
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<tr>
<td>Complementary private health insurance coverage</td>
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<tr>
<td>Supplementary private health insurance coverage</td>
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</table>
ANNEX 2. LIST OF COUNTRIES AND VARIABLES FOR WHICH DATA ARE IMPORTED FROM THE EUROSTAT DATABASE

List of 26 European OECD countries covered in the Eurostat Database

Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom, and Turkey.

List of variables imported from the Eurostat Database

Life expectancy (EVIE)
- Females at birth, at age 40, at age 60, at age 65, at age 80, all ages
- Males at birth, at age 40, at age 60, at age 65, at age 80, all ages

Life expectancy by education level (LEED) New

Maternal and infant mortality (MATI)
- Perinatal mortality (as long as the definition is reasonably close to that in the OECD Health Data questionnaire)

Perceived health status (PRHS)

Perceived health status by age and gender (SRHS)

Perceived health status by socio-economic status (SREC)