OECD HEALTH DATA QUESTIONNAIRE 2022

GUIDELINES FOR COMPLETING THE QUESTIONNAIRE

DEADLINE TO RETURN THE INFORMATION:
TUESDAY 15 FEBRUARY 2022

TABLE OF CONTENTS

NOTE BY THE SECRETARIAT

1.	These Guidelines aim to assist national correspondents in completing the OECD Health Data Questionnaire 2022. 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 **Word file with the documentation on *Definitions, Sources and Methods*** to update country-specific methodology. This Word document must be updated **using the track change mode**.

   Note: You can readily access the *Definitions* by clicking on the **hyperlink in the <u>first</u> worksheet of each Excel file**. All definitions are available online for information and for consultation at **http://www.oecd.org/els/health-systems/OECD-Health-Data-2022-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 2022 questionnaire reflects discussions from the meeting of the Working Party on Health Statistics (held virtually on October 6-7, 2021). The **main changes this year** consist in 1) **directly collecting data on life expectancy at birth for the total population**, for non-EU OECD countries (instead of calculating the data by using the unweighted average of life expectancy of men and women); 2 an improvement in the **definition of Remuneration of hospital nurses**, clarifying the categories of nurses excluded for this indicator so as to improve comparability across countries (i.e. Associate professional nurses (practical/vocational/nurses with a lower level of skills should be excluded from the categories of hospital nurses taken into account); and 3) minor **changes in the names of indicators under the Social Protection (PROT) dataset**, so as to better reflect the situation in OECD countries. Please read the corresponding Guidelines for further details and possible implications on your data reporting.

3.	Please return the questionnaire, including updated Excel files for all parts of the database <u>and</u> corresponding *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**. Please note that the OECD Secretariat will not be able to process the data provided if corresponding *Sources and Methods* are missing.

4.	The **deadline for returning the questionnaire is <u>TUESDAY 15 FEBRUARY 2022</u>**.

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 2022. There are some minor changes in the 2022 questionnaire, listed in details in the Guidelines below and in paragraph 2 above. Annex 2 provides the list of variables that are directly imported from the Eurostat Database for European countries.

Update of data in the Excel worksheets

6.   The questionnaire comprises seven Excel files, each containing several worksheets, one per sub-chapter, with the first worksheet displaying the complete list of variables for the given dataset. Note that the 2022 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.

7.   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**.

8.   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.

9.   **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 purpose**. All comments should be provided separately and/or inserted into the documentation of *Sources and Methods* (see below).

Years reported in the *OECD Health Data 2022* Questionnaire

10.   Time series in the OECD Health Data 2022 Questionnaire should cover the period **up to 2020** (*t-2*). Countries are strongly encouraged to provide any provisional estimates for the year 2021, as this will be the reference year for related OECD publications in 2022 (e.g. *Health at a Glance: Europe 2022*), due to the ongoing COVID-19 pandemic. All countries are thus encouraged to report data for the year 2021, making use of the **P flag to indicate provisional data for 2021 (t-1)** where needed (additionally to already-existing B, D and E control codes).

Updating the documentation of *Sources and Methods*

11.   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.

II. SPECIFIC FEATURES OF THE QUESTIONNAIRE

12.　　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 "Code", 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 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 still relevant, or remove it if no longer appropriate.

Correspondents can use the **following four letters** to indicate data issues:	
B	**Break in series**
D	**Deviation from OECD definition**
E	**Estimate/preliminary data**
P	**Provisional value (to be used only for t-1 data, i.e. 2021)**

13.　　The questionnaire also includes tools to **check the internal consistency of data**. These checks concern the data for **overweight and/or obese population** in the dataset on Non-Medical Determinants of Health (worksheet 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.

14.　　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.

15.　　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.

HEALTH_STAT – Health Status

Mortality

    Life expectancy > New in 2022: total at birth to report
    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
    Avoidable mortality

Morbidity

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

Life expectancy

16.   Data on *Life expectancy* (by age and gender) will be directly imported from the Eurostat Database for the European countries listed in Annex 2. Countries not listed in Annex 2 (Australia, Canada, Chile, Colombia, Costa Rica, Israel, Japan, Korea, Mexico, New Zealand, Turkey, the United Kingdom and the United States) are asked to supply data updates.

17.   Unlike, previous years, countries are invited to note that **life expectancy at birth for the total population** is no longer estimated by the OECD Secretariat (using the unweighted average of life expectancy of men and women), but either extracted from the Eurostat database for European countries, or directly provided by other non-EU OECD countries. Australia, Canada, Chile, Colombia, Costa Rica, Israel, Japan, Korea, Mexico, New Zealand, Turkey, the United Kingdom and the United States are thus invited to fill in the new additional column in the EVIE Excel file to provide data and update the *Sources and Methods* accordingly.

Life expectancy by education level

18.   The 2022 questionnaire includes a data collection for **life expectancy by education level (LEED) at birth, at age 30 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).

19.   The OECD Secretariat extracts data from the Eurostat Database for 14 of the 25 European countries listed in Annex 2 (as well as for Turkey) and also prefills the questionnaire with data collected from a previous *ad hoc* OECD Statistics Directorate project (for 9 countries). Other European and non-European countries are asked to submit updated data and corresponding *Sources and Methods*.

Causes of mortality and PYLL

20.   These data will be directly extracted 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 25 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.   The 2022 questionnaire 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 2022 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.

24.   Data for all variables on perceived health status for the European countries listed in Annex 2 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.   The Secretariat extracts data directly from the European Centre for Disease Prevention database for data on the **incidence of pertussis, measles and hepatitis** (incidence per 100 000 population) for European countries, so as to reduce the data collection burden. The worksheet **COMD** is thus not included in the Excel questionnaire file for European countries (except for Turkey). Non-European countries, however, are requested to update those data along with their *Sources and Methods.*

26.   Regarding AIDS incidence, data are 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

27.   As in previous years, the Secretariat will extract 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 in road traffic accidents

28.   Data on injuries in road traffic accidents are extracted 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 (see corresponding entry in the *Sources and Methods*) or choosing to provide their own data directly, correspondents are asked to provide data updates along with accompanying *Sources and Methods.*

Absence from work due to illness

29.   Correspondents are invited to provide data for **both** "Self-reported absence from work due to illness" and "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
    Use of vaping products
    Alcohol consumption
    Food supply and consumption
    Body weight

Use of vaping products

30.   The data collection on the **Use of vaping products** (VAPE) focuses on the percentage of adults (aged 15+) and young adults (aged 15-24 years old), split by gender, who are regular users. Countries are invited to update those data and to provide data for the most recent year available.

31.   All countries are invited to update the *Sources and Methods* document correspondingly, and to provide details about the methodology used, specifically about the size of the sample survey and about how they define "regular users" in case of derivation from the suggested OECD definition. Countries should also indicate if vaping devices taken into account include the use of nicotine or not. Any derivation from the OECD definition should be duly indicated using the D code in the Excel worksheet (in the "Code" column).

Alcohol consumption

32.   The definition in the *Sources and Methods* has been slightly amended, with a note added in order to specify that the data collection carried out by the OECD on alcohol consumption (in litres per capita aged 15+) typically uses sales data as a proxy for consumption, as indicated by most countries in the methodology provided. Countries are invited to further detail the methodology used by **filling in the summary table in the *Sources and Methods***, which address possible comparability issues.

Food supply and consumption

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

Body weight

34.   In order to clearly distinguish between <u>self-reported</u> and <u>measured</u> data, the data series continue to be split between these two data collection methods for the overweight population (BODY**OVSR** and BODY**OVMS**), the obese population (BODY**OBSR** and BODY**OBMS**), and the total number of overweight

or obese population (BODY**VBSR** and BODY**VBMS**). 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 > New in 2022: updated definition

35.   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 are collected for either salaried (unit prefix MT) or independent/self-employed (unit prefix MB) GPs or specialists.

36.   Countries are invited to note the change in the definition for the indicator on **Remuneration of hospital nurses**, as the Secretariats aims to clarify the categories of nurses excluded for this indicator, so as to improve comparability across countries. **Associate professional nurses (practical/vocational/nurses with a lower level of skills) should from now on be <u>excluded</u> from the categories of hospital nurses** taken into account when calculating this indicator. Countries should update their data and the corresponding *Sources and Methods* accordingly.

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 (including the revision of knee replacement)

37.   The 2022 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**.

38.   **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.

HEALTH_PHMC – Pharmaceutical Market

Total pharmaceutical consumption
Total pharmaceutical sales
Generic market > New in 2022: Reimbursement market renamed into Third-party-payer market

Total pharmaceutical consumption (volume of consumption of selected drugs)

39.   The data collection is based on the **2022 Anatomic Therapeutic Chemical Classification (ATC) Index**. When updating the data series, correspondents should consider any ATC/DDD changes implemented from January 2022. 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_altera/alterations_in_atc_ddd/). The Secretariat invites correspondents to clearly mention any deviation from the 2022 ATC Index (i.e. use of a national classification or an earlier ATC version – ideally all time-series should be provided using the 2022 ATC version, for consistency and comparability).

40.   Countries are invited to prioritise data, where possible, for **total consumption** of each pharmaceutical drug category, i.e. including consumption in hospitals. Also, the data should include pharmaceutical consumption regardless of whether the drugs are reimbursed or part-reimbursed by a third-party payer or not. Please make sure to clearly mention in the *Sources and Methods* the data coverage (i.e. total, community only, re-imbursed drugs only).

41.   **NOTE**: As was the case last year, the OECD Secretariat will extract **data for J01-Antibacterials for systemic use** and **J-Anti-infectives** for European countries directly from the European Surveillance of Antimicrobial Consumption Network (ESAC-Net) Database, for **all years**. Correspondents from non-European countries as well as Turkey are invited to keep providing data updates and accompanying *Sources and Methods* for these two categories.

Total pharmaceutical sales (value of consumption of selected drugs)

42.   The data collection is based on the **2022 Anatomic Therapeutic Chemical Classification (ATC) Index**. When updating the data series, correspondents should consider any ATC/DDD changes implemented from January 2022. 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_altera/alterations_in_atc_ddd/). Any deviation should be clearly noted in the *Sources and Methods*.

43.   As for pharmaceutical consumption in volume, countries are invited to prioritise data for **total sales** of each drug category, based on retail prices, and including sales in hospitals where possible. Also, sales data should include all drugs regardless of whether they are reimbursed or part-reimbursed by a third-party payer or not. Please make sure to clearly mention in the *Sources and Methods* the data coverage (i.e. total, community sales only, reimbursed drugs only).

Generic market

44.   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 **third-party-payer market** (PGENREIM – previously titled "Reimbursed pharmaceutical market"), the **community pharmacy market** (PGENCOMP) and the **hospital pharmaceutical market** (PGENHOPH). The main objective for the 2022 data collection is again to further increase the number of countries reporting data on this important variable.

45.   Countries are invited to note the minor change in the label of the indicator "Reimbursed pharmaceutical market", now titled **Third-party-payer market** for clarity and better understanding (note this is not affecting the definition in the *Sources and Methods*).

46.   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: formal sector
Long-term care recipients

Long-term care workers

47.   The chapter on **Long-term care workers in the formal sector** aims to collect data on formal caregivers. It includes six 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 are included in 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.

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

48.   The data collection on LTC recipients in institutions (other than hospitals) includes a disaggregation by gender and selected age groups (0-17, 0-64, 65+ and 80+). Automatic checks are included in this chapter, to check the internal consistency of data. 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

Note the new labels in red in the 2022 data collection:

Government/social health insurance > Government/compulsory health insurance
　　　　Total health care > Government/compulsory health insurance coverage
　　　　(+ the breakdown into In-patient and acute care, Out-patient medical care, Pharmaceutical goods has been removed)

Private health insurance > Voluntary health insurance
　　　　Total PHI coverage > Total voluntary health insurance (VHI) coverage
　　　　Primary PHI coverage > Primary voluntary health insurance (VHI) coverage
　　　　Duplicate PHI coverage > Duplicate voluntary health insurance (VHI) coverage
　　　　Complementary PHI coverage > Complementary voluntary health insurance (VHI) coverage
　　　　Supplementary PHI coverage > Supplementary voluntary health insurance (VHI) coverage

Government/compulsory health insurance coverage

49.   Countries are invited to note the change in label for this chapter, implemented so as to better reflect the situation in OECD countries and align with the SHA, i.e. the health spending category of **HF.1**. Also note that the breakdown into several categories of coverage (In-patient and acute care, Out-patient medical care, Pharmaceutical goods) has been removed. Please read the corresponding updated information in the *Sources and Methods* to adjust your data if needed.

Voluntary health insurance coverage

50.   Countries are invited to note the change in label for this chapter, implemented so as to better reflect the situation in OECD countries and align with the SHA, i.e. the health spending category of **HF.2.1**. Please read the corresponding updated information in the *Sources and Methods* to adjust your data if needed. Data are still to be reported as number of persons (in 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*.

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

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

53.   Countries are also asked to complete or revise the pre-filled information in relation to the summary table on "coverage categories" included in the *Sources and Methods*.

IV. RELATED DOCUMENTS

OECD Health Statistics

OECD Health Statistics 2021
http://www.oecd.org/health/health-data.htm

Direct access to Health datasets in OECD.Stat: https://oe.cd/ds/health-statistics		
Health Expenditure and Financing Health Status Non-Medical Determinants of Health Health Care Resources	Health Workforce Migration Health Care Utilisation Health Care Quality Indicators Pharmaceutical Market	LTC Resources and Utilisation Social Protection Demographic References Economic References

Publications and related documents

Health at a Glance 2021: OECD Indicators, OECD (2021)
https://www.oecd.org/health/health-at-a-glance/

Health at a Glance: Europe 2020 - State of Health in the EU Cycle, OECD (2020)
http://www.oecd.org/health/health-at-a-glance-europe/

Health at a Glance: Asia/Pacific 2020, OECD (2020)
http://www.oecd.org/health/health-at-a-glance-asia-pacific-23054964.htm

Health at a Glance: Latin America and the Caribbean 2020, OECD (2020)
http://www.oecd.org/health/health-at-a-glance-latin-america-and-the-caribbean-2020-6089164f-en.htm

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

Health Statistics
https://www.oecd.org/health/health-statistics.htm

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

Learn more about our work on Health at the OECD
http://www.oecd.org/health/

ANNEX 1. LIST OF VARIABLES IN THE *OECD HEALTH DATA 2022* QUESTIONNAIRE

54. This annex provides the <u>draft list of variables</u> 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.

55. The chapters for which data are imported from international sources are indicated along with their source (i.e. WHO, Eurostat Database, etc.). Please refer to the appropriate chapter in these Guidelines regarding the detailed list of countries concerned if needed.

VARIABLES	ALTERNATIVE SOURCES	CHECKLIST for countries
HEALTH_STAT – HEALTH STATUS		
Mortality		
Life expectancy Females at birth Females at age 40 Females at age 60 Females at age 65 Females at age 80 Males at birth Males at age 40 Males at age 60 Males at age 65 Males at age 80	**Eurostat Database for European Countries (except Turkey)**	
Total population at birth	To be reported by non-EU countries	
Life expectancy by education level	**Eurostat Database, OECD Statistics Directorate project, for selected countries**	
Females at birth, Low education (ISCED 0 to 2) Females at birth, Medium education (ISCED 3 and 4) Females at birth, High education (ISCED 5 to 8) Males at birth, Low education (ISCED 0 to 2) Males at birth, Medium education (ISCED 3 and 4) Males at birth, High education (ISCED 5 to 8) Total population at birth, Low education (ISCED 0 to 2) Total population at birth, Medium education (ISCED 3 and 4) Total population at birth, High education (ISCED 5 to 8) Females at age 30, Low education (ISCED 0 to 2) Females at age 30, Medium education (ISCED 3 and 4) Females at age 30, High education (ISCED 5 to 8)		

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

Causes of mortality   **WHO for all countries**

Maternal and infant mortality
Infant mortality
Neonatal mortality
Perinatal mortality   **Eurostat Database (unless these countries wish to provide data directly to the OECD)**

Maternal mortality

Potential years of life lost   **WHO for all countries**

Avoidable mortality New   **WHO for all countries**

Morbidity

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

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

Perceived health status by socio-economic status	**Eurostat Database (for all European countries participating in the EU-SILC Survey – not including Turkey)**
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	
Communicable diseases	**European Centre for Disease Prevention and WHO Regional Office for Europe (for all European Countries; refer to Guidelines)**
Acquired Immunodeficiency Syndrome (AIDS)	
Incidence of pertussis	
Incidence of measles	
Incidence of hepatitis B	
Cancer	**International Agency for Research on Cancer, for all countries**
Malignant neoplasms	
Malignant neoplasms of colon	
Malignant neoplasms of lung	
Malignant neoplasms of female breast	
Malignant neoplasms of cervix	
Malignant neoplasms of prostate	
Injuries	**UNECE for most countries (refer to Guidelines)**
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

Tobacco consumption
Tobacco consumption

Use of vaping products
Vaping population: adults (aged 15+)
Vaping population: young adults (aged 15-24 years old)

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	Updated definition, see paragraph 36

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 (including the revision of knee replacement)

HEALTH_PHMC – PHARMACEUTICAL MARKET

Total 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	**To be extracted from the ESAC-Net database for all European countries**	

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

Total 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
Third-party-payer market | Label updated, see paragraph 44
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 voluntary health insurance
Total public and primary vountary health insurance | **Calculated by the Secretariat**

Government/compulsory health insurance | Labels updated, see paragraph 49
Government/compulsory health insurance coverage
In-patient and acute care

19

~~Out-patient medical care~~
~~Pharmaceutical goods~~

Voluntary health insurance   Labels updated, see paragraph 50
Total voluntary health insurance coverage
Primary voluntary health insurance coverage
Duplicate voluntary health insurance coverage
Complementary voluntary health insurance coverage
Supplementary voluntary health insurance coverage

ANNEX 2. LIST OF COUNTRIES AND VARIABLES FOR WHICH DATA ARE IMPORTED FROM THE EUROSTAT DATABASE

List of the 25 European OECD countries covered in the Eurostat Database

Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland (and Turkey only for indicators on "Life expectancy by education level").

List of variables imported from the Eurostat Database

Life expectancy at birth and at various ages (EVIE)

Life expectancy by education level at birth and at various ages (LEED)

Maternal and infant mortality (MATI)
      Infant and Neonatal mortality (No minimum threshold of gestation period or birthweight)
      Perinatal mortality

Perceived health status (PRHS)

Perceived health status by age and gender (SRHS)

Perceived health status by socio-economic status (SREC)