



**Economic and Social
Council**

Distr.
General

ECE/CES/2006/2/Add.3
30 March 2006

Original: ENGLISH

ECONOMIC COMMISSION FOR EUROPE

STATISTICAL COMMISSION

CONFERENCE OF EUROPEAN STATISTICIANS

Fifty-fourth plenary session
Paris, 13-15 June 2006
Item 3(a) of the provisional agenda

COORDINATION OF INTERNATIONAL STATISTICAL WORK IN THE UNECE REGION

Issues and problems and Rapporteur Reports

Addendum

Rapporteur Report for Health Statistics¹

Submitted by United States and the Organization for Economic Co-operation and Development
(OECD)

I. EXECUTIVE SUMMARY

1. There are three priorities in the area of health statistics for 2006 and beyond which require the collaboration of national and international statistical agencies:

(a) Progress in implementation of the System of Health Accounts (SHA): Following the launch of the first joint OECD-Eurostat-WHO System of Health Accounts data collection in December 2005, there is a need for continued strong international cooperation to monitor progress in SHA data collection and to identify issues that need to be addressed to promote further harmonisation of health accounting practices across countries. At the national level, there is also a need to ensure that there is a sufficient commitment to implement the SHA. Connected to the preparation of the 2007 joint SHA Questionnaire,

¹ This paper has been prepared at the invitation of the secretariat.

further refinement of the International Classification for Health Accounts (ICHA) will be carried out.

(b) Improvements in the data collection on human resources for health: There is a need for national and international organizations to work together to further develop, refine, and harmonise guidelines and mechanisms for data collection on health human resources, in a context of growing concerns about shortages of health workers and concerns about the international migration of health professionals from developing countries to developed countries.

(c) Improvements in the comparability of health status measures: There is a continuing need for a core set of health indicators to inform domestic and international program and policy development aimed at improving the health of populations. Equally essential is a common set of questions that can be used in most, if not all, countries to produce valid, comparable data on these indicators at the international level. Although the lack of established health information systems in some countries and the existence of long-standing systems in others add complexities to the problem, the main stumbling blocks to developing core indicators relate to the conceptual complexities involved in measuring health and the challenges of doing so in a comparable way across cultures. While the measurement of biological and medical characteristics can more easily be separated from the cultural context, health is a social, as much as a biological, construct. Creating comparable health indicators must address this reality.

2. There are currently several activities underway that are addressing the problem of identifying core health indicators. This level of activity and commitment is commendable, but it is likely that these activities will result in multiple core sets. While the problem is much more complex when dealing at the global level, significant challenges exist within the United Nations (UN) Economic Commission for Europe (ECE) region. Much work is underway in the European Union (EU) under the direction of Eurostat, but not all ECE member countries are involved in these activities. A mechanism is needed whereby the various activities currently underway can reach convergence. Extensive methodological development to support this endeavour will also be needed. A workable solution in the ECE region that involves the relevant international organizations as well as national statistical offices would serve as a model for convergence on a larger scale.

II. PROGRESS BEING MADE COLLECTIVELY BY ORGANIZATIONS IN THESE PRIORITY AREAS AND RELATED ISSUES AND CHALLENGES

A. Progress in implementation of the System of Health Accounts (SHA)

3. Aim: To improve the completeness and comparability of health expenditure and financing data by increasing the number of countries that are reporting these data based on the System of Health Accounts, and further harmonization of health accounting practices in countries concerned.

4. Progress: Since the publication of the SHA Manual by the OECD in 2000, nearly all EU and OECD countries have, by now, at least started a pilot implementation of the SHA framework. As a result of efforts by health accounting experts in OECD countries during the last five years, twelve countries provided data to OECD Health Data 2005 based on SHA tables, and

a further seven countries have harmonised major health expenditure aggregates with SHA boundaries. In the context of a special project financed through the European Commission (PHARE 2002), a majority of the new EU member states provided to a large extent the requested data for a recent year. The Commission Statistical Programme and other European Commission initiatives have organised other projects and seminars in recent years on SHA implementation. These have contributed to the gradual implementation of SHA in the European Statistical System. Several WHO Member States have also implemented a health accounting standard (many of them following the Guide to producing national health accounts with special applications for lower and middle-income countries), while others are initiating the process. OECD, Eurostat, and WHO will continue to support the SHA data collection implementation by providing training and advice.

5. A major achievement in 2005 was the launch of the first joint OECD-Eurostat-WHO System of Health Accounts data collection in December 2005, which marks a new phase in SHA implementation and may also serve as a platform for international cooperation in other areas of health care statistics. The goal of this new joint data collection is to reduce the burden on national data providers, and increase the use of international standards and definitions in the field of health accounting. In preparation for the launch of the joint questionnaire, letters were sent in November 2005 to the heads of the relevant national organizations. This included a joint WHO-OECD letter to Ministers of Health in OECD countries, and a joint Eurostat-OECD letter to the Heads of the national statistical offices in EU and OECD countries. In order to work towards consistency in the data responses, countries were requested to nominate a single focal point for the joint OECD-Eurostat-WHO SHA data collection. The joint questionnaire was sent to the countries concerned in December 2005, with the deadline to return the completed questionnaire by 31 March 2006. It is now up to national authorities to ensure that there is sufficient commitment to achieve gradual progress in SHA implementation.

Issues and challenges

6. Experience has shown that the effective and sustained implementation of SHA at the national level requires political commitment, clear institutional responsibility with adequate human resources, and cooperation at the national level between institutions with relevant data sources. Some of these conditions for successful implementation do not seem to be met in certain countries at the moment, and therefore require action.

7. Connected to the preparation of the 2007 joint SHA Questionnaire, further refinement of the International Classification for Health Accounts (ICHA) should be carried out under the framework of cooperation between OECD, Eurostat, and WHO.

B. Improvements in the data collection on human resources for health

8. Context: Concerns are growing about health worker shortages in many OECD countries and about the international mobility of health professionals, especially emigration from some of the poorest developing countries into some developed countries. In this context, and given

differences in data collections among countries, it is important to improve and harmonize the data collection on health workers.

9. Aim: To provide more complete and common measures of the supply of health workers (with a focus on doctors and nurses), including: enrolment in and graduation from medical and nursing schools; the overall number and types of health workers; relevant information on their working conditions (including their remuneration level); and patterns in the international migration of health workers.

10. Progress: A 2004 Eurostat Task Force, involving WHO and OECD, focused on the statistical definition of nurses, with a view to improve international data collection of different categories of nurses. The Task Force recommended that the approach to international data collections on nurses should be based as much as possible on the International Standard Classification of Occupations (ISCO), while recognising that the current version of ISCO has limitations for the collection of consistent and relevant data on nurses at the national or international level. Following on the recommendations from this Task Force, Eurostat started in 2005 to carry out a mapping exercise between the national profession lists and the groups proposed for international data collection, in order to test the use of these groups for future routine data collection by Eurostat and possibly by other international organizations. Analysis of the results of this mapping exercise is still underway.

11. A data collection on the remuneration of certain categories of doctors and nurses was introduced by the OECD in its 2005 data collection. This data collection was based on developmental work carried out by two European countries (the Netherlands and the United Kingdom) and an earlier OECD project on health human resources. Reasonably comparable data have been collected for about half of OECD member countries. Further progress is required to harmonise further the data submissions and to increase gradually the number of countries reporting such data.

12. Progress has also been made by the OECD in 2005 in collecting data on the migration of health professionals into OECD countries. The OECD has started to collect information on the country of origin of the stock of health workers (physicians and nurses) in all OECD countries, using population census data for circa 2000. Although these data have certain limitations, they provide reasonably comparable snapshot estimates of variations in the foreign share of health workers across OECD countries and the distribution of this share between countries of origin. Where possible, they will be checked against other sources such as medical registers and labour force surveys. This project has also been designed to be complementary with concurrent work at the WHO, which is investigating the issue of migration of health workers from the perspective of developing countries. It will also take account of work being carried out by the EU.

Issues and challenges

13. There is a need to pursue efforts to improve and harmonise definitions, guidelines, and mechanisms used by international organizations for data collection on health workers (with a focus on doctors and nurses) in order to improve data quality and avoid the collection of data based on slightly different specifications. The focus should be on the collection of a core data set on health workers. The ISCO classification should be used as a reference for this data

collection, although additional categories and definitions of health workers are needed for relevant data collection. These specifications should ideally be agreed among international organizations.

14. There is a need also to build closer links between the data collection on health human resources and SHA-related data collection, not only to assess the share of health expenditure allocated to health workers, but also to be able to link more closely non-expenditure and expenditure statistics. More information is needed on the location of practice of health professionals, based on the SHA classification of health care providers. The joint OECD-Eurostat-WHO SHA data collection includes an experimental table to gather data on expenditure on human resources by type of providers (ambulatory sector, hospital, long-term care sector) that should provide useful information on the current availability and consistency of these data.

C. Improvements in the comparability of health status measures

15. Aim: To complement the traditional emphasis on mortality-based measures of health status with a set of reliable morbidity/disability measures, in order to provide a fuller description of the health status of populations across space and time.

16. Progress: Several activities related to the development of a set of core health indicators have been initiated in recent years. These activities all involve ECE countries, and there is considerable overlap in the country and organizational representatives involved.

17. Eurostat: Core survey modules are being developed to support the creation of a consistent set of statistics on public health within the EU. Common survey modules on health status, health determinants, and health care are being finalized and pilot tested. A common module on disability is being developed. The Minimum European Health Module will be included in the new Survey on Income and Living Conditions. A draft European Parliament (EP) and Council Regulation on statistics on health and safety in general is currently under development. This is a framework Regulation which identifies domains and topics and sets out the main principles and the procedures for adopting more specific European Commission Regulations, if needed. A draft for such a framework Regulation had been presented to the Statistical Programme Committee in November 2005 and a revised version for consultation within the Commission is being developed. After adoption by the Commission, the draft text will go to the EP and the Council, where the discussions will then take another year or so before final adoption. While there is no specific 'legal' standard for health status measurement, Eurostat is working with the Member States on the preparation and implementation of the different modules of the European Health Interview Survey with an agreed time planning for implementation. The work is also very much driven by the requirements to provide urgently comparable data to be used for the European Core Health Indicators.

18. UNECE: A task force, known as the Budapest Initiative, was established in 2004 under the joint guidance of the UNECE, WHO, and Eurostat to work towards the improvement of the comparability of health state measures in the ECE region. The taskforce's objective is to develop a common instrument for the collection of core data on health state, a dimension of health status. Two meetings have been held and agreement reached on a conceptual framework and criteria for the selection of domains and development of indicators. A draft set of questions has been

presented and is being revised.

19. WHO: Included in WHO activities to improve methods and country health information systems is the long-term objective of encouraging the development and use of standard indicators of health, disability, and disease impact for health policy and programme evaluation. WHO is also developing tools and methods to enhance the availability and use of core health indicators at subnational levels in the context of the Health Metrics Network. WHO has also identified the development of an International Classification on Functioning, Disability, and Health (ICF) short form for use in surveys and summary measures as part of its business plan. At its most recent meeting, the WHO-Family of International Classifications Network of Collaborating Centers discussed their role in developing principles for using the International Classification of Functioning, Disability, and Health for censuses and surveys, and for health and disability statistics more generally, and noted the development of generic ICF assessment instruments. A Functioning and Disability Reference Group was established to improve international comparability of health and disability data and the correct use of ICF in measuring health and disability.

20. Intersecretariat Working Group on Health Statistics (ISWG-HS): The ISWG-HS was established by the UN Statistical Commission in 2004 to develop a coordinated and integrated agenda for the production of health statistics and agree on standard definitions, classifications, and methodologies in health statistics, taking advantage of existing mechanisms wherever possible, and involving the community of official statistics at all stages. ISWG-HS is to be a platform to share key international developments in the field of health statistics and to develop recommendations to the UN Statistical Commission and all UN agencies on the promotion of: the harmonization, coordination, and prioritization in the field health statistics; the development and use of standard definitions, classifications, and methodologies in health statistics; and the development of appropriate country health information systems that include both the health and statistical constituencies. The ISWG-HS acknowledges the wide range of indicators that have been used for the measurement of the health of populations and that there is a need for clear concepts, definitions, agreed thresholds, and standardized ways of data collection to increase the quality of the resulting measures. The Terms of Reference for the ISWG-HS have just been drafted so it is not known how the group will address its mission, but it is highly likely that consideration will be given to a core set of indicators.

21. Washington Group: The Washington City Group was set up in 2001 as an international forum to address statistical and methodological problems so as to facilitate the comparison of data on disability cross-nationally. Group efforts have focused on developing a short, core instrument for obtaining information on disability from censuses and surveys.

22. UNSD: Working with the Washington Group, the UN Statistics Division (UNSD) is developing methods to improve the collection and compilation of disability statistics through surveys and censuses. In particular, UNSD is developing methods to collect extensive meta-data that will accompany country-level disability statistics.

Issues and problems

23. The measurement of health status is a particularly complex endeavour and these complexities are compounded when an important objective of the measurement process is to produce data that are internationally comparable. As a result of these complexities, there is no core set of health measures accepted at the global level. Rather, multiple sets exist and more are under construction. Several years ago, at the request of the UN Economic and Social Council, the UN Statistical Commission convened a Friends of the Chair group to evaluate the indicators that had been identified at UN summits for monitoring trends and the effects of programs. While the number of health and nutrition indicators that had been identified was quite large (80) and, in some cases indicators were quite specific, there was considerable concern that important aspects of health and nutrition were not being addressed. As a result, 15 additional indicators were identified for inclusion in any final list of priority indicators. In the end, very few measures of health were included in the project's high priority category. This was a result of the fact that there were few well-accepted core indicators of health other than mortality. The poor showing of health in comparison with that of employment and income statistics is, in part, due to the multidimensionality of health, as well as the very different needs for, and ability to produce, measures among developed and developing countries.

24. It is a given that no single, small set of core measures can deal with all aspects of health. However, without such a set, it will continue to be difficult, if not impossible, to compare health across countries. The general area of health can be subdivided into components such as risk factors, acute and chronic conditions, functioning ability, and the effects of conditions and functional limitations on role participation. A core set of indicators can be developed across or within these components. In developing a core set, it is important to acknowledge that its scope will be limited rather than comprehensive. It is possible and appropriate to develop multiple core sets that focus on different aspects of health, but as a first priority, there should be one set that is adopted at the international level.

25. Core measures must be relevant at the national, regional, and international levels, and the burden of including the measures in national surveys should be such that it will be possible for countries to adopt the core measures. The needs of developed and developing countries must be balanced, but the focus should be on universally important indicators. Success will also require the ongoing commitment of all partners, especially those from national statistical offices.

26. The activities currently underway to develop a core set of measures focus either on health or on disability. Although the political and policy uses of the measures generated can be different, the two areas are highly related. In addition, in both cases, careful conceptual work needs to be done in order to develop understandable, valid, and comparable measures. The developmental work done by the Washington Group and the Budapest Initiative provide examples of the kind of conceptualization that is required. There needs to be convergence between the health and disability based approaches. The International Classification of Functioning (ICF) presents a broad-based international effort to improve measurements in this area. The Washington Group and the Budapest Initiative both use the ICF as a conceptual model but additional work needs to be done to clarify the interrelationships. The ICF is primarily a classification system and the code structure is too complex to provide much guidance in developing core indicators. There is some disagreement between the groups concerning how the

ICF can best be used in the survey context. This is an area for further discussion and development.

27. The question batteries that are being developed will require extensive testing. To be most useful, the methods used and the results obtained need to be shared openly. Standard methodologies would greatly improve the efficiency of the testing including agreed upon decision rules for when something 'works.' Joint or parallel tests are ideal but sharing of methods used and results is essential. The Washington Group has developed a standardized plan for the cognitive and field testing of the draft set of questions it has developed which, if successful, could be adapted in other venues.

28. If internationally comparable health statistics are to progress beyond the currently accepted measures of mortality, a focused collaboration of international, regional, and national organizations is needed. The development of a core set of health indicators will require a clear conceptual basis, appropriate methodological development, and transparent evaluations. The Budapest Initiative has many of the necessary characteristics to advance work in this area. Its membership includes the appropriate organizations for coordinating work in the region (ECE, WHO, and Eurostat) as well as national statistical offices. The group has developed a sound conceptual framework, a rationale for question development, and a testing plan for its work on health state; this could be expanded to other aspects of health.

29. There is a need to address the question of how to proceed to ensure a convergence between the proposals for survey questions emerging from various processes underway at the international level, so that a common set of questions can be recommended and adopted where appropriate by all countries. Relationships need to be strengthened among the different groups now working on health and disability survey modules, especially between the Budapest initiative and the Eurostat activities to develop recommendations for health status measurement instruments in Europe. In fact, Eurostat is testing a limited number of core questions for measuring health status and the Budapest Initiative will use the results of this testing when developing their core questions. There is a need to fully share the results of any cross-country testing that is currently underway and to take these results into account in coming up with recommendations for common survey instruments. Sufficient flexibility is needed eventually to include important health domains, or more valid questions to measure a particular health domain, which may initially not have been recommended at the European or other level.

III. IMPORTANT ISSUES THAT SHOULD BE BROUGHT TO THE ATTENTION OF THE CONFERENCE

30. Progress in implementation of the System of Health Accounts (SHA)
- (a) Note the progress made in international cooperation through the launch of the first joint OECD-Eurostat-WHO System of Health Accounts data collection in December 2005.
 - (b) Need to ensure that there is a sufficient commitment at the national level to implement the SHA.

31. Improvements in the data collection on human resources for health
 - (a) Need to develop, refine and harmonise guidelines and mechanisms for international data collection on health human resources, with a focus on doctors and nurses.
 - (b) Need also to address cooperatively the growing demand for data on the international migration of health professionals.

32. Improvements in the comparability of health status measures
 - (a) Identify as a priority the need to converge on a single core set of health status measures along with standard questionnaire modules to produce the needed data.
 - (b) Ensure proper coordination among different international activities in order to move towards broad international consensus on recommended instruments to measure health and disability for adoption in national population-based surveys and census in as many countries as possible. Avoid the premature acceptance of a global standard that could preclude the development of a global standard that would allow comparisons of health status among all major developed economies.
 - (c) Encourage the methodological development that is needed to attain the goal of a single core set of health status measures including standards for question testing and the sharing of test results.
 - (d) Task the Budapest Initiative with the objective of integrating the different activities in the ECE region so that a single output is achieved (the Bureau endorsed this suggestion at its February 2006 meeting).

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