

ORGANISATION
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ORGANISATION DE
COOPÉRATION ET
DE DÉVELOPPEMENT
ÉCONOMIQUES

OECD HEALTH DATA QUESTIONNAIRE 2023

GUIDELINES FOR COMPLETING THE QUESTIONNAIRE

**DEADLINE TO RETURN THE INFORMATION:
MONDAY 20 FEBRUARY 2023**

QUESTIONNAIRE SENT OUT: 19 December 2022

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NOTE BY THE SECRETARIAT

1. These Guidelines aim to assist national correspondents in completing the OECD Health Data Questionnaire 2023. 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 first 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-2023-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 **main changes this year** consist in 1) **improving the data collection on the Use of vaping products (VAPE)** by a) renaming the variables into “Vaping population: e-cigarettes use” and b) adjusting the definition accordingly by removing any mention of heated tobacco products, so as to focus exclusively on e-cigarettes and vaping devices; 2) adding a new module on **Long-term care formal workers: Working conditions (LTCD)**, to collect data by education level and part-time/full-time/temporary/permanent employment, as discussed during the meeting of the Working Party on Health Statistics (held on October 11-12, 2022) in [Item 4](#); 3) a **pilot** to assess data availability and comparability on **Long-term care facilities by ownership status** has also been added to this year’s LTC dataset questionnaire.

3. Please return the questionnaire, including updated Excel files for all parts of the database and 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 MONDAY 20 FEBRUARY 2023**.

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 2023. The changes in the 2023 questionnaire are 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 2023 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 2023* Questionnaire

10. Time series in the *OECD Health Data 2023* Questionnaire should cover the period **up to 2021** ($t-2$). **Countries are strongly encouraged to provide any provisional estimates for the year 2022**, as this will be the reference year for related OECD publications in 2023 (e.g. *Health at a Glance 2023: OECD Indicators*). All countries are thus encouraged to report data for the year 2022, making use of the **P flag to indicate provisional data for 2022 ($t-1$)** 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 D E P	Break in series Deviation from OECD definition Estimate/preliminary data Provisional value (to be used only for t-1 data, i.e. 2022)

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.

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
- 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, Türkiye, the United Kingdom, the United States, and non-EU accession countries to the OECD) are asked to supply data updates directly.

Life expectancy by education level

17. The 2023 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).

18. The OECD Secretariat extracts data from the Eurostat Database for 14 of the 25 European countries listed in Annex 2 (as well as for Türkiye, and EU accession countries to the OECD) 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

19. 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

20. Data on perinatal mortality will be imported from the Eurostat Statistical Database for the 25 European countries listed in Annex 2 (as well as for EU accession countries to the OECD), 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.

21. The 2023 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

22. The 2023 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.

23. 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). Türkiye and non-European countries (as well as non-EU accession countries to the OECD) are asked to supply data and corresponding *Sources and Methods*.

Communicable diseases

24. 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 Türkiye). Non-European countries (and non-EU accession countries to the OECD), however, are requested to update those data along with their *Sources and Methods*.

25. 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 Türkiye. Correspondents from non-European countries (and non-EU accession countries to the OECD) are invited to provide data updates and accompanying *Sources and Methods*.

Cancer

26. 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

27. 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

28. 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 > “Vaping population: **e-cigarettes use**”

Alcohol consumption

Food supply and consumption

Body weight

Use of vaping products *Updated definition*

29. 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 of e-cigarettes**. The definition has been amended so as to **exclude heated tobacco products** and focus specifically on e-cigarettes and other electronic devices (and the title of the variable thus renamed). Countries are invited to update those data accordingly when needed, and to provide data for the most recent year available.

30. 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

31. The definition in the *Sources and Methods* was slightly amended two years ago, with a note 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

32. 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

33. 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

34. 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.

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)

35. The 2023 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**.

36. **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

Total pharmaceutical consumption (volume of consumption of selected drugs)

37. The data collection is based on the **2023 Anatomic Therapeutic Chemical Classification (ATC) Index**. When updating the data series, correspondents should consider any ATC/DDD changes

implemented from January 2023. The changes are available on the WHO Collaborating Centre for Drug Statistics Methodology website (see https://www.whocc.no/lists_of_temporary_atc_ddds_and_alterations/). The Secretariat invites correspondents to clearly mention any deviation from the 2023 ATC Index (i.e. use of a national classification or an earlier ATC version – ideally all time-series should be provided using the 2023 ATC version, for consistency and comparability).

38. 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).

39. **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 Türkiye (and non-EU accession countries to the OECD) 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)

40. The data collection is based on the **2023 Anatomic Therapeutic Chemical Classification (ATC) Index**. When updating the data series, correspondents should consider any ATC/DDD changes implemented from January 2023. The changes are available on the WHO Collaborating Centre for Drug Statistics Methodology website (see https://www.whocc.no/lists_of_temporary_atc_ddds_and_alterations/). Any deviation should be clearly noted in the *Sources and Methods*.

41. 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

42. 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)**, the **community pharmacy market (PGENCOMP)** and the **hospital pharmaceutical market (PGENHOPH)**. The main objective for the 2023 data collection is again to further increase the number of countries reporting data on this important variable.

43. 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 formal workers: Working conditions (Head counts) ^{New}

Long-term care recipients

PILOT - Long-term care facilities by ownership status ^{New}

Long-term care workers

44. 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 formal workers: Working conditions (Head counts) *New*

45. The 2023 data collection includes a new module on the working conditions of LTC formal workers (LTCD), with a breakdown 1) **by education level** (by ISCED-11 codes) for Low education (ISCED 0-2), Medium education (ISCED 3-4), and High education (ISCED 5-8); 2) **by part-time/full-time employment** and 3) **by temporary/permanent employment**. Data should be reported **in numbers** (shares will then be calculated by the Secretariat and eventually reported in OECD.Stat, with the denominator being the corresponding time series for “Total formal LTC workers”), with data **including all formal LTC workers in institutions and at home**. The age group should be 17-64 years old.

46. The Secretariat has identified that for most European countries it can rely mainly on microdata from **Labour Force Surveys for European countries** to complement the current data collection. Labour Force Surveys are conducted by national statistics institutions (and harmonised by Eurostat for European countries except for the UK) every year. They supply data on professions, working conditions, unemployment situations, education and sociodemographic characteristics. The latest wave of the European Union Labour Force Survey (EU-LFS) includes Austria, Belgium, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden and Türkiye (as well as Bulgaria, Croatia, and Romania). The Secretariat will take responsibility for accessing the data collection and the calculation of variables using the EU-LFS, through requests of semi-aggregated data at Eurostat. Please note that the questionnaires have already been prefilled with the latest data accessed via EU-LFS, as noted in the *Sources and Methods*, and countries are invited to update those data and the corresponding metadata in case they wish to provide their own national estimates. If a country has a different preferred source it should indicate this and provide the data directly in the questionnaire.

47. For non-European OECD countries, other options are available, such as **national labour force surveys or LTC-specific surveys**. The United States could rely on the Annual Social and Economic Supplement of the Current Population Survey (ASEC-CPS). In Japan, the source could be the survey on Long-term Care Workers. Korea’s data may come from the National Health Insurance Survey (NHIS)’s database for the registry of LTC providers, using the Long-term Care Provider Report for Registration. Israel and the United Kingdom could use their national labour force surveys. Australia and New Zealand could rely on national reports. In 2020, New Zealand provided data based on the New Zealand Aged Care Workforce, 2016 report, published by the New Zealand Work Research Institute. Australia’s data were based on the Australia Aged Care Workforce 2016 report, published by the Department of Health of the Australian Government. No source has yet been identified for Chile, Colombia, Costa Rica, Mexico nor Brazil and Peru (accession countries).

48. Details about the scope of the definition and available sources are provided in the corresponding *Sources and Methods*. Countries are invited to provide or update the data series when needed, and update the corresponding information in the *Sources and Methods* accordingly.

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

49. 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*.

PILOT - Long-term care facilities by ownership status ^{New}

50. The Secretariat proposes to include in the 2023 data collection a **pilot on the number of public and non-public residential long-term care institutions** (HP.2, under the System of Health Accounts 2011 classification of health care providers). Public long-term care institutions refer to any residential long-term care institution under the responsibility of a governmental unit (central or federal government, a state government, or a local government or municipality). The proposed data collection would not cover home care because of the difficulties to clearly differentiate private provision in home care in some countries. Data should be reported in numbers and cover public and private facilities, with a breakdown between for-profit and not-for-profit private facilities. Countries are invited to provide data and corresponding metadata and note any deviation from these proposed definitions in the *Sources and Methods*.

HEALTH_PROT – Social Protection

Government/compulsory health insurance

Government/compulsory health insurance coverage

Voluntary health insurance

Total voluntary health insurance (VHI) coverage

Primary voluntary health insurance (VHI) coverage

Duplicate voluntary health insurance (VHI) coverage

Complementary voluntary health insurance (VHI) coverage

Supplementary voluntary health insurance (VHI) coverage

Government/compulsory health insurance coverage

51. Countries are invited to provide data for government/compulsory coverage, which label was modified last year to align with the SHA, i.e. the health spending category of **HF.1**.

Voluntary health insurance coverage

52. Countries are invited to provide data for VHI coverage, which label was modified last year to align with the SHA, i.e. the health spending category of **HF.2.1**. Data should 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*.

53. **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.

54. **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.

55. 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 – online database

OECD Health Statistics 2022

<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 Workforce Migration	LTC Resources and Utilisation
Health Status	Health Care Utilisation	Social Protection
Non-Medical Determinants of Health	Health Care Quality Indicators	Demographic References
Health Care Resources	Pharmaceutical Market	Economic References

Publications and related documents

Health at a Glance: Europe 2022 - State of Health in the EU Cycle, OECD (2022)

<http://www.oecd.org/health/health-at-a-glance-europe/>

Health at a Glance: Asia/Pacific 2022, OECD (2022)

<http://www.oecd.org/health/health-at-a-glance-asia-pacific-23054964.htm>

Health at a Glance 2021: OECD Indicators, OECD (2021)

<https://www.oecd.org/health/health-at-a-glance/>

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 (2017, revised edition)

<http://www.oecd.org/health/health-expenditure.htm>

Health Statistics

<https://www.oecd.org/health/health-data.htm>

Health Working Papers

<http://www.oecd.org/health/health-working-papers.htm>

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ANNEX 1. LIST OF VARIABLES IN THE OECD HEALTH DATA 2023 QUESTIONNAIRE

56. 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.

57. 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	Eurostat Database for European Countries (except Türkiye, and non-EU accession countries to the OECD)	
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		
Total population at birth		
Life expectancy by education level		
Females at birth, Low education (ISCED 0 to 2)	Eurostat Database, OECD Statistics Directorate project, for selected countries	
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

Maternal and infant mortality

Infant mortality
Neonatal mortality
Perinatal mortality

Maternal mortality

Potential years of life lost

Avoidable mortality ^{New}

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+

WHO for all countries

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

WHO for all countries

WHO for all countries

Eurostat Database (for all European countries participating in the EU-SILC Survey – not including Türkiye nor non-EU accession countries to the OECD)

Eurostat Database (for all European countries participating in the EU-SILC Survey – not including Türkiye nor non-EU accession countries to the OECD)

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

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

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

Injuries

Eurostat Database (for all European countries participating in the EU-SILC Survey – not including Türkiye nor non-EU accession countries to the OECD)

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

International Agency for Research on Cancer, for all countries

UNECE for most countries (refer to

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: e-cigarettes use, adults (aged 15+)
Vaping population: e-cigarettes use, young adults (aged 15-24 years old)

Alcohol consumption

Alcohol consumption

Food supply and consumption

Total fat supply
Total calories supply
Total protein supply
Sugar supply
Fruits and vegetables supply
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

Guidelines)

Renamed (“e-cigarettes use”) to narrow down definition.

FAO (UN)
FAO (UN)
FAO (UN)
FAO (UN)
FAO (UN)

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-Anti-infectives 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-Anti-inflammatory and antirheumatic products non-steroids
 N-Nervous system
 N02-Analgesics
 N05B-Anxiolytics
 N05C-Hypnotics and sedatives
 N06A-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-Anti-infectives for systemic use
 J01-Antibacterials for systemic use
M-Musculo-skeletal system
 M01A-Anti-inflammatory and antirheumatic products non-steroids
N-Nervous system
 N02-Analgesics
 N05B-Anxiolytics
 N05C-Hypnotics and sedatives
 N06A-Antidepressants
R-Respiratory system
 R03-Drugs for obstructive airway diseases

Generic market

Total pharmaceutical market
Third-party-payer 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 formal workers: Working conditions (Head counts) ^{New}

Total formal LTC workers: Low education (ISCED 0-2)
Total formal LTC workers: Medium education (ISCED 3-4)
Total formal LTC workers: High education (ISCED 5-8)
Total formal LTC workers: All education levels
Total formal LTC workers: Part-time employment
Total formal LTC workers: Full-time employment
Total formal LTC workers: Total part-time and full-time

employment
Total formal LTC workers: Fixed-term employment
Total formal LTC workers: Permanent employment
Total formal LTC workers: Total temporary and permanent employment

Long-term care recipients

LTC recipients in institutions (other than hospitals)
LTC recipients at home

PILOT - Long-term care facilities by ownership status New

Public LTC facilities
Private LTC facilities
- of which: for-profit
- of which: not-for-profit

HEALTH_PROT – SOCIAL PROTECTION

Health care coverage

Total public and primary voluntary health insurance
Total public and primary voluntary health insurance

Calculated by the Secretariat

Government/compulsory health insurance
Government/compulsory health insurance coverage

Voluntary health insurance
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 Türkiye only for indicators on “Life expectancy by education level”).

Also including the following EU accession countries to the OECD: Bulgaria, Croatia, and Romania.

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)