



JOINT DATA COLLECTION ON NON-MONETARY HEALTH CARE STATISTICS

JOINT QUESTIONNAIRE 2013

GUIDELINES FOR COMPLETING THE OECD/EUROSTAT/WHO-EUROPE QUESTIONNAIRE 2013

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1. Introduction

This document provides the **Guidelines for Completing the OECD/Eurostat/WHO-Europe Joint Questionnaire on Non-Monetary Health Care Statistics**. The overall objective of this joint questionnaire is to provide internationally comparable data on key aspects of health care systems as they relate to health care resources and activities.

Content of the joint questionnaire

The joint questionnaire consists of three parts:

- **Health employment and education** (e.g. number of physicians, nurses, graduates, etc.);
- **Physical and technical resources** (e.g. number of beds, medical equipment, etc.);
- **Health care activities** (e.g. number of consultations, hospital discharges, surgical procedures, etc.).

Each part is associated to:

- One **Excel file with numerical data** (in Excel 97-2003 format);
- One **Word file with the documentation of *Definitions, Sources and Methods***.

Countries in the **WHO European Region** (e.g. EU members or candidates, EFTA countries, Israel) are also asked to provide Hospital Discharge Data (HDD) in a separate **comma-delimited ASCII file** (.CSV).

Note for European countries: Some **additional variables** are requested by Eurostat:

- The additional data related to **health employment and physical and technical resources** are collected in a separate Excel file, with the metadata collected in a separate Word file.
- The additional data related to **health care activities** are collected in separate spreadsheets in the common Excel file (sheets name starting with “ESTAT”).

Deadline for returning the questionnaire

The deadline for returning the questionnaire is **FRIDAY, MARCH 22, 2013**.

Contacts

For the 27 EU Member States, the 4 EFTA countries (Iceland, Liechtenstein, Norway and Switzerland) and the 5 EU candidate countries (Croatia, Former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey), the questionnaire (updated Excel and comma-delimited ASCII files as well as *Sources and Methods* in Word format) should be returned **via eDAMIS** (see the eDAMIS quick user guide provided separately).

For countries which are members of OECD or WHO-Europe only, the questionnaire should be sent directly to the corresponding contact at OECD or WHO-Europe (see below).

Any additional correspondence with OECD and/or Eurostat and/or WHO-Europe (with other aims than submitting the questionnaire) should be sent to the following contacts in each organisation:

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2. Structure of the Joint Questionnaire on Non-Monetary Health Care Statistics

The joint questionnaire on non-monetary health care statistics is divided into three parts: 1) Health employment and education; 2) Physical and technical resources; and 3) Health care activities. The first two parts have been jointly collected by the OECD, Eurostat and WHO-Europe since 2010. The extension to health care activities is introduced for the first time in 2013.

Following the approach previously adopted by the three organisations, the joint questionnaire covers two types of data requests: 1) data requested by the three organisations for the commonly agreed variables (see [Annex 2](#) for the complete list of variables); and 2) additional data requested only by Eurostat (see [Annex 3](#) for the list of variables). Countries that are not reporting their data to Eurostat do not have to complete this additional request (see the list of all countries involved in the joint data collection in [Annex 4](#)).

Common OECD/Eurostat/WHO-Europe data request

The following files are jointly collected by the three organisations:

- **Health employment and education**
 - **CCC_Health employment_Year.xls**: Excel workbook requesting *time series*.
 - **CCC_Health employment_Year.doc**: Word document containing the **definitions** of all variables and requesting information on *Sources and Methods*.
- **Physical and technical resources**
 - **CCC_Physical resources_Year.xls**: Excel workbook requesting *time series*.
 - **CCC_Physical resources_Year.doc**: Word document containing the **definitions** of all variables and requesting information on *Sources and Methods*.
- **Health care activities**
 - **CCC_Health activities_Year.xls**: Excel workbook requesting *time series*.
 - **HDD_CC_Year.csv**: comma-delimited ASCII file for hospital discharge data (inpatient cases, day cases and bed-days) by ICD or ISHMT code¹, by age group and by gender. These CSV files are requested only from countries belonging to the WHO European region.
 - **CCC_Health activities_Year.doc**: Word document containing the **definitions** of all variables and requesting information on *Sources and Methods*.

Note: CCC in the names of the files corresponds to the three-character country code (ISO 3166).

Eurostat additional data request

This additional data request needs to be completed by the 27 EU Member States, the 4 EFTA countries (Iceland, Liechtenstein, Norway and Switzerland) and the 5 EU candidate countries (Croatia, Former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey).

- **Health employment and education and Physical and technical resources**
 - **CCC_Eurostat module_Year.xls**: Excel workbook requesting *time series* (the additional data related to health employment and physical and technical resources are collected by Eurostat in a single Excel file).
 - **CCC_Eurostat module_Year.doc**: Word document containing the **definitions** of all variables and requesting information on *Sources and Methods*.

¹ ICD: International Classification of Diseases. ISHMT: International Shortlist for Hospital Morbidity Tabulation.

- **Health care activities**
 - **CCC_Health activities_Year.xls**: in the common **Excel workbook** collecting data on health care activities, two worksheets are requested by Eurostat only:
 - “**ESTAT_Non-residentDischarges**”: **Excel worksheet** requesting *data* related to patients receiving hospital care in another country.
 - “**ESTAT_AdditionalProcedures**”: **Excel worksheet** requesting *time series* for additional surgical procedures which are not included in the common shortlist.
 - **HDD_CC_Year.csv**: the common **CSV file** with hospital discharge data by ICD or ISHMT code, by age group and by gender should also contain *data by region* (NUTS 2), as requested by Eurostat.
 - **CCC_Health activities_Year.doc**: the common **Word document** also contains **definitions** as well as *Sources and Methods* for the additional variables requested by Eurostat.

The following table summarises the files that should be completed by the countries, depending on the organisations to which they belong.

Summary table for data and metadata submission, by group of countries

| | Health employment and education | Physical and technical resources | Health care activities |
|---|---------------------------------|----------------------------------|--|
| Countries reporting to OECD only (i.e. Australia, Canada, Chile, Japan, Korea, Mexico, New Zealand and the United States) | Data | - CCC_Health employment.xls | - CCC_Physical resources.xls |
| | Metadata | - CCC_Health employment.doc | - CCC_Physical resources.doc |
| Country reporting to WHO-Europe and OECD (i.e. Israel) | Data | - CCC_Health employment.xls | - CCC_Health activities.xls - HDD_CC.csv (by age, gender) |
| | Metadata | - CCC_Health employment.doc | - CCC_Physical resources.doc |
| Countries reporting to Eurostat , WHO-Europe and OECD (EU member states, EU candidate countries, EFTA countries) | Data | - CCC_Health employment.xls | - CCC_Health activities.xls (+2 sheets) - HDD_CC.csv (by age, gender, region) |
| | Metadata | - CCC_Health employment.doc | - CCC_Physical resources.doc |
| | | - CCC_Eurostat module.doc | |

Features of all Excel workbooks

All Excel workbooks contain worksheets with the following titles and functions:

- “**Country**” – the first worksheet is designed to collect information on the country respondent/national focal point and allows the respondent to provide any general or specific comment on the data collection.
- “**VariablesList**” – the second worksheet serves as a table of contents, summarising the data requested in the workbook.
- “**Definitions**” – the third worksheet provides the definitions for all variables. (The definitions are also available in the Word document requesting information on *Sources and Methods*).
- **Data worksheets** – one data worksheet is provided by main topic.

The Excel worksheets have been **protected** so that only cells of the time series can be filled/updated. This protection has been set up in order to prevent any accidental changes in the format of the Excel files (i.e. changing the structure of tables, by adding or deleting rows or columns for example, is not allowed). If really necessary, the protection can be removed easily as no password has been assigned (open the file, select the worksheet to unprotect, click the “Review” tab on the ribbon, and click on “Unprotect Sheet”).

3. General Instructions for Updating Data and Metadata

Updating the general information in Excel workbooks

National focal points should complete/update the respondent information in the “Country” worksheet. They are also allowed to provide in this worksheet any **comments** they might have regarding their data and metadata submission.

Correspondents are encouraged, but not requested, to update the ‘**Check-list**’ column in the “VariablesList” worksheet. This check-list may help them follow their progress in updating the questionnaire. It may also provide useful information for the three organisations about the availability of some variables not completed in the initial submission.

Update of data in the Excel worksheets

All tables are pre-filled with the data provided to the three organisations in previous years. National focal points are asked to **check the data currently available and update them**. 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.

If long time series are not readily available, national correspondents are invited to report 5-10 years of the most recent data. If, in addition, data could be supplied in five year intervals (1980, 1985, 1990, 1995), this would enable the construction of internationally comparative tables at fixed years, spanning a wider time range.

All correspondents are asked to 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.

Please do not write any comments into the Excel data sheets. All comments should be supplied separately (in the “Country” worksheet or by e-mail) and/or inserted into the documentation of [Sources and Methods](#) (see below). Although we are grateful for any additional supporting documentation on paper, the data update will rely **exclusively** on the electronic files of the questionnaire received from countries.

Years included in the 2013 Joint Questionnaire

Time series in the 2013 Joint Questionnaire should cover the period up to **2011**. The questionnaire also includes the year **2012**, for reporting of either final data or preliminary estimates (which can be indicated with the code “e”; see [data codification](#) below).

Data checks

The Joint Questionnaire includes a set of automatic checks that are designed to improve data quality and minimise errors. The main purpose of the data checks is to verify the internal consistency in the data reported in the questionnaire. Some checks verify that data correctly add up in one spreadsheet (e.g. for hospital beds), or that data are consistent from one sheet to another (e.g. for physicians). They calculate the difference between the data concerned; theoretically, the result should be equal to 0. Some other checks verify the data consistency/reliability (e.g. the number of practising physicians should be smaller than the number of physicians licensed to practice; percentages should not be higher than 100%; etc.).

Data codification

A tool to flag important information related to the data is included in the Joint Questionnaire. Correspondents will find in the Excel questionnaire additional columns (named “Code”), following each single data column, with the possibility of including three letters if necessary (or to revise them if they already exist). These three letters (b, e, d) should be used to reflect any of the three following data issues:

- **b = break in time series;**
- **e = estimate or preliminary data;**
- **d = differences in methodology/deviation from definition.**

These three letters should be used accurately and only when necessary. For example, the “b” letter should be used when a change in the source or in the methodology has involved a significant break in the series. The letters intend to warn data users about important issues in the data. These issues should be briefly described in the *Sources and Methods*.

Breaks in time series

Breaks in time series occur with changes in sources or methodologies. While these changes in sources or methodologies may improve the quality of the data, they seriously limit the possibility to do any trend analysis. When adopting any new source or methodology, national correspondents are encouraged to revise the data for previous years to maintain some reasonably long time series. Some methods that can be used to overcome the breaks in time series are provided in [Annex 1](#), but correspondents are welcome to use any other appropriate methods depending on the information available in their country. The adjusted data can be highlighted with an “e” code associated with the data (as described in [Data codification](#) above).

If it is not possible to adjust the time series, any significant breaks should be highlighted with a “b” code associated with the data. Some explanation for the breaks should be provided in the *Sources and Methods*.

Updating the documentation of *Sources and Methods*

National focal points are invited to document the *Sources and Methods* underlying the data for each variable based on a common structure agreed-upon by the three organisations (see below). The *Sources and Methods* have been pre-filled with information that countries have already provided to the international organisations. The electronic files to update the *Sources and Methods* are provided in DOC format, and should be **opened, updated and then returned using WORD** (or any text-processing software). Correspondents are asked to **use TRACK CHANGES MODE in Word to highlight all changes to the *Sources and Methods*.**

Structure to follow for the collection of information on *Sources and Methods*

| | |
|--------------------------------------|---|
| Source of data | <ol style="list-style-type: none"> 1. Indicate the data source, i.e. the name of the agency and/or the complete citation of the publication. 2. Indicate the full title of the original survey collection, administrative source, database or publication. 3. Indicate if different sources were used for different years. 4. Indicate the reference period (e.g. annual average, data as of December 31, etc.). 5. Add URL for website where more information can be found. |
| Coverage | <p>Indicate the data coverage if it is less than complete (geographical, population, institutions, etc).</p> <ul style="list-style-type: none"> - Do the data cover the entire country or only some part(s)? (Please specify if the geographic coverage is partial.) - Do the data cover both the public and private sectors? (If not, please specify the limitation in coverage.) - Are there any other limitations in the data coverage (e.g. military services, prisons, social services)? |
| Deviation from the definition | <p>Indicate if the data supplied do not match the proposed definition (please specify).</p> |
| Estimation method | <p>Explain if data are an estimation, interpolation or any other relevant information.</p> |
| Break in time series | <p>Indicate if there is a break in the time series (due to changing definition, source or calculation method).</p> |

4. Guidelines by Topic and Variable

The **definitions** for all variables are provided either in the Excel workbooks (see the sheet “Definitions”) or in the Word document requesting information on *Sources and Methods*.

The definitions rely as much as possible on the following existing **international classifications**:

- International Classification of Diseases (ICD), WHO (<http://www.who.int/classifications/icd/en/>);
- International Classification for Health Accounts (ICHA), *A System of Health Accounts*, OECD, WHO and Eurostat (2011) (<http://www.oecd.org/els/healthpoliciesanddata/asystemofhealthaccounts2011.htm>);
- International Standard Classification of Occupations (ISCO-08), ILO (<http://www.ilo.org/public/english/bureau/stat/isco/index.htm>).

Health employment and education

Most variables related to health employment (e.g. physicians, midwives and nurses, dentists, pharmacists, etc.) are requested according to three concepts:

- “**practising**” (i.e. health care professionals directly providing services to patients);
- “**professionally active**” (i.e. the “practising” category plus other health professionals working in administration and research who are not directly providing services to patients but for whom their medical education is a prerequisite for the execution of the job);
- “**licensed to practice**” (i.e. entitled to practice as health professionals).

Physicians by age and gender

Data should be provided for **practising** physicians by age and gender, where possible. If the data are not available according to the “practising” category, they should be reported for professionally active physicians or physicians licensed to practise. Please clearly indicate in the *Sources and Methods* if your data refer to a different concept than “practising”.

Physicians by categories

Since 2012, the common data collection includes three broad categories of doctors (corresponding to the ISCO-08 codes at the 4-digit level) and eight sub-categories:

- 1) **Generalist medical practitioners (ISCO-08 code: 2211)**
 1. General practitioners
 2. Other generalist (non-specialist) medical practitioners
- 2) **Specialist medical practitioners (ISCO-08 code: 2212)**
 3. General paediatricians
 4. Obstetricians and gynaecologists
 5. Psychiatrists
 6. Medical group of specialists
 7. Surgical group of specialists
 8. Other specialists not elsewhere classified
- 3) **Medical doctors not further defined (ISCO-08 code: 2210)**

A split has been introduced in 2012 under the broad category “General Medical Practitioners” to distinguish more clearly the number of “general practitioners” (“family doctors”), providing **continuous medical care** to individuals and families most often in private offices, from other generalists/non-specialists where possible.

Theoretically, the two first broad categories (“generalist medical practitioners” and “specialist medical practitioners”) should cover all physicians. In accordance with ISCO-08 definition, the last category “**Medical doctors not further defined**” should be used only if some doctors cannot be classified under “generalist medical practitioners” or “specialist medical practitioners”. Correspondents are strongly encouraged to verify that physicians have been properly allocated to the specific categories, and to make any adjustments if necessary.

The table on physicians by categories should cover the whole physician workforce, including **medical interns and residents** as well as physicians without specialisation. The sum of the three broad categories should add up to the total number of (practising) physicians. Medical interns and residents who are pursuing postgraduate training should be allocated in their area of training. If they have not chosen a specialisation yet, they should be reported in the category “Other generalist (non-specialist) medical practitioners”. Physicians in training who cannot be split according to the specialty in which they are training should be reported in the category “Medical doctors not further defined”.

Some guidelines are provided to help classifying different specialties, especially between the “**medical group**” and the “**surgical group**”. Please indicate in the *Sources and Methods* which specialties have been allocated to these two broad categories, particularly if the allocation does not correspond to the proposed guidelines. Please note that, in response to the request from several countries, “**occupational medicine doctors**” have been moved this year from “other specialists not elsewhere classified” to the “medical group of specialists”.

Data for different categories of doctors should be provided for **practising** physicians, where possible. If the data are not available according to this concept, they should be reported for professionally active physicians or physicians licensed to practise. Please clearly indicate in the *Sources and Methods* if your data refer to a different concept than “practising”.

To avoid double counting doctors with more than one specialty, the following criteria are proposed to report each doctor only once:

- 1) the predominant (main) area of practice of doctors; or
- 2) the last specialty for which they have received registration.

Midwives, Nurses and Caring personnel (personal care workers)

Data are collected separately for midwives and nurses. If data are not available separately for midwives, the total number of midwives and nurses should be reported as **nurses**. This should be clearly mentioned in the *Sources and Methods*.

National correspondents should also provide the breakdown between “**professional nurses**” and “**associate professional nurses**” in those countries where two levels of nurses exist. The ISCO-08 definitions are provided to guide this data collection. Please note in the *Sources and Methods* which categories of nurses have been assigned to each of these two categories.

The breakdown between “professional midwives” and “associate professional midwives” that was introduced in 2012 has been removed from the 2013 data collection, due to very limited data availability (the category of “associate professional midwives” does not exist in most countries). Therefore, only the total number of midwives will be collected in the 2013 joint questionnaire.

The ISCO-08 definitions are also provided to guide the data collection of “**caring personnel (personal care workers)**”, who may also be referred as “nursing aides” or given other titles in different countries. These caregivers are not nurses, but they do provide personal care to patients in institutions or at home. Please indicate in the *Sources and Methods* the categories of workers reported under this item.

Hospital employment

The main priority is to collect data on the **total** number of people working in hospitals on a **head count** basis. Data for six categories of hospital workers are also requested. In addition to head counts, data are also collected on a **FTE basis**. Three methods to convert head counts into FTE data are proposed below, and national correspondents may choose one of them to do the conversion, depending on the availability of detailed data on actual/usual or contractual hours of work.

1) For countries which have detailed data on actual or usual working hours

Full-time equivalent (FTE) employment should be measured by the number of hours actually or usually worked divided by the average number of hours worked in full-time jobs.

For example: if the standard working hours for a full-time job in the country is 40 hours per week, and the actual or usual working hours of a doctor or a nurse in hospital is 30 hours, s(he) should be counted as 0.75 FTE. If s(he) works 50 hours, s(he) should be counted as 1.25 FTE.

2) For countries which only have detailed data on contractual working hours

A worker with a full-time employment contract should be counted as 1 FTE. Concerning workers who do not have a full-time employment contract, full-time equivalent should be measured by the number of hours of work mentioned in each contract divided by the normal number of hours worked in full-time jobs.

For example: if the standard working hours for a full-time job in the country is 40 hours per week, and if the contract of a nurse is 30 hours per week, s(he) should be counted as 0.75 FTE.

3) For countries which do not have any detailed information on working hours

A worker with a full-time employment contract should be counted as 1 FTE. Concerning workers with part-time contracts, the practice in many countries is simply to consider that 2 part-time workers = 1 FTE.

Graduates

This part of the data collection covers medical graduates, dentist graduates, pharmacist graduates, midwife graduates and nursing graduates.

In order to be consistent with the data collection on nurses, nursing graduates can be disaggregated between graduates from “professional nurse” programmes and “associate professional nurse” programmes. If this breakdown is not available, please report only the total number of nursing graduates.

Physical and technical resources

Some definitions have been slightly amended in the 2013 joint data collection in order to reflect more closely the new edition of *A System of Health Accounts* (SHA 2011). However, these small changes do not modify the scope of the data collection.

Hospitals

The total number of hospitals should include all types of hospitals, following the International Classification for Health Accounts 2011 (including HP1.1 General hospitals, HP1.2 Mental health hospitals, HP1.3 Other specialised hospitals). Although the priority is to collect data on the **total number of hospitals**, more specific information is also requested for general hospitals (HP1.1) and for the breakdown between public, not-for-profit and for-profit private hospitals, where possible.

Hospital beds

The data collection on hospital beds aims at collecting data for different functions of care, in all types of hospitals (including HP1.1 General hospitals, HP1.2 Mental health hospitals, HP1.3 Other specialised hospitals). An additional goal is to collect the number of beds broken down between public, not-for-profit and for-profit private hospitals, where possible. National correspondents are invited to note in the *Sources and Methods* any limitation in hospital coverage.

Beds in residential long-term care facilities

The data collection on beds in residential long-term care facilities should include all types of nursing and residential care facilities as defined in the HP.2 category of the International Classification for Health Accounts 2011.

Medical technology

The data collection on medical technology includes eight types of diagnostic and therapeutic equipment. The aim is to collect data on the total number of equipment in all health care facilities, including hospitals and providers of ambulatory health care. If the data in your country are only available for hospitals or ambulatory care providers, these data can be reported in the corresponding column.

Health care activities

Consultations

The aim is to collect the number of consultations with doctors and dentists *in all settings*, including in outpatient departments in hospitals. The data may either come from administrative sources or surveys. It is requested as a **rate per capita**.

In addition, a more specific data request focuses on the number of consultations with doctors in *outpatient departments of hospitals* to provide more complete information on hospital activities. These data usually come from administrative sources. The total (absolute) number of consultations is requested.

Immunisation against influenza

The objective is to collect the percentage of elderly people who have been vaccinated **against seasonal influenza** during the last twelve months.

Screening

The data collection on breast cancer (mammography) screening and cervical cancer screening includes a breakdown between survey data and programme-based data. Correspondents are invited to update the data series and to note any deviation from the proposed definitions in the *Sources and Methods*.

Hospital aggregates

This request is designed to collect data on total (aggregate) hospital activities, including a specific focus on curative care for some indicators. It complements the more disaggregated data collection on hospital discharges and bed-days (or length of stays) by diagnostic groups. Besides providing an opportunity for countries to report such aggregated data if they are not able to report the more disaggregated data, this data request allows an assessment of the data coverage of the more disaggregated data supplied by diagnostic

groups. It also serves to collect a few aggregate indicators that can be used in analysis of hospital efficiency or utilisation rate (e.g., occupancy rates of hospital beds).

The data should cover all hospitals, and the definition of curative care is based on the standard SHA definition.

Discharges, bed-days, average length of stay by diagnostic categories

Data on hospital discharges, bed-days and average length of stay (ALOS) by diagnostic categories will be collected in two different ways, depending on countries.

1) **Countries in the WHO European Region** (e.g. EU members or candidates, EFTA countries, Israel)

For these countries, the joint data collection on hospital discharge data (HDD) will follow the approach adopted by WHO-Europe and Eurostat in recent years. The data are requested for discharges (inpatient cases and day cases) and bed-days by ICD-9, ICD-10 or ISHMT code², by age group and by gender. The data collection on discharges and bed-days allows the calculation of average length of stay.

All countries in the WHO European Region are encouraged to supply their data using a separate **comma-delimited ASCII file** (.CSV). [Annex 5](#) provides all information regarding the submission of the HDD files.

2) **OECD non-European countries** (Australia, Canada, Chile, Japan, Korea, Mexico, New Zealand and the United States)

The previous OECD data collection approach will continue for non-European countries. Data are requested for hospital discharges (inpatient cases only) and ALOS by ISHMT code, for the total population only. They are collected in the common Excel workbook, in the sheets “Discharges” and “ALOS”.

Hospital discharges should cover all hospitals (HP.1). They should include deaths in hospital and transfers to another hospital, but exclude transfers to other care units within a same hospital. Countries submitting data according to ISHMT should exclude the “external causes of morbidity and mortality” (V, W, X and Y codes, chapter 20 in ICD-10), in order to avoid any double-counting of injuries which are already recorded in “injury, poisoning and certain other consequences of external causes” (S and T codes, chapter 19 in ICD-10). Discharges with unknown diagnosis should be allocated to ISHMT code 1803 (or ICD-10 code R69).

The mapping between the International Shortlist for Hospital Morbidity Tabulation (ISHMT) with ICD-10 and ICD-9 codes is available at: http://stats.oecd.org/HEALTH_QUESTIONNAIRE/ISHMT/JQNMHC_ISHMT.pdf.

Diagnostic exams

The chapter includes three variables: the number of **Computed Tomography (CT) exams**, **Magnetic Resonance Imaging (MRI) exams** and **Positron Emission Tomography (PET) exams**³. The aim is to collect data on all diagnostic exams, including those carried out in hospitals and outside of hospitals. To allow for a more accurate reporting in those countries which may only have partial data coverage, the data collection includes a breakdown between exams in hospitals and in ambulatory care settings.

² ICD: International Classification of Diseases. ISHMT: International Shortlist for Hospital Morbidity Tabulation.

³ The first two diagnostic exams (CT exams and MRI exams) have been collected by the OECD for several years.

Surgical procedures

A common shortlist of 17 surgical procedures plus 5 subgroups has been adopted by the three organisations. In addition to the total number of procedures, a split between **inpatient cases** and **day cases** is requested for each type of surgical procedure. For the first two procedures on the list (cataract surgery and tonsillectomy), the number of **outpatient cases** in hospital and outside hospital is also requested where possible in order to provide more complete coverage of same-day surgery. Following the SHA definitions, day cases are defined as admitted patients, while outpatient cases are defined as non-admitted patients.

In reporting data on the shortlist of procedures, correspondents are invited to follow as much as possible the proposed counting method which is designed to improve data comparability by avoiding double-counting procedures when more than one code may be used depending on each national classification system. Correspondents are invited to report either **a count of the number of patients** who have received a given procedure or to **only report one code per procedure category for each patient**. For example, if a percutaneous coronary intervention including a coronary stenting is recorded as two separate codes as is the case under ICD-9-CM, only one code/procedure should be reported; if a cataract surgery is recorded as two procedures (removal of the lens and insertion of the artificial lens), only one procedure should be counted. It is particularly important for correspondents to follow this proposed counting method for percutaneous coronary interventions, coronary bypasses and cataract surgery. Correspondents are invited to briefly describe in the *Sources and Methods* the counting method used.

The **common shortlist** of surgical procedures is provided in Table 1 of the document available at the link: http://stats.oecd.org/HEALTH_QUESTIONNAIRE/Surgical%20procedures/JQNMHC_MAPPING%20ICD-9-CM.pdf.

End-stage renal failure patients

End-stage renal failure patients include patients living with a **functioning kidney transplant** (the cumulative number, not only people receiving a transplant in a given year) and patients undergoing **dialysis**.

Eurostat additional data collection

Physicians by categories

The Eurostat data collection on physicians by categories is more detailed compared to the data requested in the common module. A correspondence between the two tables is provided to promote consistency of these two data collections.

Data for different categories of doctors should be provided for **practising** physicians, where possible. If data are not available according to this concept, they should be reported for professionally active physicians or physicians licensed to practise. Please clearly indicate in the *Sources and Methods* if your data refer to a concept different than “practising”.

To avoid double counting doctors with more than one specialty, the following criteria are proposed to report each doctor only once:

- 1) the predominant (main) area of practice of doctors; or
- 2) the last specialty for which they have received registration.

Health workers at regional level

The data collection on health workers at regional level should include **practising** physicians, nursing professionals (nurses and midwives), dentists, pharmacists and physiotherapists, where possible. If data are not available according to this concept, they should be reported for professionally active workers or workers licensed to practise. Please clearly indicate in the *Sources and Methods* if your data refer to a concept different than “practising”.

The health care staff should be allocated to the place (region) where the health care service is provided.

For the regional level the **Nomenclature of Units for Territorial Statistics (NUTS)**⁴ should be used for referencing the subdivisions of countries for statistical purposes. The NUTS level 2 is required for this data collection (see http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL&StrNom=NUTS_33&StrLanguageCode=EN&IntPcKey=28439933&StrLayoutCode=HIERARCHIC).

The NUTS classification was revised in 2010: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-RA-11-011/EN/KS-RA-11-011-EN.PDF. Please note that following this revision, the whole time series should be revised for Germany, Italy, Finland and the United Kingdom in order to take into account the modifications due to this revision. These four countries are invited to re-calculate back to 1993.

Hospitals at regional level

The total number of hospitals should include all types of hospitals, following the International Classification of Health Accounts 2011 (including HP1.1 General hospitals, HP1.2 Mental health hospitals, HP1.3 Other specialised hospitals). The data should cover both public and private hospitals. Any limitation in the data coverage should be clearly explained in the *Sources and Methods*.

The hospitals should be allocated to the place (region) where the health care service is provided.

Hospital beds at regional level

The data collection on hospital beds aims to collect data for all functions of care, in all types of hospitals as listed in the International Classification of Health Accounts 2011 (including HP1.1 General hospitals, HP1.2 Mental health hospitals, HP1.3 Other specialised hospitals). National correspondents are invited to note in the *Sources and Methods* any limitation in hospital coverage.

The hospital beds should be allocated to the place (region) where the health care service is provided.

Beds in nursing and residential care facilities at regional level

The data collection on beds in nursing and residential care facilities should include all types of nursing and residential care facilities as defined in the HP.2 category of the International Classification of Health Accounts 2011. National correspondents are invited to note in the *Sources and Methods* any limitation in nursing and residential care facilities coverage.

The beds in nursing and residential care facilities should be allocated to the place (region) where the health care service is provided.

⁴ See http://epp.eurostat.ec.europa.eu/portal/page/portal/nuts_nomenclature/introduction for general information.

Hospital technical resources

The data collection of hospital technical resources includes six types of resources available in hospitals. The data should cover both public and private hospitals. Any limitation in the data coverage should be clearly explained in the *Sources and Methods*.

Discharges and bed-days by diagnostic categories at regional level

The data are requested for discharges (inpatient cases and day cases) and bed-days by ICD-9, ICD-10 or ISHMT code⁵, by age group, by gender and by region.

Correspondents are encouraged to supply their regional data using the same **comma-delimited ASCII file** (.CSV) as for the national data (corresponding to the common part of the data collection). [Annex 5](#) provides all information regarding the submission of the hospital discharge data (HDD) files.

Hospital discharges of non-resident patients

Correspondents are requested to provide any data available on non-residents discharged in their country according to the requested record structure. If the assignment of NUTS 2 codes is not possible, NUTS 1 or the national level should be reported. In case the place of residence is unknown, the codes 'EU00' (for EU residents), 'EU99' (for residents outside EU) or 'UNK' (if there is no information at all) should be used.

Surgical procedures

An additional shortlist of 14 surgical procedures is requested by Eurostat only (see Table 2 at the link: http://stats.oecd.org/HEALTH_QUESTIONNAIRE/Surgical%20procedures/JQNMHC_MAPPING%20ICD-9-CM.pdf). In addition to the total number of procedures, a split between **inpatient cases** and **day cases** is requested for each type of surgical procedure.

As in the common module, correspondents are invited to follow as much as possible the proposed counting method for reporting data on the additional shortlist.

⁵ ICD: International Classification of Diseases. ISHMT: International Shortlist for Hospital Morbidity Tabulation.

ANNEX 1. APPROACHES TO OVERCOME BREAKS IN TIME SERIES

To minimise the frequency of series breaks due to measurement changes, national statistical agencies can use a number of approaches to reconstruct the series.

A first method is to estimate a conversion coefficient for the year when the break occurred by using the average growth rate for the preceding years. This method to revise the series before the break involves the following steps:

- a) Calculate the average of the annual growth rates for x years before the break in time series.
- b) Use this average growth rate to estimate a new theoretical figure for the year when the break occurred (consistent with the old series).
- c) Calculate a conversion coefficient between the actual figure and the estimate for the year when the break occurred (i.e. divide the actual figure by the estimate).
- d) Use this conversion coefficient to estimate backwards all data before the break (i.e. multiply the original data by the conversion coefficient).

Example to overcome a break in series between 2001 and 2002

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|--|--------|--------|--------|--------|--------|--------|--------|-------|-------|-------|-------|-------|-------|-------|
| Original time series | 11670 | 11880 | 12000 | 12100 | 12460 | 12830 | 13200 | 14600 | 14960 | 15820 | 16750 | 17680 | 18370 | 19100 |
| Annual growth rates | 2.0 | 1.8 | 1.0 | 0.8 | 3.0 | 3.0 | 2.9 | 10.6 | | | | | | |
| Average of growth rates over 1995-2001 | | | | | | | | 2.1 | | | | | | |
| Estimate for 2002 | | | | | | | | 13473 | | | | | | |
| Conversion coefficient | | | | | | | | 1.084 | | | | | | |
| Revised time series | 12646e | 12874e | 13004e | 13112e | 13502e | 13903e | 14304e | 14600 | 14960 | 15820 | 16750 | 17680 | 18370 | 19100 |
| Annual growth rates | 2.0 | 1.8 | 1.0 | 0.8 | 3.0 | 3.0 | 2.9 | 2.1 | | | | | | |

[Note: A slightly different option would be to calculate the average of the annual growth rates before the break and after the break (for one or more years), and then to follow the steps b to d described above.]

A second approach involves the compilation of the series using both the old and new methods for a certain period of time around the implementation of the new method, from which a concordance coefficient can be calculated. This concordance coefficient can then be used to revise the part of the series before the break.

ANNEX 2. LIST OF COMMON VARIABLES INCLUDED IN THE JOINT QUESTIONNAIRE ON NON-MONETARY HEALTH CARE STATISTICS

Health employment and education

Physicians (head counts)

Practising physicians
Professionally active physicians
Physicians licensed to practice

Physicians by age and gender

Physicians by age group and by gender

Physicians by categories

Generalist medical practitioners
- General practitioners
- Other generalist (non-specialist) medical practitioners
Specialist medical practitioners
- General paediatricians
- Obstetricians and gynaecologists
- Psychiatrists
- Medical group of specialists
- Surgical group of specialists
- Other specialists n.e.c.

Medical doctors not further defined

Midwives (head counts)

Practising midwives
Professionally active midwives
Midwives licensed to practice

Nurses (head counts)

Practising nurses
- Professional nurses, practising
- Associate professional nurses, practising
Professionally active nurses
- Professional nurses, professionally active
- Associate professional nurses, professionally active
Nurses licensed to practice
- Professional nurses, licensed to practice
- Associate professional nurses, licensed to practice

Caring personnel (personal care workers) (head counts)

Practising caring personnel (personal care workers)
Professionally active caring personnel (personal care workers)

Dentists (head counts)

Practising dentists
Professionally active dentists
Dentists licensed to practice

Pharmacists (head counts)

Practising pharmacists
Professionally active pharmacists
Pharmacists licensed to practice

Physiotherapists (head counts)

Practising physiotherapists

Hospital employment (head counts and FTE)

Total hospital employment
- Physicians employed by hospital
- Professional nurses and midwives employed by hospital
- Associate professional nurses employed by hospital
- Health care assistants employed by hospital
- Other health service providers employed by hospital
- Other staff employed by hospital

Graduates

Medical graduates
Dentists graduates
Pharmacists graduates
Midwives graduates
Nursing graduates
- Professional nursing graduates
- Associate professional nursing graduates

Physical and Technical Resources

Hospitals (HP.1)

Hospitals
- Publically owned hospitals
- Not-for-profit privately owned hospitals
- For-profit privately owned hospitals
General hospitals

Hospital beds (HP.1)

Total hospital beds
- Curative (acute) care beds
- Psychiatric care beds
- Long-term care beds (excl. psychiatric beds)
- Other hospital beds

- Beds in publically owned hospitals
- Beds in not-for-profit privately owned hospitals
- Beds in for-profit privately owned hospitals

Beds in residential long-term care facilities (HP.2)

Beds in residential long-term care facilities

Medical technology (HP.1, HP.3 and HP.1+HP.3)

Computed Tomography Scanners
Magnetic Resonance Imaging Units
Positron Emission Tomography scanners
Gamma cameras
Digital subtraction angiography units
Mammographs
Radiation therapy equipment
Lithotriptors

Health care activities

AMBULATORY CARE

Consultations

Doctor consultations (in all settings)
Dentist consultations (in all settings)
Outpatient consultations with doctors in hospital

Immunisation

Immunisation against influenza (population aged 65+)

Screening (survey and programme data)

Breast cancer screening (% of females aged 50-69)
Cervical cancer screening (% of females aged 20-69)

HOSPITAL CARE

Hospital aggregates

Inpatient care discharges (all hospitals)
Inpatient care ALOS (all hospitals)
Curative care discharges
Curative care bed-days
Curative care ALOS
Curative care occupancy rates

Hospital discharges by diagnostic categories

Inpatient cases (requested from all countries)
Day cases (requested from countries in WHO European Region)

Hospital bed-days by diagnostic categories

Hospital bed-days (inpatient cases) (requested from countries in WHO European Region)

Hospital ALOS by diagnostic categories

Hospital average length of stay (inpatient cases) (requested from OECD non-European countries)

PROCEDURES

Diagnostic exams (HP.1, HP.3 and HP.1+HP.3)

Computed Tomography (CT) exams
Magnetic Resonance Imaging (MRI) exams
Positron Emission Tomography (PET) exams

Surgical procedures (shortlist of 17 procedures + 5 subgroups)

Total
- Inpatient cases
- Day cases
- Outpatient cases (collected for 2 procedures only)

End-stage renal failure (ESRF) patients

Total
- Patients undergoing dialysis
- Functioning kidney transplants

ANNEX 3. LIST OF EUROSTAT ADDITIONAL VARIABLES INCLUDED IN THE JOINT QUESTIONNAIRE ON NON-MONETARY HEALTH CARE STATISTICS

Practising physicians by categories, of which physicians in training (head counts)

General Practitioners
 Other generalist (non-specialist) medical practitioners
 General paediatricians
 Obstetricians and gynaecologists
 Psychiatrists
 Internal medicine
 Cardiologists
 Endocrinologists
 Gastroenterologists
 Respiratory medicine
 Oncologists
 Immunologists
 Neurologists
 Oto-rhino-laryngologists
 Radiologists
 Microbiology-bacteriologists
 Haematologists
 Dermatologists
 Pathologists
 Occupational medicine
 General surgeons
 Neurological surgeons
 Plastic surgeons
 Ophthalmologists
 Orthopaedists
 Thoracic surgeons
 Vascular surgeons
 Intensive care & anaesthesiologists
 Urologists
 Accident and emergency medicine
 Other specialists n.e.c.
 Medical doctors not further defined

Health workers at regional level

Physicians
 Dentists
 Nursing professionals (nurses and midwives)
 Pharmacists
 Physiotherapists

Hospitals at regional level

Hospitals

Hospital beds at regional level

Total hospital beds
 - Curative (acute) care beds
 - Psychiatric care beds
 - Long-term care beds (excl. psychiatric beds)
 - Other hospital beds

Beds in residential long-term care facilities at regional level

Beds in residential long-term care facilities

Hospital technical resources

Operation theatres in hospital
 Day care places altogether
 Surgical day care places
 Oncological day care places
 Psychiatric day care places
 Geriatric day care places

Hospital discharges by diagnostic categories at regional level

Inpatient cases
 Day cases
 Hospital bed-days (inpatient cases)

Hospital discharges of non-residents patients

In-patient cases
 Day cases
 Hospital bed-days (inpatient cases)

Surgical procedures (additional shortlist of 14 procedures)

Total
 - Inpatient cases
 - Day cases

Note: These additional variables should be completed by the 27 EU Member States, the 4 EFTA countries (Iceland, Liechtenstein, Norway and Switzerland) and the 5 EU candidate countries (Croatia, Former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey).

ANNEX 4. LIST OF MEMBER STATES OF OECD, EUROSTAT AND WHO-EUROPE

| Country | OECD | EUROSTAT | WHO-EUROPE |
|---------------------------------------|------|----------|------------|
| Albania | | | ✓ |
| Andorra | | | ✓ |
| Armenia | | | ✓ |
| Australia | ✓ | | |
| Austria | ✓ | ✓ | ✓ |
| Azerbaijan | | | ✓ |
| Belarus | | | ✓ |
| Belgium | ✓ | ✓ | ✓ |
| Bosnia and Herzegovina | | | ✓ |
| Bulgaria | | ✓ | ✓ |
| Canada | ✓ | | |
| Chile | ✓ | | |
| Croatia | | (1) | ✓ |
| Cyprus | | ✓ | ✓ |
| Czech Republic | ✓ | ✓ | ✓ |
| Denmark | ✓ | ✓ | ✓ |
| Estonia | ✓ | ✓ | ✓ |
| Finland | ✓ | ✓ | ✓ |
| France | ✓ | ✓ | ✓ |
| Former Yugoslav Republic of Macedonia | | (1) | ✓ |
| Georgia | | | ✓ |
| Germany | ✓ | ✓ | ✓ |
| Greece | ✓ | ✓ | ✓ |
| Hungary | ✓ | ✓ | ✓ |
| Iceland | ✓ | (1) (2) | ✓ |
| Ireland | ✓ | ✓ | ✓ |
| Israel | ✓ | | ✓ |
| Italy | ✓ | ✓ | ✓ |
| Japan | ✓ | | |
| Kazakhstan | | | ✓ |
| Kyrgyzstan | | | ✓ |
| Korea | ✓ | | |
| Latvia | | ✓ | ✓ |
| Liechtenstein | | (2) | |
| Lithuania | | ✓ | ✓ |
| Luxembourg | ✓ | ✓ | ✓ |
| Malta | | ✓ | ✓ |
| Mexico | ✓ | | |
| Monaco | | | ✓ |
| Montenegro | | (1) | ✓ |
| Netherlands | ✓ | ✓ | ✓ |
| New Zealand | ✓ | | |
| Norway | ✓ | (2) | ✓ |
| Poland | ✓ | ✓ | ✓ |
| Portugal | ✓ | ✓ | ✓ |
| Republic of Moldova | | | ✓ |
| Romania | | ✓ | ✓ |
| Russian Federation | | | ✓ |
| San Marino | | | ✓ |
| Serbia | | (1) | ✓ |
| Slovak Republic | ✓ | ✓ | ✓ |
| Slovenia | ✓ | ✓ | ✓ |
| Spain | ✓ | ✓ | ✓ |
| Sweden | ✓ | ✓ | ✓ |
| Switzerland | ✓ | (2) | ✓ |
| Tajikistan | | | ✓ |
| Turkey | ✓ | (1) | ✓ |
| Turkmenistan | | | ✓ |
| Ukraine | | | ✓ |
| United Kingdom | ✓ | ✓ | ✓ |
| United States | ✓ | | |
| Uzbekistan | | | ✓ |

1) EU candidate countries covered in the Eurostat data collection. 2) EFTA countries covered in the Eurostat data collection.

ANNEX 5. SPECIFICATIONS AND STANDARD DATA FORMAT FOR SUBMISSION OF NATIONAL HOSPITAL DISCHARGE DATA (HDD)

This annex concerns only countries in the WHO European Region (EU members or candidates, EFTA countries, Israel, and others). Table 5 below (p.27) displays the complete list of countries involved in the preparation of Hospital Discharge Data (HDD) files.

Data coverage and definition

Data should include discharges from all public and private hospitals (HP.1 according to the International Classification of Health Accounts) during a given calendar year. Data from residential long-term care facilities (HP.2) should not be included.

Whenever possible, data should be provided for both inpatient cases and day cases. If hospital discharge records do not include the special identification of day cases, any record showing that admission and discharge dates were identical, and that the patient was alive when discharged, should be assigned to the day case category.

Data should include discharges to home and to other inpatient institutions, and deaths in hospital.

Countries using hospital treatment episodes as individual record units (i.e. when patients are transferred among departments in the same hospital, each transfer is recorded as a new admission/discharge) should make an effort to merge related episodes into one discharge record in order to make the data internationally comparable.

It is recommended that the main diagnosis be defined as the condition diagnosed at the end of the hospitalisation period, primarily responsible for the patient's need for treatment or examination at the hospital. If there is more than one such condition, the one held responsible for the greatest use of resources should be selected. If no diagnosis was made, the main symptom, abnormal finding or problem should be selected as the main diagnosis.

Data files

The hospital discharge data (HDD) file should contain the number of annual inpatient discharges, bed-days and day case discharges by main diagnosis or external cause of hospitalisation, by age and sex⁶.

The HDD file should be a **comma-delimited ASCII file (.CSV)**. If preferred by data provider, the data can be submitted also as Excel or as a simple ASCII text file with the fixed field length of variables according to the record lay-out (see Table 1).

The file name should be constructed as follows: **HDD_CountryCode_Year.csv**. A 2-character ISO 3166 country code (see Table 5) should be used, e.g. a data file from Austria with data for 2011 will be named HDD_AT_2011.csv.

Each record in this data file should contain data on one diagnosis for one gender by defined age groups. The total length of the record depends on the age grouping used. Normally, 23 age groups should be used (option 1, see Table 2) and in this case the total number of variables per record is 75. In case of four age groups, or if no age disaggregation is used, there should be respectively 18 or 9 variables per record.

⁶ Eurostat also requires these data by region (NUTS 2 level).

Table 2. Options for age groupings

| Age group No (n=) | Option 1 (Age=1) | Option 2 (Age=2) | Option 3 (Age=3) | Option 4 (Age=4) |
|-------------------|------------------|------------------|------------------|------------------|
| 0 | All ages | All ages | All ages | All ages |
| 1 | < 1 year | 0-14 years | | < 1 year |
| 2 | 1-4 | 15-64 | | 1-4 |
| 3 | 5-9 | 65+ | | 5-9 |
| 4 | 10-14 | | | 10-14 |
| 5 | 15-19 | | | 15-19 |
| 6 | 20-24 | | | 20-24 |
| 7 | 25-29 | | | 25-29 |
| 8 | 30-34 | | | 30-34 |
| 9 | 35-39 | | | 35-39 |
| 10 | 40-44 | | | 40-44 |
| 11 | 45-49 | | | 45-49 |
| 12 | 50-54 | | | 50-54 |
| 13 | 55-59 | | | 55-59 |
| 14 | 60-64 | | | 60-64 |
| 15 | 65-69 | | | 65-69 |
| 16 | 70-74 | | | 70-74 |
| 17 | 75-79 | | | 75-79 |
| 18 | 80-84 | | | 80-84 |
| 19 | 85-89 | | | 85+ |
| 20 | 90-94 | | | Age unknown |
| 21 | 95+ | | | |
| 22 | Age unknown | | | |

Table 3. Code table for gender

| Gender | Code |
|----------------------|------|
| Male | 1 |
| Female | 2 |
| Unknown/not recorded | 0 |

Note: Normally, all hospital discharge records should have valid gender codes. In cases where gender has not been recorded, the additional record with the gender code = 0 may be generated to ensure that all discharges are included in the total after adding figures for male, female and unknown gender.

5. ICD version: Indicates which version of the International Classification of Diseases is used to code the diagnosis (see Table 4).

6. Diagnosis:

- Where ICD-10 is used, three-character codes are sufficient.
- In the case of ICD-9, four-character codes are preferable. Do not use a dot to separate the fourth character in the code. For external causes (Supplementary Classification of External Causes), use prefix E. For example, if ICD-9 3-character codes are used, a motor vehicle traffic accident involving collision with a pedestrian should be coded as E814.
- The four-character codes of the International Shortlist for Hospital Morbidity Tabulation (ISHMT) can also be used.

In the case of fixed record length, codes should be aligned to the left.

The HDD file should include an additional record for each gender containing the total of all discharges with the diagnosis code ‘TOT’. Hospitalisations due to external causes will contribute twice: once with the code of the injury (Chapter 17 of ICD-9 or Chapter 19 of ICD-10), and once with the code corresponding to external causes (Supplementary Classification of External Causes with prefix ‘E’ of ICD-9 or Chapter 20 of ICD-10). Care should be taken not to count such cases twice in the summary record with code ‘TOT’. If external causes are not recorded, corresponding records will not appear in the HDD file.

Table 4. Code table for ICD version used to code main diagnosis

| Code | Classification system |
|------|---|
| 093 | ICD-9 3-character list |
| 094 | ICD-9 4-character list |
| 103 | ICD-10 3-character list (most preferable) |
| 104 | ICD-10 4-character list |
| HMT | International Shortlist for Hospital Morbidity Tabulation (ISHMT) * |

* Can be downloaded from:

<http://www.who.int/classifications/icd/implementation/morbidity/ishmt/en/index.html>.

ISHMT was adopted at the meeting of WHO Collaborating Centres for the Family of International Classifications (WHO-FIC), Tokyo, Japan, 16-22 October 2005. It contains 149 groups of diagnoses including the total. It originates from the list developed under the Hospital Data Project (funded by DG Sanco of European Commission).

Note: It is highly preferable that the original **3-character ICD-10 codes** be used whenever possible, as this will allow for much more flexibility in subsequent data analyses. When the original ICD codes are aggregated into a short list, analysis of the data by detailed individual ICD codes (diagnoses) becomes impossible.

Aggregation of the ICD codes into shorter tabulation lists can be done by international agencies depending on needs and data dissemination practices.

7+3n. Discharges: The total number of inpatient discharges (excluding day cases) with the above diagnosis for a given gender and age group. The total figure for all ages is included in position 7, age below 1 year in position 10, age group 1-4 years in position 13, etc. See Table 2 for **n** value corresponding to each age group.

8+3n. Bed-days: The total number of bed-days used by inpatients (excluding day cases) with the above diagnosis for given gender and age group. The total figure for all ages is included in position 8, age below 1 year in position 11, age group 1-4 years in position 14, etc.

9+3n. Day cases: The total number of day case discharges with the above diagnosis for a given gender and age group. The total figure for all ages is included in position 9, age below 1 year in position 12, age group 1-4 years in position 15, etc.

Table 5. Two-character country codes for countries in the WHO European Region

| | | | | | |
|----|------------------------|----|---------------------|----|--------------------|
| AL | Albania | GE | Georgia | MT | Malta |
| AD | Andorra | GR | Greece | NL | Netherlands |
| AM | Armenia | HR | Croatia | NO | Norway |
| AT | Austria | HU | Hungary | PL | Poland |
| AZ | Azerbaijan | IE | Ireland | PT | Portugal |
| BE | Belgium | IL | Israel | RO | Romania |
| BG | Bulgaria | IS | Iceland | RU | Russian Federation |
| BA | Bosnia and Herzegovina | IT | Italy | SE | Sweden |
| BY | Belarus | KZ | Kazakhstan | SI | Slovenia |
| CH | Switzerland | KG | Kyrgyzstan | RS | Serbia |
| CZ | Czech Republic | LI | Liechtenstein | SK | Slovakia |
| CY | Cyprus | LT | Lithuania | SM | San Marino |
| DE | Germany | LU | Luxembourg | TJ | Tajikistan |
| DK | Denmark | LV | Latvia | TM | Turkmenistan |
| EE | Estonia | MC | Monaco | TR | Turkey |
| ES | Spain | ME | Montenegro | UA | Ukraine |
| FI | Finland | MD | Republic of Moldova | UK | United Kingdom |
| FR | France | MK | FYR of Macedonia | UZ | Uzbekistan |

Source: ISO 3166 (except UK).

Metadata

The data should be accompanied by the “metadata”, i.e. the description of national sources, methods, definitions, degree of data completeness and coverage, and explanations of any peculiarities in national statistical and coding practices, etc. (see Table 6 for recommended content). The metadata should be entered in the common Word file (CCC_Health activities_Year.doc).

Table 6. Recommended content of metadata related to the sources and methods of hospital discharge data

| |
|---|
| 1) List the type, name, location and owner or operator of the national hospital patient registers or discharge database(s) (NHDDB), which were used to produce the HDD file. |
| 2) Does the NHDDB cover all inpatient institutions in the country, which are classifiable as HP.1 providers according to the “System of Health Accounts”? List types of hospitals, which are covered and not covered, e.g. private hospitals, military or prison hospitals, etc., and, if possible, estimate their total capacity as compared to those that are covered by the NHDDB. |
| 3) Does the NHDDB include all inpatient discharges and day cases in hospitals covered? List cases, which may not be included in the NHDDB (e.g. uninsured patients, foreigners, military staff, etc). If possible, estimate the proportion of missing discharge records. |
| 4) If the discharge records were based on treatment episodes (consultant episodes, department discharges), have such multi-episode cases been combined into one discharge record? If possible, estimate the proportion of multi-episode in-patient cases. |
| 5) If the HDD file includes day cases, how were they defined? Was there a special index flagging planned day cases in the NHDDB or were they identified by the same admission and discharge dates? |
| 6) Describe any other known or suspected peculiarities in the coverage of the data. |
| 7) Explain principles involved in defining the main diagnosis (condition) in the hospital discharge record. |
| 8) Describe any known or suspected peculiarities related to the national diagnostic and recording practices and related to how the main condition is selected. |

User instructions for HDD_Converter (a computer programme for the conversion of individual records into an aggregated HDD file)

Purpose

The programme HDD_Converter has been built to help countries aggregate individual hospital discharge records into standard tabular format for further submission to international organisations, thus avoiding the burden of developing the same computer programme in each country.

The HDD_converter.exe programme is available upon request via email from HIUData@euro.who.int.

Input data file

Data in hospital discharge databases in different countries may be stored in different ways. Therefore, the standard minimum set of variables has first to be retrieved from these databases and saved as a temporary data file. This temporary file then is used by the HDD_converter programme as an input for further aggregation of data into the standard format.

When pooling together hospital discharge records into a temporary file make sure that:

- they include available discharge records from all hospitals in the country during the reference year;
- discharge records are only from hospitals that are classified as HP.1, according to the International Classification of Health Accounts (i.e. general hospitals and specialised hospitals, including mental health hospitals);
- if individual records correspond to treatment episodes in different departments, these records are merged into one discharge record, if possible.

(See also "[Data coverage and definitions](#)" for further details.)

Variables in the temporary input file record must appear in the following sequence and should be separated by commas:

- 1) Year of discharge, e.g. 2011 (Integer).
- 2) Age of discharged patient at the moment of admission, in full years, e.g. 50 (Integer).
- 3) Gender code: 1-male; 2-female (Integer).
- 4) Main diagnosis ICD code, e.g. for diagnosis "Atherosclerosis" it should be **I70** if ICD-10 is used or **440** in case of 3-character ICD-9 codes (Character).
- 5) External cause code, if hospitalisation was due to accident or other external cause and this cause was recorded (Character). If such a code is missing or not applicable leave it blank or, preferably, enter missing data code "-1".
- 6) Day case index: 1 - if the patient was admitted with the intention of discharging him/her on the same day, and if the patient was actually discharged on the same day; 0 - in all other cases (Integer).
- 7) Length of stay in a hospital in full days (Integer). If the day case index = 1, length of stay should be = 0.

Example of records in temporary input file:

```
2011,50,1,I70,-1,0,5
2011,33,2,L02,-1,1,0
2011,20,1,S01,V43,1,0
.....
```

All of the above variables have to be created and their values calculated during the data retrieval from national hospital discharge databases, e.g. age = admission date minus birth date; valid values between 0-120 years, etc.

If data are missing for some variables, leave them blank or enter missing value code “-1”.

Retrieve the above variables for all discharge records for the required year(s) and save them in .CSV (comma separated value) format under the name **HDDinput.csv**.

How to use the HDD_converter:

Make sure that the above input data file HDDinput.csv and HDD_converter.exe are in the same directory.

- Start HDD_converter.exe.
- Enter the required parameters in the dialogue box or select from the list:
 - the 2-character country code;
 - the data reference year;
 - the ICD codes used (103 is default);
- Click on “proceed”.

The programme reads all the individual discharge records from the HDDinput.csv file and aggregates them into the standard format in accordance with specifications. It also counts missing values and displays summary information on how many records with missing or incorrect data values were found. The summary information will be saved in the file HDD_LOG_country code_year.txt.

Click on “exit” to close the programme. The resulting file **HDD_country code_year.csv** will be created and saved in the same directory.

Contact

For assistance in case of problems or queries, please contact:
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