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(25-29 October 1976)

INDEXED



REPORT

of the second joint meeting held in Geneva, 25-29 October 1976

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I INTRODUCTION

1. The second Meeting on Health Statistics was held in Geneva from 25 to 29 October 1976 under the joint auspices of the Regional Office for Europe of the World Health Organization and the Conference of European Statisticians. The Meeting was attended by participants from Algeria; Austria; Belgium; Canada; France; Germany, Federal Republic of; Hungary; Ireland; Italy; Luxembourg; Netherlands; Norway; Portugal; Spain; Sweden; Switzerland; Turkey; USSR; United Kingdom; United States and Yugoslavia. The following specialized agency was represented: International Labour Organisation. Representatives of the European Economic Community also attended. Also present at the invitation of the secretariat were staff officials of the Organization for Economic Co-operation and Development.
2. The provisional agenda (CES/AC.36/8; EURO/ICP/DHS 003/1), was adopted, on the understanding that item 4 (development of economic accounts for health services within the systems of national accounts and balances) would be discussed after item 8 (methods of collecting more comprehensive and reliable data on morbidity).
3. Professor R. Beckers (Belgium) was elected chairman and Dr. G. Cerkovnyj (USSR) was elected vice-chairman.
4. The Meeting had before it the following documents:
 - (a) a working paper on content of statistics and users' needs, by Dr. A.S. Hårø, (temporary adviser to WHO) (CES/AC.36/9; EURO/ICP/DHS 003/2);
 - (b) a note on the health subsystem of the System of Social and Demographic Statistics (SSDS) and its links with other subsystems by the ECE secretariat (including extracts of the relevant parts of the latest version of the SSDS) (CES/AC.36/10; EURO/ICP/DHS 003/7);
 - (c) a paper on social indicators in the field of health, by Dr. A.A. Weber, WHO, (CES/AC.36/11; EURO/ICP/DHS 003/4);
 - (d) a working paper on various aspects of the integration of health statistics with social, economic and demographic statistics, by Dr. P. Gilliland (temporary adviser to WHO) (CES/AC.36/12; EURO/ICP/DHS 003/5);
 - (e) a working paper on measuring morbidity, by Professor W.W. Holland, (temporary adviser to WHO) (CES/AC.36/13; EURO/ICP/DHS 003/3);
 - (f) a working paper on the development of health accounts within the system of national accounts, by J.T.P. Bonte, (temporary adviser to WHO) and H.W.J. Donkers (CES/AC.36/14; EURO/ICP/DHS 003/6);
 - (g) a working paper on problems which arise in the establishment of a health classification suitable for use as a common classification in the SSDS, by Dr. A. Vessereau, WHO (CES/AC.36/15; EURO/ICP/DHS 003/8);
 - (h) a document reproducing the latest version of the United Nations draft guidelines on social indicators, submitted by the ECE secretariat (CES/AC.36/16; EURO/ICP/DHS 003/9);

- (i) extracts from the latest version of the draft International Standard Classification of all Goods and Services (ICGS), submitted by the ECE secretariat (CES/AC.36/17; EURO/ICP/DHS 003/10);

In addition the following background papers were tabled:

- (a) Recommendations and Statements of WHO Expert Groups in relation to Health Statistics (WHO/HS/NAT.COM/75.345);
- (b) Classification of impairments and handicaps (WHO/ICD.9/REV.CONF/75.17).

II INTEGRATION OF HEALTH STATISTICS WITH OTHER SOCIAL AND DEMOGRAPHIC STATISTICS

5. The Meeting considered this subject on the basis of the papers by Dr. Härö (CES/AC.36/9; EURO/ICP/DHS 03/2) and Dr. Gilliland (CES/AC.36/12; EURO/ICP/DHS 03/5) and the relevant parts of Towards a System of Social and Demographic Statistics 1/ (reproduced in CES/AC.36/10; EURO/ICP/DHS 003/7).
6. The Meeting was informed of the evolution of work on a system of social and demographic statistics (SSDS) since the publication by the United Nations of Towards an SSDS in 1974. It noted in particular that the Statistical Commission had approved the publication of this report as a technical or methodological study, and not as an outline of international guidelines on an integrated system of statistics for national and international application.
7. Towards an SSDS had stimulated a great deal of national and international discussion and study of suitable approaches to the collection and analysis of integrated social and demographic statistics, of social indicators, and of problems in harmonizing social, demographic and related economic concepts, definitions and classifications. The Meeting agreed that as concerns health statistics, much further work is needed in all these areas before a suitable general structure for the integrated development of health statistics as a whole can be agreed on. In this regard the Meeting agreed that further work on selected problems of harmonizing classifications and definitions within the field of health statistics and with related elements of other social, demographic and economic statistics, deserves high priority. In addition country experiments to achieve greater integration would also be useful in testing practical possibilities and addressing concrete problems of collection, compilation, harmonization and analysis. These should be pursued at national, regional and local levels. Criteria of eventual usefulness of the statistics collected to policy-makers, programme and policy managers, administrators and analysts should be paramount in evaluating the results of these studies.
8. The Meeting agreed to discuss detailed questions concerning series and classifications in the health field under the agenda item relating to social indicators of health.

1/ United Nations publication, Sales No. E.74.XVII.8.

9. It was recognized that any information system should serve a defined purpose. This topic was elaborated in Dr. Härö's paper which deals with the contents of the information system from the point of view of health planners and administrators. The paper described the decision-making process and stresses the role of the information system in providing management with relevant information. The Meeting agreed that there is a need for a closer dialogue between users and providers of information. It was pointed out, however, that the information requirements of managers are often not well defined. It is therefore desirable that statisticians be given the opportunity to participate in the discussion on policy-making from an early stage so that they are in a better position to assess the kinds of information needed to support the decision-making process and to contribute to the analyses needed for interpretation of this information.
10. Several participants discussed the role and tasks of the two main groups of sources of information: governmental statistical services; and research institutes, departments of universities or other bodies. It was pointed out that the two sources should complement each other, but it was recognized that their possibilities are different. It was therefore suggested that while governmental statistical services should be responsible for the generation of background information on a routine basis, research institutes or departments of universities could usefully participate in work on methodological problems and the collection of information by conducting special ad hoc field surveys and studies. Several participants gave examples of this approach by referring to their national experience and pointing to the co-ordinating role of bodies such as central statistical offices in their countries in the collection and compilation of health statistics. In this connexion the importance of standardized concepts, definitions and classifications which enable data derived from different sources to be correlated was emphasized.
11. The discussion indicated that in recent years a growing number of countries in the ECE region have started to use household surveys to collect data on the health conditions of the population and, in some cases, on the costs of health care of different groups of the population. In some countries the data are collected by means of multi-purpose surveys, in others by means of specialized surveys and in at least one country by means of both types of survey. A number of participants described the types of data collected in the surveys carried out by their countries and plans for further development. In many countries response rates for well-planned and carefully tested health surveys have been high. However, it must be recognized that there are some topics such as mental illness, venereal disease and consumption of alcohol on which it is particularly difficult to collect reliable data from households, and which may tend to lower overall response if they are included.
12. There was general agreement that household surveys are a most promising approach to the integration of data on a variety of social and demographic factors, such as income, housing conditions, occupation, working conditions and environmental conditions, which influence the health conditions of the population, and that further efforts should be made to develop this approach to the integration of health statistics with other social and demographic statistics. It was felt that the use of data from household surveys for the analysis of these interrelationships may give better results than efforts to include variables from other sub-systems, such as occupation, marital status and level of education, in routine health statistics because medical personnel are often not able to collect sufficiently reliable data on these variables. However, the discussion indicated that some countries are

planning to harmonize, as far as possible, the concepts, definitions and classifications used in household surveys and in routine health statistics with a view to making joint use of the data. One participant stated that in his country every enterprise has a physician who knows the occupations of the workers and that this information could be used in analyses of medical records. Another participant reported on plans to link data on causes of death with occupational data from the population census for use in medical research.

13. Attention was drawn to the demand from legislators, health planners and administrators for the client-group approach proposed in Sir Claus Moser's paper on the potential uses and usefulness of the SSDS. ^{1/} It was pointed out, for example, that health services for the elderly are so closely intertwined with welfare services and income maintenance that they have to be considered in conjunction with one another. Multi-purpose household surveys are an effective means of compiling the data needed for analysing the situation and problems of particular groups of the population. The Meeting noted that the paper on a strategy for further work on an SSDS includes proposals for developing this approach, and the Working Party on a System of Social and Demographic Statistics of the Conference of European Statisticians also plans to study it.

14. Support was expressed for the proposal in Dr. Gilliland's paper that pilot studies of very definite scope be undertaken at a regional level to encourage efforts to integrate statistics in different fields by demonstrating the practical usefulness of integrated statistics for decision-making at the regional level. Regional data are important for many types of health statistics and the costs of regional pilot studies may be less than those at the national level. The Meeting suggested that some discussion of this approach to testing the usefulness of the SSDS be included in the final version of the paper on a strategy for further work on an SSDS.

III A HEALTH CLASSIFICATION SUITABLE FOR USE AS A COMMON CLASSIFICATION IN THE SSDS

15. For the discussion of this item, the participants had before them a paper by Dr. A. Vessereau describing the problems raised by the establishment of a health classification suitable for use as a common classification in the SSDS (CES/AC.36/36/15; EURO/ICP/DHS 003/8). The paper drew attention to the options and constraints which condition the structure and content of such a classification. In particular, it is not only necessary to specify the health aspect (states of health, diseases, treatments, handicaps) which would be covered by the classification, but also to consider the use which would be made of it, who would be the users, what would be the sources of information and the conditions for collecting it. Moreover, as in any classification, it is necessary that the facts or events to be classified should correspond to criteria and definitions which are as objective and unambiguous as possible.

^{1/} Document ST/ESA/STAT.75 of the United Nations Statistical Office.

16. It was pointed out that the Working Party on a System of Social and Demographic Statistics of the Conference of European Statisticians, having again discussed the question at its fifth session in May 1975, hoped that a common classification in the SSDS would be prepared as soon as possible, to meet urgent requests. It would therefore be necessary to have very simplified classifications available in a short time, which would cover the needs of the SSDS and make it possible to provide guidelines for national health policies. However, the Meeting noted that there may be difficulty in resolving the contradiction between the need for a classification that is sufficiently detailed to play a useful role, and one that is sufficiently abridged to be easily used in connexion with the other sub-systems of the SSDS.
17. The Meeting devoted particular attention to the question of incapacitated persons. It took note of the draft classification of impairments and handicaps which had been submitted to the International Conference for the Ninth Revision of the International Classification of Diseases in September 1975. ^{1/} Although that draft classification had been accepted by the Conference only for use on a trial basis, it had been considered a very useful working document for following up studies on the common classifications of the SSDS. The Meeting noted with interest that experiments would be carried out in several countries in 1977.
18. However, serious doubts were expressed about the possibility of drawing up a classification of disabilities at the present time, so long as the problems of nomenclature had not been solved and a minimum agreement had not been reached on the definitions; it was also emphasized that in the present situation any classification of disabilities would meet with considerable obstacles because of differences in the social and legal institutions of different countries. Doubts were also expressed regarding the feasibility of implementing the WHO classification of impairments and handicaps.
19. The Meeting considered that, even if it would be difficult to carry out the recommendations quickly in a general way, that ought not to delay progress towards an objective which remains urgent. It was urged that further research activities should be carried out, with increased resources, in order to overcome the difficulties which had been referred to and permit real progress to be made in taking account of information on states of health within the framework of the SSDS.
20. To this end, it is necessary to strengthen the collaboration already established between all the bodies particularly concerned. It may be necessary to confine initially this work to countries in the WHO European region and the ECE region.
21. It was also stressed that all future activity should be carried out on the basis of a dialogue between users and suppliers of information.

^{1/} WHO/ICD9/REV.CONF/75.15, to be published by WHO in 1977.

IV SOCIAL INDICATORS IN THE FIELD OF HEALTH

22. For its discussions under this item the Meeting had before it a paper reproducing the latest version of the Draft Guidelines on Social Indicators prepared by the United Nations Statistical Office (CES/AC.36/16; EURO/ICP/DHS 003/9) and a paper by Dr. A.A. Weber, WHO, containing a summary and analysis of comments by national health administrations on an earlier version of the draft United Nations guidelines, and additional information available to the WHO Regional Office for Europe.

23. The Meeting was informed of the progress achieved thus far in the development of the draft international guidelines on social indicators and of the source and purpose of the draft guidelines. It noted that the document set forth rather general principles which would be useful to national and international statistical authorities and others with broad interests in planning and policy-making in the various social fields in the selection and compilation of indicators. The relevance, validity, accuracy and timeliness of such indicators would of course be dependent on the quality and scope of the underlying data. The series and classifications for selecting indicators shown in the annexes to the guidelines were for illustrative purposes only; to the extent possible, these were based on and consistent with the relevant international standards relating to concepts, definitions and classifications. The series and classifications should not be viewed as recommendations for statistics to be collected or indicators which should be compiled at national or international levels. Nor would they highlight the major differences currently found among countries of sources, methods and standards in compiling social and demographic statistics.

24. The Meeting noted, however, that substantial progress is being made toward improving international comparability in a few areas of health statistics in European countries, and that much more progress toward comparability now seems possible as health statistics collected in household surveys become more widely available.

25. The Meeting agreed that the approach to social indicators set out in the draft guidelines, at this stage of the development of health statistics in most of the countries represented, is a pragmatic and useful one, but emphasized that the illustrative series and indicators should nonetheless represent the best thinking of health statisticians as to useful concepts, definitions and classifications which might be used in compiling them. It was also agreed that reservations as to the possibility of compilation of some of the series and classifications shown by only a few countries should be clearly indicated in the corresponding part of the text. It should also be noted that their usefulness and interpretation might vary considerably from country to country. The Meeting also stressed the importance of concerted co-ordination among all concerned international organizations on the subject of social indicators.

26. In reviewing in detail the scope, content and definitions of the illustrative series, classifications and indicators in the health field, the following comments and suggestions were made:

- (a) There is a need for uniform definitions of several terms such as "person at risk" used as the denominator in several of the indicators shown.

- (b) Some of the classifications shown in the illustrative series of social indicators, e.g. social economic classes, urban/rural areas may present difficulties:
- (i) A suitable distinction between urban and rural populations is not always possible, as data are usually aggregated by administrative divisions which may include both urban and rural areas.
 - (ii) Owing to large migration flows and the fact that adequate information in receiving countries on such items as past vaccinations and past disability of migrants is often lacking, it may be difficult to present indicators by nationality.
- (c) In addition to the indicators of state of health, of availability and use of health services and of the performance of health services, there is need for indicators to show the relationships between different series, e.g. indicators on the use (and non-use) of services in relation to state of health or indicators comparing the performance and use of health services.
- (d) The following types of indicators are often used for the management and evaluation of health services and may be added to the illustrative series:
- (i) Indicators based on biometric and physiological characteristics of the population;
 - (ii) Indicators of risk factors including smoking;
 - (iii) Indicators of mortality, morbidity and disability from road traffic accidents; and
 - (iv) Indicators of congenital malformation, mortality and morbidity.

It was also noted that indicators on population satisfaction with regard to health services and programmes, particularly concerning access to them, could also be useful.

Indicators of handicaps, disabilities and activity limitations are considered extremely important. However, the presentation of information by type of disability and by cause of disability is difficult and requires further study.

27. The Meeting suggested that an international reference service could be developed on health indicators currently used in order to assist countries in the selection and utilization of adequate indicators and to assist in the assessment of their usefulness and validity.

V THE CLASSIFICATION OF HEALTH SERVICES IN THE INTERNATIONAL STANDARD CLASSIFICATION OF ALL GOODS AND SERVICES (ICGS)

28. The Meeting considered this item on the basis of an extract from the third draft of the ICGS (E/CN.3/493) comprising the part relating to medical, dental and other health services that had been circulated with a covering note with the reference symbols CES/AC.36/17 and EURO/ICF/DHS 003/10. A limited distribution of the introductory text of document E/CN.3/493 had also been made in English only.

29. The meeting noted that the ICCS is a classification of all goods and services according to the industries of which they are the characteristic products that is linked to the International Standard Industrial Classification (ISIC). It is based on the criteria of production processes and technologies, materials employed, stage of fabrication, purpose to which the goods or services are to be put, types of markets in which they are to be sold and the way in which production is organized. The classification is designed for such purposes as analysis of production and consumption, supply and demand analysis, commodity-flow analysis and input-output analysis.

30. A number of participants pointed out that in various important respects the classification does not reflect the ways in which health services are delivered in their countries, notably the breakdowns at the 8-digit level of specialized hospital services and of other specialized medical and surgical services. For example, various services provided by hospitals such as laboratory and radiological services cannot be broken down by type of disease, surgical services provided by hospitals to cancer patients cannot be distinguished from other therapeutic services provided to these patients, and services provided to elderly persons who are in hospital for multiple reasons cannot be broken down as proposed. It was also pointed out that dental services are treated differently from medical services, e.g. services in the field of oral surgery and auxiliary services provided by hospitals are classified under dental services and auxiliary services, respectively, rather than under hospital services. Some participants stated that it would be very difficult, if not impossible, for their countries to compile data in accordance with the proposed classification. The view was also expressed by several participants that the classification is unduly detailed for use in economic analysis and not sufficiently detailed for use by health specialists.

31. The following specific suggestions were made in the course of the discussion:

- (a) Drugs and medicines (ICCS Class 3522) should distinguish between preparations for veterinary use and those for human use;
- (b) Psychiatric and neurological services should be distinguished as separate headings; and
- (c) Separate headings should be added for services in the fields of
(i) gerontology and (ii) rehabilitation and physical medicine, in view of the growing importance of these services in the countries represented.

32. Several participants pointed out that the proposed classification could not be used for analysing the costs of different types of illnesses. Moreover, it did not seem to be desirable, except for experimental purposes, that this criterion should be retained in the classification of health goods and services because of the difficulties in most countries of gathering the statistics required for this purpose.

33. Attention was also drawn to the need for ensuring compatibility between the classification of health services in the ICCS and the draft classification of prophylactic, diagnostic and therapeutic procedures in medicine that was examined by the International Conference for the Ninth Revision of the ICD and will be published in 1977 by WHO for use on a trial basis.

34. The Meeting recommended that the classification of health goods and services in the ICGS be re-examined by WHO and the United Nations Statistical Office in the light of the discussion before the final version of the ICGS is published.

VI METHODS OF COLLECTING MORE COMPREHENSIVE AND RELIABLE DATA ON MORBIDITY

35. The Meeting considered this subject on the basis of a paper on measuring morbidity by Professor W. Holland, temporary adviser to WHO (CES/AC.36/13; EURO/ICP/DHS 003/3).

36. In introducing his paper the author stressed the importance of knowing what morbidity indicators are to be used for. There are five main sources of morbidity information:

- (1) Notification data, e.g. infectious disease, congenital anomalies, occupational accidents;
- (2) Registers - which can be divided into (a) continuing - e.g. cancer; (b) - to solve a particular problem, e.g. care of patients with a stroke;
- (3) In-patient hospital data;
- (4) Out-patient, ambulatory, including primary care data;
- (5) Social security.

37. For morbidity information to be useful it must be flexible and adaptable. The difficulty with much of the routinely collected data is that it is very inflexible and rigid. Also there are problems of reliability and delay in analysis.

38. The major direction of change should be to collect data in relation to prevention, care and cure. One must, however, remember that only a small proportion of perceived symptoms lead to contact with medical care services and that perception of symptoms is dependent on both environmental and personal psychological factors. Therefore data recorded on the basis of utilization are insufficient for the measurement of morbidity.

39. In the discussion various participants raised the question of what is meant by morbidity. Some participants considered that morbidity is not equivalent to the presence of a disease but is the presence of symptoms which could sometimes be equated to presence of underlying pathology. In the future therefore a classification based on perhaps 10-20 symptom groups was suggested. In this connexion the hope was expressed that these would be compatible with the recommendations of WHO in this area.

40. Several participants mentioned the use of data derived from fee-for-service systems in collecting morbidity information. Many also emphasized the difficulty in the boundaries between care/cure and prevention axes of classification.

41. Several participants felt that feedback of information to the providers of the information would improve their accuracy. Others felt that that was not enough and that incentives are necessary, as for instance the dependence of resource allocation on accurate statistics.

42. The problem of confidentiality in morbidity reporting was raised. It was noted that a small EEC Working Party is preparing a document on this as customs varied between countries.

43. Some participants emphasized the need for speedy notification of outbreaks of communicable illness because of the measures that would be taken. It was pointed out that in morbidity surveys one is not putting on diagnostic labels but is measuring the perceived problems, how they affect life style, and thereby perhaps the severity. This could lead to appropriate resource allocation. In this connexion several participants also raised the problem of the "heavy" user of resources, and the need to identify the characteristics of these groups. It was suggested that data from household interview surveys could usefully be combined with data from medical records to improve the reliability of health surveys, but it was pointed out, on the other hand, that some studies have shown that medical records are often incomplete.

44. Several participants considered that the paper was too pessimistic about the usefulness of routinely collected data; that it exaggerated some of these problems. It was recognized, however, that unless managers were trained in the interpretation and use of data and understood their limitations, little advance was possible.

45. In conclusion, the need to agree on useful systems of classification of morbidity data was generally accepted.

III DEVELOPMENT OF ECONOMIC ACCOUNTS FOR HEALTH SERVICES WITHIN THE SYSTEMS OF NATIONAL ACCOUNTS AND BALANCES

46. For its discussion of this item the Meeting had before it a paper prepared by Mr. Bonte, temporary adviser to WHO and Mr. Donkers (CES/AC.36/14; EURO/ICP/DHS 003/6). The paper described the development of a system of health accounts within the framework of both the System of National Accounts (SNA) and the System of Social and Demographic Statistics (SSDS), as at present being developed in the Netherlands.

47. It was noted that the establishment of health accounts within the national accounting framework is the approach used in countries where health accounts have been or are being developed. There are differences between countries, however, in the ways in which this approach is applied, which result from differences in health care delivery systems, availability of data and views regarding the priorities to be given to the development of the various parts of the system.

48. The Meeting considered that input-output tables as proposed in the paper could make a substantial contribution to the development of economic accounts for health services, and that a satellite system of the central national accounts system should respect the definitions in SNA and SSDS.

49. With regard to the scope of "health" to be covered in the accounts, the Meeting considered that such areas as health research, education of medical personnel, health administration and medical services of enterprises for their employees should be included but shown separately, so as to permit the elimination of double-counting with other categories of the accounting system, and within the accounting system as a whole.

50. In connexion with the tabular presentation of the cost of health care by kind of activity and by purpose given in the document, the Meeting considered the kind of purpose classification or classifications needed for health accounts. The multi-dimensional aspects of this question were illustrated by the information on national practices reported by several participants which showed that, in addition to a classification for the population as a whole, breakdowns by socio-economic groups, categories of diseases, etc. were also considered necessary.
51. The problems encountered appeared to be similar in most countries. From assumptions based on diagnostic data for hospital in-patients and/or data on hospital charges, results were likely to be obtained sooner for in-patient care than for out-patient care.
52. It was stressed that the purpose classifications should take account both of classifications of transactions and of transactors. It was noted that on this point the Meeting on Public Sector Statistics, held in July 1976 under the programme of the Conference of European Statisticians, at which a draft extended version of the SNA classification on government purposes had been discussed, had already stressed the need for a classification based on transactions.
53. It was proposed that in developing the classifications relevant to health accounts, the SNA purpose classification and the classification of health services in the International Standard Classification of All Goods and Services should be given due consideration.
54. From the discussions it appeared that several countries expect to be able to develop health accounts according to national accounting and input-output methodology on the basis of additional information or better analysis of existing data, e.g. interview surveys relating to consumption and health expenditure, social security data, in-patient data, etc. The need was stressed for the development of a set of complementary tables, based on the same classifications of services and purposes, for non-financial data such as number of visits, personnel, number of in-patient days, etc., to serve as a tool for health management and planning.
55. It was pointed out that problems arising in time series as a result of shifts in consumption (changes in patient-flows or earlier consultation) and of difficulties in distinguishing between primary diagnosis and underlying cause, could hardly be solved by a system of health accounts and should be explored by other means.
56. The importance of accounts in constant prices as well as in current prices, especially for planning purposes, was stressed by several participants.
57. The Meeting considered that the possibilities of drawing up recommendations for a standardized accounting system, especially for in-patient services, should be examined. Several participants indicated their interest in collaborating more closely in the development of a system of health accounts.

VIII FURTHER WORK

58. The Meeting reviewed the programme of work in the field of statistics of health in the light of the progress made on the various items included in its agenda and the conclusions reached on these items. The Meeting's proposals are

set out below. The Meeting stressed once more the importance of proper co-ordination of the work of different international organizations on statistics of health. Such co-ordination is required not only between activities of the organizations in the field of health statistics, but also between the work on health statistics and work in other fields related to health.

59. The Meeting's specific proposals for further work are the following:

A. Classifications

(a) Classification of goods and services:

The classification of health goods and services in the ICGS should be re-examined by WHO and the United Nations Statistical Office before the final version of the ICGS is issued.

(b) Classification of impairments and handicaps:

The possibilities of drawing up a classification that is suitable for use in classifying data from household surveys and compatible with the more detailed classification issued for trial purposes by WHO should be studied jointly by WHO and the United Nations. In this work account should be taken of the results of any other pertinent work such as that of the OECD on the development of indicators of impairments.

B. Linking population-based data and institution-based data

Countries with experience in linking data from these sources might be invited to prepare reports on their work at an appropriate stage for consideration at the next joint meeting.

C. Social indicators in the field of health

The Regional Office for Europe of WHO might be invited to make a comparative study of social indicators in the field of health compiled by countries in its region and other countries in the ECE region for consideration at the next joint meeting. This study might be used as a basis for reviewing the list of health indicators in the United Nations Guidelines on Social Indicators in the light of the results of national work and work by other international organizations.

D. Economic accounts for health services

Further work on the development of economic accounts for health services might be undertaken jointly by a small group of interested countries. This work would require the participation of both economists and health specialists, and it should include further consideration of the classifications by kind of activity and by objectives to be used in compiling the accounts. A report on the results of the work should be prepared for consideration at the next joint meeting. The report should also be submitted to the Working Party on a System of Social and Demographic Statistics of the Conference of European Statisticians for consideration in a wider context.

E. Bibliography of studies and other documents

The secretariats should be requested to consider the possibilities of setting up a bibliography of studies and other documents relating to the methodology and analysis of health statistics.

60. The Meeting considered that the implementation of the programme of work outlined above would take some three years, and proposed that 1980 should be aimed at as the year of termination. The Meeting considered that a further meeting on statistics of health to review the results of the work on the different subjects was desirable but suggested that the timing of the meeting should be considered later in the light of the progress made. The Meeting also recommended that the possibilities should be explored of holding technical consultations of small groups of interested countries to carry out preparatory work on the different subjects, particularly on problems of classification and economic accounts for health services.