INTERNATIONAL COMPARISON OF HEALTH CARE DATA IN SIX COUNTRIES 1994, 1995

Supporting paper submitted by Statistics Netherlands

1. Preface

In 1994 the project "International Comparison of Health Care Data" was initiated by Statistics Netherlands at the request of the Ministry of Health, Welfare and Sports, which provided the necessary financial support.

The project consisted of two Phases. The first phase of the project (1994-1995) focused on the intramural health care sector. The second phase (1996-1997) contained the description of the design, procedures and results of the project, which have been devoted to extramural health care, prevention, other services and medical goods.

Within the framework of the project the Ministry of Health, Welfare and Sports requested the collaboration for two special items, namely advanced medico-technological procedures (1996) and transport of patients (1997). Two distinct reports were produced on these subjects, based on inquiries of limited size.

The realisation of this project would not have been possible without the valuable contributions from the participants in the network of experts from Belgium, Denmark, France, Germany and Switzerland, supplemented by participants from international organisations like OECD, WHO/Europe and EUROSTAT.

Prepared by Cor van Mosseveld.
Their contributions in terms of attending the yearly consultations and providing the data are gratefully acknowledged.

This work is only one step on the difficult road to improve international comparability of health care data. Reactions to the report of the first phase showed great interest in the project. This meant that further steps were possible, based on the critical discussions of the approaches and results.

2. Introduction

Every nation has built up a structure of organising and financing of health care based on historical conditions and national concepts of social solidarity and justice. Nowadays these national concepts receive mighty impulses from international panels, where governments are challenged to solve their health care policy problems against the background of international philosophies and programmes like the new Health for All programme of the World Health Organisation and other international organisations like the OECD and the European Union. The latter has entered the field of public health by the Maastricht treaty in 1992. Like WHO and OECD did before the EU paid attention to the development of information systems to support the policy development in this field.

It may be clear, that these developments have a long term perspective. Reaching consensus on common conceptual frameworks as a solid base for practically applicable information systems must follow time-consuming procedures.

Meanwhile countries are confronted with the short term need to reform their health care systems under the increasing pressure of rising costs. At the same time their cost containment policies should not affect accessibility, quality and solidarity. International orientation on policy instruments take place from the viewpoint, that if these policy instruments are successful in one country, they might also be successful in other countries.

Comparing results of different ways of organisation of health care and the use of specific instruments to guarantee the fair distribution of the benefits of the system among the population, requires a certain transparency of the national health care systems. This transparency should be provided by the availability of valid comparable data.

Therefore the Ministry of Health, Welfare and Sports requested Statistics Netherlands (the international name for the Dutch central bureau of statistics) to start a project on the comparison of Dutch health care data with those of a selected number of countries: Denmark, Germany, Switzerland, France and Belgium.

Experts from these countries were invited to form a network for information and consultation. Representatives from WHO/EUR, OECD and EUROSTAT also participated in this network.

The project aims at the improvement of the comparability of a package of selected variables. These variables refer to the production function of health
care supply, consumption, cost and financing. The first phase of the project (1994-1995) concentrated on statistics relating to intramural (in-patient) health care. A great deal of attention was paid to methodology development. In the second phase (1996-1997) the approach, that had been developed in the first phase, was applied to extramural care (out-patient care), preventive health care, medical goods and other services.

The project did not aim at the development of a set of definitions on common concepts and procedures. This would take too much time and in the last instance would require changes and adaptations of national health information systems. Leaving intact national definitions insight was gained by so called "country profiles", brief and general overviews of the national health care systems involved and by a set of descriptions of provisions in operational terms.

The field described in Phase II can be characterised by an enormous diversity of activities and heterogeneity of functions, in contrast to the relative uniformity of the field described in Phase I of the project on Intramural health care on which updated data are supplied in Phase II and presented as well.

3. Process

3.1 Aims and objectives

The overall aim of this project is to improve the international comparability of health care data. In order to benefit more from the experiences with changing health care policies in other countries, the Dutch authorities want to compare their system with those in other countries. For this comparison a package was assembled containing selected variables on supply (provisions and manpower), consumption, and the cost and financing of health care. It should be stressed that the project focuses on broad categories of care and sets of variables, i.e. macro-level comparability and statistical data, not on figures for administrative purposes.

Within the general framework concrete objectives have been formulated for improvement of international comparability of health care data. These objectives are:

- the collection of comparable data on costs and financing of extramural health care, preventive health care, medical goods and other services;
- determination of the boundaries of health care;
- improving the methodology for international comparison;
- description and comparison of the health care systems of the participating countries by means of a reference model;
- development of keys for conversions to be used in comparison.

In phase II (more than in phase I) problems showed up with regard to the availability of data on supply, consumption and manpower. Therefore we focused on expenditures and financing in this phase.
3.2 Network of experts.

One important element of this project is the functioning of a network of experts. Statistics Netherlands has had very good results with this approach on many occasions as in the development of common methods and instruments for Health Interview Surveys. This interactive approach is characterised by the exchange of information in writing (e.g. by leading papers) and other means and intensive consultation sessions of the network members as strong incentives for progress.

For practical reasons an initial choice was made for experts from neighbouring countries (Belgium, Denmark, Germany, Switzerland and France). Representatives of international organisations (OECD, WHO, Eurostat) were also invited to participate (see Annex 2.1).


3.3 General approach

The project "International comparison of health care data" advocates a pragmatic approach to comparing the organisation and financing of the health care systems in the participating countries.

The starting point for this approach is the description of health care used by Statistics Netherlands.

Health care concerns the supply of goods and services in the area of medical, paramedical and nursing care:

- provided for human beings suffering from diseases, physical and/or mental disabilities or limitations;
- related to prevention, diagnostics, treatment and nursing/caring;
- provided by trained experts and/or companies (or parts of companies) set up for this purpose.

Every country has its own views on the description, institutionalisation and organisation of health care, usually the outcome of a long history of government decisions to solve imminent problems. National health care provisions are thus made to measure, in tune with feelings of social justice among the population and with the organisation and functioning of other institutions in society. Against this historical background it is understandable that health care systems have different contents, different organisational forms and different financial sources.

Because of the different contents of health care systems, within the framework of the project attention was paid first to the activities or functions of health care as implemented by the providers. Participants were sent an activities list with the quest to indicate which activities are performed by
which health care provisions. The returned lists provided basic information for an overview of health care provisions: data on the existence of provisions and related expenditures and financing sources.

Thus an overall insight has been obtained into the boundaries of the health care systems of the participating countries, according to the following steps:

\[
\text{Activities} \rightarrow \text{Provisions} \rightarrow \text{Costs} \rightarrow \text{Financial sources}
\]

The boundaries of care were defined more precisely during the process of bilateral comparisons which took the Dutch health care system as a starting point (see figure 1).

**Figure 1: Bilateral Comparison**

The next step examined the possibilities of creating a Common Comparable Package (CCP) of health care, based on the results of the bilateral comparisons (see figure 2).
By means of additions, deductions and reshuffling of provisions, the CCP of health care for the participating countries was constructed. This CCP (figure 3) can be used as a reference, a common concept (instrument) for international comparison.

Figure 3: The Common Comparable Package

### 3.4 Description of the process

The data collection process consisted of the following steps:

a. List of operational definitions
Right from the very beginning of the project, definitions of activities and services in health care were considered crucial. A provisional inventory of definitions was produced. As the construction of a system of definitions used in health care soon proved to be too time consuming, an operational list,
based on CBS definitions, was drawn up to help participants understand the nature of Dutch health care provisions. During the process this set of operational definitions was expanded and improved according to the need felt at that moment, but not with the intention to develop an exhaustive, well structured and final set of definitions.

b. List of activities
Based on an analysis of activities performed in health care (together with the country profiles), a list of activities was drawn up. The aim was to get insight into which activities are performed by which provisions.

c. List of provisions
Based on the response received to the list of activities, a list of provisions was compiled consisting of all health care provisions indicated by participants.

d. Matrices
The list of health care provisions served as the core for two questionnaires in the form of matrices. The first dealt with the existence of provisions in the participating countries and their inclusion in the health care sector or other sectors. The information received (especially information about expenditure) formed the basis for the determination of boundaries of care. The second matrix dealt with the financial sources of the provisions.

Below the method used in this project and the model developed accordingly is described in more detail.

3.5 Description of the method

Knowing that comparability can only be obtained by eliminating differences, and differences can only be eliminated by having information on these differences, it was imperative for the project to get detailed descriptive information on the health care systems of the participating countries.

The descriptive information that was supplied at the request of Statistics Netherlands, resulted in the country profiles, a selected description of the functioning of the health care system.

It is known that knowledge of the system alone is not enough to create comparison. Knowing how health care is organised, what actors or providers are involved is necessary but not sufficient. It is common knowledge that separate activities are supplied in different combinations in various countries. And knowledge of the combinations of activities and providers is essential. So an extensive list of activities was created, originating in the country profiles and supplemented by information from literature. Activities are the actions in the health care field that can be separately distinguished. Activities however do not supply data. Actors or providers are the nationally defined clusters of activities that are able to supply the data.
This list of activities was sent to the participants with the request to supply all the actors/providers of health care performing those activities. This resulted in a country specific set of activities and their providers.

All these country specific lists of providers made it possible to create one list of providers.

Next, information on providers and corresponding expenditures was needed. So this list of provisions were sent to the countries to specify which provisions are present in their (health or national) accounts, and the expenditures on these provisions.

Returned were country specific sets of provisions with amounts of expenditures or costs. Every participant was asked to add annotations, remarks and questions to this list. These lists made it possible to construct a health account for every country containing the providers of health care and their expenditures.

3.6 Description of the model

The core theme of the project was the notion that expenditures can only be obtained at the provider level in the health care system; that these providers are different in various countries, but that a lot of activities in the health care field are the same whatever the system used.

Whether or not the data of the countries were collected in the health accounts or the sector of health in the national accounts is not important. The method of activities linking to providers and providers linking to expenditures offered the possibility to construct a health account.

At least one step between the information at hand and the creation of multilateral comparable packages was necessary.

Because the goal of this exercise was comparability, the idea was launched to limit every comparison to just two countries. Because the project was initiated in the Netherlands and we knew best how, the Dutch health care system is the key country in every comparison. This first part of the process resulted in five bilateral comparisons.

Comparing the systems of two countries, using all the data at hand, but especially the data on the activities gave the possibility to separate every health account in three parts: one on a set of provisions (containing a comparable cluster of activities) in both countries, and two other sets of provisions, one set not available in the Netherlands and one set not available in the other country (the so-called non Bilateral Packages).

The set of providers in both countries is the so called Bilateral Comparable Package. If for any reason a comparison of just two countries is needed, this BCP-approach is the solution.
Having six countries in the project and selecting one country to be the key country, resulted in five distinct Bilateral Packages. Although each pair of results was comparable, the five Bilateral Packages were not. The package of the key country was different in every bilateral comparison. A multilateral comparable package was needed, in which all the bilateral packages were transformed to one multilateral comparable package, the so called Common Comparable Package.

One way to solve this problem is to create multilateral comparison by excluding every provision or part of it that was not present in every country. The consequence of this approach would have been that each inclusion of a new country would limit the contents of the comparable package, ultimately resulting in a very thin comparable package.

Another approach is to include every provision of any of the participants constructed Bilateral Package. This approach could lead to the opposite; a continuous expanding comparable set.

So a different approach was taken. In this approach those provisions are included that are listed either in the Bilateral Packages or in the non Bilateral Packages as long as the activities of these provisions can be fitted into the general notion of health care. As a consequence some additions and deductions were necessary, but only in a limited number of cases. Another consequence is that a rather stable package could be constructed, that does not need to change when a country is included or excluded.

The general notion of being part of the health accounts had one problem, namely that some provisions had to be added that were not part of the health accounts in some country but part of the social sector.

The last problem to be solved concerned calculations of parts of provisions or sets of activities, although present in any country, for which no data could be supplied separately. Sometimes it concerned a reshuffling of expenditures from one sector to another sector inside the health accounts. In other cases the amount of expenditures had to be calculated as an addition to the CCP. Of course in creating a common comparable package some provisions are eliminated from the bilateral comparisons because they are not providing health activities, in spite of the fact that in some countries these provisions and their activities are included in the health accounts.
Figure 4: Method & Completed model

METHOD:
ACTIVITIES - PROVISIONS - EXPENDITURES

HEALTH ACCOUNTS
NATIONAL ACCOUNTS

CONSTRUCTED
HEALTH ACCOUNTS

BCP

HEALTH ACCOUNTS
NON BCP

SOCIAL SERVICES

DEDUCTIONS

ADDITIONS

ADDITIONS

CCP
This last figure on the method and model of the CCP presents the complete picture. Starting with the health or national accounts, using the method to reach a bilateral package, using all the bilateral packages, adding and deducting some provisions or parts of provisions ultimately leads to a common comparable package.

4. Construction of the Common Comparable Package of health care

4.1 Introduction

In this paragraph the results of the Common Comparable Package (CCP) are presented. The basic data supplied by the participants and the procedures and processes leading to the Bilateral Comparable packages (BCP) and the CCP’s are not presented.

In the project the following blocks of health care are distinguished:

Block I consists of provisions and activities in the intramural health care sector which is to a large extent identical to the term in-patient care sector or stationary care sector. In Block II the extramural health care sector is presented, identical to the out-patient sector (excluding prevention) or non-stationary care. Block III includes the preventive activities. Block IV represents the medical goods, consisting of pharmaceuticals and therapeutic appliances. Finally Block V contains the other services (Research & Development, Education & Training and Administration).

An attempt is made to present the total CCP of health care in the participating countries. The total CCP consists of the CCP on Block I: Intramural health care, the CCP on Block II: Extramural, the CCP on Block III: Preventive health care and the CCP on Block IV: Medical goods. From Block·V: Other services only the section on Administration is added to create a total on health care, very much in line with the contents of health care in the participating countries.

4.2 The CCP of health care

The first preliminary constructed CCP results are presented in the table below.
Table 1: Expenditures on the total CCP of health care, 1994, 1995 (US $)

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>3642</td>
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<td>658</td>
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<td>29413</td>
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<td>4371</td>
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<td>9245</td>
<td>1880</td>
<td>740</td>
</tr>
<tr>
<td>Health care</td>
<td>31214</td>
<td>12369</td>
<td>160012</td>
<td>28190</td>
<td>19928</td>
</tr>
</tbody>
</table>

The data as supplied in the table above has a limited meaning in a comparable way. For that reason in the graphs below (graph.1 and graph.2) the data on the CCP Blocks are presented as shares in the total of health care.
In all countries Block I is of great importance in the total of health care (between 50 and 60 percent). In Denmark Block I represents 66 percent of the total CCP, in Germany on the contrary Block I only represents 46 percent. Block II is of great importance in Germany (30 percent) followed by Switzerland (28 percent). In all other countries it is about 17 percent of the total of CCP. Block III on prevention - in all countries politically very
important – only takes between 2 and 4 percent of total CCP expenditures. Block IV on medical goods ranges between 12 (Switzerland) and 19 percent (Belgium) of total CCP.

In the table below the expenditures on the total CCP are expressed in US dollars and in ECU per capita.

Table 2: CCP on total health care, 1994, 1995 (US $ & ECU per capita)

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditures per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>US $</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1995</td>
</tr>
<tr>
<td>Denmark</td>
<td>2372</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1994</td>
</tr>
<tr>
<td>Germany</td>
<td>2426</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1995</td>
</tr>
<tr>
<td>France</td>
<td>2754</td>
</tr>
<tr>
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<td>1994</td>
</tr>
<tr>
<td>Switzerland</td>
<td>3304</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1995</td>
</tr>
<tr>
<td>Switzerland</td>
<td>3934</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1994</td>
</tr>
<tr>
<td>Belgium</td>
<td>1664</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>1995</td>
</tr>
<tr>
<td>Belgium</td>
<td>1968</td>
</tr>
</tbody>
</table>

Comparing the amounts spent on health (CCP) in the participating countries the differences do not seem big. In the Netherlands around $ 2000 per capita is included in the CCP on Health ($ 1724 in 1994 and $ 2016 in 1995), in Germany and France $ 2426 respectively $ 2754. The differences in percentages with respect to the Netherlands for France and in Germany reveal that 37 percent and 40 percent per capita is spent more, than in the Netherlands. In Switzerland a considerable amount more is spent on the CCP on Health $ 3304 in 1994 (94 percent per capita more than in the Netherlands) and $ 3886 in 1995 (93 percent more than in the Netherlands). In Belgium $ 1644 per capita is spent on health in 1994 and $ 1968 in 1995 (about 70 percent less than in the Netherlands).

A comparison of two years is possible for the Netherlands, Switzerland and Belgium. Because the ECU is less volatile than the dollar, the ECU is better suited for a comparison of two years. In the Netherlands the expenditures per capita grew by 6.3 percent from 1994 to 1995. In Switzerland the growth per capita (expressed in ECU) was only 5.9 percent and in Belgium it was 8.5 percent considerably more than in the Netherlands.
A graphic representation of the relative importance of the various Blocks per capita (in US $) is provided in the graphs below, one for 1994 (graph 3) and one for 1995 (graph 4).

Graph 3: Expenditures per capita of Block I to Block IV & Administration, 1994

Graph 4: Expenditures per capita of Block I to Block IV & Administration, 1995
In table 3 the expenditures (shares of GDP) originating from the OECD and the CCP-project are compared.

Table 3: Total health care expenditures: OECD and total CCP compared, 1994, 1995 (% of GDP)

<table>
<thead>
<tr>
<th>Year</th>
<th>OECD Total Health care</th>
<th>CCP Total</th>
<th>Difference 1</th>
<th>Difference 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Netherlands</td>
<td>8.8</td>
<td>7.9</td>
<td>10.3</td>
<td>9.6</td>
</tr>
<tr>
<td>Denmark</td>
<td>6.4</td>
<td>-2.4</td>
<td>7.2</td>
<td>-0.7</td>
</tr>
<tr>
<td>Germany</td>
<td>8.8</td>
<td>7.9</td>
<td>9.6</td>
<td>1.7</td>
</tr>
<tr>
<td>France</td>
<td>9.9</td>
<td>1.1</td>
<td>10.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Switzerland</td>
<td>9.8</td>
<td>1.0</td>
<td>9.2</td>
<td>1.3</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>8.8</td>
<td>7.9</td>
<td>8.1</td>
<td>7.3</td>
</tr>
<tr>
<td>Belgium</td>
<td>8.0</td>
<td>-0.8</td>
<td>7.4</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

1) Difference in percentage points with respect to the Netherlands

Expressed in percentages of GDP the Netherlands spent 7.9 percent on the CCP on Health (in 1994 and 1995). In Germany (1994) 1.7 percentage points more was spent, in France (1995) 3.0 percentage points more than in the Netherlands. Switzerland compared to the Netherlands spent 1.1 percentage point more in 1994 and 1.2 in 1995. Denmark and Belgium spent less than the Netherlands (0.5 and 0.7 percentage points respectively in 1995). The difference between France and the other participants can to a certain extent be explained by the treatment of the nursing home care and the administration. The calculation of the Nursing home care and the additionally supplied data on the Administration in France lead to an addition of 0.6 percent of GDP in the expenditures. This results in 10.4 percent of GDP devoted to health care in the CCP of France. This becomes clear in comparing the results of the CCP with the data presented in the OECD Health data bank. In the OECD health data bank France spent 9.9 percent of its GDP on Health compared to 8.8 percent for the Netherlands. The difference between France and the Netherlands is 1.1 percentage point (in the OECD data), but this is much less than the difference in the CCP on health between the two countries (2.5 percentage points).
For five participants (the Netherlands, Germany, Denmark, Switzerland and Belgium) the share devoted to health is smaller in the CCP approach than in the data supplied in the OECD health data bank. For the other two countries (Denmark and France) the results in the CCP-approach are higher than the results in the OECD health data bank.

For Belgium the difference between OECD data and the CCP is 0.8 in 1994 and 0.6 percentage points in 1995; for Switzerland 0.6 percentage points in 1994 and 0.7 in 1995. For Germany the difference is 0.7 percentage point, the same as for Denmark. For the Netherlands the difference is 0.8 percentage points.

For France the difference (in expenditures as percentage of GDP) between the OECD and the CCP is 1 percentage point.

Comparing the results in the CCP approach (as percentages of GDP) the packages are more uniform, ranging from 7.2% for Denmark to 10.4% for the France. Leaving out the highest and the lowest (France and Denmark), the range is limited from 7.4 percent (Belgium) to 9.6 percent in Germany.

Finally in the last graph the relative positions of the OECD data and the CCP data are presented for the participating countries.
5. Evaluation

5.1 Generalised conclusions of the Project

- Contrary to the construction of the Bilateral Comparable Packages in Phase I, calculations were necessary in the Phase on extramural health care, prevention and medical goods, even in the construction of the Bilateral Comparable Packages. To a large extent this is caused by the complexity of the field and the large heterogeneity of activities and providers.

- The approach of the CCP method supplies more uniform, comparable results, even in such heterogeneous sectors as extramural health care, prevention and medical goods.

- The large importance of intramural health care is not always accompanied by an opposite or minor importance of the non-intramural health care sectors.
Only in Germany a relative small intramural sector is compensated by a large non-intramural sector. In France however a large intramural sector is accompanied by a large non-intramural sector.

5.2 Evaluation of aims and objectives

- **Determination of the boundaries of health care**

  In determining the boundaries of health care the country profiles were used extensively. The country profiles supplied an overview of the health care system in all its aspects of a country. More detailed information was acquired through the matrices in which participants indicated whether care provisions existed or not and belonged to the health care systems or not. The results provide a clear overview of the boundaries of health care of the participating countries.

- **Development of the methodology and model for international comparison**

  The most important feature of the development of the methodology is the notion that activities are the basic starting point. Based on these activities it was possible to describe provisions and the production factors (expenditures) connected with them. The bilateral comparisons were carried out at the level of health care provisions. Principally this method can be used successfully in all sectors of health care and for non-financial variables as well.

- **Comparison of the health care systems of the participating countries by means of a reference model**

  A Common Comparable Package (CCP) was constructed based on the bilateral comparisons. The CCP consists of provisions selected from the lists of provisions used in the bilateral comparisons. Those selected provisions are counted as part of the common health care systems of the participating countries.

  Our conclusion is that the CCP - approach can be used as a reference: a common concept to be used in international comparisons.

5.3 Some final remarks:

- The intention of the pragmatic approach by Statistics Netherlands was to leave intact definitions at national level and not to impose uniform definitions, as is common practice in international data collection. The possibilities for comparison have been enlarged by annotations and comments facilitating better understanding of the data.

- The project offered the opportunity to benefit from the value of interaction especially within the network of experts and to establish increasing consensus and, as a consequence, a better understanding of the meaning of data. However, not all problems were solved. R&D and E&T e.g. were too difficult to be compared. In the field of the transport of
patients the availability and quality of data made comparison difficult
(see the report on “Transport of patients”).

• The participating countries are encouraged to compare their own data with
other countries, using the same methods; by discussing the results
一起，因此影响所谓的本位主义判断
被消除，并且更多地在改进方法方面获得经验。

• Not only among participating countries interest was raised in the topic of
international comparison of health care data and the methods applied. Also
other countries as well as international organisations have taken further
steps in this field. This justifies the expectation, that although this
project - financed by the Dutch Ministry of Health, Welfare and Sports -
came to an end, the process of improving international comparison of health
care data will be continued more or less along the same lines.

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Data; Advanced Medico-Technological Procedures”, December 1997
Mosseveld, C.J.P.M. van, Son, P. van: “International Comparison of Health Care
Data; Transport of Patients”, April 1998
Mosseveld, C.J.P.M. van, Son, P. van: “International Comparison of Health Care
Data; Phase II: Extramural health care, Prevention, Medical goods and Other
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