



WORLD HEALTH ORGANIZATION

Consultations on Measurement of Health

GPE/EBD/SMPH/00.1

**REPORT ON WHO MEETINGS OF EXPERTS
ON MEASURING AND SUMMARIZING HEALTH**

1. Introduction

This report is a summary of major conclusions and recommendations of the following meetings of experts on measurement of health and summary measures of population health organized by WHO and held over the last two years to support the development of summary measures or reporting on average levels of population health for WHO Member States:

- Conference on Summary Measures of Population Health, Marrakech, 6-9 December 1999
- 1st Preparatory Working Group Meeting on Measuring Health Status, Geneva, 2-3 August 2000
- 2nd Preparatory Working Group Meeting on Measuring Health Status, Geneva, 4-5 September 2000
- Meeting of Committee of Experts on Measurement and Classification for Health, Geneva, 11-12 September 2000
- Joint ECE/WHO Expert Meeting on Measuring Health Status, Ottawa, 23-25 October 2000

In addition to WHO staff, the participants at these meetings included experts on the measurement of population health from all WHO Regions and senior representatives of national and international health statistical agencies. A full list of participants and their affiliations, as well as details of the agendas for these meetings, can be found in the Annexes.

2. Summary Measures of Population Health

Summary measures of population health (SMPH) are measures that combine information on mortality and non-fatal health outcomes. Interest in summary measures has been rising in recent years, and the calculation and reporting of various measures have become routine in a number of settings. With the proliferation of work on summary measures, there has been increasing debate about their application in public health, ranging from the ethical implications of the social values incorporated in these measures, to technical and methodological issues regarding the formulation of different measures, to concerns about distributive justice and the use of summary measures in resource allocation. Given these developments, and the diverse opinions about the construction and use of summary measures, the World Health Organization's Global Programme on Evidence for Health Policy convened a conference in Marrakech, Morocco, on 6-9 December 1999, to provide a forum for discussion and debate over the scientific, ethical and policy issues around SMPH.

The Conference brought together over 50 internationally recognized experts from a range of disciplines, including population health analysts, statisticians, epidemiologists, health economists, health policy makers and philosophers and ethicists.

Uses of Summary Measures of Population Health

There are a variety of uses of SMPH. These range from comparisons of the health of populations or of the same population over time), quantifying health inequalities, incorporating the effects of non-fatal outcomes in measuring overall population health, setting priorities for health services delivery and planning, to guiding research and development in the health sector, improving professional training, and analyzing the benefits of health interventions for use in cost-effectiveness studies.

Basic Concepts

Given this array of potential uses of summary measures, the Conference considered some of the basic concepts underlying their definition and construction. How broadly, for example, should the concept of "health" be defined? Should SMPH try to measure well-being as distinct from, and in addition to health, and if not, are these two concepts really separable? Quite apart from such philosophical considerations, how should well-being be measured and what are the critical concerns, such as additivity, in measures of well being? An important issue raised was the need for summary measures to reflect both distributional as well as overall level concerns. There was a general consensus that summary measures should not try to simultaneously assess both the level of health, as well as inequalities in healthy, but that separate measures were preferable.

Health Expectancies, Health Gaps and Causal Attribution

Summary measures of population health fall into two broad categories: health expectancies and health gaps. A wide range of health expectancies has been proposed since the original notion was developed. The Conference reviewed the basic characteristics of health expectancy measures, including the implications of the methods used to calculate life expectancy (period or cohort) and the methods used to estimate health expectancies (prevalence-rate life tables, multi-state life tables). Of key concern was the consequences of using different definitions and measurements of health status in the calculation of health expectancies, and, perhaps most importantly, the implications of basing health expectancy measures on dichotomous versus multi-state valuations of health states.

Of the different summary measures that have been widely used, none simultaneously includes information on both incidence and prevalence. There are longstanding arguments in health statistics about the relative merits of incidence-based and prevalence-based measures, but simple evaluative criteria suggest that summary measures should include information on both for the purpose of comparing the health of different populations. The Conference debated the necessity for inclusion of both types of information, and the implications for the construction and measurement of SMPH.

While less easily interpreted, health gap measures are critical to understanding the comparative importance of disease, injuries and risk factors for population health levels. Over the last 50 years, a variety of health gap measures have been proposed and calculated. Health gaps extend the notion of mortality gaps to include time lived in health states worse than ideal health. Several aspects of health gap measures were discussed such as the choice of implicit or explicit population targets, the goals for health gaps, and normative choices for health gap measures were provided. The implications of the age-dependent characteristic of gap measures, which is not an issue for health expectancies, were also discussed, and criteria advanced and debated for desirable properties of health gap measures.

Given one of the fundamental goals in constructing summary measures is to identify the relative magnitude of different health problems, including diseases, injuries and risk factors, an appropriate framework is required which will be both coherent and readily interpretable. There are two dominant traditions in widespread use for causal attribution: categorical attribution and counterfactual analysis. In categorical attribution, an event such as a death is attributed to a single cause according to a defined set of rules (in this case the International Classification of Diseases). In counterfactual analysis, the contribution of a disease, injury or risk factor to overall disease burden is estimated by comparing the current levels of a summary measure with the levels that would be expected under some alternative hypothetical exposure scenario. Discussion focussed around the relative advantages and disadvantages of these two approaches and the implications for comparability, of using the two approaches in the same analysis.

Health Status Description and Classification

Standardized, multi-dimensional assessments of health states are increasingly being used to describe a population's health status, quite apart from the need for such data in summary measures. Well known examples include the SF-36, Nottingham Health Profile, Quality of Wellbeing Scale and WHO-DAS II, but there are many others. Yet all efforts at measuring health state valuations and the subsequent calculation of severity weights incorporated within a summary measure of population health depend on using meaningful, complete and comprehensible health state descriptions. Two key issues in describing health states were discussed: (i) what constitutes a complete description of a health state, and (ii) how to convey this information effectively to an individual undertaking the valuations? WHO work on a comprehensive classification scheme, the ICF (or ICIDH-2) was also discussed. The presentations and discussion also identified the need for a stronger theoretical and methodological basis to: (i) explain and potentially adjust for gaps between self-reported health and observed health status measures or medical diagnosis; (ii) explain and potentially adjust for systematic patterns of deviations between self-reported health status and selected socio-economic and cultural factors; and (iii) enhance the cross-population comparability of measures of health status from surveys using standardized calibration techniques.

Health State Valuation

Any summary measure of population health, by definition, requires the quantification or explicit valuation of states of health worse than perfect health. There has been extensive debate in the health economics literature on a number of fundamental issues relating to health state valuation, including: (i) whose values should be used, e.g., individuals in health states, the general public, healthcare providers or household members caring for individuals in health states; (ii) what type of valuation approaches should be used, such as the standard gamble, time trade-off, person trade-off, or visual analogue; (iii) how should health states be presented for the elicitation of valuations, that is, with what type of description and what level of

detail, including some selection of domains; (iv) what range of health states from mild to severe are to be valued at the same time; and (v) what combination of valuation questions and what type of deliberative process should be used. While there were conflicting views on some of these issues, many of the participants agreed that empirical basis for the calculation of summary measures would be improved considerably through the collection of population-based data on individual valuations of a wide range of health states.

Regardless of the resources available, it is clearly not feasible to measure health state valuations in a population for every possible health state. For the calculation of summary measures of population health, a predictive model that allows one to impute health state valuations from information on health status associated with a particular state would be clearly desirable. To date, there have been at least four published attempts to develop systems that can be used to map from levels on a set of domains of health status to valuations of health states described along these domains: the Quality of Well-Being (QWB) scale, the Disability and Distress Scale, EuroQol, and the Health Utilities Index (HUI). The characteristics of such approaches, as well as a broader research agenda for developing new methods were debated at the Conference.

One of the major substantive issues relating to health state valuation is the question of variation in values within and across populations. There are a number of compelling reasons why health state valuations might be expected to vary between populations that have different cultural beliefs on disease causation, individual responsibility, fatalism, social roles and functioning or expectations for well-being, *etc.* Further, individual variation in valuations according to age, sex, education, income and other socio-demographic variables might also be expected. To date, however, there is little empirical evidence that health state values vary markedly within and across populations. This may simply be a function of insufficient power to detect these differences or of the paucity of comparable data on health state valuations. On the other hand, it is possible that the contributions of different domains of health to the overall valuation of a health state are similarly viewed across populations, but what differs between populations are the health status characteristics associated with a given disease state. Concepts and methods for modelling the determinants of variation in health state valuations within and between populations were presented and discussed.

Goodness, Fairness and Social Value Choices

A key concern in the use of summary measures for resource allocation is that policies and programmes are chosen based on several considerations, and not only on the concern to maximize health outcomes. Optimizing the health of populations is but one option, and others may be, and generally are, better supported by moral arguments. Should we give moral priority to the worst-off? Or should we attach greater significance to large benefits than to the sum of many small gains, with life-saving interventions counting the most of all? Or might we attach less importance to life extension past a normal lifespan, thus attaching greater moral weight to achieving what has been described as a "fair innings". Cutting across these moral choices are two methodological issues which have broad implication for measurement. One is whether our judgments on these moral trade-offs should be explicitly incorporated into the summary measures themselves, via weighting, or should they be regarded as an altogether separate set of considerations in the allocation debate. The other is whether these issues of resource allocation should ideally be settled by processes of democratic deliberation and the elicitation of the public's values, or by the best of moral argumentation and theory. Several presentations were made to guide and encourage debate around this moral arithmetic.

The calculation and specification of summary measures of population health also involves several explicit social value choices. One key issue is whether or not to differentially weight healthy years of life lost at different ages, and if so, on what basis. Even if most people consider the period of young adulthood (e.g., the early childbearing years) as more valuable than years lived at the beginning or end of life, this view may be objectionable if the basis is the societal value of young adults compared to other people. Secondly, the choice of a discount rate for health benefits, even if technically desirable, may entail morally unacceptable allocations between generations. Are there other widely held values and on what basis should we decide to incorporate social values into the summary measure, or should we keep them distinct? If they are to be incorporated, should these values be determined at local/national level for country analyses and/or at the international level for cross-national comparisons? There was extensive debate on such social value choices, as well as their application in summary measures.

Outcomes of the conference

One key objective for WHO, in addition to advancing the technical work on summary measures, has been to promote greater transparency and understanding of the inputs to calculate summary measures and

their appropriate application. The Marrakech Conference provided a unique opportunity to challenge existing notions and advance the conceptual and methodological research agenda concerning

SMPH and their use. Leading experts from a range of disciplines addressed the current state of the art, beyond basic concepts and uses, covering the conceptual frameworks for measurement of population health, the description and valuation of health states, as well as social values and ethical considerations. Given the expected heterogeneity in social values and ethical considerations, the meeting fostered debate about conceptual, technical and practical concerns and addressed a number of implications for the use of summary measures.

The various papers presented at the Marrakech meeting, supplemented by additional chapters that arose from the discussion or were commissioned to fill important gaps in the debate, will be published in an edited, peer-reviewed volume by WHO in December, 2001¹. This book should represent a milestone in the evolution of health metrics, and contribute substantially to the ongoing development and use of SMPH.

A draft version of this book was also provided as a background document to support the discussion of SMPH and development of appropriate recommendations by the WHO Committee of Experts on Measurement and Classification for Health (see Section 4 below).

3. Measuring health status

Following the Marrakech Conference on SMPH, WHO undertook expert consultations on the measurement of health status during 2000, leading up to a Meeting on Measuring Health Status held in Ottawa on 23-25 October, 2000. This meeting was jointly sponsored by WHO Geneva and the United Nations Statistical Commission and Economic Commission for Europe (UN/ECE), and hosted by Statistics Canada.

Two preparatory working group meetings of experts on measuring health status were held in Geneva during August and September 2000 to prepare for the Ottawa meeting.

The main objectives of the Ottawa meeting were:

- To review briefly the main health policy and related considerations driving the need for internationally comparable population health status information;
- To share information on and review the status and direction of a number of key initiatives currently underway regarding the development of health status measures, particularly in relation to international comparability;
- To discuss new approaches towards the collection and analysis of such data;
- To present a proposal from the WHO for a generic framework for internationally comparable health status measurement based on the ICF (ICIDH-2);
- To develop specific approaches and actions leading to a broadened consensus on a framework, as well as concrete actions leading to its adoption and implementation.

Background

For several years, the Conference of European Statisticians (CES) has had as its objective in the area of Health Statistics, "To develop a comprehensive and coherent system of health statistics capable of supporting policy analysis and decision-making in the field of health, particularly monitoring the inputs, throughputs and outcomes of the health care system in both monetary and non-monetary terms." Pursuant to this objective, a Joint UN/ECE-WHO Meeting on Health Statistics (CES/AC.38/1998/3) was held 14-16 October 1998 in Rome. This meeting strongly recommended that the Conference further encourage international organizations involved in health statistics to increase their cooperation and coordination in those areas of health data collections and research which are not yet adequately coordinated. The meeting further recommended that the Conference give a higher priority to the area of health statistics, and that its work program focuses more on the conceptual issues of measurement, classifications, standardisation and harmonisation of data.

As a result, the agenda of the Conference of European Statisticians (CES) meeting on June 14-16, 1999 in Neuchatel devoted an hour to discussing issues in health statistics. This meeting " ... concluded that the area of health should be a priority area and that coordination should be further encouraged in international health work and data collection. Furthermore, intellectual leadership should be promoted to advance

¹ Murray CJL, Salomon JA, Mathers CD, Lopez AD (eds.). *Summary measures of population health: concepts, ethics, measurement and applications*. Geneva, World Health Organization, 2002 (forthcoming).

conceptual issues of measurements and classifications. Finally, a health monitoring system capable of supporting policy analysis and decision making in the field of health should be the long-term goal of the Conference's work." The meeting also endorsed an international experts conference in Ottawa in 2000 to follow up the October 1998 Joint UN/ECE-WHO Rome meeting.

Also in December 1999, the OECD, with the sponsorship of the U.S. Department of Health and Human Services, organized a meeting on the implications of disability for aging populations. Amongst the conclusions of this meeting were that policy-oriented discussions were seriously hampered by the lack of internationally comparable data, and that development of valid and comparable statistical measures (based on a coherent and agreed conceptual framework), as well as further analysis of the primary topic of the meeting, should be top priorities of the OECD.

Objectives of the Ottawa Meeting

In early 2000, it was decided to enhance the scope of the Ottawa Meeting to move beyond review and discussion of existing initiatives in order to capitalize on developmental efforts underway at WHO Geneva to develop a generic framework for health status assessment with a particular focus on cross-population comparability. Measures of health that are valid and comparable cross-nationally necessitate not just a common conceptual approach, but also common operational methods. In practice, this translates to a common process for data collection, analysis and reporting of core measures of health, whether at the global, regional or national level. Reviews of existing methods by several organizations and groups, such as the OECD, REVES, WHO Geneva, and WHO EURO and EC, had revealed an array of data collection approaches and instruments, different methods to analyze and report multi-dimensional profiles or indicators of health status, and a lack of interpretation guidelines for estimates obtained. These issues seriously hamper the comparison of data collected, and substantially limit the utility of these data for health policy.

Given the increasing priority attached to assessing trends in health status, and linking them as outcomes of health policy, it was decided that the Ottawa meeting should address this fundamental objective.

Preparatory Working Group Meetings

Two preparatory Working Group Meetings were held in Geneva on 2-3 August and 4-5 September, 2000, to consider these issues and to advise on the preparation of the agenda and agenda papers for the Ottawa Meeting. The agendas and participants for these preparatory meetings are listed in Annex 2.

Joint UN/ECE and WHO Meeting on Measuring Health Status, Ottawa, 23-25 October 2000

The meeting was attended by 41 experts from the following countries: Australia, Canada, Denmark, France, Italy, Netherlands, France, New Zealand, Spain, United Kingdom and United States. Eurostat was also represented. Representatives from the OECD, World Bank, Inter American Development Bank, WHO-EURO, WHO-PAHO and the United Nations Statistical Division also participated. The Agenda and participants are listed in Annex 3.

The meeting concluded that enhancing cross-population comparability of health status is important and that it also raises important issues for the use of health status data within countries, especially those with ethnically or culturally diverse populations. The meeting saw the WHO framework as a major step towards meaningfully connecting health status assessment to health policy and recommended development of operational standards and transparent methods of analysis.

The candidate domains for inclusion in the standardized health state measurement instrument were discussed in detail and six of the 21 domains were singled out to form a shorter profile as the basis of SMPHs: mobility, self-care, social functioning, pain, affect, cognition.

The meeting examined the utility of various methods for assessing cross-population comparability of survey item responses. The strong assumptions necessary to use methods such as Rasch analysis and Differential Item Functioning were highlighted in the discussion, leading to recognition of the inability to assess cross-population comparability without external criteria. WHO speakers presented new methodological work in this area using measured tests and vignettes to provide external calibration of self-response items.

The meeting concluded with a discussion of the need for methodological advances and systematic collection of evidence on how to test and adjust for cross-population comparability.

4. Measurement and Classification for Health

In order to prepare draft recommendations on the measurement and classification of health status for the consideration of the WHO Executive Board and the 2001 World Health Assembly, WHO convened a Committee of Experts on Measurement and Classification for Health, which met in Geneva on 11-12 September 2000. The Agenda and composition of the Committee of Experts is given in Annex 4.

The Committee of Experts considered the following three components of a common health-reporting framework:

1. WHO Family of International Classifications on Health.
2. Operational systems of data collection on Health States of Populations
3. Summary Measures of Population Health.

The Committee of Experts made a series of recommendations on the development of these components of a common framework for reporting on population health status.

4.1 WHO Family of International Classifications on Health.

The International Classification of Impairments, Disabilities and Handicaps (ICIDH) was created in 1975 (WHA Resolution 43.24) to report the consequences of diseases and needs of individuals. ICIDH was used in several countries for field trial purposes and a revision process was commenced in 1995 to address various issues, including the need to use ICIDH as a framework for the reporting of the health status of populations. Over the five years 1995 to 2000, several collaborating centres, governmental and non-governmental organisations have taken part in revision and field testing three successive versions of the classification. Following an extensive consultation process during this five year period (not documented here), the Pre-final Version of the ICIDH Revision 2 was examined by the Committee of Experts, who recommended its endorsement by the WHO Executive Board and World Health Assembly.

Renamed the International Classification of Functioning, Disability and Health (ICF), this classification was endorsed by the World Health Assembly in May 2001 as a member of the WHO family of international classifications on health².

4.2 Operational systems for data collection on Health States of Populations

Building on the work of the Ottawa Meeting, and on the results of pilot applications of a standardized health status survey module in the general population in several Member States, the Committee of Experts concluded that cross-population comparability is an essential requirement for reporting on health for WHO Member States in addition to cross-cultural applicability, reliability and validity. It recommended that Member States use an explicit strategy to establish cross-population comparability which is incorporated into the common instrument design for each health domain. Finally, it recommended that a subset of core health domains selected from ICF should be the basis of the development of this common survey instrument for measuring health states in general populations (see Appendix 9 of ICF).

4.3 Summary Measures of Population Health

The Committee of Experts deliberated on the need for standardised summary measures of population health that are sensitive to both mortality and non-fatal health outcomes to report on average level of population health for WHO Member States. They concluded that comparison of levels and distribution of population health for Member States requires a positive summary measure of population health: healthy life expectancy, whereas reporting on causes of loss of population health to inform policy formation and evaluation requires health gaps measures. The Committee also recommended that

- (a) because distribution of health within populations is important, as well as level of health, separate summary measures should be used to report on level and distribution of health.
- (b) because health state valuations are a critical input to the reporting of both health expectancies and health gaps, health state valuations should be measured in population-representative samples in each Member State.

² World Health Organization. *International Classification of Functioning, Disability and Health (ICF)*. Geneva, World Health Organization, 2001.

- (c) that WHO, in consultation with Member States and appropriate expert networks, develop guidelines and standards for the calculation and reporting of summary measures of population health for purposes of international comparison.

ANNEX 1. Conference on Summary Measures of Population Health, Marrakech, 6-9 December 1999

Agenda: Conference on Summary Measures of Population Health

Monday, 6 December

Opening Ceremony Dr Abdelouahed El Fassi, Minister of Health, Morocco

Session I : Uses of Summary Measures of Population Health

Chair: Dr J. Marks, CDC, USA
Speaker: Dr P. van der Maas, Erasmus University Rotterdam, The Netherlands
Discussants: Dr G. Mooney, University of Sydney, Australia
Dr P. Mahapatra, HACA Bhavan, Hyderabad, India

Session II : Basic concepts and data inputs for Summary Measures of Population Health

Chair: Dr J. Marks, CDC, USA
Speaker: GPE/WHO
Discussant: Dr D. Brock, Brown University, USA
Dr J. Richardson, Australia

Session III : Health Expectancies

Chair: Dr E. Crimmins, University of Southern California, USA
Speaker: Dr C. Mathers, Australian Institute of Health and Welfare, Australia
Discussant: Dr J.M. Robine, INSERM, France
Dr E. Sondik, NCHS, USA

Session IV: Health Gaps

Chair: Dr E. Crimmins, University of Southern California, USA
Speaker: GPE/WHO
Discussant: Dr A. Hyder, Johns Hopkins University, USA
Dr J. Barendregt, Erasmus University Rotterdam, The Netherlands

Tuesday, 7 December

Session V : Incidence and Prevalence issues in Summary Measures of Population Health

Chair: Dr M. Wolfson, Statistics Canada
Speaker: Dr J. Barendregt, Erasmus University Rotterdam, The Netherlands
Discussants: Dr J. Broome, University of St Andrew's, UK
GPE/WHO

Session VI : Decomposition of Summary Measures of Population Health into contributions of different diseases, injuries and risk factors.

Chair: Dr M. Wolfson, Statistics Canada, Canada
Speaker: Dr S. Greenland, University of California, USA
Discussants: Dr C. Mathers, Australian Institute of Health and Welfare, Australia
GPE/WHO

Session VII : Health status descriptions and classification approaches

Chair: Dr A. Mechbal, WHO/EMRO
Speaker: Dr I. McDowell, University of Ottawa, Canada
Discussants: Dr D. Feeny, University of Alberta, Canada
Dr M.L. Essink-Bot, Erasmus University Rotterdam, The Netherlands
GPE/WHO

Session VIII : Self-reported versus observed measures of health

Chair: Dr A. Mechbal, WHO/EMRO
Speaker: Dr D. Thomas, RAND/UCLA, USA
Discussants: Dr A. Sebai, American University of Beirut, Lebanon
GPE/WHO

Wednesday, 8 December

Session IX : Overview of methods and valuation instruments

Speaker: Dr M.L. Essink-Bot, Erasmus University Rotterdam, The Netherlands
Discussants: Dr P. Mahapatra, HACA Bhavan, Hyderabad, India
Dr J. Richardson, Centre for Health Program Evaluation, Australia
GPE/WHO

Session X : Modelling the relations between health status domains and health state valuations

Chair: Dr P. van der Maas, Erasmus University Rotterdam, The Netherlands
Speaker: Dr P. Dolan, University of Sheffield, UK
Discussants: Dr D. Feeny, University of Alberta, Canada
Dr C. Mathers, Australian Institute of Health and Welfare, Australia

Session XI : Determinants of variance in health state valuations

Chair: Dr P. van der Maas, Erasmus University Rotterdam, The Netherlands
Speaker: Dr J. Sommerfeld, University of Heidelberg, Germany
Discussants: Dr P. Dolan, University of Sheffield, UK
GPE/WHO

Session XII : Goodness: conceptual and ethical issues

Speaker: Dr J. Broome, The University of St Andrew's, UK
Discussants: Dr E. Nord, National Institute of Public Health, Norway
Dr D. Hausman, University of Wisconsin, USA

Thursday, 9 December

Session XIII : Fairness and Equity

Chair: Dr D. Wikler, WHO
Speakers: Dr F. Kamm, New York University, USA
GPE/WHO
Discussants: Dr D Brock, Brown University, USA
Dr F. Peter, Harvard Center for Population and Development Studies, USA

Session XIV : Social value choices in Summary Measures of Population Health

Chair: Dr D. Wikler, WHO
Speaker: Dr A. Tsuchiya, University of York, UK
Discussants: Dr J. Richardson, Centre for Health Program Evaluation, Australia
Dr J. Barendregt, Erasmus University Rotterdam, The Netherlands
Dr N. Dachs, Pan American Health Organization, USA

Review and closing

Speakers: Dr J. Marks, CDC, USA
Dr A. Mechbal, WHO/EMRO

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ANNEX 2. Preparatory Working Group Meetings on Measuring Health Status, Geneva, 2-3 August and 4-5 September 2000

Agenda: Preparatory Working Group Meetings on Measuring Health Status

2-3 August

I. Review and discuss WHO Draft Framework on Health Status Assessment

II. Review of strengths and limitations of Item Response Theory

III. New approaches to improving comparability of health status data across countries

IV. Design issues for proposed WHO standardized health status measurement instrument

4-5 September

I. Introduction and update on draft WHO recommendations

II. Overview of first working group meeting

III. Design of standardized health status module

Background and criteria for selection of domains and items

Background and selection of observed calibration tests: physical locomotion, cognitive and vision tests

IV. Selection of domains and items

Domains, items, ICDH classification and relation to existing instruments

Domains for health status assessment vs. domains for health state valuations

V: Cross-Population Comparability

Current status of new statistical methods (IRT with exogenous calibration)

Calibration techniques: vignettes and reference populations

Calibration techniques: observed tests

VI: Preparation of working papers for Ottawa meeting

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ANNEX 3. Joint UNECE/WHO Meeting on Measuring Health Status, Ottawa, 23-25 October 2000

Agenda: Joint UNECE/WHO Meeting on Measuring Health Status

Monday, 23 October

Official Opening: Ivan Felligi, Chief Statistician, Statistics Canada

Session I: The uses of and needs for population health status measures

Chair: Michael Wolfson, Statistics Canada
Speakers: Ed Sondik, National Centre for Health Statistics, U.S.;
Michael Decter, Chairman of the Canadian Institute for Health Information;
John Fox, Chief Statistician, Department of Health, UK
Marleen de Smedt, Eurostat

Session II: Roundtable on National Initiatives

Chair: Alan Lopez, WHO
Speakers: U.S. - Healthy People 2000 (retrospective) and 2010 (prospective), Jennifer Madans / NCHS
U.S. - Institute of Medicine work, and other initiatives, Marthe Gold / NYLI
Canada - Gary Catlin (Statistics Canada)
Australia - Richard Madden, Director, Australian Institute of Health and Welfare, Australia
Italy – Vittoria Buratti, Italian National Statistical Institute (ISTAT)
Denmark -- Niels K Rasmussen, Danish Institute for Clinical Epidemiology (DICE)
U.K. - Siobhan Carey, Office of National Statistics UK (ONS)
New Zealand – Martin Tobias, Ministry of Health of New Zealand
France - Jean-Louis Lanoe, Institut National de la Statistique et des Etudes Economiques (INSEE)

Session III: International Agencies' Initiatives

Chair: Gary Catlin, Statistics Canada
Speakers: Eurostat : Marleen De Smedt
Other European perspectives: Pieter Kramers, National Institute of Public Health and the Environment
WHO/EURO: Anatoli Nossikov
WHO/PAHO: Norberto Dachs
OECD: Manfred Huber
UNSD: Margaret Mbogoni
Pharmaceutical Industry: Margaret Rothman, Johnson and Johnson

Session IV: Toward a Framework for Measuring Population Health Status

Chair: Ed Sondik, NCHS USA
Speakers: Michael Wolfson, Statistics Canada
Chris Murray, WHO Global Program on Evidence for Health Policy, Geneva
Bedirhan Ustun, WHO Global Program on Evidence for Health Policy, Geneva
Alan Lopez, WHO Global Program on Evidence for Health Policy, Geneva

Tuesday, 24 October

Session V: Critical review of the comparability of surveys and data

Chair: Richard Madden, Australian Institute of Health and Welfare
Speakers: Marleen de Smedt (Eurostat) - European Survey
Gaetan Lafortune (OECD) - OECD Survey
Niels Rasmussen - EURO-REVES Experience
Ritu Sadana (WHO Geneva) - WHO Analysis

Session VI: Use of Existing Standardized Health Status Measures at the National Level

Chair: John Millar, CIHI
Speakers: UK: Siobhan Carey, ONS
Canada: Jean-Marie Berthelot and Julie Bernier (Statistics Canada):

Session VII: Comparability of health status assessment methods

Chair: Marijke de Kleijn-de-Vrankrijker
Speakers: John Ware, Quality Metric, Inc., USA
Alan Tenant, University of Leeds, UK;
Gouke Bonsel, University of Amsterdam, Netherlands

Session VIII: New methodological approaches towards cross-population comparability. External calibration

Chair: Gouke Bonsel, University of Amsterdam
Speakers: Chris Murray, WHO Global Program on Evidence for Health Policy, Geneva

Wednesday, 25 October

Session IX: Perspectives on Health Status Assessment and the WHO Common Framework: -Discussion

Chair: Michael Wolfson, Statistics Canada
Speakers: Ed Sondik, USA
John Fox, UK

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ANNEX 4. Meeting of Committee of Experts on Measurement and Classification for Health, Geneva, 11-12 September 2000

Agenda: Meeting of Committee of Experts

- I. Provisional Agenda*
- II. Introduction of Participants*
- III. Election of Chairperson, Vice-Chairperson, Rapporteur*
- IV. WHO Family of International Classifications for Health: ICDH Beta-2 Draft*
- V. Concepts and Operational Methods for Health Status Measurement*
- VI. Principles and Indicators for Summarizing Population Health*
- VII. Recommendations and Next Steps*
- VIII. Closure of Meeting*

Associated Documents

Document 1. Measuring and Reporting on the Health of Populations
Document 2: WHO Family of International Classifications on Health.
Document 3: Survey measurement of Health Status of Populations.
Document 4: Summary measures of population health — requirements and standards.
Background Annex: ICDH-2 Pre-final Draft Short Version.

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