

Final recommendations of the Core Group Care on non-expenditure data for the common part of the Joint Questionnaire.

September 29, 2011

Introduction

In the Partnership Health meeting of June 30, 2011, it was agreed, that:

- The CG will take account of the results of the WG PH and produce a document with emphasis on more elaborate recommendations and possible solutions in view of specific problems such as getting comparable estimates for practising physicians, e.g. by using LFS results, or comparability of sources such as use of hospital census, and create a template on which Eurostat can base its activities.

This document has the purpose of providing more elaborate recommendations and possible solutions. That means that the recommendations as presented in the report on the Evaluation of the Joint Questionnaire on Non-Monetary Health Care statistics as of April 30, 2011, still stand. In that report the remarks of the Technical Group Care were incorporated. The recommendations of that report are enclosed in this document as annex A.

The first part gives the finale stance of the Core Group Care on the inclusion of variables in the Joint Questionnaire. The more extended second part explores the recommendations on how to arrive at a figure for practising (para)medical professionals, with remarks on estimates and sources.

Final recommendations on the in- or exclusion of variables in the Joint Questionnaire

Variables	Elements on context and Core Group Care (CG) opinion
End-stage renal failure patients	
Functioning kidney transplants + Patients undergoing dialysis + End-stage renal failure patients	In addition to number of kidney transplants OECD is interested in collecting data on kidney transplants as an end-stage to renal failure treatment. CG had suggested to consult the TG Care. The majority of the TG members that reacted was in favour. So, we suggest that it should be taken in the common module of the joint questionnaire.
Consultations	
Doctors' consultations	OECD is interested in collecting the number of consultation of doctors separately for hospital and private practice ambulatory care, if possible divided by general practitioners and specialists. CG would agree , given that the duration of such consultation should also be considered
Dentists' consultations	CG Care would agree; however the opinion of the TG Care was split. Recommendation is to have it in the common module.
Screening	
Mammography screening and Cervical cancer screening	Expansion of the JQ on cancer screening (mamma, cervix and colon cancer): CG would agree (administrative data, complementary to the 5 yearly EHIS; <i>proposal to add colon screening</i>).
Diagnostic exams	
CT and MRI exams	OECD proposal to improve the JQ on physical resources. CG would agree.

However, all these remarks are on the wish list of the Core Group Care. The practical implementation of course could give results with sometimes many missing data. E.g. data on screening or doctor's consultations (e.g. only for the public sector).

Recommendations on sources and estimates for variables on labour

Practising physicians – how to arrive at an estimate, possible solutions for countries that do not deliver data on practising physicians

As regards the physicians, table 1 shows that for the European Union, each country (with one exception – Portugal) has at least delivered data on either practising physicians or professionally active physicians. This leaves an opening for a solution for estimates based on professionally active physicians, as the ratio of practising to professionally active physicians is less prone to fluctuations compared to the ratio to licensed physicians.

For 2008 the median ratio was 92.7 per cent (the average was 92.0 per cent) for the 12 countries that have data on practising as well as professionally active physicians (including the candidate and acceding countries and EFTA countries).¹

¹ Excluding Switzerland, as for that country the figures on practising and professionally active physicians are identical.

Table 1 Data on the number of physicians

Country 1)	2008			2009			2008 estimated	min	max
	Practising	Professionally active	Licensed	Practising	Professionally active	Licensed			
<i>Belgium</i>	31 281		50 843	31 578		51 923	31 281	31 281	31 281
Bulgaria	27 480	35 039		27 988	34 444		27 480	27 480	27 480
Czech Republic	36 921			37 351			36 921	36 921	36 921
<i>Denmark</i>	18 825	20 293	28 933				18 825	18 825	18 825
Germany	292 129	319 697	421 686	297 835	325 945	429 926	292 129	292 129	292 129
Estonia	4 469		5 622	4 378		5 628	4 469	4 469	4 469
Ireland		13 022	17 741		13 663	18 168	12 068	11 516	12 437
<i>Greece</i>		67 795			69 030		62 828	59 956	64 752
Spain	159 500	172 000	213 977	162 600	173 500	219 031	159 500	159 500	159 500
France		212 478			210 723		196 910	187 911	202 941
Italy		246 834	365 280	202 866	246 688	367 420	228 749	218 295	235 755
Cyprus	2 276						2 276	2 276	2 276
Latvia	7 040	7 120	10 234	6 753	6 866	10 358	7 040	7 040	7 040
Lithuania	12 413	13 403		12 191	13 228		12 413	12 413	12 413
<i>Luxembourg</i>	1 331		1 910	1 350		2 040	1 331	1 331	1 331
Hungary	31 024		33 830	30 276		33 048	31 024	31 024	31 024
Malta 2)			1 374	1 257	1 286	1 541	1 268	1 257	1 279
Netherlands		47 138	60 439				43 684	41 688	45 022
Austria	38 313			39 123			38 313	38 313	38 313
<i>Poland</i>	82 397	90 461	131 418	82 813	88 580	132 832	82 397	82 397	82 397
Portugal			38 932			40 095	26 965	25 944	29 493
Romania	47 617	50 267				53 414	47 617	47 617	47 617
Slovenia	4 854	5 015		4 915	5 069		4 854	4 854	4 854
Slovakia		18 121			17 799		16 793	16 026	17 308
Finland	14 455	16 287	23 186		16 487	23 882	14 455	14 455	14 455
Sweden	34 383		49 654			51 325	34 383	34 383	34 383
United Kingdom	157 649			164 891			157 649	157 649	157 649
Iceland	1 188	1 188	2 011				1 188	1 188	1 188
Norway	19 088	21 916	23 990	19 428	22 920	25 215	19 088	19 088	19 088
Switzerland	29 194	29 653		29 680	30 166		29 194	29 194	29 194
Croatia	11 801			11 813			11 801	11 801	11 801
<i>FYR of Macedonia</i>		5 364					4 971	4 744	5 123
<i>Turkey</i>		113 151			118 641		104 861	100 068	108 072
EU	1004357	1334 970	1455 059	1108 165	1223 308	1440 631	1593 621	1566 951	1613 344

1) The countries in italics have not responded to the questionnaire by the Core Group Care on quality of data.

2) Estimate for Malta for 2008 : the average of their 2009 and 2010 figures has been used.

Source: figures: EUROSTAT; sources: Core Group Care questionnaire, metadata EUROSTAT

For reporting, EUROSTAT can use these data to arrive at an estimate by applying the average ratio for the countries that do not have delivered data on practising physicians. As a first approximation, a comparable estimate may be arrived at for Portugal, using the ratio of practising to licensed physicians (median 69.3 per cent). However, a footnote should indicate then that such a figure is a rough estimate. The lowest (59.1) and highest ratio (91.7 per cent) could be used to have a bandwidth, or plus or minus two standard deviations. For 2008, the number reported for the 27 Member States was 1.00 million doctors, the estimated figure would be 1.59 million practising doctors, between 1.57 and 1.62 million (using two times the standard errors of the ratio for the countries with estimated figures).

However, this is not helpful for the countries themselves. Depending on the source(s) used for the professionally active physicians different strategies can be deployed to arrive at a figure for practising physicians. Basically, sources can be divided into two groups: 1 administrative sources (including registers), for which the observation is indirect, and 2 survey sources (sample surveys and censuses), for which the observation is direct. The former is generally large and has possibilities for much detailed cross tabulations, but is also generally not precisely covering the subject and is also more often than not, not completely compliant with the definition, i.e. its validity is not 100 per cent. The latter is (or can be) compliant with the definition at hand, and if the survey instrument has been validated, it measures what we want to know. However, possibilities for details is often less, and in case of a sample survey we have to deal with the reliability.

Table 2 Type of source and available definitions for employed physicians, 2008-2009

Country 1)	Type of source		Data available according to these definitions		
	Practising	Professionally active	pract and no prof act	pract and prof act	no pract, but prof act
<i>Belgium</i>	adm or reg				
Bulgaria	adm or reg	adm or reg		1	
Czech Republic	survey or census		1		
<i>Denmark</i>	adm or reg	adm or reg		1	
Germany	adm or reg	adm or reg		1	
Estonia	survey or census		1		
Ireland		adm or reg			1
<i>Greece</i>					1
Spain	survey or census	survey or census		1	
France		adm or reg			1
Italy		survey or census		1	
Cyprus	adm or reg		1		
Latvia	adm or reg	adm or reg		1	
Lithuania	survey or census	survey or census		1	
<i>Luxembourg</i>	adm or reg		1		
Hungary	adm or reg		1		
Malta 2)	adm or reg	adm or reg		1	
Netherlands		adm or reg			1
Austria	adm or reg		1		
<i>Poland</i>	adm or reg	adm or reg		1	
Portugal					
Romania	survey or census	survey or census		1	
Slovenia	adm or reg	adm or reg		1	
Slovakia	survey or census	survey or census			1
Finland	survey or census	survey or census		1	
Sweden	adm or reg		1		
United Kingdom	adm or reg		1		
Iceland	adm or reg	adm or reg		1	
Norway	adm or reg	adm or reg		1	
Switzerland	survey or census	survey or census		1	
Croatia	adm or reg		1		
<i>FYR of Macedonia</i>					1
<i>Turkey</i>					1
EU			9	15	7

Possible solutions – and this is by no means exhaustive – could be the following.

For administrative sources:

1 If the country has the possibility to link the sources to other sources on the microlevel (i.e. on the person level or job level), it could be possible to construct decision rules for groups of (professionally active) physicians. This means for instance that data on registered physicians could be linked to registers on economic activity, and determine whether they are economically active. In a next step the decision rule could be if they are economically active in a health care provider industry, they could be indicated as professionally active. E.g.:

- Do they have an income (i.e. are they economically active)? This is prerequisite for going further
- Is it possible to assess where they are working? I.e. is it possible to link the to a business register or another register of economic activity?
- Is it possible to assess whether they were employees or self-employed?
- Can they be split into age and gender groups?

In general, administrative sources tend to give a complete picture of the physicians concerned, but not always according to the definition of practising.

2 The crucial step is then to assess whether the professionally active physicians can be split into practising and non-practising. This is by no means simple. The most straightforward way would be to have a special survey among the professionally active physicians. The second possibility is to integrate the results of the administrative data with – often more scattered – data on practising physicians. Several of sources, not always consistent with each other – can be investigated. E.g.: - Hospital statistics; statistics on ambulatory care (GP's, medical specialists). The hospital statistics could deliver data on practising physicians; of the data on GP (practices) one could presume that almost all of the physicians are practising. By matching these data with the administrative data, it could be possible to assess the plausibility of either of the sources.

So, basically two methods are available: ask – or register – the physicians, or ask the providers (leaving out a cumbersome possibility to ask the patients). If these are not possible or available, one has to rely on estimates based on e.g. one-time surveys in the own country, or estimates based on the data of one or more other countries that are more or less comparable.

For survey and census sources:

1 If the source is a person-survey or census, like the LFS, the most likely course of action is to include a question on being a practising doctor (or other medical professional) or not. The question could be in the survey itself, or in a follow-up survey (for e.g. the LFS).

2 If the source is a business-survey or census, the same course of action applies, although the reformulation of the question(s) could be more problematic. Moreover, the data should be available at the provider level.

However, in case of a survey, the number of respondents is likely to be low (e.g. the number of respondent doctors in the Dutch LFS is around 50 to 60 per year). An estimate of the number of practising physicians is therefore a rough estimate (e.g. in the Dutch case 2 years have to be averaged to arrive at an estimate that is at least reliable in an interval of plus or minus 5 percent of the number of doctors).

As a census is usually carried out at intervals of several years, also in this case a sample survey could be used. The same proviso's apply as mentioned before.

Final remarks

If it is possible to have as sources the LFS and surveys of health care institutions, then the following line of thought may help to arrive at estimates of practising professionals:

- 1 The figures from the LFS are considered as professionally active professionals.
- 2 The data on professionals out of the survey(s) of health care institutions are considered as practising professionals.
- 3 All the professionals working in (para)medical practices are considered as practising. For this the NACE classes are needed; these are available in the LFS.
- 4 All the professionals working in ancillary services are considered as non-practising (in the sense of not having (much) direct contact with patients).
- 4 For the figures on professionals working in institutions a ratio has to be applied of practising / professionally active; as the NACE classes are available in the LFS and should be possible to deduct out of the surveys, in principle such a ratio could be calculated.

These possible solutions, however, need to be tested in real life situations in the countries themselves, for instance in a pilot project.

ANNEX A Conclusions and proposals of the Evaluation on the Joint Questionnaire on Non-Monetary Health Care statistic, Eurostat project ESSnet Public statistics.

In view of the preparation of the Implementing Regulation (IR) on care non-monetary data there is a need to further improve comparable, timely, and consistent reporting of all variables in the JQNMHC by all Member States and to further investigate development of metadata information.

An overall reflection is that if variables from the Joint Questionnaire on Non-Monetary Health Care statistics should be part of an Implementing Regulation on health care at EU level the variables must be policy relevant, reliable and valid and also be possible to collect from a majority of the Member States. There must be an aim and objective for collecting the variables that is useful for comparison, analyses and evaluation of the health care systems between countries. It is also important for countries to know why different variables are to be collected. It would also be an advantage if the Member States themselves have a benefit of the variables collected for national analyses. In view of budget restriction in Member States further improvements and developments of the JQNMHC must be in tune with the possibility for the Member States to provide data. A step way approach is to prefer.

This report lays the groundwork for Eurostat in coming up with proposals for improvement of the JQNMHC in view of the future implementing regulation on health care.

Proposals

The following proposals are based on the results of the questionnaire on the quality on the Joint Questionnaire on Non-Monetary Health Care statistics sent out to 33 countries and also on discussions in the Core Group Health Care.

Main proposals

More explanations and examples in Sources and Methods

Over 60 per cent of the countries have data according to the definitions. Nevertheless it is important to improve the statistical definition. More clear examples are needed with detailed explanations, for example for long-term care. Long-term care applies specifically to the class of Caring personnel. In the definition two ISCO codes are given. However, as such, these codes do not cover always the whole range of possibilities. Especially if for the nurses an extra requirement of having a license to practice is asked. In that case several professions that could also be grouped under the ISCO code for associate professional nurses could be headed under the group of caring personnel, e.g. personnel specifically trained for help with ADL.

In the guidelines of the JQNMHC for health employment the ISCO code must be more strictly specified in all categories. It will be even clearer if in the spread sheet (Excel worksheets) the ISCO code is shown for each employment variable. Countries must also in the Sources and Methods fill in more explanations with details on what is included and what is excluded in respective variable.

Report all three dimensions: Practising professions, professionally active professions, professions licensed to practice.

The recommendation from the Core Group Health Care is to keep the concept for the health employment variables since the three variables are a complement to each other. Though several professionally active professions are for some countries difficult to measure. But the number of professionally active professions could be used as an estimate together with some kind of template for the number of practising professions. Another possibility to count the practising professionals is to use the number of professions licensed to practice together with the NACE code for health care sector. A problem is the mapping of the breakdown between professional nurses and associate professional nurses, as well as the distinction between nurses and midwives. Given the possibilities of the countries in data collection, these variables should be asked.

A new split between professional midwives and associate professional midwives

To increase the comparability on health employment the proposal is to report a *new split between professional midwives and associate professional midwives* in the JQNMHC in the same way as professional nurses and associate professional nurses. Professional midwives with ISCO code 2222 on a separate row in the JQNMHC and associate professional midwives with ISCO code 3222 on a separate row as shown below. The classification of midwives and nurses must be based more on the level of education. Different levels of nurses and midwives could be defined by the level of education, higher level and lower level of education.

Given the level of skills needed in the ISCO classification, the distinction between professional and associate professionals would be the distinction between ISCED (1997) level 5 and levels 4 and 3(A). Moreover, as the JQ asks for these professions, an additional requirement may be needed: registration as licensed to practice, to exclude professions that may be grouped under the respective ISCO headings.

Midwives and Associated midwives

Professional midwives ISCO code 2222

Professional midwives - practising

Professional midwives - professionally active

Professional midwives - licensed to practice

Associate professional midwives ISCO code 3222

Associate professional midwives - practising

Associate professional midwives - professionally active

Associate professional midwives - licensed to practice

Indicate the level of education

Countries should be stimulated to supply ample metadata and also indicating the level of education needed for the health employment variables especially for nurses and midwives.

Exclude the variables hospital and general hospitals and hospitals at NUTS 2 level from the JQNMHC

The meaning of what a hospital is differs among EU countries. It is not clear in the definitions what is regarded as a hospital or as a general hospital and how the number of hospitals should be counted. In some countries hospitals can also be used for the care of the elderly. In

Portugal e.g. there are centres of hospitals for financial reasons which lead to one statistical unit with many locations. Is a hospital an administrative unit or is it a building or a group of buildings quite close to each others? One question is also if all kinds of hospitals should be included. However, not all hospitals provide all medical specialities which would lead to comparability problems. Therefore it is questionable if the numbers of hospitals give any relevant information for health policy issues, such as on the quality of the health care system in the countries. The reason why hospitals have been counted may be to develop a relation between the System of Health accounts (SHA) and non-expenditure data.

The Core Group Health Care has the opinion that the number of hospitals, general hospitals and hospitals at NUTS 2 level is not relevant or interesting for policy analyses or for international comparison and should therefore be removed from the JQNMHC due to methodological reasons and the incomparability.

Exclude the variables hospitals/beds HP.1 in public, not-for-profit privately and for-profit privately owned hospitals

The Core Group Health Care discussed the usability of the breakdown into public and private hospitals as well as into for-profit and not-for-profit hospitals in the case of the question to the number of hospitals beds. These variables on ownership are more useful and policy relevant on national level. As this breakdown was enclosed to link to SHA data, and as the proposed new revised SHA 2.0 manual does not have that split anymore, the Core Group Health Care advises to drop this breakdown altogether in the JQNMHC as it is questionable from the viewpoint of usability. That comprises also publicly owned hospitals, not-for-profit privately owned hospitals and for-profit privately owned hospitals which are new variables in the data collection 2011.

Exclude the variables for numbers of on medical technology or add instead indicators for the use of them

The Core Group Health Care discussed whether the variables of medical technology are relevant to collect in the JQNMHC as they have been collected so far. Some of these variables are for some countries difficult to measure. It is not possible to do any kind of relevant analyses due to the fact that it is difficult to connect the equipment to the outcome of health status. You also have to know if the different diagnostic and therapeutic equipment are functioning or not. The way of using the diagnostic and therapeutic equipment, all the day or just a part of the day, affects the effectiveness. There is also a big difference between new medical technology and old medical technology. New medical technology can do more and better medical and surgical procedures which give more precise answers than older ones. But older technology could be quite adequate relative what kind of patient you have to treat. The list of equipment will also have to change regularly to reflect the changing (expensive or new) technology used in health care. An alternative could be to add indicators for the use of this equipment, but that could be difficult to measure.

The Core Group Health Care raised the question if it was possible to group some of the variables together. For example CT Scanners and PET Scanners together or angiography units combine with gamma cameras. But after having consulted medical experts, the conclusion is that it is not possible to group those variables together.

In conclusion the Core Group Health Care proposes to remove all the variables for numbers of medical technology from the JQNMHC, or at least to add indicators for the use (how often) of this different technical equipment.

Included the variable number of visits

At a recent trilateral Eurostat/OECD/WHO meeting the OECD proposed to include the number of consultations of the doctors and dentists (number of visits) in the common module of the Joint Questionnaire (now only in OECD health data). The Core Group Health Care would agree to that approach. The length of a visit should also be considered to incorporate. However, the comparison between countries may not always be possible due to differences between the systems.

Minor proposals

Update the figures in the data base and on the Website twice a year

The point in time when data are available in countries varies a lot. That indicates that it could be an improvement on the data quality and timeliness if it is possible to update the figures at least twice a year: one updating in the data base and on the Website in springtime (as now) and one in the autumn. Of course that is time consuming but also an improvement of data quality while data then are more up-to-date. Countries sending in data after the stipulated time could then have the possibility to have their data submitted on the Website the same year. Today the JQNMHC is sent out in December for data on t-1.

Reporting data

To clarify and make it more distinct what kind of data different countries submit to the JQNMHC the proposal is to show data with a *split into public providers - private providers - total providers*.

For nurses it must be clear that the three variables nurses practising, nurses professionally active and nurses licensed to practice are *a total* of professional nurses and associate professional nurses. Professional nurses and associate professional nurses are on different education level. Countries should be stimulated to supply metadata indicating the level of education needed for these variables.

Physicians and midwives working in hospital on a Service contract

Very few countries can provide data on physicians, midwives and professional nurses employed in hospital with a service-contract. In the JQNMHC 2011 these variables have already been removed from the questionnaire due to limited availability and comparability.

Inpatient curative beds instead of hospital beds

The Core Group Health Care is of the opinion that data on beds is interesting. In the present JQNMHC data are collected on *curative (acute) care beds*. However, *Inpatient curative beds* would be a better entity than *hospital beds* and in correspondence with SHA. In addition, for the definitions it should be clearly defined if the measurement should be on the *administrative number* of beds or the actual or *occupied numbers* of beds.

In order to calculate a meaningful number for e.g. the bed occupancy rate, the number of available beds is to be preferred, instead of the number of administrative beds. If a country does not have data on that variable, information on the practice in the country of dealing with the administrative beds (or beds allowed out of the budget) is warranted.

Collect the variable operations theatres on HP.1 and HP.3 level

Operations theatre is a variable which is uncertain how to analyse, while it depends on how the operations theatres are equipped and also how they are used, all day or only part of the day. Should only well equipped operations theatres be counted or can just a simple room be included. The variable is for many countries difficult to measure.

If the variable is going to be collected the variable should be reported on hospitals (HP. 1) and also on providers of ambulatory health care (HP. 3) in conformity with SHA.

Number of day care procedures instead of day care places

The Core Group Health Care is not convinced of the necessity of the number of day care places. A question is why psychiatric and geriatric day care places are chosen. The variable is for some countries difficult to measure.

If they are going to be collected the proposal from the Core Group Health Care is to report the variables both on hospitals (HP. 1) and providers of ambulatory health care (HP. 3). According to the Core Group Health Care a more interesting variable is *the number of day care procedures* in combination with expenditure data.

Proposals on work shops

ISCO -08 work shop

The ISCO code for respective health employment staff is used for more than half of the countries. An area of improvement to increase the comparability is to support and encourage countries in “translating” what the new ISCO-08 codes mean in their own country (national label), e.g. for allocating categories of nurses to professional nurses and associate professionals nurses and also for caring personnel. Preferentially this support should take place in a workshop after the implementation of ISCO-08.

It is for instance possible in the practice of applying the ISCO in the Labour Force Survey to subsume e.g. ambulance personnel under the heading of nurses. The workshop should make clear what is now the practice in the member states. That means that also people from the departments that deal with the LFS and with the ISCO and ISCED classifications will be involved in such a workshop.

Work shop on relevance of variables in the JQNMHC

The analyses of the result of the questionnaire on quality indicate that some variables in the JQNMHC are more relevant than others and some variables may be removed from the Joint Questionnaire. In table 8 and 9 below there is a thinkable list on variables for health employments and graduates and physical and technical resources, that indicates which variables are relevant, less relevant and variables that are not relevant and could be dropped.

The proposal is to discuss this list and the definitions of the variables at a workshop with Member States as a preparation before the Implementing Regulation (IR) on health care statistics for non-monetary data.

Table 8. Relevance of health employments and graduates variables

Relevant	Not so relevant	Not relevant at all - could be dropped
Practising Physicians - practising	Professionally active Physicians - professionally active	Physicians/ employed in hospital with a service-contract
Dentists - practising	Dentists - professionally active	Midwives and professional nurses employed in hospital with a service- contract
Midwives - practising	Midwives - professionally active	
Nurses - practising	Nurses - professionally active	
Professional nurses - practising	Professional nurses - professionally active	
Associate professional nurses - practising	Associate professional nurses - professionally active	
Caring personnel - practising	Caring personnel - professionally active	
Pharmacists - practising	Pharmacists - professionally active	
Physicians by age and gender	Licensed to practice	
Physicians by categories of specialty	Physicians - licensed to practice	
Physiotherapists	Dentists - licensed to practice	
Graduates all kind	Midwives - licensed to practice	
	Nurses - licensed to practice	
Physicians - by NUTS2	Professional nurses - licensed to practice	
Dentists - by NUTS2	Associate professional nurses - licensed to practice	
Nursing professionals - by NUTS2	Pharmacists - licensed to practice	
Pharmacists - by NUTS2		
Physiotherapists - by NUTS2	Hospital employment, Head Count	
	Hospital employment (FTE)	
	Physicians training specialty	

Table 9. Relevance of physical and technical recourses

Relevant	Not so relevant	Not relevant at all - could be dropped
Beds HP 1 total	Beds in publically owned hospitals	Hospitals
Beds HP.1 - acute care	Beds in not for profit privately owned hospitals	General Hospitals
Beds HP.1 - psychiatric care	Beds in for profit privately owned hospitals	Hospital NUTS 2
Beds HP.1 - long-term care		
Beds HP.1 - other	Operations theatres	CT Scanners HP1, HP3, HP1+3
Beds HP 2		MRI Units HP1, HP3, HP1+3
Beds HP.1 by NUTS 2 - total	Day care places, total	Pet Scanners HP1, HP3, HP1+3
Beds HP.1 by NUTS 2 - acute care	Day care places - surgical	Gamma cameras HP1, HP3, HP1+3
Beds HP.1 by NUTS 2 - psychiatric care	Day care places - oncological	Angiography units HP1, HP3, HP1+3
Beds HP.1 by NUTS 2 - long-term care	Day care places - psychiatric	Mammographs HP1, HP3, HP1+3
Beds HP.1 by NUTS 2 - other	Day care places - geriatric	Radiation therapy equipment HP1, HP3, HP1+3
Beds HP.2 by NUTS 2 - total		Lithotriptors HP1, HP3, HP1+3