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An injection of statistics into health policy



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Chief editor

Gunter Schäfer

Editorial team

Philippe Bautier, Annika Östergren-Pofantis, Aurora Ortega Sánchez

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Eurostat

Press & Communication Team

Bech A3/094

L-2920 Luxembourg

Fax: + 352 4301 35349

e-mail: eurostat-pressoffice@cec.eu.int

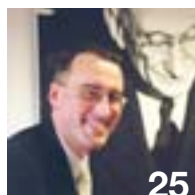
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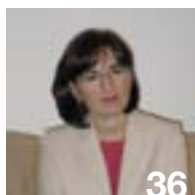
Contents



5



25



36



42



44



49

4 Editorial

HEALTH THEME

5 1994-2005: a prominent decade for statistics on health and safety at EU level

12 Partnership on public health statistics

17 Facts and figures on health

19 Health statistics – Doing the same in different ways

25 Improving information and knowledge for the development of public health

27 Safety first!

30 “Comparisons with other Member States a must”

32 Monitor, alert and prevent: the tasks of the French Health Monitoring Institute

34 Focus on the “Injuries” unit

36 Towards harmonization of health statistics in Europe

38 The OECD Health Division – Four strands on new agenda

NEWS FROM EUROSTAT

42 Joaquín Almunia Economic and monetary affairs Commissioner

44 Eurostat’s Director-General wants stronger cooperation within the ESS

46 Quality top of the agenda for Eurostat’s deputy Director-General

48 News in brief...

PORTRAIT OF A MEMBER STATE

49 “More Statistical than Office...”

53 A young graduate sees a future with the Office

NEWS FROM MEMBER STATES

54 A granary for agricultural data

56 Do you have dissemination problems? Don’t worry, PC-Axis comes to the rescue!!

57 Modernising the Statistical Infrastructure in the UK Office for National Statistics

59 eSTATISTIK.core: Digitally linking statistics and accounting

61 Statistisches Bundesamt’s new statistics shop open

62 Household panel surveys and international comparability

Editorial

After a two year break I am happy to present the first issue of the 'new' Sigma. As you see the layout has changed, but we will continue to focus on a special theme in each issue and give room for news from Eurostat and the different actors in the European Statistical System.

This issue focuses on health statistics, an area that has become more and more important over the years. Today Eurostat provides data on health status and its determinants, on health and safety at work, causes of death, and health care in the EU – all data based on statistics from the Member States. Sigma will give you an insight into how the collection of health statistics is organised in the EU Member States, how the work is organised on an EU level and how the data is used in the European Commission and in the Member States. Eurostat's close international cooperation partners in this area – the World Health Organisation and the OECD – are also presented.

Over the past year the top management has changed in Eurostat. This issue presents the European Commissioner in charge of Financial and Monetary Affairs, Joaquín Almunia, the deputy Director-General and myself in the news section. The National Statistical Institutes (NSI) in Germany, Hungary, Sweden and the United Kingdom have also contributed with articles on a wide range of issues. Finally, we have continued the series of presentations of the NSIs in the new Member States. In this issue you meet the Director-General for the Slovak Statistical Office and some of his colleagues.

I hope that you will enjoy the first issue of the 'new' Sigma and I would very much welcome your feedback.

Günther Hanreich
Eurostat Director-General

1994-2005: a prominent decade for statistics on health and safety at EU level



By Marleen De Smedt, Head of the Health and Food Safety Unit, Eurostat

“What are the statistical data on occupational accidents in the EU for the last three years?”, “What data are available on alcohol consumption among teenagers and young adults?”, “How many people in the EU suffer from a severe visual disability?”... These are a few examples of requests for statistics on health and safety issues that Eurostat receives regularly from the European Institutions, from researchers and interested parties, from industry or from the public at large. The demand and need for health statistics is increasing rapidly, and more can be expected due to changes in the political agenda, at both national and at EU level, and to a more explicit interest of people in their own health situation.

Through Eurostat’s activities on statistics on health and safety over the last decade within the European Statistical System (ESS) we have significantly improved our capacity to respond with reliable data. The increased demand will to a large extent

be met through a further increase in the production and dissemination of health and safety statistics as a result of efforts for renovation and harmonisation.

An increasing demand for statistics on health and safety

The first initiatives in Eurostat on health statistics were on statistics on **accidents at work** due to the specific Community policies and EU Directives in the field of occupational health and safety in 1990. (See also article on page 27)

The Maastricht Treaty from 1992 then introduced explicit provisions on **public health** providing the basis for actions in the field of public health.

A year later, the Council mentioned **statistics on health and safety** as a priority area for actions to be undertaken in the field of statistical information. And at the seminar on social statistics organised by Eurostat in 1994 in Mondorf 'health statistics' was on the agenda for the first time.

Eurostat's actions on health and safety statistics then continued in the context of the Community statistical programme 1998-2002 and were also supported through actions funded in the context of the programme for Community action on health monitoring 1997-2002. The latter programme was succeeded by the Programme of Community action in the field of public health for the years 2003-2008. This programme contains 'health information' as one of its three main strands and it contains an explicit reference to the development of the **statistical element of a health information system** using the Community Statistical Programme.

The 2003-2007 Community Statistical Programme builds on this reference and sets out the main lines for health statistics: to further develop the system of health statistics and to reinforce its infrastructure in order to better respond to the specific requirements that result from the Community action programme on public health and from other Community Programmes.

Did you know that on average, each inhabitant visited a general practitioner five times in Belgium, Italy and Austria in 2001, compared to twice in Greece and Finland?

Source: Eurostat

The issue of equal opportunities for all persons, regardless of their gender, ability, race, is rising on the agenda within the European Union. Community policies and programmes have been launched in order to enable people with disabilities to participate fully in society. The need for reliable statistical information about people with disabilities is highlighted in the Commission Communication of 2000 'Towards a Barrier Free Europe for People with Disabilities'. Moreover, in 1999 the European Council on Equal Opportunities for People with Disabilities called upon the Commission to monitor and analyse the development of the employment of people with disabilities on the basis of comparable data. And consequently statistics on **disability and on social integration of people with disabilities** are also included in the Community Statistical Programme.

The European Statistical System will also have to deal with information needs arising from the Council Social Protection Committee's focus on **sustainability, accessibility and viability of health care** – physical and financial resources of health care – in the framework of 'Social Protection'. Data may also be needed for the recent initiatives on migration of health professionals and patients and for the Council Economic Policy Committee's discussion on specific requirements for providing health care in ageing societies.

At national level, the EU Member States face challenging policy and social developments which put a heavy burden on the health and social services and on the resources required to finance these services. The structure of the national health care services is undergoing considerable changes in every Member State. There is not only a general shift from in-patient care to out-patient and ambulatory care but in Member States with traditional national health care insurance systems there is also a tendency towards more private care and/or more public limited reimbursement. Comparable statistics at EU level support Member States in these processes.

Over the years, work on statistics on work-related health problems has been intensified and supported by various Community programmes. The Community strategy on health and safety at work 2002-2006 requires the full implementation of the European statistics on **accidents at work** and on **occupational diseases** and further developments on their **socioeconomic costs**, as well as indicators on **quality of work** and **work-related health problems**.

A new system of health statistics

In the eighties Eurostat had already begun to collect data related to health and safety, such as some general data on causes of death, on number of doctors and on accidents at work, but the activities were part of other statistics and there was no common strategy for statistics on health and safety.

In 1994, I started to work in Eurostat as the first administrator recruited for work on health statistics. Gradually the team in Eurostat grew and regular contacts were established with the colleagues in other Commission services, in particular with the Directorate on Public Health in the then DG V of the Commission (now DG Health and Consumer Protection). In 2002 health statistics was attributed to a Unit together with Food Safety.

Gradually since 1994 and together with colleagues working on health statistics in the Member States – steps were taken to put in place a framework for health statistics and to renovate and modernise the existing statistics. The basic idea was, following the principles of epidemiology, to put in place a coherent set of core statistics which would describe on the one hand the status of health of populations in all its dimensions (from health to death) and its determinants, and on the other hand the health care services and resources for coping with the health problems and the financing of these services and resources.

The aim was (and still is) to construct a system of health statistics that can reflect the health-related risks and determinants, show adequate socio-economic differentials of the populations and includes, where needed, regional breakdowns. The system can be seen as a sub-system of the social statistics also with functional links to the relevant economic statistics by means of concepts, definitions and classifications. The emphasis is on the development of a durable system for adequate trend analysis, which should be at the same flexible enough to be adapted according to changing policies and demands, health services and methodology.

Development in close cooperation with the Member States

Statistics on causes of death was one of the first domains in which significant improvements were made. In cooperation with the World Health Organisation (WHO) Eurostat elaborated a more structured mechanism for regular reporting by Member States of causes of death statistics at national and

sub-national level. With the help of a number of national experts in the field of causes of death statistics a short list of 65 (groups of) causes was established which is mainly used for dissemination purposes but which Member States could also use to report the data to Eurostat.

At its first meeting of February 1996, the Working Group on Public Health statistics discussed and agreed on the new systematic approach and recommended to develop further work along three lines: *causes of death statistics*, *health and health related survey data* and *health care statistics*. Task Forces were established for each of these areas.

Since 1994 close cooperation with experts from Member States grew step by step, with active support from Jacques Bonte, then deputy director for socio-cultural statistics at Statistics Netherlands. Other key members of the growing team of voluntary experts were Karen Dunnell from ONS-UK, Eric Joula from INSERM-F and Gunter Brueckner of StBA-D, covering the major domains of health statistics.

Did you know that there were 850 inhabitants for each dentist in Greece and 3 600 in Poland in 2002?

Source: Eurostat

This form of cooperation grew in a difficult period for health statistics in most Member States. In the waves of budget restrictions for statistics which started in most Member States during the eighties and nineties, health statistics were hit severely in many if not most Member States. This resulted in a drain of expertise, less analysis and sometimes also in a loss of quality. The creation of the collaborative EU effort provided an active forum for mutual support and sharing of knowledge and expertise and for coping with common problems, a partial counterbalance for the reduction in resources.

The Leadership Group on Health Statistics and Partnership Health

An important step forward in cooperation with Member States was the establishment the Leadership Group on Health Statistics (LEG Health) in 1998. Together with Euro-



The health team: from left to right, Marleen De Smedt, Bart De Norre, Tine Christiansen, Sabine Gagel, Elodie Niederlaender, Lucian Agafitei, Susanne Resmalm, Antti Karjalainen, Marko Ylitalo and Didier Dupré

stat, Statistics Netherlands as co-ordinating and leading partner shared responsibility for co-ordination of the various projects in the complex domain of health statistics. The other three leading partners – INSERM-F, ONS-UK and StBA-Germany – have also done an outstanding job in sharing the leadership of the different Task Forces. Between them, they established – with the Member States – a solid network, which over the years has created a positive reputation for itself and for the ESS.

In view of the enlargement and because the activities shifted from the development phase towards implementation, the

LEG Health proposed that the work in partnership on health statistics between Eurostat and the Member States, as successfully exercised in the LEG Health, should be continued in an adapted structure. The Partnership Health was established in 2002 by the Directors of Social Statistics.

The adapted structure was reshaped to clearly distinguish work on implementation of data collection and delivery to Eurostat from (further) development work on methods for data collection, analyses and dissemination. The UK Office of National Statistics (ONS-UK) offered to take over the co-ordinating role from Statistics Netherlands and colleagues of the

National Public Health Institute (DK), CSO (IRL) and ISSG (Lux) agreed to take the lead for each of the topical groups.

From the start in May 2003 Partnership Health included the full participation of the then 10 Candidate Countries (CC) and operated through the establishment of Technical Groups (with all Member States and mainly focussing on implementation) and Core groups (with a limited group of Member States and aiming at coordination and steering). In addition the structure allowed for the setting up of ad-hoc Task forces for specific tasks such as for further development of methodological issues. (See article on page 12).

Cooperation with international organisations

Efforts on health statistics were further developed while drawing also on the expertise and experience of international organisations, e.g. United Nations' Statistical Division (UNSD), World Health Organisation (WHO), Organisation for Economic Co-operation and Development (OECD) and the International Labour Organisation (ILO), in whose work many experts from EU Member States are also involved.

Over the years, practical working arrangements for the collection of data and statistical methodology, e.g. on classifications have been established between Eurostat and international organisations active in the field of health information, i.e. WHO and OECD.

Milestones in causes of death statistics

The 'oldest' series of health statistics – causes of death statistics (COD) – was already on the agenda of the International Conference for Statistics some 150 years ago. But the introduction of the 10th revision of the International Classification of Diseases (ICD10-WHO) around 1990 was at first unsynchronised in the Member States. Some Member States continued using ICD8 or ICD9, while others used ICD10. For many years this made comparisons between the 15 Member States and still now between the 25 Member States impossible. This is not only an example of the results of resource problems in Member States but it created serious problems for the renovation of these statistics in Eurostat. This situation was a reason for the creation of a new short list of 65 causes (see above). The list allows trend analysis and inter-country comparisons for the major causes irrespective of the use of the three ICD versions mentioned.

The statistical series on COD is still considered as the cornerstone for providing information on the evolution of the health status of the populations. COD statistics have been at the source of the observations of emerging threats, such as AIDS and Alzheimer disease. However it faces serious problems in Member States and therefore rapid implementation of several recommendations agreed by Member States is needed during the coming years, e.g. a common module for death certificates in Member States, the dissemination of the European manual for inter-active training of certifiers (a training package was prepared in 2004) and implementation of automated coding of causes of death.

Creation of a system for health and health-related survey data

One of the first initiatives taken in the field of Health Interview Surveys (HIS) was the establishment of an inventory on health and health-related data, and on the instruments available in the EU Member States in particular on existing and planned HIS or HIS modules.

This was the basis for the collection of data on 18 subjects (such as self-perceived health, smoking, physical activity, use of medicines...) from existing national surveys. In 2004 the data of the new Member States were collected also for the first time. However analysis proved to be difficult because of differences of concepts, definitions, classifications and of different years of data collection.

These problems are at the origin of the design and agreement by the Directors of Social Statistics in 2002 for the creation of a European Health Survey System (EHSS). It is composed of a set of modules for a regular European Core (ECHIS) to be done in the ESS and a range of European Special (ESCHIS), which can be done ad-hoc and cover special topics, such as 'health of children and mothers' or 'nutrition', and should not be done primarily in the framework of the ESS. The EHSS has also been adopted by colleagues in the DG Health and Consumer protection and is therefore a good example of the co-operation of statisticians, researchers and public health authorities, while avoiding duplication of work, efforts and resources and making use of scarce expertise.

In the field of disability statistics, the first Community-wide results became available through the European Community Household Panel (published in a Pocketbook on Disability and Social Participation). The 2002 Labour Force Survey con-

tained an ad-hoc module on employment of disabled people and the first results were published in a Statistics in Focus in 2003. A short instrument for measuring disability is included in the Statistics on Income and Living Conditions (SILC) and the development of a longer module is planned for 2005.

Towards implementation of the System of Health Accounts

In 2000 experts from Member States, the OECD and Eurostat completed the development of the “System of Health Accounts” (SHA) (See also article by OECD on page 38). It aims at defining and structuring the health care systems of the Member States and Candidate Countries in a comparable way, referring to health expenditures, health resources, and health outputs.

The development of SHA was accompanied by setting up a meta data system that systematically describes the “actors” in the countries and how they interact in work sharing on providing – i.e. producing and financing – health care: the EU-COMP project.

Did you know that the average length of stay in hospital was ten days in the Czech Republic, Latvia, Lithuania and Finland compared to five days in Malta and Cyprus in 2002?

Source: Eurostat

Both developments set up a systematic framework, which allows the compilation of comparable statistical data across organisationally different health care systems. Subsequently Eurostat has launched various efforts to “implement the SHA”. These efforts cover both the introduction of new data collections and the improvement and extension of existing ones.

With respect to *new data collections*, the focus was and is on preparing Member States for the first-ever data collection of SHA-compatible health expenditure data, envisaged for late 2005. SHA guidelines have been developed and workshops

are being and will be organised to qualify countries for providing high-quality SHA expenditure data. With respect to *improving existing data collections*, the focus is on health staff, – doctors, nurses, other health professionals – and other professions active in the sector health care.

Developments in health and safety at work

For several years all ‘old’ Member States have sent annual data to Eurostat according to the European Statistics at Work (ESAW) methodology now including also data on the causes and circumstances of the accident (phase 3). For the collection of European Occupational Diseases statistics (EODS) a methodology (first phase) has been developed and a first data collection has been realised. Both ESAW and EODS are and will be implemented in the new Member States in 2004-2006. The 1999 Labour Force Survey (LFS) contained an ad-hoc module on work-related health problems which will be repeated in 2007.

Achievements in indicators and publications

Indicators on health and safety have gradually been included in different sets of indicators at Community level, such as the Sustainable Development Indicators (SDI), the Quality of work indicators, the structural indicators and the European Community Health Indicators (ECHI).

Data and more detailed information on health and safety statistics can be found in the Eurostat Panorama publications ‘Key Data on Health’ and ‘Work and health in the EU’ both released in 2004.

The future

In the field of **public health** future actions will concentrate on cooperation within the Partnership Health focussing on the full implementation of the System of Health Accounts (SHA), on the development and implementation of the European Health Survey System (EHSS) and on the implementation of the recommendations to improve quality and comparability of COD statistics.

Furthermore, the existing data collection for the most important group of health care providers – hospitals – will be broadened and deepened. In the short run it will provide detailed information on hospital discharges by age, gender and diseases treated, and on high-tech equipment installed in

hospitals. In the medium term perspective, it will also cover hospital staff and equipment data, hospital characteristics and capacity information and data on hospital finances.

In the field of **health and safety at work** the emphasis will be on full implementation and improvement of quality and comparability of ESAW phase 3 and of EODS phase 1 data, on the collection of data on the socio-economic costs of accidents and on the planning of the 2007 LFS ad-hoc module on work-related health problems.

One of the most important tasks ahead will be the preparation of EU legislation for the production of Community statistics in the field of health and safety, for which the Member States gave, at the 2004 meetings of the relevant Working Groups, their support for Eurostat to start the process.

Did you know that on average five heart transplants took place each day in the EU15 in 2002?

Source: Eurostat

Overall we can say that over the last decade Eurostat has with enthusiasm and with the continued efforts and support of the Member States made a lot of progress in arriving at a comprehensive system for statistics on health and safety across the EU. Some say the growing data base is a 'goldmine', now the challenge is in making the best use of it by ensuring good analysis and dissemination of the data in an integrated and user-friendly approach and addressing the existing and emerging concerns on health and safety. Σ

Dr. Marleen De Smedt graduated at Antwerp/Leuven university as a doctor in medicine, specialised in public health and occupational health. After eight years of practising in internal and in occupational medicine in Belgium, she joined the European Commission in 1988, where she worked for more than 5 years in the policy department dealing with occupational health and safety. In 1991 she completed further training at Brussels university in epidemiology and statistics, and in 1994 she joined Eurostat to set up health statistics; she is actually heading the Eurostat Unit D6 'Health and Food safety'.

Partnership on public health statistics



Didier Dupré: Head of Health Statistics Team

The topics covered by public health statistics are diverse – data on causes of death, health status and diseases, disability, health determinants, health service personnel, health costs are all needed. Public health is the subject of a number of major policy concerns at EU level.

The Partnership on Public Health statistics lies at the heart of Eurostat and the European Statistical System's work on public health statistics. So what is the partnership and how does it work? To answer these questions, Sigma talked to some of those involved.

Firstly Didier Dupré, of Unit D6 “Health and Food Safety” at Eurostat, explained the basic set-up of “Partnership Health” to us.

“In 2002, the Directors of Social Statistics (DSS) took a decision on the work of the Leadership Group Health (LEG Health). The aim of LEG Health, which was established by the Statistical Programme Committee in 1997, had been to de-

velop specific aspects of health statistics. While selected experts from a number of National Statistical Institutes took the lead in the work, all Member States were involved. The final report of the LEG made proposals for future work, which the DSS accepted.”

As a consequence of this DSS decision, “The new Partnership Health started work in 2003 as the successor to the LEG. Its

remit went further though, as it was not just to develop, but also implement and follow-up work in the field of health statistics.”

So how is the Partnership organised?

“There is a co-ordinating group, Partnership Health, which is currently chaired by the Office for National Statistics of the UK and includes the leaders of the three Core groups and Eurostat. The Core groups cover three statistical domains: Health surveys-morbidity-disability statistics (HIS), Health care statistics (CARE) and Causes of death statistics (COD). Each one is chaired by a Member State, with eight or nine Member States represented in the group. To date, Ireland chairs the Core group on causes of death, Denmark on health surveys and Luxembourg on health care. Each domain also has a technical group, which include all Member States and Candidate Countries and which tackles implementation and follow-up issues, and task forces as needed for specific developments.”

How does this differ from the LEG?

“The key difference from the previous system is the level of involvement of the new (at the time Candidate) Member States. Core group leaders and members should really take the lead in their domain in making proposals and seeing through developments. There is more involvement from Member States at all stages. This doesn’t mean that Eurostat gives up all responsibility though. We ensure co-ordination with the Community and Eurostat statistical programmes, as well as other DGs’ programmes, e.g. the Community action in the field of public health (SANCO) or the use of the Open method of coordination in the area of health care and long-term care (EMPL); we launch and follow up calls for proposal and tender for complementary developments as well as preparation and support for implementation; we carry out the data collection, control, processing and dissemination, including provision of data for indicators (e.g., structural indicators); we ensure coordination with international organisations and make presentations to the meetings of the various groups and report on data; etc.”

In addition to the co-ordination of the Core group activities, Partnership Health has also been active in providing input, advice and attendance on, for example, the European Community Health Indicators (ECHI) list, particularly on the

availability of data, on the joint WHO/UNECE/Eurostat meeting on measurement of health status held in Geneva in May 2004, on the annual programmes and regular Working Party meetings of the Community action in the field of public health, as well as providing comments on the UN Friends of the Chair Group paper on international co-ordination and co-operation between international organisations and with countries in the field of health statistics.

Did you know that Sudden Infant Death Syndrome has halved from about eight deaths each day in 1994 in the EU15 to on average four deaths per day in 2001?

Source: Eurostat

What is the future for the new system?

Didier explains that with Partnership Health really beginning in 2003, it is still early days, but things are looking promising. “At the end of 2004, a first report went to the DSS, covering 18 months of work, and the DSS welcomed the ongoing activities and work programme. We have recently achieved important goals, e.g. concerning the data collection on hospital activities and preparation of the further implementation of the Systems of Health Accounts and the European Health Interview Survey. To support these strategic projects and go further, Unit D6 is preparing a proposal for a European Parliament and Council Regulation in order to replace the existing “gentlemen’s agreements” in the fields of public health and health and safety at work statistics. The Partnership co-ordinating group and Core groups have provided an important input for the drafting. Obviously such a Regulation, if adopted, will reinforce European statistical activities in these domains. But it will not reduce the role of the Partnership, or any similar system in future, as decisions will still be prepared and followed-up, for implementing measures and methodological guides for example, with a high degree of involvement of the Member States as in the current situation of the Partnership”.



Mary Heanue, chairman on the Core group on Cause of death statistics

Core group on cause of death statistics

Sigma also spoke to Mary Heanue and Niels Rasmussen, who chair the Core groups on cause of death statistics and

health surveys respectively.

After graduating in Physics, Mary Heanue worked for Intel, before joining the Irish Central Statistical Office. She has worked on cause of death statistics for about eight years, and has been involved in the Partnership Health project for “officially 18 months, but really two years including planning.”

What does the Core group do?

“The causes of death group is working on three main areas: certification, coding and dissemination, and aims eventually to get results down to NUTS 2 level.”

What is involved in each of these areas?

“Certification of death is usually carried out by doctors, and here we are looking at standardisation of the data collected – age, sex, cause of death... In this area we have been working on training tools for certification. ISTAT has under a contract prepared an ‘EU training package on certification on causes of death’. The Core group has provided comments on this package and in 2005 we plan to distribute it to medical certifiers and medical students so that the tool can be implemented. Part of the drive to improve death certification also includes the development of an electronic death certificate”.

“In coding we are concerned with coding causes of death to conform with WHO guidelines. Member States should all be moving to use ICD-10, but there are concerns about the degree of harmonisation. Once you have a harmonised classification of causes it should be possible to implement this using software. For example the Americans have developed a tool, ACME (Automated Classification of Medical Entities), to help with this process.”



Niels Rasmussen, chairman on the Core group on Health surveys

“In dissemination, Eurostat published in 2004 the ‘Atlas of Mortality’, giving details of mortality for the years 1994-96 analysed at NUTS 2 level for all the EU15 Member States, and a Statistics in Focus on ‘mortality in the EU15 1997-1999’. Future plans include a mortality atlas covering the years 2000-02 and a historical mortality data set for the EU25.”

In addition to the Partnership activities, Eurostat held a brainstorming meeting on cause of death statistics at the end of June 2004. This meeting was organised to respond to the concerns expressed by the Core group about the lack of use, visibility and support of CoD statistics. At the meeting, an overall strategy to strengthen CoD statistics was developed, which is now to be implemented

And what does the future hold for cause of death statistics?

“One issue is the speed of reaction of these data to current events. A number of major diseases or changes in patterns were first seen in cause of death statistics (CJD, AIDS, ...), but the 2003 heat-induced excess summer deaths for example were first analysed using non-official data sources. Cause of death statistics have always been annual data – perhaps shorter reference periods might be worthwhile.”

“With the information deluge that IT makes possible there is a lot of potential work in helping to make sense of the data, in summarising and disseminating data to meet user needs.”

And finally, asked if cause of death statistics are perhaps a depressing area in which to work, Mary replies “Not at all! This is an important and interesting domain of statistics. In some sense it is the ultimate measure of what we are trying to achieve in improving the economy, the environment, lifestyles... At what age, and how people die are measures of our success in improving the quality of life.”

Core group on Health Interview Surveys

Niels Rasmussen chairs the Core group on Health Interview Surveys. He is a sociologist by training, and works for the Danish National Institute for Public Health, a semi-independent body within the Ministry of Health responsible for monitoring public health.

Niels explains that his group covers “any subject on which we interview individuals – for example health status and health determinants, working environment, use of the health care

system... The results are used by national and EU policymakers to monitor the current situation. This is not a new area – there are many years of experience in the Member States. We also cover morbidity statistics and disability statistics.”

“We are developing a methodology for a European Health Survey System (EHSS). This system has three components: a database of Health Interview or Examination Surveys carried out by Member States; the DG SANCO programme of European Special Health Interview Surveys (ESHIS) on specific issues such as injuries, mental health or drugs; and a European Core Health Interview Survey (ECHIS) to be developed and carried out by the European Statistical System.”

Did you know that deaths due to drugs have decreased from 13 each day in 1996 in the EU15 to nine each day in 2001?

Source: Eurostat

“The ECHIS has two parts. The first is the minimum health module (MEHM), covering health status, whether the person suffers from a chronic illness or condition and whether his activities are limited by this. Questions on these topics were piloted in 2003 and from 2004 onwards included in the Statistics on Income and Living Conditions Survey (SILC).”

“The second part of ECHIS, to which the Core group has devoted much attention, has four separate modules. The first module on health status covering self perceived health, diagnosis, conditions related to disability, personal and domestic care and mental health will be tested in 2004/05. Other modules on health determinants, background variables and health care will be developed in 2004 and 2005. The aim is to have fully tested modules by the beginning of 2006 for pilot testing within countries and implemented in 2007/2008, and thereafter carried out on a five-yearly basis. A specific module on disability will be developed and tested in 2005/06.”

Niels mentions one problem that is common to much work within the ESS. “Language is a major problem in developing the modules – we have to be sure that we have the same

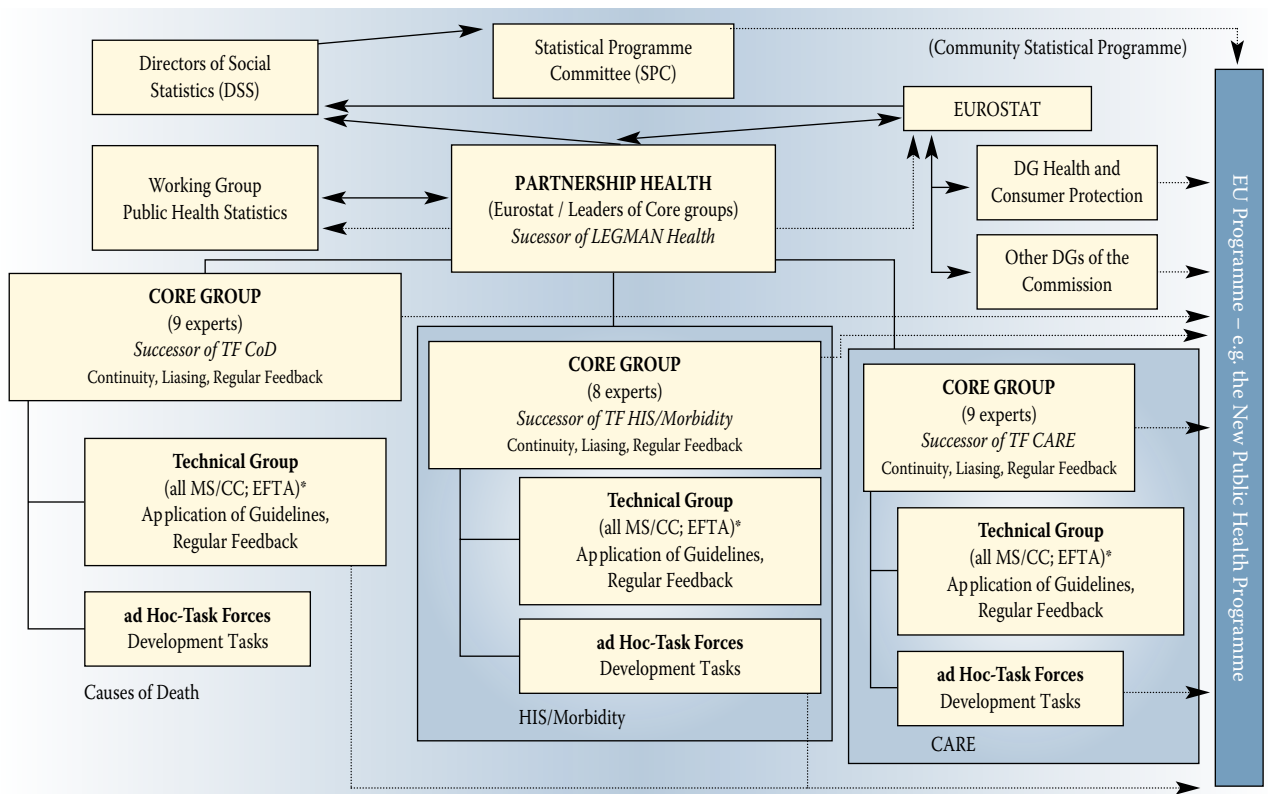
meaning in all languages. Translation may take a 'technical' approach, but 'meaning' is important. Even then, if you do ask the same question you may get different response in different Member States because of cultural factors."

Another important part of the work concerns guidelines for the surveys. "The core group has been working on guidelines for sample sizes, age ranges, methodology..."

And what does the future hold?

"There are a number of issues in testing and implementing the modules. Then there is the need to respond to latest health threats, and to keep up with new concepts such as social capital. As for all areas of statistics there is always pressure to speed up." Σ

Partnership Health Statistics Structure



* Observers: WHO, OECD

Facts and figures on health

In which Member States are there most doctors per inhabitant? Where has AIDS or cancer struck the most? What is the main cause of death? In which Member States has safety at work improved? These are some of the questions which can be answered through statistical indicators in order to get a picture of the health situation in the different Member States of the EU25.

Most doctors in Greece and most hospital beds in the Czech Republic

On average in the EU25, there were 328 practising doctors per 100 000 inhabitants in 2001. The Member States with the highest density of practising doctors were Greece and Italy, with more than 400 practising doctors per 100 000 inhabitants, while the Netherlands had the lowest number (192), followed by Slovenia (223) and Poland (228).

The Czech Republic had by far the highest number of hospital beds per inhabitant (1137 per 100 000 inhabitants), followed by Ireland (994) and Germany (902). The Member States with the lowest amount of hospital beds per inhabitant were Sweden, Spain and Portugal, who had around 360. This compared to the EU25 average of 639 hospital beds per 100 000 inhabitants in 2002.

Lowest rates of new cases of AIDS in Slovakia and the Czech Republic

In 2003, the highest number of newly diagnosed AIDS cases were found in Portugal (79 cases per million persons), Spain and Italy followed with incidence rates around 30, Latvia had 25 and Luxembourg 18. The remaining Member States, for which data are available, were all below the EU25 average of

14.2 cases per million persons in 2003, with the lowest rates in Slovakia (0.4) and the Czech Republic (0.8).

The second most frequent cause of death in the EU25, after diseases of the circulatory systems, is cancer (malignant neoplasm). 188 persons per 100 000 inhabitants died from cancer in the EU25 in 2000. The Member State with the lowest rate was Finland (146), followed by Sweden (158). The highest rate was found in Hungary with 262 persons having died from cancer per 100 000 inhabitants, the second highest rate in the Czech Republic (234).

Compared to 1998, safety at work improved most in Belgium, Poland and Slovakia

The index of the number of serious accidents at work per 100 000 persons in employment compares the current situation with the situation in 1998 (1998 = 100). A general trend for improved safety at work can be observed in 1998-2002, with the index indicating a 12% reduction in the incidence rate of accidents at work in EU25 (index value 88 in 2002). This trend is true almost all across the EU25, but varies between Member States, with Belgium (-28%), Poland (-24%) and Slovakia (-23%) showing the biggest reduction in the index. Σ

Some figures on health

	Nb of practising doctors per 100 000 inhab. in 2002*	Nb of hospital beds per 100 000 inhab. in 2002**	AIDS Incidence rates per million inhabitants in 2003***	Standardised death rate due to malignant neoplasm (per 100 000 inhab.) in 2002****	Accidents at work: Index of the number of serious accidents at work per 100 000 pers. in employment (1998=100) in 2002*****
EU25	328 ^e	639	14.2	188	88 ^p
Belgium	385	712	8.4	205	72
Czech Republic	388	1 137	0.8	234	89
Denmark	365	423	7.6	223	82
Germany	334	902	4.3	176	82
Estonia	311	606	7.4	201	125
Greece	454	488	6.5	163	83
Spain	331	365	32.8	173	103
France	302	796	11.5	187	99
Ireland	:	994	2.1	190	:
Italy	437	455	30.6	177	83
Cyprus	264	438	:	:	92
Latvia	266	810	25.0	193	108
Lithuania	399	893	2.6	196	86
Luxembourg	245	644	17.8	171	109
Hungary	319	806	2.6	262	84
Malta	312	750	:	171	91
Netherlands	192	463	2.8	194	100
Austria	332	846	5.3	171	84
Poland	228	710	4.4	212	76
Portugal	265	365	78.6	162	:
Slovenia	223	509	3.0	205	94
Slovakia	334	757	0.4	226	77
Finland	313	737	4.9	146	85
Sweden	298	359	5.8	158	101
United Kingdom	:	408	14.1	185	105

* 1999: France and the Netherlands, 2000: Portugal and Sweden, 2001: EU25, Belgium, Greece, Latvia, Malta, Slovakia, 2003: Luxembourg

** 2000: Belgium, Greece, Sweden, United Kingdom, 2001: Denmark, Germany, Spain, Italy, Latvia, Hungary, 2003: the Czech Republic, France and Malta

*** AIDS Incidence rates: The number of newly diagnosed AIDS cases reported by year of diagnosis, adjusted for reporting delays, 2001: the Netherlands. Source: EuroHIV, EU25 Eurostat

**** 1997: Belgium, 1999: Denmark, 2000: EU25, Greece, France, Italy, Malta, United Kingdom, 2001: Spain, Poland, Slovakia, Sweden

***** 2001: Portugal

: Data not available

p: provisional

e: estimated

Health statistics – Doing the same in different ways

The collection of health statistics in the European Union is organised differently from one Member State to the next. In some Member States, such as Germany and Italy, the National Statistical Institutes are responsible. In the Czech Republic it is the National Board of Health and in other Member States it is the Ministry of Health.

Sigma sent a questionnaire to some Member States to find out how the production of health statistics is organised in their countries. Jaroslav Novák, Head of Sector for education, health, culture and social security statistics in the Czech Statistical Office, Christiane Rosenow, Head of Sector for hospital and causes of death statistics at the Federal Statistical Office in Germany and Dr Roberta Cialesi, Head of the health unit and Dr Alessandra Burgio, researcher on statistics in the National Institute of Statistics in Italy replied.

How is the production of health statistics organised in the Czech Republik?



Jaroslav Novák, Head of Sector for education, health, culture and social security statistics in the Czech Statistical Office

The production of health statistics in the Czech Republic is centralized on a national level, but there is a division of labour. In the health statistics domain the Czech Statistical Office cooperates with the Institute of Health Information and Statistics (IHIS). This institute reports to the Ministry of Health and is responsible for the health interview survey domain (HIS/HES) and for the causes of death domain from a methodological point of view. In the field of health care statistics the institute is also partly responsible for hospital data and health care personal data. The Czech Statistical Office is responsible for data on disability and injuries at work, health data relating to the labour force survey, for causes of death data from a practical point of view and for statistics on disabled people. In the health care domain the CSO is responsible for data from private doctors and recently for health accounts as well.

What are the strengths and weaknesses?

Our strength is the good cooperation between the above mentioned bodies. Our constrained budget and the linked shortage of staff are our weaknesses.

Which are the challenges you are facing at the moment?

Our present challenges are the compilation of the system of health accounts and disability statistics.

What priorities do you have for the future?

Our priorities are firstly quantitative and secondly qualitative understanding of the whole object of European health statistics.

How do you experience the co-operation on EU and international level?

I have a very good experience of cooperation on the EU level and I believe that the Partnership on health statistics is a very good approach.

How is the production of health statistics organised in Germany?

In Germany the Federal Statistical Office plays the major role when it comes to health statistics. However, there are also some other government bodies, such as the Robert-Koch institute, that cover other health statistic areas.

In Germany there is also a distinction between the central and the regional level. Both the causes of death statistics and hospital statistics are not centralised, meaning that the data collection is done by the 16 Statistical Offices of the Länder.

Statistics on abortions are centralised, meaning that organisation and data collection is done by the Federal Statistical Office.



Christiane Rosenow, Head of Sector for hospital statistics and causes of death statistics, in the Federal Statistical Office of Germany.

For the non-centralised statistics, statistical production is organised on both national and regional level, but there is a division of work between the

Federal Statistical Office and the Statistical Offices of the Länder.

The responsibility for the different working steps is organised as follows:

Responsibilities of the Federal Statistical Office

The responsibilities of the Federal Statistical Office are defined in the Federal Statistics Law and the main tasks are the following:

- Methodology of the questionnaire: e.g. layout, formulation of the questions
- Methodology of the data collection
- Methodology of plausibility control

Apart from that the Federal Statistical Office is responsible for the

- publication of results (only) at NUTS level 0 and 1,
- specific analysis for customers at NUTS level 0 and 1 and
- contact with working groups and international organisations (e.g. Eurostat, WHO)

Responsibilities of each of the 16 Statistical Offices of the Länder

- Realisation of the data collection
- Close contact with the respondent (if the respondent needs help or if the statistical office needs to call back)
- Evaluation of the data
- Publication of results at NUTS level 2 and 3
- Specific analysis for customers at NUTS level 2 and 3

The health statistics are completed by three health-related accounting systems to provide data about health expenditure, costs of illness and health personnel. These are exclusively based on existing data. The international comparability of the results has been an important aspect in the development of the three accounting systems.

What are the strengths and weaknesses?

The strengths for hospital statistics are the very good information available for all hospitals and on the diagnosis of all inpatients, because the survey covers all hospitals. For causes of death statistics it is the complete inventory count of all deaths and the continuity with which data is collected (some causes of death can be reported back to the end of the 19th century).

One of the organisational weaknesses arises from federalism. The Federal Statistical Office is not authorised to instruct the Statistical Offices of the Länder. All the decisions concerning a statistic have to be discussed to reach agreement on major questions.

It also means that for non-centralised statistics the Federal Statistical Office has only aggregated data to work with. Single data sets are kept in the Statistical Offices of the Länder. For the publication of results on national level fixed tables are defined. If a customer is interested in slightly different results new programmes have to be discussed with the Statistical Offices of the Länder, which usually needs a lot of time.

Weaknesses for hospital statistics are:

- Statistics in Germany, whether done in the Federal and/or Statistical Offices of the Länder usually have a legal basis, which is the case for hospital statistics. This means there is not much flexibility to change variables. Changes arising from developments in the health system cannot be made without changing the legal basis.
- Because there are no European laws concerning hospital statistics it is a complex task to compare numbers throughout Europe.

There are two weak spots in the causes of death statistics:

- There is a lack of acceptance by physicians of importance of filling out the death certificate accurately. This causes lower data quality.
- The collection of death certificates and the coding is done by the 16 Statistical Offices of the Länder, which results in differences in the coding practice.

Which are the challenges you are facing at the moment?

The German health system went through many changes over recent years. This is especially true for hospitals. A new ac-

counting system (DRG – diagnosis related groups) has been established in hospitals at the moment with far-reaching effects for statistics. Statistics have to adjust to the changes.

Another challenge is a project that aims to create anonymous data sets for scientific use (so called “scientific-use files”) within official statistics. There is a great demand within the health sciences for a data set on diagnosis of inpatients.

A third challenge in the causes of death statistic is the improvement of data quality. Because of the different regional coding practices and the increase of WHO-rules, we are going to implement an automated coding system in each statistical office of the Länder. The intention is to optimise the process of coding and to make sure that there are no differences in the coding practice.

What priorities do you have for the future?

One very important aim is to minimise the burden on the respondents. Because the information required for hospital statistics can be drawn from management accounting systems and inpatient documentation systems, the goal is to create an interface to read the data out of these systems into an electronic questionnaire that can be sent via internet.

Furthermore we are working very hard on publishing data close to the date they were collected, although this is hard to realise because the effort has to be made not only by the Federal Statistical Office but also by the 16 Statistical Offices of the Länder. Our speed in publishing national data depends on the slowest federal state.

Efforts are being made to prepare data in a more convenient way. That means that data users should make use of the internet to reduce telephone inquiries. Not only data will be published via internet, but also more methodology and other background information should be available.

How do you experience the co-operation on EU and international level?

The co-operation on the working level in the fields of health statistics is very effective. Germany joined various project groups and the experiences were very positive. There is a lot to learn from other countries.

On the other hand we sometimes have the feeling that there could be more coordination between different health projects. Do the results really built upon each other in order to avoid duplication of work and achieve the best possible comparability of the data?

The points of contact between the different projects could also be more transparent.

How is the production of health statistics organised in Italy?

In Italy, many public, central and regional institutions currently produce administrative and sample data on health, at national and local level.

These include, first of all, the Ministry of Health but also the Ministries of Interior, Welfare, Defence, Treasury and Regions and many institutes such the National Institute of Statistics (ISTAT), the National Social Security Institute (INPS), National Institute for occupational accident insurance (INAIL).

As a matter of fact, the pillar of health information is based on the administrative data sources from the Ministry of Health and on the Cause of Death and the Health Interview Surveys carried out by ISTAT.

The Ministry of Health coordinates the main information flows at central level, collecting information on primary care, outpatient services, hospitalisation and expenditure using standard forms or data sets. Data goes from local health units



Dr Roberta Cialesi, Head of the health Unit and Dr Alessandra Burgio, researcher on statistics in the Italian National Institute of Statistics.

(LHU) and independent hospitals to the region where they are located. Then the region, after having controlled the data, sends it to the Ministry. At national level most data are aggregated (that is quantitative data referred to the LHU or to the hospital). Only in the case of hospital discharges and of deliveries are individual data available. But at regional level more individual data are available (for instance on outpatient care or on pharmaceuticals) since many regions have started their own collection of health data and have implemented information systems. The Ministry of Health publishes health statistics on its internet web site (www.ministerosalute.it).

The National Statistical Institute receives data from the Ministry and uses them to produce publications, to calculate indicators for statistical information systems and for different studies and researches.

ISTAT is responsible for the statistical information on mortality and cause of death. ISTAT collects copies of death certificates, coming from the registration office of all Municipalities. The statistical information on these records is edited, coded and processed at central level.

In recent years, re-engineering has been an integral part of the process of updating ISTAT data systems on cause of death.

Did you know that there were 53 commuting accidents per hour in the EU15 in 2002?

Source: Eurostat

The implementation of automatic coding was the most important innovation. The main benefits include not only the reduction in the time required to process and disseminate data but also an expansion of the amount of information available related to multiple causes of death.

Information on the health conditions of the population have been the object of a renewed interest in the official statistics produced by ISTAT.

They have been included in a yearly survey system, the New Multipurpose Household Survey (NMHS), that is a permanent data collection system on social items, based on sample surveys.

The Health Interview Survey, included within this permanent information system (NMHS), has been redesigned as a quarterly sample survey and will be carried out every five years. It covers many topics on health or related to health (e.g. life styles, determinants of health, prevention). The last surveys have been planned together with the Ministry and the regions in order to produce health statistics useful for the health programmes. The sample is large enough to allow estimations on health and lifestyles on a sub-regional level (60,000 households, 150,000 persons). The Italian health system has invested in a non-traditional source in order to have the necessary data for planning and managing at a government, mostly regional, level.

ISTAT collects data also on residential institutions carrying out social and health services.

What are the strengths and the weakness?

The process of information production and innovation in the health sector is suffering the effects of a profound political and institutional change. This is mainly characterised by the decentralisation of power from the state to the regions (under a wider devolution process). The state's role in the health sector is transforming from a main function of service organisation and management to that of guaranteeing its uniformity throughout the country. The recent National Health Plan 2003-2005, the first launched under this new scenario, gives great importance to the need to adopt "a co-ordinated strategy of the actions of the various institutions, to fully and specifically respond to the population's new health needs" (Ministry of Health, NHP 2003-2005). On the statistical information front, this has already determined the launch in recent years of an information flow rationalisation process and the development of synergy among the institutions at various levels of responsibility. However, the quantitative information currently available for a systematic approach to understanding the Italian health situation is not yet sufficient. Among the critical points is the persistence of a fragmented, heterogeneous picture, with strong qualitative and quantitative differences over the country and among the regions. All this points to the great need to manage this complexity by adopting a unitary strategy within the National Statistics System: this requires investing in a statistical information system, increasing public awareness of the importance of such information, and developing the ability to construct it.

Moreover, the use of health information for the management of health services at the local level is still limited.

From the information point of view, the main current information gaps are related to health expenditure and financing, health personnel and practising physicians by age, gender and speciality, private sector. Moreover there is an increasing demand for health care quality indicators that need new information sources.

In any case, substantial progress has been made in the field of health information during the last decades and now we can count on an increased volume of data on health status, health services utilization, and determinants of health through population-based health interview surveys and administrative recording.

Which are the challenges you are facing at the moment?

National demand for health information is ever more oriented towards monitoring of changes to the National Health System. The development of statistical information systems to measure health, performance and outcome objectives of the services system nationally, regionally and sub-regionally will take on strategic importance in the next three years. With respect to indicators, the National Health Plan 2003-2005 considers as a strategic objective the “preparation of a consolidated monitoring system of essential levels of welfare, through indicators which exhaustively operate at all three verification levels (hospital, area and work environment)”. This requires the launch of new surveys for sectors not yet covered and the use of data processed by the new Health Information System coordinated by the Ministry of Health. A request for information on the areas and Objective Projects of the Regional Health Plans is also likely.

From an international point of view, the major challenges should be the implementation of a System of Health Accounts. Unfortunately, it is not yet included among the priorities of the Italian Health Information strategy (mainly due to the shortage of resources).

What priorities do you have for the future?

Generally speaking, to respond to the requirements of the new scenario, strategic objectives are directed at:

- exploiting existing sources and enlarging the information offered,

- development of thematic integrated statistical systems,
- development of international harmonisation,
- information transparency and accessibility.

The work of official statistics will be aimed at improving the coherence and consistency of health information between local and national levels.

Did you know that 4% of the physicians in Luxembourg and 26% of the physicians in Slovakia were 35 years old or younger in 2002?

Source: Eurostat

Monitoring of the progress attained in this area must legitimise and reinforce the function of the official statistics body in the health sector in the near future.

Moreover, because of local government's growing need for statistical information, disaggregated data must be made available on a territorial level.

Among the priorities and the activities planned in the near future are:

- **Implementation of the X revision of the “International Statistical Classification of Diseases and Related Health Problems” (ICD-10).** This implementation, which requires a great effort in terms of innovation in both process and products, should be completed by the end of this 3-year programme.

It also requires spreading awareness and assistance in using ICD-10 centrally and locally through a series of training courses aimed at all officials involved in codifying causes of death.

- **Hospital and Health System activities.** Development of thematic integrated statistical database information systems. Further extension of the local harmonised Italian information system, called Health for All-Italy. The next versions of the system will contain more information on both historical trend updates and presence of indicators, updated weekly.
- **Disability.** Development of statistical information on persons with disabilities and their level of social integration,

through the integrated use of new surveys and the acquisition of new sources and other activities specified by the work programme of the project “Statistical information system on disability”. (Ministry of Work and Social Policies – Istat agreement)

- **Welfare.** Development of welfare statistics in compliance with the welfare reform law no. 328/2000, in the light of the realisation of an information system on social services. Specifically, this three-year period will see: implementation of a census survey on “Interventions and social services offered by individual or associated municipalities”, aimed at supporting activities of essential social welfare level definition, as established by art. 46 of law 289/2002; realisation of activities connected with monitoring of public expenditure on social welfare provided overall in Italy.

How do you experience the cooperation on EU and international level when it comes to the field of health statistics?

Considering that health is a relatively “young” topic, since international cooperation to increase the harmonisation of

health statistics started in the second half of the nineties, a lot has been done. Nevertheless we are still at a starting point, since many statistics traditionally considered of good quality and often used for international comparisons, when analysed deeply and at a detailed level, show many discrepancies and weaknesses. Much statistical work is still necessary. Unfortunately this aspect is in contrast with the increasing demand for information at political level, since health has become one of the “hot” social topics in a situation of restriction of resources. It is important to concentrate efforts on few strategic subjects, ensuring a strict coordination among international organisations and Member States in order to guarantee an optimum use of resources, to avoid double work and to obtain results in a short time. Σ

Improving information and knowledge for the development of public health

Being healthy is important to all of us. We expect to be protected against illness and disease and we want to bring up our children in a healthy environment. We also depend on reliable and high-quality health advice and assistance. Public health is one of the European Commission's key priorities and an area where the Commission's Directorate-General for Health and Consumer Protection works closely with Eurostat and the European Statistical System.

The European Union has a small but important body of legislation covering specific areas, where the Treaty requires that a high level of public health protection be assured. It also includes laws restricting tobacco advertising and regulating other aspects of how cigarettes are manufactured and sold. The main thrust of EU public health policy, though, is to help EU countries pool their expertise on health, to identify and share best practices and to help coordinate EU responses to health threats such as infectious disease outbreaks. Fostering cooperation between Member States' healthcare systems is also becoming an increasingly important area of activity.

Three main axes

In 2002 the European Commission adopted a new public health programme, which runs until the end of 2008. The programme has three priorities. The first is to improve information and knowledge in the development of public health. The second is to enhance the capability to respond rapidly and in a coordinated fashion to threats to public health and the third is to promote health and prevent disease through addressing health determinants across all policies and activities. The overarching objective of the programme is to establish and operate a sustainable health monitoring system and to identify common problems and challenges associated with the health status of the population in the Member States.

It is within the first priority – to improve information and knowledge – that Eurostat and the Directorate-General for



John F. Ryan, Head of the Health Information Unit in DG Sanco.

Health and Consumer Affairs (DG Sanco) have a long standing cooperation. The aim is to produce health indicators which will help policy makers identify health risks, take steps to prevent diseases and health problems occurring and to put resources at the right spot.

“We work together with Eurostat, in working groups and through projects to establish health indicators. Today we have a shortlist of 70 indicators, including 30 to 40 indicators for which data is available (mainly through Eurostat), but we are working hard to have a more complete list”, says John F. Ryan, Head of the Health Information Unit in DG Sanco.

The available indicators are divided in four categories: indicators on demographic and socio-economic status, health status, determinants of health and health systems. They range from birth rates and drug-related deaths to intake of fruits and the vaccination coverage of children. One – the ‘healthy life indicator’ – which measures people’s life expectancy without limitation in usual activities because of health problems is part of the Lisbon strategy on competitiveness, social cohesion and environment.

The work to establish the indicators is carried out in a complex web of experts that meet in subject related working parties, a network of competent authorities with representatives from the Member States, EU financed research projects, Eurostat and international organisations such as WHO and OECD. About 20M€ is invested by the Public Health Programme per annum on health information projects.

A health portal in the pipeline


In parallel to establishing the indicators, Mr Ryan and his colleagues want to set up and operate a sustainable health monitoring system and to bring the information gained from the projects, Eurostat, international organisations and the future centre of communicable diseases together and to facilitate access to reliable, up-to-date and comparable information.

“We want to adapt a dynamic approach where we develop flows of information to both the public and policy makers and we want to improve the factual basis for policy making”, says Mr Ryan.

The unit publishes health status reports at regular intervals; the last dates from 2003 and is called “The health status of the European Union, narrowing the health gap”. The unit also

publishes a number of special subject matter reports on for example mental health in the EU, on accidents and injuries and environment and health. These reports are the results of some of the numerous projects the unit handles. Conferences are also organised to disseminate information on particular topics, particularly in association with Council Presidencies. Events in 2005 include a Conference on e-health (how the application of information and communication technologies affect the health sector) with the Norwegian government and a conference on rare diseases with the Luxembourg presidency in June.

Another step to enhance the flow of information is the planned health portal which will be launched in 2005. It will introduce in a thematic way an across the board picture of health issues at EU level. It will have links to a wide set of related websites such as national and regional authorities, DG Sanco, Eurostat and other Commission DGs working in the health field, Commission financed health projects, civil society organisations, indicators and health data to mention a few.

“We are moving from health monitoring to implementation. We have information and now we want to use it to analyse health policies, see how they can be improved, compare strategies between countries to establish best practices etc.”, says Mr Ryan. 

For further information:

Directorate-General for health and consumer affairs
http://europa.eu.int/comm/dgs/health_consumer/publichealth.htm

Safety first!

Prevention at heart of DG Employment's policies to protect workers

Prevention and keeping accidents at work and occupational diseases at a minimum is the objective of the Commission's policy on health and safety at work. The existing European legislation in this field sets minimum requirements for the improvement of health and safety conditions at the workplace. Legislation alone is not enough, the European Commission's Directorate-General for Employment also needs an instrument to measure how efficient the legislation is. To this end the Employment DG and Eurostat have had a long and fruitful cooperation.



José Ramón Biosca, Head of Unit for Health, Safety and Hygiene at work at the DG for Employment

“Health and safety measures at the workplace have contributed significantly towards improved working conditions and, at the same time increased productivity, competitiveness and employment. Over the last decade the number of accidents resulting in three days or more off work has fallen by around 15 percent and the number of fatal accidents by 30 percent”, says José Ramon Biosca, Head of Unit for Health, Safety and Hygiene at work at the Directorate-General (DG) for Employment.

“One accident at work occurs every 5 seconds in Europe.”

Health and safety at work is one of the European Union's (EU) most detailed and important social policy sectors. In fact, as early as 1951, the European Coal and Steel Community set about to improve the safety of workers. The Treaty of Rome in 1958 extended this duty to cover all employed persons in all sectors. Today the corpus of the health and safety at work EU legislation ⁽¹⁾ has a preventive character and lays down the general principles concerning the prevention of occupational risks, the protection of safety and health, the elimination of risks and accident factors, the informing, consultation, participation and training of workers and their representatives, as well as general guidelines for the implementation of the said principles.

The first evaluations of the legislation have shown a positive influence on national standards of occupational health and safety.

⁽¹⁾ Since 1989 legislation relies on Article 137 of the Amsterdam Treaty, which provided a specific legal basis in the policy area of health and safety at work. The treaty is the basis for a framework Directive 89/391/EEC and a series of underlying Directives.

More detailed data over the years

The cooperation between Eurostat and DG Employment started at the beginning of the 1990s, when DG Employment needed to develop harmonised and reliable European statistics on accidents and diseases at work. The result of this cooperation has been the development of criteria and methodologies to be applied for the collection of comparable data in occupational accidents and diseases. The first phase consisted of defining the type of data Member States should report – for example which types of accidents, in which sectors of activity they occurred, the size of company and the gender of the persons in the accident etc.

“The early data already helped us see which types of accidents were most frequent and which activities were most at risk, but in order to prevent accidents it was important to refine the data and to understand the circumstances of the accidents”, says Mr Biosca.

“*More than 210 million days are lost each year because of accidents at work.*”

Therefore the details of the data have increased over the years. Employers now give more background data, such as how the accident occurred, which type of action was performed, which type of machinery was handled etc. These data are then used to assess the main reasons behind the accident. But a major problem today is that the national authorities in the Member States don't get information on all accidents at work that occur in their country and, as the submission of data from the national authorities to Eurostat is made on a voluntary basis, there are also gaps at the EU level. This is something DG Employment and Eurostat would like to change.

“Due to high rates of underreporting it is not possible to make comparisons between countries. We can more reliably see the evolution of occupational diseases and accidents at the EU level, but we also need to be able to accurately follow the trends in the Member States and to compare between them. Today we don't know why in some Member States the application of the regulation to prevent accidents and diseases works and why in some countries it doesn't give results”.

“*About 5000 fatal and 5 million non-fatal accidents occur in Europe every year.*”

Prevention at heart of strategy

In 2002 the *Strategy on health and safety at work 2002-2006* ⁽²⁾ was adopted by the European Commission, the European Parliament and the Council. It focuses on how to pre-

vent and combat new workplace risks, such as stress, depression, harassment, anxiety and violence. Such problems account for 18% of all reported problems associated with health at work, with a quarter of them resulting in a two weeks or more absence from work.

“The strategy takes into account *well-being* at work, which is not only the absence of accidents or illnesses, but includes peoples' physical, moral and social well-being. Stress and violence are emerging problems and as a responsible legislator we need information to know if we need to tackle these issues and call for action in the area. We have called on the social partners and come to a collective agreement on EU level when it comes to combating stress. The same will be done when it comes to bullying and violence at work”, says Mr Biosca.

As a response to the new workplace risks in the strategy DG Employment and Eurostat are also planning a new data collection and a set of indicators. The plan is to include a new ad hoc module on health and safety at work in the Labour Force Survey in 2007. At the same time ongoing work on the harmonisation of occupational accidents and illnesses are being stepped up to ensure adequate instruments to measure progress towards the quantifiable targets of reduction of accidents and diseases set for every sector of economic activity.

“*More than 350 million days are lost each year because of work-related diseases.*”

“The collection of accurate health and safety statistics will make a crucial contribution to the achievements of the health and safety objectives in the strategy both at EU and national level. The strategy invites Member States to set targets particularly in sectors of activity with above-average rates of accidents and occupational diseases. The monitoring of progress towards these objectives will provide useful information which will assist in the development of new and carefully targeted prevention policies. And the involvement of Eurostat in this endeavour is fundamental”, says Mr Biosca.

⁽²⁾ COM(2002) 118: "Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006."

FACT BOX

Three EU bodies are involved in the field of occupational diseases and accidents at work:

• European Commission

Directorate-General for Employment

The European Commission's DG Employment headed by Unit for Health, Safety and Hygiene develops policies and legislation on EU level on health and safety at work. The DG also follows-up legislation and makes sure it has been transposed and implemented in Member States.

http://europa.eu.int/comm/employment_social

Eurostat

Eurostat's Unit for Health and Food Safety is responsible for the development of methodology and collection of data in the field of health and safety at work.

<http://europa.eu.int/comm/eurostat/>

• European Foundation for the Improvement of Living and working Conditions

The European Foundation for the Improvement of Living and Working Conditions is an autonomous body established by the EU to assist the formulation of medium and long term policy for the improvement of social and work-related matters. It is situated in Dublin, Ireland.

<http://www.eurofound.eu.int>

• European Agency for Health and Safety at Work

The European Agency for Safety and Health at Work provides Community bodies, Member States and those involved in health and safety at work with useful technical, scientific and economic information. The agency is situated in Bilbao, Spain.

<http://europe.osha.eu.int>

“Comparisons with other Member States a must”

Statistics are an indispensable tool for politicians in order to make sound decisions. Sigma met Angela Blanco, responsible for economic analysis and health expenditure in the Directorate-General for National Health System Cohesion and High-Level Inspection at the Ministry of Health and Consumer Affairs in Spain to find out how they use international health data and methodology and what challenges she sees in the area.

As the head of economic analysis, Ms Blanco mainly uses statistics referring to health care and social protection expenditure, health sector structural data and, to a lesser extent, statistics on mortality, morbidity and health surveys.

“Statistics are central for my team in compiling reports to support management decision making and for that both international references and comparison with the other EU Member States are a must”, she says.

Did you know that in 2002, 33% of Portuguese women had a mammograph, compared to 10% in Ireland?

Source: Eurostat

She finds the EU data is crucial and that the European System of Social Protection Statistics (ESSPROS) and the database on social protection and health care expenditure are particularly valuable. ESSPROS, however, defines health expenditure slightly differently from the System of Health Accounts (SHA), published by OECD, that has been adopted as the methodological framework by EUROSTAT and by WHO to measure health expenditure. For example, health expenditure linked to disability and maternity are included together with other kind of benefits in the disability or maternity ESSPROS functions. Therefore, although her team treats health expenditures from OECD data they have the ESSPROS data as a reference, especially for the whole social protection expenditure.

What she sets most store by in Eurostat is the process of standardisation, whereby statistics are harmonised and made

comparable between the different Member States. She believes that considerable progress has been made in terms of health care, although there are still gaps in terms of definitions and in certain areas.

“I believe the short-term statistical priorities should be to consolidate the progress made on comparability in the areas in which most ground has been made, such as hospital care, information on human resources and implementing the System of Health Accounts (SHA) methodology in health expenditure, which is scheduled for 2005”.

“In the longer term, following discussion in the working groups, a case could be made for reliable statistics on primary care and information on nurses, which is one gap on the subject of human resources. It should be a methodological objective to work towards harmonising the definition of long-term care. Member States treat expenditure on assisted accommodation for the elderly in different ways, in that some consider it health expenditure and others social benefits.”

Ms Blanco says that her relationship with Eurostat is excellent. While, in principle, the Instituto Nacional de Estadística (INE) is Eurostat’s counterpart, it has shared its responsibilities in healthcare statistics with the Ministry of Health and Consumer Affairs. The Ministry also takes part in the working groups on health systems organised by the European Commission’s Directorate-General for Health and Consumer Protection.

Prevention is better than cure

Asked which are her main challenges, she identifies three:

“The first is to give the management team information and ideas to develop a strategy for the health system to be financially sustainable, while maintaining and even improving its

current quality rating (the WHO ranks the Spanish health system seventh in the world). This is a challenge to which collegiality and team work can rise. To that end different issues should be dealt with, and it is important to work on prevention and promoting healthy (e.g. non-smoking) lifestyles. As the saying goes, ‘prevention is better than cure’.”

“Another more attainable and more localised challenge would be to implement the European System of Health Accounts methodology nationally and in the Spanish ‘regions’ – the autonomous communities. There has been substantial progress so far, particularly in terms of information systems and coordination”.

“A third challenge, which is perhaps the most novel project, would be to set up a health cohesion fund, linked to the financing of the autonomous communities. An information system would identify the flow of patients between the different autonomous communities, such as complex pathology cases which cannot be treated in a patient’s community of origin. This would make the system rational and, in particular, the host community could be compensated”. Σ

At the time of this interview, Angela Blanco was responsible for economic analysis and health expenditure in the Directorate-General for National Health System Cohesion and High-Level Inspection in the Ministry of Health in Spain. She has always worked as health and social statistician for the Spanish State, first at the Spanish Statistical Office (INE) and then in a number of ministries (Health, Social Affairs, Economic Affairs). She is currently working in the Ministry of Economic Affairs (Institute of Fiscal Surveys).



Monitor, alert and prevent: the tasks of the French Health Monitoring Institute

The job of the Institut de veille sanitaire (Health Monitoring Institute), based near Paris, is to monitor the state of health of the general public in France, and to alert the authorities in the event of a threat to public health. It is placed under the supervision of the Ministry of Solidarity, Health and the Family.



The Institut de Veille Sanitaire, based near Paris

Following a law adopted in July 1998, France established a comprehensive system of health monitoring and safety. Other bodies set up alongside the InVS include the French agency for the safety of health products (AFSSAPS), the French agency for food sanitary safety (AFSSA), the National Agency for Accreditation and Evaluation in Health (ANAES), the Institute for Radiological Protection and Nuclear Safety (IRSN), the French Blood Agency (EFS), the French Transplant Agency (EFG) and, more recently, the French Agency for Environmental Health Safety (AFSSE).

Since it was set up seven years ago, the InVS has steadily developed its activities and responsibilities and has strength-

ened its role in the collection and analysis of epidemiological data and boosted both its position in the French public health network and its contribution to international projects linked to health monitoring.

Four main spheres of action

To fulfil its mission, the InVS is responsible in particular for collecting, assessing and developing knowledge of health risks, their causes and their evolution. The compilation and analysis of epidemiological data are the main tasks in the role played by the InVS, which in this context conducts various surveys and studies likely to contribute to its health monitoring tasks (see example below of the “injuries” unit). The InVS then drafts recommendations and methodological guides and also publishes an annual report summarising health monitoring data and listing all the recommendations made to the public authorities.

Furthermore, the InVS contributes to the training of health professionals in epidemiological monitoring and risk assessment methods.

The InVS mission covers a cross section of all public health service activities:

- infectious diseases: infection by HIV, hepatitis C virus, sexually transmissible diseases, risk of infection from food and zoonoses (infectious diseases which can be passed from vertebrate animals to man), diseases that can be prevented by vaccination (e.g. meningitis, hepatitis B), nosocomial in-

fections and resistance to antibiotics, imported respiratory infections (e.g. tuberculosis, legionnaire's disease);

- the effects of the environment on health (e.g. risks linked to air pollution, exposure to chemical pollutants, ionising radiations; waterborne risks; physical hazards);
- occupational risks (e.g. occupational cancers; effects of asbestos and replacement fibres; musculoskeletal disorders);
- chronic diseases and injuries (e.g. cancer, nutrition, accidents and injuries).

The range of areas covered is adjusted regularly according to needs.

The network of partners: regional, national and international

All health professionals play a part in health monitoring. The aim of the InVS is to mobilise, coordinate and support the various teams of the public health service.

At local level, responsibility for InVS work is assumed by 16 interregional epidemiological cells (CIRE). These cells focus mainly on issuing infectious disease alerts and on identifying risks linked to the environment (chronic industrial pollution or natural phenomena).

The ongoing extension of the scope of the InVS is also facilitated by the support of the **national networks**, which play a part in monitoring the state of health of the population. By way of example, we could cite the National Reference Centres (laboratories or units within care or research institutions), morbidity registers, networks to combat nosocomial infections and all hospital and private health professionals (through the mandatory reporting of certain illnesses).

Lastly, the InVS coordinates its activities with bodies which, among other things, supply public health and monitoring data, such as sickness insurance funds and the French National Institute for Health and Medical Research (INSERM).

A national food safety committee, chaired by the Minister of Health, is responsible for analysing events liable to affect the

health of the population, collating the available information, analysing reports on health crisis management and ensuring the coordination of the scientific policy of health safety agencies. Within this committee, the InVS has a cross-disciplinary function as it is the recipient of information from various partners.

At international level, the InVS participates in the European network for the surveillance, alert and control of infectious diseases, a project financed by the Directorate-General for Health and Consumer Protection (DG Sanco) of the European Commission and which coordinates cooperation between the Ministries of Health and the monitoring institutes of the 25 Member States. The warning system, based on a network of secure online transmission between the Member States, allows a rapid exchange of epidemiological information on infection risks that may affect several countries. Its aim is to allow the rapid identification of emerging risks of infection in Europe and to coordinate any responses that may be offered.

The InVS also contributes to the development of the monitoring and control of transmissible and environmental diseases in Europe and throughout the world. It coordinates European monitoring programmes for HIV/AIDS (Euro HIV), tuberculosis (EuroTB), listeriosis and the effects on health of air pollution (Apheis), and also European activities in the field of training (Epiet) and information (Eurosurveillance). Furthermore, it participates in other programmes coordinated by other Member States.

Lastly, the InVS is part of three major world monitoring networks: the office of the World Health Organisation in Lyon, the Global Outbreak Alert and Response Network (GOARN) and the WHO regional office for Europe, based in Copenhagen. Σ

For further information, consult the Website:

<http://www.invs.fr>

Focus on the “Injuries” unit

In the InVS, the “Injuries” unit is part of the chronic illness and injuries department. It is run by four full-time staff members (a head of department, an epidemiologist, a trial physician and a secretary). Two trainees per year on average also contribute to its work. In order to better understand the functioning of one of the Institute’s services, Sigma met its head of department, Doctor Bertrand Thélot.



Bertrand Thélot, head of department chronic illness and injuries, in the Institut de Veille Sanitaire

currence. Our collection methods include the “Enquête Permanente sur les Accidents de la vie Courante” (EPAC, ongoing survey of everyday accidents), intro-

duced in 2000, and a certain number of thematic surveys, the subjects of which vary according to needs.

How is the EPAC organised?

The EPAC is the French contribution to the “Injury Data Base” (IDB), a European monitoring system that took over from the “European Home and Leisure Accidents Surveillance System” (Ehlass) network established in 1986. InVS has been managing this survey only since 2000. The data come from records kept in the emergency units of the hospitals participating in the survey. These records contain anonymous data on the patients (age, sex, place of residence), care provision (date of arrival in the emergency unit, treatment, possible hospitalisation), details of the accident (mechanism, place, type of injury, etc.) and, lastly, on the products used (agents, elements). Each month, we receive a file of these records, which gives us a total of about 80 000 records per year. We then carry out consistency checks, quality analyses and finally statistical processing. The survey is extremely valuable and its results are subject to an annual report and more specific articles in several reviews or journals. One of the aims is give an account of the incidence of everyday accidents in terms of population and according to the circumstances, products or mechanisms in question. For example, how many accidents occur per fall, per use of pressure cooker or barbecue, per practice of a certain sport, etc.

Who uses the results of this survey?

The EPAC results are made available first and foremost to public health professionals but also to ministries, administrative authorities, journalists, students and various associations in the form of publications, notices or communications. We

What type of injuries do you study?

That is indeed a very important question, as it defines our unit’s sphere of activity. The official WHO definition of “injury” is as follows: “Injuries are caused by acute exposure to physical agents (...) interacting with the body in amounts or at rates that exceed the threshold of human tolerance”. In our work, we concentrate mainly on unintentional injuries, including accidents in everyday life, such as domestic accidents and accidents that occur when engaged in a sporting or leisure activity. We are starting some preliminary work on monitoring road accidents. Suicides or suicide attempts, assaults and acts of war are not currently covered, and occupational accidents are monitored by the Occupational Health Department of the InVS.

What does the work of your unit entail?

The focal point of our activity is the collection and analysis of data, and the dissemination of results concerning everyday accidents. In spite of their importance – they are the cause of almost 20,000 deaths in France – everyday accidents are not always a major concern, whereas many could and should be avoided through the adoption of suitable preventive measures based on a good epidemiological knowledge of their oc-

also regularly receive and respond to requests for specific data. Some of the cases covered may appear to be trivial, such as accidents due to opening champagne bottles or those which occur when opening oysters, but their consequences can also be serious.

Could you say a few words on the thematic surveys that you can carry out?

Each year, we conduct several thematic surveys, the subjects of which are defined according to the combination of four criteria: observation frequency for the injury; whether or not it is avoidable; its degree of seriousness; the correspondence of the surveys with requests or topical issues. The projects for the following year are generally defined in autumn. Recently, we conducted several thematic surveys on drowning using accident records provided by responding services (fire, police, ambulance services). We have plans, as of 2005, to conduct a survey on accidents involving children falling out of windows, one or more surveys on sports accidents and a survey on the victims of fires. We also sometimes participate in surveys coordinated by partners, into which we insert a number of questions. Take, for example, the health survey conducted by IN-SEE, the French national statistical institute.

In what way do you contribute to European projects?

As I mentioned earlier, by supplying and exchanging data, we make an active contribution to the European project for the surveillance of everyday accidents coordinated by DG Sanco, the Directorate-General for Health and Consumer Protection. We also participate in the “Injury Prevention Network” (IPN) working group. It is within this context that we are currently completing the “rapid alert” project, the aim of which is to analyse how a declaration or alert linked to an everyday accident is dealt with at European level, according to various

criteria: newness, degree of seriousness, etc. For instance, one interesting and very important question is: how can data from ongoing surveys be compared with those taken from cross-sectional surveys? This question has been examined in the context of a different project at European level that is now nearing completion. Finally, we are also concerned by and involved in various projects on the harmonisation of collection procedures for certain types of data, such as data on causes of death – and have thus been in recent contact with the “Health and Food Safety” unit of Eurostat – or on everyday accidents. The “ANAMORT” project (comparative analysis of death by injury at European level) will start in 2005 in cooperation with numerous European partners and, of course, Eurostat.

How do you see developments in your field in the upcoming years?

I think that, today, we are in the process of gradually building a system that will allow us to follow the development both of “classic” everyday accidents (falls, drowning, fires, DIY accidents, etc.) and of accidents that will occur due to new lifestyles, for example as a result of new sports (paragliding, kitesurfing, “acrobranch” tree-walking, etc). In any case, there is a great need for epidemiological information that will make it possible to measure the danger inherent in certain activities and to establish rules and instructions for the purposes of prevention and the dissemination of information on the risks incurred. All types of data and information compilations must be maintained and developed. The EPAC system will continue to exist and, I hope, be consolidated, because it is the only ongoing source of information that allows us to survey, study and prevent everyday accidents. In addition to EPAC, thematic surveys are equally important, as is the capacity to react to “new” accidents. I also hope that in the next few years, we will have progressed further in terms of communication and the distribution of our information and also as far as concerns the range of themes covered. Σ

Towards harmonization of health statistics in Europe

The World Health Organization (WHO) and Eurostat face many of the same issues in the collection, analysis and dissemination of information. Measuring the health status of populations is a complicated task, particularly so if the purpose is to produce internationally comparable data. Measuring population health is essential for the successful development, implementation and evaluation of programmes to improve health at global, regional, national and local levels.

*Dr Anca Dumitrescu,
World Health Organisation*



One of the first areas of cooperation identified in the exchange of letters in 2001 between WHO and the European Commission was the collection, processing and dissemination of information and data, as well as the development of common methodologies and tools for health monitoring and disease surveillance.

In recent years, the collaboration between WHO, particularly its Regional Office for Europe, Eurostat, and the Health and

Consumer Protection Directorate-General (DG Sanco) has intensified, with continuous exchanges of information and work on joint projects on health data and indicators.

Both WHO and the Commission have developed data collection procedures, though they naturally differ according to each organization's specific goals, health policy framework and member states' ability to provide the required data.

52 Member countries

The WHO Regional Office for Europe has 52 European member countries, only about half of which are European Union Member States. The Regional Office therefore has to cope with more variation in the availability and comparability of data from its member countries than does the EU. For instance, the basic health data that countries report to both Eurostat and WHO may be similar in content but differ in the level of aggregation, definition and format. This not only limits the international comparability of the data, but burdens countries with duplicate requests for similar data. Both WHO and Eurostat are working to reduce these differences and to improve the quality and comparability of data.

Practical cooperation between Eurostat and the WHO Regional Office for Europe occurs through the participation of technical experts in joint meetings, mostly in the framework of Eurostat's Partnership on Health Statistics. This recently resulted in a practical working arrangement between WHO and Eurostat to coordinate the collection of mortality data from the new Member States.

When, several years ago, Eurostat expanded its collection of mortality data to cover countries of central and eastern Europe, both agencies agreed to coordinate this collection with WHO's existing arrangements in these countries. Common focal points for data reporting were identified in each country and a common data-reporting format was agreed. As a result, these countries now only have to prepare one data file, which is simultaneously e-mailed to the WHO Regional Office for Europe and to Eurostat.

Discussions on common format

Discussions on the possibility of extending such common format-based reporting to cover hospital discharge data and some other routinely collected health statistics are currently in progress.

Eurostat's work on causes of death data will significantly improve EU Member States' abilities to report more comparable and accurate mortality data. The work of the ad hoc task force on hospital minimum data sets should also contribute significantly to the international harmonization and efficiency of national health statistical systems. WHO anticipates that the results of this work will also benefit other countries of the WHO European Region.

Another example of cooperation is the EUROHIS project conducted by the WHO Regional Office for Europe, which culminated in a set of recommended common instruments

for core indicators. These instruments were tested in over 10 countries and the results will contribute to the activities of DG Sanco and Eurostat to set up a European health interview survey system.

Did you know that in 2001, the average height of Danish men aged 16 years and older was 179 cm and 170 cm for Portuguese men?

Source: Eurostat

Strengthening the cooperation between international agencies, active in the field of international health data collection and dissemination, is the only way forward, the prerequisite for improving our services and working together with our common member countries. Σ

Dr Anca Dumitrescu is the Director for the Division of Information, Evidence and Communication, World Health Organization, Regional Office for Europe, Copenhagen

The OECD Health Division – Four strands on new agenda

At their first-ever meeting in May 2004, OECD Health Ministers mandated the OECD to carry out further work on health, as the Organisation “is centrally placed to provide international comparisons and economic analyses of health systems”. During the three preceding years, the OECD Health Project had investigated a number of ways to improve the performance of health systems. While this work has filled a number of knowledge gaps, Ministers recognised that OECD countries in Europe and outside Europe can only benefit from further experimentation, combined with conscientious performance measurement, benchmarking and sharing of information.



*Gaétan Lafortune, Marie-Clémence Canaud
and David Morgan, OECD Health Division*

In light of the growing importance of work on health at the OECD, a new Health Division was established in January 2005, located in the Directorate for Employment, Labour and Social Affairs. The new work programme on health for 2005-2006 covers four mandates assigned by OECD Health Ministers: the improvement of the *OECD Health Data* collection, the implementation of the System of Health Ac-

counts, the development of indicators of the quality of health care, and the comparative analysis of selected policy issues. The work programme will be carried out in close collaboration with national administrations, WHO and the European Commission and progress will regularly be reported on the OECD health website.

Improving OECD Health Data collection

The OECD collects a wide range of data on health status and health systems across its 30 member countries, which are published in June each year in *OECD Health Data* database on the OECD website. The OECD database provides an important tool for health researchers and policy advisors to carry out comparative analyses and draw lessons from international comparisons of diverse health care systems.

Although progress has been made in recent years, work is ongoing to improve the availability and comparability of health statistics in many areas. Increased coordination between the data collection of the OECD, WHO and the European Commission – more specifically Eurostat – is an essential part of current efforts to achieve steady progress in developing and using common international standards and definitions.

Strengthening cooperation with Eurostat

There are already many examples of fruitful coordination in data collection among international organisations, which equates to a reduced data reporting burden for member countries as well as more consistent statistics. Several types of health statistics published in *OECD Health Data* are furnished by the producers of other international databases. This is the case, for instance, for data on causes of mortality, which the OECD extracts from the *WHO Mortality Database*, as well as data on life expectancy for European Union countries, which are extracted from the Eurostat on-line free database. The data exchange works both ways, with WHO and Eurostat up to now using health expenditure and financing data that were originally collected for *OECD Health Data*.

With a view to strengthening the cooperation between the OECD and Eurostat in the collection of health statistics, the Chief Statistician and Director of the OECD Statistics Division and the Director-General of Eurostat agreed in summer 2004 in principle, to move further towards a joint data collection on certain health statistics. Officials from the Eurostat's Health and Food Safety Unit, the OECD Health Division and the WHO met in November the same year in Luxembourg to discuss the best ways to implement this common objective. This first meeting agreed among other things on the need to harmonize data collections based on the System of Health Accounts, in order to ensure consistency of data collected at the national and international level, while reducing the data collection burden on countries. A second meeting to pursue

discussions on practical arrangements and other potential areas for coordinated data collection between OECD, Eurostat and WHO is scheduled before summer 2005.

Implementation of the System of Health Accounts

One of the key strands of work on health statistics at the national and international level is the continuing implementation of a standard system of health accounts, which will allow for more consistent and reliable comparisons of health care expenditure across countries and over time. The manual, *A System of Health Accounts (SHA)*, was established by OECD with a considerable input from Eurostat through the Taskforce on healthcare statistics composed of experts from the EU Member States who took the initiative to set up a system of health accounts for the EU. It sets out a standard framework for producing a set of comprehensive and internationally comparable accounts. The manual, published by OECD, establishes a conceptual basis of statistical reporting rules that are compatible with other economic and social statistics. It proposes a newly developed International Classification for Health Accounts (ICHA) which covers three dimensions of health care: functions of care, providers of care, and sources of funding.

Did you know that there were 28 reported cases of Salmonella per hour in the EU25 in 2001 and 23 in 2003?

Source: Eurostat

With the majority of OECD countries in Europe and outside Europe either having implemented or in the process of implementing the standards set forth in this manual, this should ensure that data supplied by national administrations to the OECD, Eurostat and other international organisations are based on a consistent health accounts framework. The annual meeting of the Eurostat Working Group on Public Health Statistics, held in November 2004, agreed that one of the key priorities for 2005 was the implementation of a data collection complying with the SHA manual,

and on the need to maintain close coordination between Eurostat, OECD and WHO.

In 2004, the OECD, along with experts from thirteen countries, carried out a project to present the first results of SHA implementation. This collection of more comparable data, based on the SHA manual, opened up a wide range of opportunities to examine more closely the interaction between how much is spent on different types of health services (hospital care, out-patient care, pharmaceuticals) and how these health services are paid for by different sources (public funding, private health insurance, or out-of-pocket spending by patients). This comparative analysis can be used by national authorities to identify potential issues regarding the current allocation of health spending and its financing, and help them formulate policy options based on the experience of other countries. At the same time, this initial attempt to gather SHA-based health accounts data clearly signalled where differences in accounting practices remain and, therefore, where further progress is required.

Through the regular collection of SHA data, a website will present new information on SHA-based health accounts in OECD countries as they become available. This website will present: country-specific SHA reports, SHA tables with short methodological notes, interim reports and methodological studies on implementation of the SHA in countries, and other relevant information.

Developing indicators of the quality of health care

As the third mandate arising from the meeting of OECD Health Ministers, the OECD has also been asked to develop, in collaboration with national experts, indicators of the quality of health care, as an important component to measuring health system performance.

In the context of this project, 'quality of care' indicators have been defined somewhat narrowly as indicators related to the technical quality with which medical care is provided, i.e. measures of health outcome or health improvement attributable to medical care (changes in health status attributable to preventive or curative activity). Such measures can be interpreted to represent the 'value' side of the 'value for money' equation in health care.

Many OECD countries have already instituted national strategies to begin to collect technical quality indicators, of-

ten for benchmarking purposes in a performance measurement setting. However, there are still a lot of domains for which the international comparability is not fully satisfactory to allow policy-makers to compare the performance of their health care delivery systems against a peer group.

During 2004, the OECD health care quality indicators project started to collect preliminary data and examined its international comparability for an initial set of 17 indicators. Specific recommendations have also been made for the collection of quality of care indicators in five priority areas: cardiac care, diabetes care, primary care and prevention, and mental health and patient safety. During the experts meeting to discuss this project held at the OECD in December 2004, the Directorate for Health and Consumer Protection (DG SANCO) reported on related work supported by the European Commission and their intention to co-operate closely with the OECD in this area.

The ultimate objective of this ambitious data developmental work is to reach a consensus on a scientifically based set of reliable indicators and to gradually increase the availability of information on health care quality furnished in OECD Health Data and other international databases.

Addressing key policy issues

Finally, the OECD work programme will address a number of health policy issues considered to be particularly important at this time by national authorities. These will include:

- investigating the factors influencing the efficiency of primary care and hospital care in OECD countries, and the cost-effectiveness as assessed from the perspective of the full continuum of patient care;
- undertaking research on the role of economic levers in promoting healthy behaviours and preventing avoidable illnesses;
- understanding trends in disability among elderly populations in OECD countries in Europe and outside Europe, and their implications on health care and long-term care expenditure;
- evaluating methods for establishing prices or reimbursement levels for pharmaceuticals, and assessing the cross-national impact of domestic policies;
- drawing lessons on how to overcome barriers to implementing cost-effective information and communication technology applications in health care.

It should be noted, concerning the first area on efficiency and effectiveness, that a meeting was organised in February 2005 in Brussels by Directorate-General (DG) Employment, Social affairs and Equal Opportunities, with participation of OECD and DGs Health and Consumer Protection, Economy and Financial Affairs, and Eurostat, to discuss this topic on the basis of a presentation by Eurostat of its report “Development of a methodology for collection and analysis of data on efficiency and effectiveness in health care provision”. This project is

another illustration of the good cooperation on health statistics between Eurostat and the OECD, collaboration that will most probably intensify in the coming years. Σ

For further information:

www.oecd.org/health

Joaquín Almunia Economic and monetary affairs Commissioner

On 22 November 2004 the new European Commission took office. The Spanish commissioner Joaquín Almunia is responsible for the economic and monetary affairs portfolio, which includes Eurostat. In fact he was first nominated to this position on 26 April 2004, to replace Commissioner Pedro Solbes who returned to Spanish politics.



Joaquín Almunia, Economic and monetary affairs Commissioner

On 7 January Commissioner Almunia addressed Eurostat staff and outlined the priorities concerning the statistical office in 2005. He underlined the importance of Eurostat's role in providing a crucial input for the formulation of EU policies, which have to be based on reliable and trustworthy statistics. Furthermore, Eurostat should underpin the 2005 priority policies of the European Commission – enlargement, growth and competitiveness, security and citizenship and external relations.

“Firstly, there is a need to ensure the success of enlargement, and this means guaranteeing the proper functioning of the enlarged Europe and the full application of EU policies and rules in the new Member States. From the point of view of Eurostat we need to finalise their integration into the decision making and advisory bodies of the European Statistical System. There is also a need to continue supporting the national statistical systems of the new Member States to provide data of a high scientific level, and integrating new colleagues and institutions within the European Statistical System”.

Concerning competitiveness and cohesion, Mr Almunia said that an upturn in the EU's growth potential will be the central policy objective of the Commission. The main goal will be to improve competitiveness while maintaining prosperity, employment, cohesion and environmental protection in line with the Lisbon strategy. Eurostat's role in this is to:

- further improve indicators of productivity and competitiveness;
- prepare the statistics needed for the mid-term review of the Lisbon strategy;
- further develop statistics on services, research, and the development of human and technological capital; and

- improve the indicators linked to sustainable use and management of resources.

In the field of security and citizenship, the Commissioner underlined that a greater effort and better co-ordination will be needed from the point of view of managing the new common borders and dealing with the increased mobility of individuals within this area. This includes developing statistics on migration and asylum.

When it comes to external relations, Mr Almunia said that in a spirit of partnership, certain EU policies will be extended to larger areas.

“Statistical co-operation will aim at providing the statistical data necessary for the management of these policies, but also at strengthening the statistical infrastructure of countries outside the European Union”.

Reinforcing Eurostat when it comes to monitoring debt and deficit data

Mr Almunia also mentioned the recent debate on fiscal statistics, due to the Greek misreporting of debt and deficit data and underlined that the Eurostat report and the two Communications adopted in December 2004 by the Commission aim at reinforcing Eurostat’s resources and give Eurostat the power to better monitor the Member States’ debt and deficit data.

He also saw the forthcoming proposal on European-wide minimum standards on independence of statistical institutes as being important.

“By June 2005, Eurostat has to finalise another important exercise. Following the request of the Economic and Financial Affairs Council in June last year, the Commission has to establish European-wide minimum standards regarding the organisational status of statistical institutes, in order to reinforce their independence, integrity and accountability. The same will of course also be required from Eurostat. A task force with representatives from the Member States has already started to work on this”.

The new standards will have a dual purpose. On the one hand, they will serve to improve trust and confidence in statistical authorities by imposing certain institutional and organisational arrangements. On the other hand, they will also reinforce the credibility and quality of statistics, by promoting the coherent application of best international statistical principles and practices.

Statistics as a public service

Commissioner Almunia also attaches great importance to the idea of statistics as a public service. Good quality statistics is a basic service for the Commission, other European institutions, the academic world and the public in general.

“It is crucial that the policy of free access to statistical data that was started in October 2004 will continue and is further developed”. Σ

Joaquín Almunia was born in 1948 and he has a degree in law and economics from the University of Deusto in Bilbao. His political career began in 1979 when he became a Member of the Spanish Parliament. Mr Almunia was the Minister for Public administration (1986-1991) and the Minister for Employment and social security (1982-1986). Between 1994 and 1997 he was the spokesperson of the socialist parliamentary group. In 1997, he became the leader of the Socialist party, and in 2000 he was the socialist candidate for Prime Minister.

On 22 November 2004 the new European Commission took office and Joaquín Almunia became the Commissioner for Monetary and financial affairs, which includes responsibility for Eurostat. In fact he was first nominated Commissioner for the same portfolio on 26 April 2004 to replace Commissioner Pedro Solbes – who returned to Spanish politics as Minister of the Economy and Finance.

Eurostat's Director-General wants stronger cooperation within the ESS

Standing 202 centimetres tall, Eurostat's new Director-General is hard to miss. Since 16 December last year, Günther Hanreich holds the reins of the office. Among his priorities are improvements in quality of data and statistical governance which need stronger cooperation within the European Statistical System (ESS).



Günther Hanreich, Eurostat's new Director-General

Together with the newly appointed deputy Director-General, Marie Bohatá, and the six Directors of Eurostat, he believes they will ensure a good management team for Eurostat. Mr Hanreich believes that Ms Bohatá's in-depth knowledge of statistics and his ten years of experience of the European Commission and how issues are managed in the institution makes them a complementary team.

Their different experiences will naturally make them focus on different tasks within Eurostat and the European Statistical System.

"I will, for example take, on staff management and financial management issues etc, since I have a lot of experience in this field from my earlier jobs in the Commission, and Ms Bohatá will focus on quality and evaluation of statistics. However, there are also a number of questions that we will address together such as the organisation of Eurostat and how to enhance the working environment. There our expertise is equally valid to improve the approach", says Mr Hanreich.

Having said this, Mr Hanreich underlines that he has for years been a user of statistics, both in his other jobs within the European Commission and in his various positions within the Austrian administration.

"I have been confronted by questions on how statistics can be used, and I am well aware that in order to prepare good policies and their follow-up, you indeed need high quality and timely statistics".

Quality on the agenda

For 2005 and beyond Mr Hanreich sees several challenges for Eurostat which are in many ways inseparable from those of the ESS. The first is quality and timeliness of statistics.

"Quality is a crucial issue. It is extremely important that Eurostat rightly can claim that data is reliable, timely and independent. This has been identified as a particular priority".

"Timeliness is particularly critical, but difficult since there are a great variety of actors who are part of the production process within the ESS. If we compare ourselves with the US we are lagging behind – although not as much as people

sometimes think. I am glad to see that we have improved during the last couple of years and that we are able to release data quicker now than before, but I believe there is room for improvement”.

To improve quality, Mr Hanreich believes that a closer cooperation between the National Statistical Institutes and Eurostat within the ESS is important.

He also points to the full integration of the new Member States and preparing the Candidate countries for the European Statistical System as a challenge for the coming years.

“Enlargement is not only a question of bringing the new countries into the system, but also to see what we can learn from them. How do they approach issues and how do they function? I am convinced that there is an untapped potential for cross-fertilisation”.


Furthermore, Eurostat will need to adapt its activities better to the Commission’s political priorities 2005-2009 and make sure that the office can supply the required data for the development, implementation and follow-up of the new policy priorities. It is important to work out what this means for our work programme in concrete terms. However, Mr Hanreich underlines that there will not be a major increase in human resources in order to cover new tasks.

“We will pretty much have to work with what we got, although I’m quite hopeful that we’ll get some limited reinforcement in 2005/2006. But we will also have to look at negative priorities. We should not kid ourselves and think we can do all the old and all the new”.

Statistical governance

Mr Hanreich mentions the highly motivated and professional officials that work in the statistical offices around Europe as

a very positive factor and he believes that the active cooperation and the exchange of best-practices between the National Statistical Institutes (NSIs) are particular strengths of the ESS. However, he sees a need to strengthen statistical governance in Europe.

“It is a complex situation and the institutional set-up is very different from one Member State to the other. However, Eurostat and the Commission are working on guidelines to improve statistical governance. There is a need to establish minimum European wide standards in the domain of statistics, which reinforce independence, integrity and accountability”. 

Günther Hanreich, 50, is Austrian and has been Eurostat’s Director-General since 16 December 2004. He comes from the European Commission’s Directorate-General for Energy and Transport where he was Director for Trans-European Networks.

Mr Hanreich is a mechanical engineer by training and has been working at the Commission since 1996 where he has held different Director posts in DG Energy and Transport (and DG VII). Between 1988 and 1995 Mr Hanreich was the Director-General for Transport Policy and Road Transport in the Austrian Federal Ministry of Public Economy and Transport. Before 1988 he worked in various positions in the Austrian administration.

Quality top of the agenda for Eurostat's deputy Director-General

Eurostat's first deputy Director-General, and first official from a new Member State, Dr Marie Bohatá started work on 1 December last year. She will focus on improving the quality of statistics and establishing minimum standards for European statistics.

Ms Bohatá has formulated the mission statement for Eurostat's deputy Director-General as follows: "The deputy Director-General role is to contribute to the shaping of European statistical policy and coordinate activities aimed at enhancement of the quality of official European statistics. To this end the deputy Director-General should cooperate closely with the National Statistical Institutes".

This rather broad and horizontal mission can be translated to more precise tasks. Such as her 'baby' – quality in statistics.

"My first priority is to improve the quality and enhance the coherence of structural and infra-annual statistics to make them more adequate for EU policy purposes, and I will work with the new Quality Unit on these issues".

The new Quality Unit will for example start the mid term evaluation of the Community Statistical programme 2003-2007 and possibly a number of other evaluation activities. The Unit further aims at intensifying its contacts and work with Member States on all issues concerning quality and at promoting integrated methodological frameworks. In general, Ms Bohatá says, the already high awareness among statisticians about the need for quality in the process of statistical production and dissemination of information, as well as the ability of statistical authorities to communicate on quality with users, should be further strengthened.

"I am also part of the taskforce that is working on a Code of Conduct for European Statistics and the work to implement the code will be on my table. However, that is more of a longer term task, since a system of compliance monitoring and periodical revisions should also be developed".

In this context, the concept of independence of statistical offices should be considered. Due to a wide variety of institutional set-

tings and varying traditions in particular Member States, this is a very difficult and also delicate issue.

"It is important to find a good model which could enhance the power of official statistics and not in the end lower their profile in relation to governments. I believe that some kind of backing from professional and scientific circles and peer reviewing should be considered in order to limit the potential political pressure and guarantee that offices live up to the rules and high professional standards".

"Take stock and look forward"

Marie believes the main challenges for Eurostat at the moment are to improve its reputation, to serve users even better and to anticipate future user needs.

Basically she believes Eurostat should look forward and take stock of what can be learned from the crisis in 2002. She quotes a passage from the *Memoirs of Eurostat*, which she found very useful: "Like any human endeavour, Eurostat has known highs and lows and the hard times that it has experienced has served to strengthen its character, and will enable it to deal with the inevitable crises that will occur in the future".

In her experience this is absolutely true. As the President of the Czech Statistical Office she faced two major crises. The first was the flooding of Prague in August 2002, when the office lost its premises and a major part of its technical infrastructure. The second crisis related to a substantial underreporting in external trade statistics compiled from the customs office data. Due to the floods and their impact on the economy, it took a long time for the office to notice the problem and react. The result was the office came under attack and not only its reputation, but also its independence were at stake.

“It was a tough period and nobody in the country was interested in how the mistake had occurred in a shared responsibility/working arrangement between the Czech Statistical Office and the Czech Customs Office. After a Eurostat audit, which I asked for – not earlier under political pressures – I decided to take personal responsibility and resign. The mistake was not on the side of statisticians, but the mutual communication was found weak. And I have to admit that after some time I really felt much stronger and even more motivated. I also believe that the fact that I am here in Eurostat today demonstrates my words”.

She underlines that although the Eurostat crisis was deep, she is certain that with the very committed people she has met working in the office, Eurostat will once again become a strong and highly respected body. Σ

Marie Bohatá started work as Eurostat’s deputy Director-General on 1 December 2004. Prior to her appointment she was vice Rector of the University of International and Public Relations and Professor at the Czech Management Centre Graduate school of Business in Prague. Between 1999 and 2003 she was the President of the Czech Statistical Office.



Marie Bohatá, Eurostat's new deputy Director-General

News in brief...

Free dissemination of all Eurostat data

Since 1 October 2004 all Eurostat's data and publications are available free of charge on the Internet. This is an important new initiative which is of great significance for public access to economic and social information on the euro-zone, the EU and the 25 Member States. More than 300 million data are available online, varying from consumer prices, to detailed external trade data by product, to attitudes towards smoking.

According to the needs of the user, there are two ways to access the data. For general users, the 'Key indicators' are pre-defined tables, which include "short term economic data" available for the euro-zone, the EU and the Member States, "Long term indicators" on many areas of life and "Structural indicators" covering the domains of employment, innovation, research, economic reform, social cohesion, and the environment. Specialists can find more sophisticated data in the detailed databases. Data can be extracted online with the help of a user-friendly browser. There are links to the methodology, which follows the IMF's common "Special Data Dissemination Standard (SDDS)", and provides all the information necessary to interpret the data.

Electronic versions of all Eurostat publications are also available free of charge online, and can be downloaded in PDF format.

To provide help and guidance to Internet users of European statistical data, a new user support function began operation on 1 October 2004, with a central support function in Eurostat and 17 national support centres based in National Statistical Institutes.

For further information:

europa.eu.int/comm/eurostat

Commission strategy to improve fiscal statistics

In December 2004 the European Commission adopted a strategy to improve the governance of the European system of fiscal statistics, which has three elements.

The first line of action is to complete the legal framework, and for this purpose the Commission adopted in February 2005 a proposal for a Council Regulation, which allows the Commission to conduct a thorough monitoring of data in the Member States. The second line of action seeks to strengthen the operational capacities of Eurostat and the Directorate-General for Economic and Financial Affairs. The third one concerns the establishment of European standards in order to reinforce the integrity and accountability of statistical institutes. They should be adopted by June 2005.

For further information see:

[Eurostat's website / Eurostat News](#)

Switzerland joins the ESS in 2006

A statistical cooperation agreement between the EU and Switzerland was signed on 26 October 2004 in Luxembourg. The agreement will make Switzerland a full member of the European Statistical System (ESS) will enter into force 1 January 2006, once it has been ratified by both sides.

It means that Switzerland will adopt most of the statistical "acquis".

The agreement also foresees a financial contribution currently estimated at around €4 million per year to Eurostat. Σ

For further information:

www.bfs.admin.ch

“More Statistical than Office...”

Bratislava, the capital of Slovakia, is a city with a long history. The area saw Celtic and Roman settlements, and the first written mention of the city, in the Salzburg Annals, dates from the year 907. The river Danube flows through the middle of the town, where Bratislava Castle, situated on a plateau 90 m. above the river, towers over the historic old town (Staré Mesto). Today Bratislava lies right on Slovakia's western border with Austria, only 60 km from Vienna, and close to the Hungarian border to the south.



Peter Mach, President of the Statistický úrad

A short tram ride, or about 20 minutes walk, from the old town, the Statistical Office of the Slovak Republic occupies a 1970s office block. Sigma took the number 6 tram to meet Peter Mach.

As Mr Mach explained, the history of statistics in Slovakia dates back much further than the country itself. A first census

was held in 1715, and regular censuses date from 1857. The earliest statistical records for Slovakia are to be found in Hungarian archives, as they date from the period when Slovakia was part of the Kingdom of Hungary. Following the creation of Czechoslovakia, a Czechoslovakian Statistical Office was set up in 1919, and re-organised on a regional basis in 1971, with the Slovak regional office in Bratislava.

In the spring of 1992, when preparations began for the split of Czechoslovakia into the Czech and Slovak Republics, all the “federal” statistical functions - methodology, international relations... - were in Prague. It took about two years to re-build the existing Slovak regional office into a fully functional Statistical Office of Slovakia.

Preparing to join the EU

Then the office quickly found itself involved in preparations for EU membership. The 1994 common declaration of co-operation with Eurostat set the basis for the work to follow, as the candidate countries, with Eurostat's help, set out to bring their Statistical systems up to EU standards. Mr Mach notes, “Statistics was among the

first eight chapters opened by Slovakia, and one of the first six closed in May 2000.”

In this process the PHARE programme was very important, particularly the multi-beneficiary horizontal programmes run in statistics. The national PHARE programme also played a significant role in upgrading the IT infrastructure of the Office. The PHARE programmes involved assistance from the

“old” Member States as well as Eurostat, as Mr Mach recalls. “ISTAT for the agricultural census, INE in Spain with SMEs, Statistics Finland in regional statistics, ONS, Austria, Germany all gave assistance, but above all INSEE from the mid 1990s onwards.”

And the result of all this work? “We are generally in a good position with respect to harmonisation,” says Mr Mach. “Now we are mainly in the position of keeping up with the evolving legislation. And then there is the EMU Action Plan, which we monitor regularly.”

Good on inputs

When asked about the strengths and weaknesses of the Office, Mr Mach mentioned inputs and outputs. “We are good on the input side – the collection of data. We could, however, improve our outputs – create new products with value-added for users. We should not produce only figures, but provide more complex information as well.”

Mr Mach feels that the Office has built a good reputation with politicians and the public. As an example he mentions the 2001 Population Census. “A public opinion survey connected with the census showed that the reputation of the Statistical Office with the public was good, with more than 80% positive responses. The response rate for the Census itself was very good – 99.6% - and there were no difficulties with media coverage. We also avoided any data protection problems.”

One difficulty statistical offices in both old and new Member States face is the recruitment of staff in competition with the private sector. Mr Mach recognises this problem, and adds that even other state bodies sometimes offer higher salaries than the Statistical Office!

Statistical law

One achievement of which Mr Mach is particularly proud is the new statistical law, which came into force in 2001. The law, which he wrote in co-operation with Eurostat, gives the Office a firm foundation of independence and impartiality in the production of official statistics. Mr Mach himself became the first President of the Office appointed under the new law in 2002, when he was appointed by the State President for a five year term, which is renewable. In 1999, when he first became President of the Office, he had been appointed by the Slovak Government.

For the future he sees a number of challenges. There is the increased use of administrative data sources, in order to reduce the reporting burden on businesses. Then there is the improvement of the Office’s dissemination products, with better value added and a greater use of the internet. Like many other statistical offices, and Eurostat itself, they are moving towards more electronic publications and more free dissemination. The needs of international users are taken into account as well, with an increasing number – around 60% at the moment – of the Office’s publications produced in Slovak and English.

On a personal note, he describes his management style as “motivate by example”. His dream is that he and the Office should be “better each year”, and he sees it as his task to motivate all his colleagues to do the same! He also says that they should be “more statistical than office – independent in work, behaviour and culture” and that they are “producing data for people”.

A triple challenge

Sigma also spoke to Magda Holubova, Head of International Relations and European Affairs. She has been working for the Statistical Office since 1992, when this department was established and gradually developed.

Her work includes the co-ordination of co-operation with Eurostat and other international organisations, managing Slovak participation in multi-beneficiary PHARE programmes, managing pilot projects and co-ordinating the national Phare programme. She was closely involved in preparations for EU membership. “Of course during the 1990s we were working on three overlapping challenges. Firstly we were creating a full independent statistical office from the existing regional office. Then we had to introduce the new statistics needed to monitor the economic transformation following the change from a centrally planned to a market economy. And finally we had to work on European integration. Compared with other ministries we had a big advantage with this task, as Eurostat involved us in its activities and invited us to participate in working groups several years before enlargement.”

She says that Mr Mach was “very European oriented, and fully supported this work. He introduced an internal mechanism for regular monitoring of progress reached in harmonisation with the European statistical legislation.”



*Magda Holubova,
Head of International Relations and European Affairs*

Asked if, and how, things have changed since enlargement, Ms Holubova says that “We feel more involved as a Member State than as a candidate. Our responsibilities have increased. Before we were observers, now we are participants. We are now an integral part of the European Statistical System.” Σ

Slovakia

Slovakia is a landlocked country in central Europe bordered by four other Member States, Austria, the Czech Republic, Hungary and Poland. It also has a short stretch of the new external border of the European Union, with the Ukraine to the east.

Slovakia was under Hungarian control from the 10th century up until 1918, initially as part of the Kingdom of Hungary, then within the Austro-Hungarian Empire. When the Austro-Hungarian Empire collapsed in 1918 following World War I, the Slovaks joined the Czech lands of Bohemia, Moravia, and part of Silesia to form Czechoslova-

kia. After Nazi Germany was defeated in 1945, Czechoslovakia was reinstated, though the province of Ruthenia was ceded to the Soviet Union. The Czechs and Slovaks held elections in 1946. In Slovakia, the Democratic Party won the elections, but the Czechoslovak Communist Party won in the Czech Republic, and eventually seized power in February 1948. Nearly 42 years of Communist rule for Czechoslovakia ended when Vaclav Havel became president in 1989 and democratic political reform began. After the general election in June 1992, it was decided that two independent republics would be created. The Republic of Slovakia came into existence on Jan. 1, 1993.

Statistical Office of the Slovak Republic

The Statistical Office of the Slovak Republic has around 1130 staff, one third working in the HQ in Bratislava and two thirds in eight regional offices. Just under 80% of the staff are women, although the proportion of women is higher in regional offices (84%) and lower in head office (69%). Another difference between HQ and the regional offices lies in the level of qualification of the staff: while three quarters of HQ staff are graduates, there are less than 30% of graduates in the regional offices, where two thirds of the staff are educated to high school level. Around a quarter of the staff are under 35 years old, and about half are over 46.

Peter Mach

Peter Mach (53) graduated in 1974 with a doctorate in Probability and Mathematical Statistics from Comenius University, Bratislava.

After first working at Comenius University as a scientific assistant, he worked from 1979 to 1995 in informatics in a number of official bodies. It was then that he came into contact with the Statistical Office, initially working for the first body to supply data to the Office on magnetic tape, then in 1994 as the director of the National Centre for Informatics - the research institute of the Office. After three years working in informatics in the private sector, he returned to the Statistical Office in January 1999, when he was appointed as the third President.

A young graduate sees a future with the Office

Sigma also met Michal Cigas, to get the point of view of a young graduate working at the Office. Michal joined the Office at the end of 2001, after graduating in Economic Sciences. Between January and May 2004 he worked at Eurostat as a PHARE trainee.



Michal Cigas, Business Register Department

He works mainly on methodological issues of the Business Register within the Department of comprehensive methodology, and he has been involved in European projects – SMEs Census 2002, and Business Demography 2003/2004.

So why did he choose the Statistical Office?

“After I graduated I saw an advert for a government programme offering traineeships in Public Administration. I ap-

plied and was selected by the Statistical Office. I thought this offered a good opportunity, with interesting work. The chance to improve my English and work on a European project was very attractive.”

Did the traineeship and the job meet your expectations?

“It has been very interesting, and I have been glad to take part. I have had the opportunity to visit many countries and Eurostat. It has met the personal goals I set when I started: a real job with specific tasks, travel and experience, working on Europe, and the chance to advance in my career. And of course the PHARE traineeship.”

Can you see a future for yourself in the Slovak Statistical Office?

“Yes! Although I would also like to work for Eurostat... I have a good boss, and I am involved in projects which contribute to developing statistics not only on a national but also a European level. I have a lot of personal friends among statisticians from the whole world and thus I feel part of the international statistical community.”

Michal recognises that the starting salary for a young graduate may not be as good as they could get elsewhere, “but after two or three years the difference is not so great, and career prospects are good.” Σ

A granary for agricultural data

Submitted by HCSO' Department of Agricultural and Environmental Statistics

In Hungary, a newly established database system stands a fair chance of becoming a trailblazer for the whole Statistical Office's professional work. As agricultural statistics developed to comply with the data requirements of both Hungary and the European Union in the years around the new Millennium it became a necessity to use more informatics in the data collecting and processing activities. Well before joining the EU on 1st May 2004, Hungarian agricultural statistics faced two challenges: firstly an agricultural census in 2000 and then an orchard and vineyard census in the following year.

While both challenges were carried out successfully, it became clear that the whole process of statistical production needed more technical support. Furthermore, the agricultural branch of the European Statistical System is one of the most developed and regulated among its subsystems, its written legal rules comprising more than a thousand pages. Data requirements formulated in the course of the accession negotiations by the EU showed that Hungarian agriculture needed a statistical database system, which would be able to quickly adapt to changing data requirements and to process considerable data-stocks with a high degree of reliability. Therefore a preparatory effort began in order to construct such a system, developed by a Hungarian IT-company within the PHARE framework and with expertise contributed by Statistics Sweden. By the end of 2002 the main parts of the new system had been developed, and during the first half of 2003 a gradual installation began.

A storehouse for agricultural statistics

The new database system was baptized 'Hombár', the Hungarian word for 'granary', a storehouse for threshed grain. Just as farms, the basic units of agricultural statistics, use granaries to store grain, so statisticians employ the database to stock large quantities of agricultural data. While farmers gather up their valuable grain in granaries in order to process

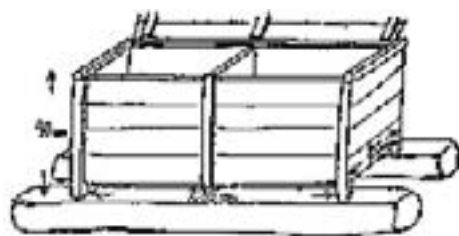
it into flour and bread, statisticians collect in their 'granary' invaluable data to produce information about agriculture.

What was expected from the new system by statisticians as its would-be users? First of all that it be able to treat the data processing of the agricultural statistics as a standard system, and be linked to and compatible with the existing systems of the Hungarian Central Statistical Office (including, for example, the metadata system, survey/data collection design and implementation, the data entry system and the business entities register). Secondly, in order to improve data quality, it had to guarantee the follow-up of data generation and modification thus ensuring the coherence of data during processing. Thirdly, it should improve the analyses of time series both for the 150-year long period of Hungarian agro-statistics and for the last 4 years. Fourthly, it should drive data processing by using a task management system. And last but not least, the new system should be user-friendly.

The various tasks have been solved either by register-type systems or by theme-tailored ones. The first group includes farm and plantation registers, the second the main agricultural branches and is supplemented by a workflow database. The farm register was built in accordance with the Eurostat's Eurofarm database and complies with both its Individual and Tabular Database (BDI and BDT, respectively).

May serve as a model for other fields

During the first year in operation Hombár proved to be an excellent granary and if equipped with the necessary extensions, it may serve as a model for other fields of statistics in Hungary. Among Hombár main advantages the Hungarian Statistical Office's IT experts mention its general character. Following the data input all kinds of processing may be carried out by statisticians themselves. Σ



Wooden granary from Szalaf, Hungary

Do you have dissemination problems? Don't worry, PC-Axis comes to the rescue!!

By **Ulrika Arver, Statistics Sweden**

PC-Axis is a software family aimed at facilitating quick and easy dissemination of statistics. It is the result of an ongoing development project, started at statistics Sweden in the 1970's. Today the software family has grown to not only include the statistical browser for windows and Internet but also complimentary software such as programs to create files, internet solutions and publishing facilities.

To use PC-Axis, you first need a license agreement with Statistics Sweden. Currently over 50 statistical agencies and international organizations use the products and they are all part of the PC-Axis consortium. All members are encouraged to actively participate in the growth of the program. The responsibility for the different programs and their development are distributed between the Nordic countries that form the core of the consortium. Once a year a reference group meeting is held to assemble all the licensees together and give them the opportunity to discuss the product, current developments and make requests for the future. The common goal is to improve the product in such a way as to meet the needs of the users, and new functions are added in each version.

Today, PC-Axis allows the display of dynamic tables that can be modified, recalculated and displayed in graphs or maps. It is also possible to make a connection to an SQL database, as is done at Statistics Sweden. Another popular solution is to use PX-Web as a first step in statistical dissemination. PX-Web is a MS Internet Information Server-based tool for the presentation of statistical tables on the Internet. It is a quick and easy way to publish a functioning database as the applications are generated automatically. The subject areas are created from the folders containing the PC-Axis files (the statistical data). PX-Web as well as PC-Axis allows the presentation of data in a variety of different ways (pivot func-

tion), using graphs and maps. If needed, there is also the option to add an additional language if yours is not one of the 15 already in use!

Agricultural census in Croatia

But how does PC-Axis work in practice? A great example is the Central Bureau of Statistics in Croatia, who in 2003 conducted an agricultural census. They needed to get the data to the users in a timely manner and a PX-Web database was created on their website. The project was a success. Today they are working on a PC-Axis solution with a connection to a relational database (SQL) to facilitate production and metadata access.

If you are interested in finding out more or try out the software for yourself please make sure to visit the website www.pc-axis.scb.se. There you will find all the programs to download, detailed technical information, as well as reports on all new developments. You will also find information on who to contact if you have questions or are interested in setting up a license agreement. Σ

Ulrika Arver is a Statistics Consultant in Statistics Sweden

Modernising the Statistical Infrastructure in the UK Office for National Statistics

By John Kinder, ONS

The UK Office for National Statistics (ONS) has embarked on a modernisation programme which will renew the entire statistical infrastructure and re-engineer key statistical systems. The business vision is to converge on an agreed set of statistical methods and tools that function efficiently within a technical environment. This will allow national statistics to be shared amongst users with common tools and methods which will create opportunities currently prevented by technical obstacles.

The modernisation is being conducted in phases. The first is essentially to prove the concept and to operationalise a substantial number of the components, as well as creating the central database. The following three phases focus on implementing the design in social, business and national account statistics. The fifth phase looks at surveys and sources integration, including the application of new methodology through the new tools and systems. Other phases are likely to follow including the implementation of the vision to produce statistical outputs in real time.

A key element in creating the architecture was the selection of the standard statistical processes and a "buy, not build" strategy was applied for the standardisation.

Hardware and data and component architecture

In the first phase hardware infrastructure was replaced. A centralised, shared hardware system will support the Statistical Modernisation Programme (SMP).

The development of the logical data architecture model was driven by an analysis of the high-level business re-

quirements of SMP rather than a replication of ONS legacy systems. The highest priorities were for the model to support the flow of data through a sequence of standardised processes, sharing a common source of Metadata. The data model realises a foundation principle that the key information to which every data item must be linked are the statistical unit to which the data refers (e.g. household, business), the classification of the data (e.g. Standard Industrial Classification), the related geography (e.g. grid reference, region) and time period.

The technical architecture also includes a component model. Key components include a statistical array, folders, computational plan and statistical activity. A statistical array can take many forms (e.g.: survey response, aggregate source and others). The statistical array provides the common means of exchange of data and metadata between other components of the system. The status of the statistical array will denote the stage of processing it has reached. Folders will be created to hold objects and will be a convenient set of views on the data, following a similar pattern to the directories of a file system for Windows. Each object – including statistical arrays, computational plans, metadata etc – will be able to be viewed through at least one folder. The processing of the contents of a folder are defined and managed by a computational plan which includes a list which could be a single operation or a segment of the statistical process.

A metadata based system

At the heart of the new system and database is a metadata system comprising a classifications repository, a variable

definitions list and a set of common core metadata for each dataset, known as the Administrative and Survey Data Management System (ASDMS). The metadata structure is capable of holding the range of classifications, and their versions, required for official statistics and provides a variable and question library which can support the full range of data collection instruments and publication types envisaged by ONS. [Σ](#)

For further information:

John Kinder, Office for National Statistics, Statistical Infrastructure Development Programme,
John.Kinder@ons.gov.uk

eSTATISTIK.core: Digitally linking statistics and accounting

By Christian Bösnecker, Statistisches Bundesamt

For some time, statistical offices have been offering respondents the option of making their statistical returns by means of internet questionnaires. Any respondent with internet access can use this channel. The advantages to respondents are obvious: there is no need to complete and send the paper questionnaire and dispatch of the return is immediate and usually cheaper.

A task that still has to be performed by the respondent is acquisition of the statistical information required. Respondent firms generally obtain such information from their company IT systems using business software. It is often not directly available and has to be derived from the existing data. It is also frequently stored in different software systems within a company and must then be compiled. The ideal would be for the company IT system to include a "statistics module" which would automatically prepare and compile the statistical information "at the touch of a button" and so relieve the respondent of the task.

The labour-saving potential of such a technical approach is huge, since ideally the respondent need only press one "button" to launch the compilation and dispatch of a statistical return. The whole data acquisition process is thus automated for the respondent. But there are also advantages for the statistical offices. Automated generation of the statistical raw data improves their quality considerably and they can be uniformly processed.

What is eSTATISTIK.core?

Starting from this idea, the statistical offices of the Länder, in cooperation with established software houses and the *Arbeitsgemeinschaft für wirtschaftliche Verwaltung e.V.*, developed the system "eSTATISTIK.core – supply of statistical

data to a common data entry point". The package consists of the following infrastructure and software components:

1. an internet-based common data entry point for statistical raw data;
2. standard XML formats for data delivery, acknowledgement of delivery and survey description;
3. electronic XML-based survey descriptions for selected statistical collections;
4. free software to assist respondents and software manufacturers in producing statistics modules.

Common on-line raw data entry

The internet-based common data entry point for statistical raw data allows any respondent with internet access to make automated statistical returns to a central point serving the whole country, irrespective of the statistical collection and statistical office for which the returns are intended. The data entry point checks the returns received and distributes them to the statistical offices concerned.

Standard XML data formats

Only XML formats are used for transmission of data between respondents and the common entry point. The XML format DatML/RAW is that for the supply of statistical raw data and is used for all statistical collections. It supports delivery of returns by third parties (e.g. tax consultants) and conversely acceptance of returns by third parties (e.g. common entry point). When a set of data is dispatched, the sender can indicate whether an acknowledgement of receipt is desired. Receipts are issued in the XML format DatML/RES and can thus be processed automatically. This option is particularly useful to IT service providers (e.g. computer centres) that wish to automate the same processes for many customers. The XML

format DatML/SDF is used for the formal description of a statistical collection, its features and list of characteristics. It is also the format in which survey descriptions are made available.

Survey descriptions

A survey description describes the number and nature of a statistical collection's characteristics and other particulars such as the reference period and periodicity. The survey description is the basis for compiling and checking the raw data supplied for a statistical collection. These descriptions can be downloaded automatically from the common data entry point in the XML format DatML/SDF and thus allow generic methods to be used in compiling and checking statistical returns.

Supporting software

The program library CORE.connect was developed specifically for automated acquisition of statistical raw data from company IT systems. It is an aid to respondents and software houses in producing statistics modules. This software component takes over the task of acquiring and dispatching statistical raw data from the company IT system. The library provides all functions needed to compile and check a data return in the XML format DatML/RAW and to send it to the common data entry point. The PC application CORE.reporter is designed for respondents who do not use industry-specific software but only standard office software. This ap-

plication enables respondents to produce, dispatch and manage returns in the XML format DatML/RAW on the basis of statistical raw data available in a common office format (e.g. CSV, Excel).

Operational from summer 2005

In the early summer of 2005, several well-known firms such as SAP, Datev and Oracle/PeopleSoft will initiate the pilot phase of the software modules they have developed for selected wage statistics. Among the pilot firms willing to obtain statistical data automatically by means of these modules is, for instance, the Deutsche Lufthansa. The objective is to offer eSTATISTIK.core also for other economic statistics. With this project, the German statistical offices of the Federation and the Länder won the 5th eGovernment competition of the international consulting company BearingPoint and Cisco Systems in the field of "Economy and Employment". The prize was awarded at the computer fair CeBIT in March 2005. Σ

For further information:

www.statistik-portal.de/Statistik-Portal/datenOnline.asp (in German)

Christian Bösnecker

e-mail: christian.boesnecker@destatis.de

Statistisches Bundesamt's new statistics shop open

Since April last year, a completely redesigned web-based Statistics Shop has been open to all Statistisches Bundesamt customers. The distribution platform has not only been redesigned, but has also acquired a considerable number of additional functions, and its product range has been extended to include the entire gamut of standard publications.

All Statistisches Bundesamt publications can be ordered online from the Statistics Shop, and numerous publications can be downloaded in pdf and/or xls formats. Moreover, the Statistisches Bundesamt is now making a large number of publications available free of charge, for example the specialist series "Fachserien".

No prior registration is needed for the free downloads. The information which a customer requires is made available directly and without any formalities. Furthermore, registration for receiving pay products is simple. Registered customers are informed by e-mail when new products which are of interest to them are published.

Customers have a number of options for searching Statistics Shop products. In addition to the standard 'full-text' search, a hierarchically structured search for the various themes of official statistics is available, as is an advanced search option in-

volving titles and article numbers. Another useful option is the possibility of restricting a search to a particular medium of publication.

More than 550 000 visitors to the Statistics Shop were recorded over the last year, and more than 11 000 customers registered during the same period.

The new Statistics Shop has been made possible by a partnership with the distributor Servicecenter Fachverlage (SFG), which is part of the Elsevier Group, Kusterdingen. SFG, which was selected on the basis of a public call for tender, provides the technical platform and overall logistics. This co-operation project between the public and private sectors will produce synergies for both sides. It is part of the German Government's initiative to reduce red tape, which since 2003 has been implementing the reforms contained in the "Modern State, Modern Administration" programme. Σ

For further information:

www.destatis.de/shop

Household panel surveys and international comparability

Statistisches Bundesamt

Harmonisation and international comparability of household panel surveys is the central theme of an omnibus volume produced in English in 2004 under the title *Harmonisation of Panel Surveys and Data Quality*. It was published by the Statistisches Bundesamt, Wiesbaden, in its series *Spektrum Bundesstatistik* and is based on the results of the European Commission funded research project CHINTEX (The Change from Input to Ex-post Harmonisation in National Samples of the European Community Household Panel – Implications on Data Quality). The project consortium consisted of the Statistisches Bundesamt (Wiesbaden), the Johann Wolfgang Goethe-Universität (Frankfurt), the Deutsches Institut für Wirtschaftsforschung (Berlin), Statistics Finland (Helsinki), the University of Essex (Colchester) and the Centre d'Études de Populations, de Pauvreté et de Politique Socioéconomique / International Networks for Studies in Technology, Environment Alternatives, Development (Differdange).

The contributions are of general academic interest and deal with the quality of statistical results obtained from panel data. The findings are thus particularly pertinent to research and development within the official statistical systems but also have wider relevance. Some results are discussed below by way of illustration.

Data comparability is greatly affected by survey methods

A comparison of estimates based on Finnish survey data from the European Community Household Panel (ECHP) and Finnish register data for the same individuals revealed considerable differences in the distribution of household equivalent income. These differences are stable over time. This discrepancy generates a relative error of 50% in the poverty rate. Discrepancies of this magnitude affect the ranking of the European states in terms of the findings derived from the house-

hold panel. The same is likely to be true of the EU Survey on Income and Living Conditions (EU-SILC). The differences in distribution are explained by a substantial overestimate of gross earned income in the survey data for the lower deciles and a moderate underestimate of income in the upper deciles.

As regards non-response, the research revealed that fieldwork practice varied greatly across the national subsamples of the ECHP. This is linked to inter-country differences in the panel attrition structure. Significant differences in the panel attrition and non-response patterns are also apparent between different surveys within a single country. The research indicates that both panel attrition and item non-response can be minimised by better fieldwork. In particular, the studies showed that it was very helpful to retain the same interviewer for as long as possible. For an interview-based panel, the main panel attrition risk factors are changes of address and interviewer.

Changes in income are difficult to measure

One finding with regard to data quality was that there is a tendency for surveys to underestimate changes in earned income. Using Finnish register data, it was shown that attrition is affected by changes in household and earned income and in family status. As a general rule, a bias must be assumed towards underestimation not only of household income variability but also of the measures of income distribution. All distortions found confirm the hypothesis that changes in the individual values of variables increase the risk of respondents' dropping out of the panel.

Data quality improves with increasing panel duration

Over the life of a panel, there is an apparent trend for participants to give more accurate replies, presumably leading to a gradual improvement in the quality e.g. of income data. The study findings also show that attrition changes with panel duration. A possible reason could be growing cooperation of the respondent with the interviewer or with the survey as such. It can be deduced that cross-sectional surveys, and to a lesser extent panels running for a limited time, suffer from maximum measurement error and non-response bias. Both of these can be reduced to some extent by longer panel duration. These findings indicate that long-running panels are generally preferable. Σ

Further information:

<http://www.destatis.de/chintex/index.htm>.

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European statistical data support helps internet users

Eurostat set up with the members of the 'European Statistical System' a network of support centres, which exist in nearly all Member States as well as in some EFTA countries. Their mission is to provide **help and guidance to Internet users of European statistical data**.

