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Community Action Programme on Public Health

First Meeting of Network of Competent Authorities

Health Information and Knowledge Strand

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Discussion on Community health indicators

A discussion document on the first phase of a set of core EU health indicators

Aims and Objectives of the new EU Public Health Programme

The overall aim of the new public health programme ((Decision No 1786/2002 EC of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008)) is to "*contribute towards the attainment of a high level of physical and mental health and well-being and greater equality in health matters throughout the Community, by directing action towards improving public health, preventing human diseases and disorders, and obviating sources of danger to health with a view to combating morbidity and premature mortality, while taking age and gender into consideration. To fulfil this aim, actions should be guided by the need to increase life expectancy without disability or sickness, promote quality of life and minimise the economic and social consequences of ill health, thus reducing health inequalities, while taking into account the regional approach to health issues*."

The programme is expected to underpin the health strategy of the Community and to yield Community added value *"……by addressing new developments, new threats and new problems for which the Community would be in a better position to act to protect its people, by bringing together activities undertaken in relative isolation and with limited impact at national level and by complementing them in order to achieve positive results for the people of the Community, and by contributing to the strengthening of solidarity and cohesion in the Community. The new health strategy and public health action programme should provide the opportunity to further develop the citizens' dimension of Community health policy*."

The programme puts forward several specific major public health concerns that deserve EU level attention:

- ✓ Increasing life expectancy without disability or sickness
- ✓ Reducing differences in health status and health outcomes – tackling inequalities in health
- ✓ Attention to major burdens of disease
- ✓ Addressing health determinants through promotion and prevention – e.g. tobacco, nutrition and alcohol
- ✓ Health protection in all EU policies and activities
- ✓ The citizens' dimension and equal access to information
- ✓ Needs of the candidate countries

The programme of Community action in the field of public health is also intended to build on activities and the work of the eight programmes from the previous public health framework (Cancer, HIV/AIDS, Drugs, Health Promotion, Health Monitoring, Pollution-related Prevention Programme, Rare Diseases and Injuries and Accidents), as well as on relevant research projects funded under previous Community Research Frameworks.

The role of the Health Information and Knowledge System in the new EU public health programme

Actions and Support Measures set out in the text of the new programme, (Decision no 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community Action in the field of public health (2003_-2008), include:

*"**Developing and operating a sustainable health monitoring system to establish comparable quantitative and qualitative indicators at Community level on the basis of existing work and of accomplished results,** and to collect, analyse and disseminate comparable and compatible age- and gender-specific information on human health at Community level concerning health status, health policies and health determinants, including demography, geography and socio-economic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health*;" (Annex 1.1).

The statistical element of the health information system will be developed, in collaboration with the Member States, using as necessary the Community Statistical Programme to promote synergy and avoid duplication.

Further actions entail improving the system for the transfer and sharing of information and health data, including public access, and developing and using mechanisms for analysis, advice, reporting, information and consultation with member States and stakeholders on health issues relevant at Community level.

The previous Health Monitoring Programme (HMP) and the development of European Community Health Indicators

The main body of work undertaken so far towards the development of the future Health Information System is work undertaken under the Health Monitoring Programme 1997-2002. It will be recalled that the Health Monitoring Programme was established to:

- Measure health status, trends and determinants throughout the Community;
- Facilitate the planning, monitoring and evaluation of Community programmes and actions;
- Provide Member States with appropriate health information to make comparisons and to support their national health policies.

The Programme had three pillars, namely:

A Establishment of Community Health Indicators
B Development of a Community-wide network for sharing health data
C Analyses and reporting

Annex 1 of the decision No 1400/97/EC of 30 June 1997 adopting a programme of Community action on health monitoring within the framework for action in the field of Public Health (1997 - 2002) noted as a key objective: "*To establish comparable Community Health indicators by means of a critical review of existing health data and indicators, by developing methodologies for obtaining comparable health data and indicators and by developing appropriate methods for the collection of the progressively comparable health data needed to establish these indicators*.". The programme text also referred to the "***identification of a set of Community health indicators, including a subset of core indicators*** *for the monitoring of Community programmes and actions in public health* ***and a subset of background indicator****s for the monitoring of other Community policies, programmes and actions, for providing Member States with common measures for making comparisons*."

This programme has funded 54 projects in total, most of them indicator projects, many of them undertaken in conjunction with Eurostat. To these should be added the published results of indicator projects carried out under the auspices of other public health programmes, such as cancer, rare diseases and pollution-related Prevention Programme.

HMP Indicator Projects: Some key results to date.

One HMP project, namely the ECHI (European Community Health Indicators) project, has provided an overarching view of the development of Community Indicators. This project has produced a list of indicators in use, including those used by Eurostat, WHO and OECD, divided under four headings as follows:

- Demography and socio-economic factors
- Health status (mortality, morbidity)
- Health determinants (personal factors, health behaviours, living and working conditions)
- Health systems (prevention, health promotion, health protection, health care services)

HMP indicator projects are often cross-cutting through these headings (e.g. mental health includes mental health status, its determinants and the appropriate services). As well as this, HMP indicator projects have been funded in response to calls for proposals. Consequently, the contribution of the projects to the ECHI list has been patchy, in some cases very detailed and innovative whilst in other area there remains substantial development work still to do. For example, projects concerning the development of health inequalities and health promotion need to receive particular attention in the future.

Those HMP indicator projects which have been funded have made a very substantial contribution to the development and understanding of health indicators in use, particularly for use at a European level and it is worth rehearsing some of their achievements with respect to specific projects. For example, one of the major obstacles to a better understanding of patterns and determinants of health status has been the absence of standardised survey instruments. The EURO-REVES project has proposed a set of instruments covering functional limitations, activity restriction, global activity limitations, perceived health, and mental health. This is a major contribution that should ultimately provide the basis for meaningful comparisons of the health of Europeans.

Another project looked at the general problem of comparing data from surveys that, while each looking at the same issue, use slightly different versions of the same question. They show how, if there is some overlap between the surveys, it is possible to achieve some degree of comparability, applying a new method, response conversion, to a widely used question of functional ability.

Methodological development has not, however, been limited to health status. There is an urgent need to obtain much better information on exposure to risk factors. One of the most obvious ways in which the people of Europe differ is in what they eat. Yet, while it is easy to describe a 'typical' Italian, Spanish or Swedish diet, it is much more difficult to assess what people actually do eat, and in particular how this varies with one's position in society. The EFCOSUM (European Food Consumption Survey Method) project has made recommendations on how to monitor this by specific surveys, while the DAFNE group have been working on the use of household budgetary surveys for this purpose. They also illustrate the need to go beyond national averages to look at the distribution of variables within a population, thereby showing, for example, how, in the United Kingdom, consumption of fresh vegetables has, reassuringly, increased in non-manual households but, alarmingly, has fallen in those households where the head of the family is in manual employment.

Other projects looked at existing information and future needs in relation to particular age groups in society. The PERISTAT group, for example, has critically assessed relevant indicators for the perinatal period. They indicate how widely used statistics, such as perinatal mortality, are still not strictly comparable among countries.

A range of other projects has covered the issue of monitoring the changing burden of disease due to some of the leading causes of ill health, along with their determinants and associated prevention/health care issues. They critically assess existing data sources and also make innovative recommendations on new monitoring instruments (mental health, cardiovascular diseases, cancers, musculoskeletal disorders, diabetes).

A core set of indicators. Why a shortlist is proposed?

The 2003 Work Programme, which is the first year of implementation of the new public health programme, made provision in Section 2.2 for the continuing "*development of a sustainable information system at EU level*" involving "*the definition, collection and exchange of data*." Section 2.2.1 noted the need for "*completing the technical and scientific background work for the establishment of a list of health indicators that will be agreed for use in the ECU…developing the operating principles of the information and knowledge system…*" and section 2.2.2. mentioned : "***This action aims at starting to operate the comprehensive EU health information and knowledge system in a systematic and stepwise way. The action builds on the outcomes of the past programmes****…".*

One of the main purposes of establishing a short list of indicators at this point is to set priorities in the time scheduling of the development of statistics within the health Information and Knowledge System. Indicator definition is the first stage in the cycle of data collection, data analysis and reporting. It will be important to establish what data is available with which to support the other stages of analysis and reporting. There is also the question of how to obtain and store the data. These steps need to be taken in manageable amounts of work, and to be programmed as efficiently as possible so as to also demonstrate early results. There may be lessons to be learned from the initial exercise for the future development and integration into the system of more indicators.

This rationale coincides with an aim of the ECHI-2 work plan, namely that the comprehensive indicator list, which could be expected to grow steadily with the input of all the HMP projects, would need some restriction to enable effective work on harmonisation of data collection, but not on too many topics at the same time.

There is no obvious reason to prefer one set of criteria against which to develop the initial indicator set, except perhaps to start from a *general public health policy perspective.* From this perspective, health policy seeks (1) to address the big health problems, as well as (2) unwanted health inequalities, and (3) the best opportunities to improve health and reduce inequalities through appropriate interventions.

On this basis, indicators/issues should be selected which (1) represent overall (negative or positive) health measures, or the largest health problems ('disease burden'), whether in terms of diseases or functional health at the population level, (2) contain the most important health inequalities (possibly to be implemented by SES stratification of other selected indicators), and (3) focus on determinants of health which can be influenced by health and other policies and on associated interventions in health promotion, health protection, prevention and/or health care.

Availability of data has been suggested and discussed as a criterion for selection. However, although data was always likely to be available for the majority of indicators listed under points (1)- (3) above, at the same time it was expected that the selection process would point to a limited number of issues/indicators for which future data development has high priority. The inclusion of such indicators would be for the purpose of promoting future data collection.

Process of Selection

The possibility of developing an initial set of indicators was first presented at the Health Monitoring Project Co-ordinators meeting in Luxembourg on 20 March 2003 and was the subject of a general discussion. Whilst no HMP co-ordinators wished to see the detailed results of their work ignored, several were able to suggest possible methodologies for determining a priority ranking among indicators. It was agreed that the ECHI project team would develop a Delphi-type tanking tool with respect to the first set of indicators. The protocol for this process is set out at Annex A to this note. This resulted in a proposal for a first set of some 60 indicators (see Annex B) instead of 25-50 initially recommended. For these, Eurostat have already been able to provide preliminary comment on data availability.

Discussion of Results

The list of indicators which scored highest according to the scoring exercise described at Annex A was scrutinised for face validity and for overall coherence, by a meeting of the ECHI project on 19 June 2003. This prompted a discussion about the philosophy underlying the overall "shape" and balance of the list. It was felt that the scoring exercise had produced an initial list which was rather conservative and followed the traditional "medical model" in terms of its emphasis on tracking disease and attention to conventional health risk factors. Not only is the EU in the position of being able to develop indicators which are innovative in terms of definition and the technical quality of the data collected, as described above, but it also has the opportunity to be innovative in terms of the importance it gives to certain types of indicators. A key objective of the new EU public health programme is health promotion, where health is described in positive terms rather than simply in terms of the absence of disease. One ongoing health monitoring project is in the process of developing possible health promotion indicators. At the same time, since another key objective of the public health programme is to promote action on the determinants of health, it was also regarded as potentially important to keep, or develop, composite indicators, such as "smoking-related diseases" at least alongside traditional measures of morbidity (such as "cancer"). Along these lines of thought, some additions as well as deletions were made to the list, as described and documented in Annex B.

Indicators concerning the role and impact of health systems were felt to be inherently difficult, and not the main focus of attention for a first set of indicators. It was felt that in this initial selection, such indicators should be confined to those where health status is directly influenced by health care.

Future Development of EU Health Indicators

The main rationale for selecting a restricted set of topics is to allow for an early, and stepwise implementation of the indicators. This means that the status of this core set is for the short term, and is part of a longer term strategy for the gradual implementation of all the indicators that have been recommended in the various areas by the various projects, and the associated data collection. Therefore, the core set has been termed '*first phase set of core indicators'*. The longer term strategy has still to be specified. The ECHI-2 project will carry this work further during its last year until July 2004, by further integrating the results of HMP projects into the comprehensive indicator list, and by defining specific 'user-windows' of indicators (i.e. subsets arranged according to specific topics of interest such as health inequalities, health of the young or the elderly, etc.). This will be done in close co-operation with the Working Parties, the Network of Competent Authorities and the Commission Services as part of the ongoing implementation of the new public health programme.