Summary

Regions in the European Union (EU) are becoming an increasingly important political and administrative level. In the field of health monitoring, the exchange of health indicators at the regional level across Europe would allow health professionals and decision-makers to put the characteristics of their own area in the wider context of all other regions across the EU.

The Fédération Nationale des Observatoires Régionaux de Santé (FNORS) has undertaken a project entitled "Health Indicators in the European Regions" (or ISARE - "Indicateurs de Santé dans les Régions d'Europe). The ISARE project is part of pillar A of the Health Monitoring Programme from European Commission. Its aims are to identify for each country the most appropriate sub-national level for exchange of health indicators within the EU (thereafter referred to as "health regions"), and to assess the extent of data availability at these levels.

Existing literature on health care systems and local democracy, and contacts with representatives from each EU member states were used in order to identify the "health regions". The ISARE approach consisted of focussing on the one or several sub-national administrative levels or other divisions which were most likely to be appropriate for health information exchange.

The ISARE project team felt able to make a recommendation on the appropriate "health region" for 13 countries out of the 15 EU member states. These are shown in the table, together with the corresponding NUTS level (or nearest corresponding). It is important to note that, despite the active involvement and contribution of the country representatives in the project work, these recommendations do not equate to a formal commitment from the member states.

The recommended levels represent 300 health regions across 13 countries. The average health region population size is around 1,2 million, with considerable variations. All recommended levels have responsibilities in the field of health promotion and all but one perform the function of public health reporting. Ten out of the 13 recommended regions correspond to a level of local democracy and 9 correspond exactly to one of the levels of the NUTS classification (1,2 or 3).

No recommendation for a regional level could be made for Finland and for Greece. Regarding the latter, a new level, "health region", will be effective at the beginning of September. We had not enough information to include this level at this time. In Finland, significant responsibilities regarding health and health care lie in the municipalities, which also represent a level of local democracy. However their small population size prevents them from being an appropriate level for health information exchange. Further thought needs to be given to this problem and it is possible that we will need to identify another level for Finland.

Regional level recommended by the ISARE project for health information exchange in 13 EU member states

COUNTRY	Recommended "health region"	No of regions	Average population (000)	Corresponding (or nearest) NUTS level
Austria	Bundesländer	9	892	2
Belgium	Province	10+1*	920	2
Denmark	Amtskommuner	14	335	3
England	Health Authorities	99	503	*(3)*
France	Régions	26	2 315	2
Germany	Land	16	5 090	1
Ireland	Health Board	10	370	*(3)*
Italy	Regioni	19+2**	2 857	2
Luxembourg	National level	1	420	1
Netherlands	GGD	50	315	*(3)*
Portugal	Health care region	5	1 721	*(2)*
Spain	Autonomous Communities	17	2 344	2
Sweden	County	21	422	3
All		**300**	**1 166**	

** Ten provinces + the Brussels capital region*
*** Nineteen Regioni + the two provincies of the Trentino-Alto Adige region*

The availability of a set of key data at regional level was explored by means of a questionnaire based on the framework of the European Community Health Indicators project (or ECHI project, also part of the HMP). The wide scope of the questionnaire meant that responses did not always cover the complete range of data investigated. In some countries availability of data could only be assessed for part of the health regions.

As expected these findings suggest that demographic and mortality data are widely available across the recommended "health regions". Assuming data comparability, it would be possible to build some indicators related to health care professionals and facilities, as well as health care utilisation for the "health regions". The same applies to the field of socio-economic, living and working conditions, and preventative data. However, availability of data regarding generic health status and morbidity is poor at "health regions" level.

The ISARE project suggests that despite the amount of disparity between the recommended "health regions", the exchange of health indicators is feasible. Virtually all recommended levels are already involved in public health reporting. The ISARE project approach consisted in identifying one level in each country according to a series of criteria. These "health regions" appear to be the best compromise for a successful health information exchange at sub-national level within the EU. Wherever appropriate, it might be preferable to use a more flexible approach and to recommend different sub-national levels to undertake comparisons about different levels of health care (e.g. primary, secondary), or analysis of different epidemiological patterns. Further work might be needed to identify variations in levels of competencies and autonomy at sub-national level between and within countries. Recommendations may need to evolve with regard to changes taking place in health care systems and local democracy.

It is hoped that the findings of the ISARE project represent a useful contribution towards identifying the "health regions" across the EU, understanding their role, and fostering their use as units for health indicators' exchange within the Health Monitoring Programme. A follow up project has been proposed with the aim of collecting data in each country and building a pilot regional health indicators database.