

ANNEX 10

TO THE ECHI-2 REPORT, JUNE 20, 2005

REPORTS OF ECHI-2 MEETINGS

- ECHI-morbidity meeting, october 2001.
- 1st meeting, 7 February 2002.
- 2nd meeting, 12 September 2002.
- 3rd meeting, 20 March, 2003, attached to HMP project co-ordinators.
- 4th meeting, 19-20 June, 2003, especially on the shortlist.
- 5th meeting, 19-20 February 2004, with HMP project co-ordinators, Working Party Leaders and Eurostat Core group Leaders.
- 6th and final meeting, 28-29 October 2004.

HMP Project ECHI (European Community Health Indicators)

Meeting on disease-specific morbidity indicators

Luxembourg, October 15-16, 2001.

Report by Pieter Kramers and Sue Davies

Present (some not for the entire meeting):

Katerina Ananiadou (ONS morbidity), Arpo Aromaa (HIS/HES), Carine de Beaufort (Diabetes), Dag Bruusgaard (musculoskeletal disorders), Henriette Chammouillet (Sanco). Sue Davies (ONS morbidity), Marleen Desmedt (Eurostat), Helmut Friza (Sanco), Simona Giampaoli (Cardiovascular diseases), Tapani Piha (Sanco), Michael Rigby (CHILD), Jean-Marie Robine (Euro-Reves), Francois Schellevis (Sentinel practices), Jennifer Zeitlin (perinatal health).

This meeting was organised in the context of the second phase of the ECHI project (co-ordinator Pieter Kramers), during which one aim is to further establish operational definitions for the indicators selected in the first phase, and to link these with recommendations for data sources and data collection mechanisms. In this process, the intensive interaction with all projects within the HMP, and with several initiatives outside HMP, are essential. For this meeting, the area of disease-specific morbidity indicators was selected out of the wider array of indicators, since this is a difficult area and quite a number of the various HMP projects are involved with it.

Pieter Kramers welcomed the participants and started out with a short repeat of the main points from ECHI-1. First he addressed the question of which diseases to select for a comprehensive but compact indicator system. Given the fact that you cannot include all ICD codes, there are several reasons for monitoring diseases, resulting in different criteria for disease selection such as: overall population burden, preventability, avoidability, and cost. In ECHI-1, the main criteria for the selection was population burden, and a few diseases were added for reasons of preventability and avoidability (relation with quality of care). Since the monitoring of diseases can be done by different types of data sources, he proposed a matrix of disease versus data source and a procedure to select the 'best source for each disease'. At the same time it is recognised that there is no such thing: the preferred source may differ by the primary question and also by country, and sources may be complementing. He said he nevertheless hoped the accumulated and interactive knowledge from the various projects could bring this question further ahead.

In terms of the matrix, one project (ONS morbidity: Sue Davies) covers the whole field, two projects do this for specific age classes (perinatal and child health: Jennifer Zeitlin, Michael Rigby), three projects cover specific diseases/disorders (cardiovascular, diabetes, musculoskeletal and mental conditions: Simona Giampaoli, Carine de Beaufort, Dag Bruusgaard, Jyrki Korkeila), and five projects cover specific types of sources (medical registries and population surveys: Francois Schellevis, Hugh Magee, Raphael Lagasse, Arpo Aromaa, Jean-Marie Robine). This was

proposed as the order of the agenda. Some participants presented partly the same material as later during the HMP project co-ordinators meeting.

After this presentation some more general issues were put forward. On the question of the formal status of the ECHI indicator list it was replied that at some stage parts of might be formalised, meaning that countries would have to comply. The feasibility, in relation with the degree of detail of the formal statement is a matter of close attention. There were pleas for simplicity and for the definition of indicators in direct relation with the relevant data sources. It was again stated that comparability between countries is the first priority in the HMP, and that in order to reach this goal, subsets of indicators could be implemented in subsequent phases. The remark was made that the matrix of disease versus data source was useful, but with a link to the purpose of the measurement and the diagnostic quality/requirements. It was also suggested that for each indicator (as there may be more than one per disease), preferred data sources should be ranked.

On the selection of diseases, the need was felt to add the criterion of political relevance. Items from the category of 'rare diseases', e.g., would easily fall outside the criteria mentioned, but still be important for political reasons. The dilemma may be that there are so many of these. Do we want to collect data about all diseases? Or on a subset of rare diseases? On what selection criteria? Information will be sought from the Rare Diseases Programme.

The '*ONS-morbidity*' project was presented by *Sue Davies*. She gave the result of the past 1st phase and some plans for the forthcoming 2nd phase. On the basis of an extensive questionnaire, an electronic inventory was developed containing information on morbidity data sources. This information can be viewed/accessed either through the data sources (7) or the diseases (11); however, in the case of viewing by diseases, the focus is currently mostly on disease registers. For different combinations of Country, data source and disease, qualifications were given on the data collection characteristics. The results show that for many diseases there are no national registers. For the next phase it is foreseen to upgrade the inventory and fill the gaps.

During the discussion the question was raised who are the users of this database. Another point was whether this project could perhaps get beyond the inventory phase and get engaged in judgments like 'for measuring population prevalence of disease X in country Y this one or these two data sources is/are the preferred one(s)'. It was quite clear that from the interactions with the disease-specific as well as with the source-oriented projects not only the inventory-type information can be strengthened, but also the qualification of 'best data source for situation X' could be added. It was also remarked that we should work towards less country-specific solutions for this type of data collection in order to enhance comparability. On the other hand, data from regional surveys are sometimes among the best.

Jennifer Zeitlin (Inserm, France) shortly outlined the directions chosen in the project on perinatal health. They started with a definition of the areas in which indicators on perinatal health could be defined. These include outcome, health care practices and other determinant factors. A review is started on existing recommendations/guidelines in the field. From a rather extended list of candidate indicators they will work towards

a feasible selection, with definitions. Much account is taken of indicators and data collections already in use. There is already a lot, but apparently the quality is such that many experts do not believe the data. There is a need to give guidelines on how to improve underlying data collection. The project will also produce an inventory of data sources, writing to Member States for the relevant information. Connections are or will be made with the child health project, the newly started project on reproductive health and a few other ones.

Michael Rigby (University of Keele, U.K.) presented the Child health project. Somewhat similar to the perinatal project (above), they made an inventory of all possibly relevant issues in the area of children's health and of the possibilities to build indicators from these. The focus is less on illness itself than on causes and impact. Among the causes (determinants) are pre-birth events, socio-economic, nutritional and environmental factors, and the possibilities to act on these by preventive and health promotion interventions. Among the impact factors are things like burden to carers, loss of schooling and delays in development. Accurate measurement of many of these items is difficult. There is sometimes the need to aggregate data across sources, for example GP and hospital data for accidents.

Simona Giampaoli (ISS, Italy) presented the project on cardiovascular diseases. Explicitly addressed were the three selected diagnoses: ischaemic heart disease/AMI, CVD, and heart failure. As sources were considered: hospital discharges, surveys, longitudinal studies, primary care registers and community-based disease-registers. She proposes for IHD: attack rate, incidence and prevalence. Additionally she proposes some 'process' indicators referring to common clinical interventions. She proposes if possible to develop this by gender, age, region and SES. Although much work has been done, indicators for regular monitoring of cardiovascular disease are not well-developed. This project is not collecting data, just the availability of data, and definitions, to assess comparability.

Dag Bruusgaard (University of Oslo, Norway) presented the project on musculoskeletal conditions. In this area, seven conditions were selected, ranging from concrete diagnoses like inflammatory arthritis to more symptomatic categories such as chronic widespread musculoskeletal pain. He emphasised the importance of the consequences of these conditions for disability pensions etc.. The project includes a strong link to the initiative called 'Bone & Joint Decade' (2000-2010). A clear view on the relevant data sources is still under development.

In the Diabetes project (*Carine de Beaufort, Luxemburg*) a systematic approach was taken similar to the CVD project. For both the disease itself and its complications indicators on the epidemiology and on the risk factors were included. Much effort is being taken to trace the various data sources. Pilot data collection is to start this month, with analysis taking place in February 2002. It is hoped to find out whether data sources are representative, validated etc.

During the discussion on the three disease-specific projects it was made clear that in general the projects would not collect primary data themselves. It was pointed out that often regional data collection systems are of better quality than national ones, as they are often more closely guided by expert centres. When these regional registries are sufficiently representative, they could be taken as proxy for the country.

Francois Schellevis (Nivel, The Netherlands) presented the past and forthcoming projects on sentinel network and primary care registries. He emphasised the need to obtain epidemiological indicators from these sources. In 6 Member States there is now an infrastructure for the continuous collection of primary care data on a national and/or regional basis which could be used for this purpose. He proposes to focus on the diseases/indicators for which GP registries is (in practical terms) the best source, in which data from other sources can serve for mutual validation. He wants to co-ordinate work on this with the other projects. The project will collect information from existing registration networks about definitions, data collection methods and analyses, representativeness, etc.

Unfortunately the representatives of the other projects on medical registries were not present. In the discussion, Bruusgaard was especially interested in GP registries for the musculoskeletal disorders. It was pointed out that some countries are starting GP networks, but – again - that for this source type certainly not all countries have similar possibilities.

Arpo Aromaa (KTL, Finland) got into a more general discussion of HIS and HES. These sources are mainly useful to measure prevalence. For some conditions they are the only source available. Problems inherent to HIS/HES remain non-response and the non-inclusion of the institutional population. The project primarily wants to make an inventory of surveys.

Jean-Marie Robine (INSERM, France) more specifically dealt with the chronic morbidity part of HIS. The Euro-Reves project recently co-ordinated its efforts on this point with EuroHIS, in which a precise recommendation is being worked out for an instrument to be used in HIS. This instrument includes a general question and specific questions on some 20 diseases, largely overlapping with the ECHI-selection. In indicator terms, a 12-month prevalence can be extracted from it, which for chronic conditions is close to a point prevalence. In HIS a direct medical verification is lacking, but additional questions ask whether the diagnosis was verified by a doctor. The reliability of this measure depends on the condition.

In the discussion on HIS/HES, it was pointed out by Robine that in spite of the question of the medical verification, surveys are the only type of source directly intended to obtain information at the population level. Still, the validation question remains. It was also pointed out that specific aspects of childrens and perinatal health are not covered in regular surveys, e.g. by age cut-offs.

At the end, a short evaluation was held. It seems that the projects dealing with disease-specific morbidity can indeed, by their different and complementing views on the matrix, produce much added value by engaging in the proper interaction. The combined action will enable us not only to make inventories but also choices.

It was suggested that this type of meeting indeed should have a close link with the project co-ordinators meeting, and it would perhaps have been relevant and interesting to more co-ordinators than the ones present. It was found useful to have such discussions on a smaller area within the overall field covered by all the projects. Some mentioned they found the presented matrix a useful model for the work within and the

contacts between the projects, and asked about a follow-up. Since so many cross-links were indeed identified between the projects, the follow-up should perhaps mainly take place bi- or trilaterally. The experience of this ECHI-morbidity meeting will be taken along with the discussions on the organisation of future HMP project co-ordinators meetings.

Finally, *Marleen Desmedt (Eurostat)* briefly outlined the plans for a morbidity seminar to be organised by Eurostat in May-June 2002. This will continue very much on the stage set by the present meeting, and will more specifically try to work out the question of how certain parts of the matrix can be implemented in terms of regular data collection and the calculation of statistics.

European Community Health Indicators; phase 2

ECHI-2

Report of the first meeting

7 february, 2002

Jean Monnet building, Rue Alcide de Gaspari, L-2920 Luxembourg

Present:

G. Badeyan (France)
N. Bossuyt (replaces H. van Oyen, Belgium)
G. Brückner (Eurostat)
H. Chamouillet (Sanco)
E. Duran (Spain)
C. Ecklon (Denmark)
P. Ferrinho (Portugal)
R. Gisser (Austria)
P. Kramers (the Netherlands, chair)
H. Markowe (U.K.)
M. Rognerud (replaces H. Strand, Norway)
E. Scafato (Italy)
A. Sissouras (Greece)
Z. Voko (Hungary)
R. Wagener (Luxemburg)
E. van der Wilk (the Netherlands, report notes)
T. Ziese (Germany)

Excused:

A. Aromaa (Finland)
G. Lafortune (OECD)
H. Magee (Ireland)
R. Prokorshas (WHO)
M. Rosén (Sweden)

1. Opening

The chairman welcomes the participants for this second round of ECHI. The participants agree with the proposed agenda.

2. Introduction of new participants

Since there are some new persons around the table, a short introduction round is held.

3. Reimbursement business

The chairman has reimbursement forms available. He stresses the need for everybody to fill in correctly all the required information on bank account, bank keys etc., and to send the form with the **original tickets** back to:

RIVM, National Institute of Public health and the Environment.

P.O. Box 1, 3720 BA Bilthoven

The Netherlands.

To the attention of:

Vera Mallee,

Department VTV

internal RIVM postal box no. 54.

A participants list is circulated, for correction and for signing for proof of presence.

4. Review of activities and reactions following the finalisation of ECHI-1

Pieter Kramers gives an overview of what happened with ECHI since the last meeting of ECHI-1 in October 2000. This includes a range of meetings in which he participated in relation to ECHI, the relevant activities in Sanco and Eurostat and the progress on the submission of ECHI-2. The powerpoint file of the presentation is circulated.

Then the participants commented on this and reported on how in their countries ECHI has or has not been used over the past year.

- Duran: What is the match between what is done elsewhere (other meetings) and ECHI in terms of health status measurement? Kramers: the general frame of ECHI is not discussed, but non-disease specific issues are. EUROREVES proposed a set of new survey instruments that are based on reviews. WHO/headquarters works with its own newly developed version of a questionnaire on health status based on the ICF.
- Markowe uses the ECHI frame and text in the U.K.. The report is not widely disseminated. A lot is going on at the indicator front (national indicators, inequalities, children indicators, QOL indicators, performance indicators). Markowe sees ECHI as a way to get consistency in this mushrooming business. He wonders whether there is any scope to develop a website to exchange the results of work from the Health Monitoring Programme (they are available on the Commission's IRC web site).

- Ziese: The German regions (Länder) redefined their indicator sets. ECHI was used as a guideline for indicator development, and to increase vertical comparability at regional level. Information needs were identified via ECHI. It was mentioned a lot in the Berlin meeting on health reporting last fall.
- Ecklon: ECHI was not much used in Denmark. There is a new right-wing government. It is not sure what the the new minister wants.
- Sissouras: In Greece, ECHI is sometimes used as a platform. Otherwise there are three relevant developments worth mentioning:
 1. The World Health Report 2000 (WHR2000), which ranked all 191 countries in the world, used its own selection of indicators. There is much debate on this.
 2. A recent OECD meeting in Canada was very successful in promoting the discussion on indicators of 'health system performance assessment'. We should try to include these views in ECHI.
 3. In the recent Berlin meeting on health reporting there was much reference to ECHI.
- Ferrinho: In Portugal there is an unstable period. The current minister made clear that continuity of information collection is important. Managers of regional authorities and others are going to use indicators and user-windows. The ECHI report was useful in trying to activate indicator work. It is permanent work, never finished.
- Rognerud: In Norway ECHI is used to monitor the Norwegian system (2000 indicators). The Norwegian system is now being evaluated. It is used by doctors and health professionals but too complex for politicians. We need a small set of key indicators (user-window). Like others, she does not prefer a combined index including everything, like WHO does.
- Duran: Finally he is in touch with the ministry in Madrid. They take on board recommendations, but Duran is afraid there is still discussion needed in order to handle the matter in the right way. There are 17 autonomous regions in Spain. ECHI is sent to all. Recently there was a Catalonian meeting which focussed on indicators. He criticises the lack of scientific background in the WHO indicators (WHR2000); maybe write a scientific article on this?
- Scafato: The Italian ministry shares the criticism about WHR2000. The ECHI report was circulated in Italy, and there was an informal meeting with people in charge at national and regional level. A draft report of this meeting will be given to Kramers. Five categories are used more or less the same as in ECHI. There are initiatives for monitoring health care systems and specific funding for the elaboration of indicators on health status and determinants. Cooperation with the Italian statistical office ISTAT is improving.
- Voko: The final ECHI report was distributed within the ministry. It was used as a framework in a health forum discussing development of data collection in relation to accession to the EU.
- Gisser thanked Kramers for keeping the group informed. In Austria not so much has happened. In the annual meeting of the statistical office health status committee, he reported about ECHI and the other HMP projects. As a result, the Federal Institute of Public Health was interested. The topic of health systems performance has also been discussed in Austria. Connected to this, the WHO survey on health status and responsiveness measurement was launched in Austria by mail. He also joined a consultation by Euroreves on health status measurement.

- Badeyan: WHR2000 was criticised a lot in France. France had good performance (no. 1) but this was based on a wrong estimate of education level. There is a new health report issued in France. Health inequalities are a big issue there. There will be an election soon, which is not a good moment for progress. Still, there is a movement away from only financing issues towards a broader public health scope.

Kramers replies and adds to some remarks.

- Dissemination of results from the HMP projects: these are on a Commission website 'IRC', which is now not accessible to all of this group. There is a discussion about better dissemination on the web and maybe also by a book. In the context of the proposal to be discussed later to work in smaller groups, the reports may be sent directly to the ones that are involved and interested, from the ECHI-co-ordination.
- About using ECHI in the countries: very nice but the work is still under way, nothing is finalised and there will probably be no formal status shortly. Countries should be careful using ECHI too literally and give also feed-back. Hopefully we're getting more refinement than big changes.
- As to the WHR2000: In the Netherlands it was stated that a ministry of health can do nothing with a ranking only. The concept has good elements, but the calculation of one final index is not the way.
- The Netherlands is not a champion in using indicators. At RIVM they are used in the preparation of the health report but the Ministry of Health does not use indicators in any official setting. However, we are moving in the direction.

Brückner (Eurostat) points out a few important developments from the side of the Commission:

- We should not underestimate the impact of the ECHI list. The expectations are high but perhaps it does not yet fully realise all these expectations.
- What is the status of the indicator set? Is it comprehensive? Is it complete? Is it growing? What about its consistency and sustainability? Do we expect change?
- The new PH program will hopefully start in 2003. Information will address not only policy makers but also citizens and professionals. Can we allocate indicators to target groups, and narrow down or diversify the size of the indicator set accordingly?
- From an EU policy point of view, a few important issues nowadays are: health in other policies, sustainable development, social exclusion. Are these issues included?

Kramers thanks all participants for their valuable input. This will hopefully help to put ECHI-2 on track.

5. Overview of past and current HMP projects

Kramers now presents a tour of all HMP projects, with emphasis on what the useful interactions with or contributions to the ECHI work have been or still can be. This is included in the powerpoint file distributed earlier to the ECHI group. The file is called 'meeting-1-plans.ppt'.

Brückner makes some additions on the work going on in the Task Forces (TF's) under the Eurostat Working Group on Public Health Statistics. There are 4 TF's: on causes

of death, on health surveys, on morbidity and on health care (these TF's are linked to some HMP projects). The latter TF has made much progress in implementing the system of health accounts (SHA) originally started by OECD, in terms of expenditures but now also on other subjects like manpower. The SHA is being finalised and starts to be implemented in member states. The SHA compares health care functions instead of health care sectors as defined different by each member state, and thereby enables a better comparison between countries. A further project focuses on data requirement for linking health and economy. Goal is to find out which data can give information on the efficiency of health care provision, in other words: how do we get the 'most health out of a dollar/euro'?

Rognerud: is it about all primary care, cure and prevention?

Brückner: Yes. For some countries it means thinking differently; putting in things, taking out things.

Ferrinho asks how development areas are identified and HMP projects are started up. Kramers explains how this is done via priority areas formulated each year in the HMP annual workplan.

Markowe asks about the status of HIEMS, since it is the centre of how the indicators are thought to be used and disseminated. Kramers gives some information about the present status of HIEMS: It is still in a test phase containing five datasets derived from elsewhere and having few connections per Member State, by a private connection. Brückner adds that the old contract to build HIEMS has run out and another IT firm now got the follow-up. The actual server containing the system is now in Luxemburg. The plan of Sanco is to have this year a test phase of feeding new data into the system by the Member State national data administrators, as foreseen in the original plan. In the future, HIEMS may have to compete with other networks/databases.

6. Discussion of plans for ECHI-2

After lunch, Kramers shows the plans developed so far for the second phase of ECHI. These are written in the document sent before the meeting, and are included in the powerpoint file 'meeting-1-plans.ppt' mentioned above. The discussion is structured along the 6 points in the work plan.

Improve and specify the indicator list

Brückner asks which morbidity-groups should be included? Shortlist of 65 COD? ICD categories? He proposes a systematic approach. Kramers replies that for mortality the Eurostat 65 causes of death list was adopted, and for disease-specific morbidity explicit criteria were used, primarily based on overall disease burden.

Scafato remembers as one of the ECHI aims to serve as a guide to health reporting. How will we link to MS priorities? How do we merge our previous ECHI aims into the new public health programme (be consistent!)? We should not focus on all the

indicators but rather on the user-windows, i.e., focus on priorities, e.g. take some determinants from other HMP projects.

Chamouillet mentions projects from the Health Promotion Programme which are relevant for us, on harmonisation of training in epidemiology. Each Member State should be represented.

Sissouras: What will we be doing in ECHI-2? He wants to introduce a two-level structure for going ahead. At one level there is a list of indicators that is a useful tool for policy. At the second level the structure is made clear, including the link with strand one of the new programme:

1. policy-makers
2. public/patients/professionals

Kramers interprets this as type of user-window.

Ziese wants to stress flexibility and a cook-book approach for making a good indicator list, i.e. keep the user interest as a dominant guideline. Local politicians may lack the expertise and the manpower and may need a smaller set of indicators. This is endorsed by Duran.

Brückner again stresses the importance of prioritization, or stratification of the list by importance, because politicians can't do this. He says the ECHI list is taken more as the Gospel than is justified. Kramers agrees on this.

Ferrinho stresses that regular revision is important. We should identify mechanisms to do so.

Chamouillet, from her side, indicates that the ECHI list is distributed a lot within the Commission. Questions have been raised however to the point that it is not always made clear why an indicator is selected and why not another. This is especially relevant when indicators were recommended by other HMP projects. It is necessary that it is made clear who agreed on the inclusion of an indicator. Kramers agrees that this is a crucial point which should be worked on.

Badeyan: How formal are the intended consultations of the Member States concerning the indicators? And how is this reported?

Chamouillet: All committees of the past programmes have finished their work. So we have to look at the future programme. The Commission could send ECHI informally or formally (as commission report) or as a directive. For the time being it is unclear.

Markowe is concerned about talking on directives. This may be too early.

Chamouillet: A decision at Commission level can be used. An official network is needed. There is no legislative support. It should be done stepwise, to begin with the more general terms. This has been done for communicable diseases. An official decision may help when it contains an obligation to deliver data.

Ecklon says in Denmark the web-based character is considered very important. HIEMS should be adapted to ECHI. Chamouillet will talk about this with Piha.

Ferrinho thinks this group is not the one to develop user-windows: we are not the users.

Wagener says we should focus on hot-items or core-sets of indicators.

Brückner asks whether there are European health targets. As far as we know there are not. Voko suggests to refer to national targets, if present.

Chamouillet wants more attention for communicable diseases, by approaching the appropriate people in the other EU programmes. We also should keep in touch with the various Agencies such as the one on Bilbao on work safety.

Link with policy priorities.

Badeyan also here raises the question on the formal status of the consultation. Gisser proposes to let that be done by health council ministers. Duran asks to what level of detail this should be. In Spain some regions have 200 health targets.

Kramers proposes to start in an informal way. This implies that each participant collects documents on health targets and policy objectives from his/her country and sends this to him with a short evaluative note by **June 15 at the latest**.

Updated inventory of indicators

Kramers announces that a person is being sought to work on this in Bilthoven. The person will have to seek communication with WHO-Euro, OECD and Eurostat.

Organisation of the work in subgroups

Kramers introduces the idea of working in subgroups. This implies that some 4-5 ECHI-participants will work together with the appropriate HMP project co-ordinators on a partition of the overall indicator set.

The selection of a core set of indicators, or several such sets fit for different audiences, has been raised a lot. In this context Brückner suggested that all of the subgroups should think of such core sets. He also suggests to contact the MS (e.g. Germany, Norway) whose indicator-systems have login-counts in order to decide which are the indicators used most often.

Ferrinho asks for a deadline for the completion of the 1st phase. Voko says he is not clear of what the subgroups should do. Kramers explains that in his idea, the subgroups should very concretely be working from the generic towards the operational definitions of indicators, by considering all the material brought about by the relevant HMP projects and other initiatives.

Scafato doesn't feel himself in the position to judge about whether indicators should be included. Both Brückner and Kramers indicate that this group should have sufficient expertise to study the relevant material and make proposals to the entire ECHI team.

Duran proposes conference calls for the subgroups. Kramers says he has allocated money for subgroup-travelling. Also, if participants get engaged in substantial amounts of work for ECHI, the possibilities of a subcontract could be considered.

The next meeting will be held on September 11-12 september, thus making a combination with the HMP project co-ordinators meeting on September 10-11. The proposal is to start at 11 September afternoon and then continue the next day. Brückner says there will be a conflict with a meeting of the task force Care in London. This will be worked out later.

7. Closure of the meeting

Kramers thanks all participants. The following agreements are made:

Kramers will:

- send copies of the powerpoint presentations to all participants;
- prepare a report of the meeting and circulate this;
- make a more detailed proposal for the work in the subgroups; this includes the partition of the work areas, the team members involved, the HMP projects involved, and a precise description of tasks and time schedule;
- send material of the HMP projects accordingly.

The ECHI team members will:

- give their detailed comments to the written workplan, or new thoughts arising after the meeting to the project co-ordinator (**very soon!**);
- submit their reimbursement forms (**very soon!**);
- collect current health policy documents on priorities, objectives or targets from their countries, and send these with their commentary to Kramers, **by June 15.**

P.S:

Short note on discussions of Kramers at Sanco (Chamouillet, Piha, Freese, Seguinot) and at Eurostat (Desmedt, Brückner, van den Berg), on February 8, 2002.

The discussions at Sanco were mainly meant to improve the impact from other Programmes besides HMP on several topics within ECHI, and the possible links between ECHI and the new Public Health Programme. The former included the areas of communicable diseases, of environment-related health and cancer. The main point was getting to know people and exchange material.

At Eurostat, the issue was how the further work on the indicators in ECHI-2 based on the HMP projects could be optimally co-ordinated with the work of Eurostat. In the Task Forces under the Working Group on Public Health Statistics, ECHI-1 is already used informally as a guide for the work. Issues came up such as:

- Make recommendations on optimal frequency of indicator calculation, in relation to data collection?
- Make projections to have as much timeliness as possible?
- Make a uniform age breakdown, and how far?

- How link the indicators to a database?
- Has ECHI gone far enough to find out the actual information needs?

It was decided that ECHI will try to further define the optimal co-ordination with Eurostat. In the frame of working on the updated inventory of internationally used indicators (ICHI) close contact with Eurostat will be needed.

ECHI-2
European Community health Indicators, phase 2
A Project under the EU Health Monitoring programme

2nd meeting, 12 september 2002
Ministry of Social Security and Ministry of labour, 26, Rue Zithe
Luxembourg

Member States Participants:

Peter Achterberg (NL)
Arpo Aromaa (FI)
Gérard Badeyan (FR)
Paulo Ferrinho (PO)
Richard Gisser (AT)
Eva Hammerby (DK)
Pieter Kramers (NL, co-ordinator)
Hugh Magee (HM)
Rutger Nugteren (NL)
Herman van Oyen (BE)
Mans Rosen (SW)
Emanuele Scafato (IT)
Aris Sissouras (GR)
Heine Strand (NO)
Zoltan Voko (HU)
Raymond Wagener (LU)
Richard Wilmer (UK)
Eveline van der Wilk (NL)

WHO:

Remigijus Prochorskas

Commission:

Gunther Brückner
Henriette Chamouillet
Ole Henriksen
Lindsay Mountfort
Tapani Piha
Frederique Sicard

Absent:

Thomas Ziese (DE)
Enric Duran (SP)

1. *Opening, adoption of the agenda*

Pieter Kramers acted as chairman and welcomed everyone to the meeting. He introduced Eva Hammerby for Denmark, Remigijus Prochorskas from WHO and Rutger Nugteren from the Dutch team as new participants, and Richard Willmer as replacing Hugh Markowe from the UK. Quite some colleagues from the Commission could be welcomed. He also thanked Raymond Wagener for arranging the facilities for the meeting. A change in the order of the agenda was proposed to allow Tapani Piha to present the new public health programme. This report will follow the original order of the agenda.

2. *Reimbursement business; other procedures*

The participants were urged to provide all the required material in order to get things reimbursed.

3. *Review of activities over the past 7 months*

Pieter Kramers quickly went over what was done over the past period, including:

- Recall of goals of ECHI-2.
- The start of the work of the subgroups.
- The response on recent policy priorities from 5 countries.
- The start of ICHI-2.

All of these were covered later in the agenda. Pieter asked special attention for the proper communication between himself and the participants: response to e-mails was sometimes disappointing. Scafato, Hammerby and Voko mentioned serious e-mail problems at their locations. It was agreed around the table, however, that we should improve on this. Even a simple acknowledgement of receipt of a message would help a lot. Pieter also indicated that he has asked for an extension of the project until July 2004.

4. *Review of activities by the four subgroup co-ordinators*

Out of the four subgroup co-ordinators: Zoltan Voko, Richard Gisser, Pieter Kramers and Enric Duran, the latter is not present. Peter Achterberg has information from Enric. He is planning to organise a telephone conference within the subgroup.

The chairman first gave a short outline of the work until now, including:

- Distribution of relevant HMP reports to subgroup co-ordinators.
- Same for some discussion items (especially health status).

With respect to indicators that are described by the different HMP-projects, there has been a low level of detail, except for Child Health (M. Rigby), CVD (S. Giampaoli) and Perinatal Health (J. Zeitlin). Herman van Oyen stressed the importance of links between the projects. The need of a close link with the Eurostat Task Forces on mortality, HIS/HES and health care statistics was stressed. Gunter Brückner says there has to be mutual support between task forces and HMP projects. He and Herman van Oyen indicate that the Eurostat task forces will be replaced by a new form of partnership. Eva Hammerby will shift to the health systems subgroup.

Subgroup on health systems (ECHI section 2.3 and 2.4).

Zoltan Voko presented the activities in the subgroup on functioning/health status. The scope is 'generic health status' and 'composite measures of health status'. Zoltan mentioned as points of general agreement: Perceived health: good agreement about 5-items questionnaire.

- Global activity limitation: 'Euroreves Gali question' can be used.
- Chronic disease general: question from REVES (No clear recommendations come from EUROHIS).
- Functional limitation: ICF is used as conceptual framework.
- Health Expectancies REVES recommendations are followed.
- Inequality measures: guidelines by EU Working Group on Socio-economic Inequalities in Health
- Absenteeism from work: Labor Force Survey (disease specific info needed?)

Some questions remain (on some of these there has been e-mail communication with Jean-Marie Robine of REVES)

- Short term activity restriction (EUROHIS); what to do with this?
- General mental health; is there room for a separate domain?
- Quality of life; use of multi-attribute utility measures (i.e. EuroQol) not yet justified in health monitoring. What would descriptive health status measures (i.e. SF-36) add to functioning and perceived health?
- How to fit perinatal and other age, gender specific etc. health in ECHI (user windows?)

Subgroup on demography/determinants (ECHI sections 1, 2.1.1, 2.1.2 and 3)

Richard Gisser has received the material and has started reading.

Subgroup on health systems

Pieter Kramers sent out relevant HMP reports to the subgroupmembers in June, plus a discussion paper on a possible improvement of the arrangement of indicators in the Health Systems Group.

5. *Review of Member States' recent policy priorities*

Pieter Kramers shortly explains what he received from the participants (see also his powerpoint presentation). Gunter Brückner mentions the problem that some lists of priorities are not official and not the ones from the ministry. Arpo Aromaa says that it is unlikely that some of them have explicit priorities. Things are splitting up more and more within countries. Talking about regions, indicators are needed on the regional level at which policymakers are acting. Emanuele Scafato mentions the autonomy of regions in Italy, although there is each year a national health plan. In addition there is the argument that priorities that are mentioned at a certain moment of time are sometimes not complete, only the new ones are sometimes mentioned. Peter Achterberg stated that the general areas of policy-priorities are shared by most MS and can be derived by constructing a general conceptual policy-field.

6. *Presentation of a first prototype of ICHI-2, by Rutger Nugteren*

ICHI-2 builds on ICHI-1, the International Compendium of Health Indicators made by WHO-Euro. Rutger presented the outline and gave a short demonstration of a

computer-based prototype. R. Prochorskas stresses an additional point of the usefulness of such a system: a guideline to translate things to the international level, and a stimulus for more co-operation between international organisations, also to prevent double work. The relation between indicators and underlying datasets is an important issue. There was a discussion on different values for life expectancy in different databases. R. Prochorskas explained that there are at least 5 methods and numerous software applications to calculate life expectancy. Gunter Brückner mentions a German document on indicators (Indikatorengrundsatzpapier). Tapani Piha noted the importance of knowing exactly where and how the intellectual property rights are positioned and the ins- and outs- of the technology for making it available on the web (in relation to EU prerequisites). Participants asked for restricted web-access to the database well before the next meeting.

Henriette Chamouillet says only 'official' indicators should be taken up in the system. This point will be taken on board. Remarks were made on the usefulness to include some reference to the (preferred) method of data collection (Mans Rosén), or results from HMP projects on data sources (Richard Willmer). R. Prochorskas says that in the WHO European HFA database there is some information from countries on details of data collection. There is general support to continue this track. This will include further bilateral contacts with WHO, OECD and Eurostat.

7. *Separate discussions of the 4 subgroups*

The chairman proposed to divide the members of the Duran-subgroup among the other three, at their preference. The three remaining groups got the following questions as hook-up for the discussion:

- Do we agree with the proposed tasks?
- How can we work with the material (HMP-reports)?
- Do you already see concrete results for improvement of the ECHI list?
- How do we see further work, also in relation with the HMP project co-ordinators and task forces of Eurostat? Are separate meetings needed?

Reporting back from the subgroup on health status.

There is general agreement with the proposed structure and tasks. About the reports of the HMP projects, it was concluded that it is not the subgroup's role to evaluate. On the other hand, it is not enough to just collect and summarise. At least some reflection of the results is needed. Going through the specific indicators (see above under 4), some indicators are generally agreed, some are distributed within the subgroup to discuss and exchange ideas. There are clear links by Arpo Aromaa being involved in the HIS/HES project and Herman van Oyen in REVES. These links extend into the newly formed Eurostat task forces. In these task forces the discussion is not primarily on indicators other than describing the current situation.

Reporting back from the subgroup on determinants.

This is a huge area. A diversity of HMP projects, e.g. on diseases or socio-economic differences also relate to it. The discussion was mainly about question 1. The group found they have to add to ECHI the proposals from the HMP projects, to see how concrete they are and whether there are overlaps. They want to consider other

indicators that are outside the HMP projects at a later stage. How much is needed in ECHI what is not covered by HMP projects (e.g. sexual behaviour – note: this is in new reproductive health project)? How to arrange exchange of information and discussion with other subgroups? Henriette Chamouillet has requested the project co-ordinators to provide indicator definitions and background. These should be a primary source. What about early warning indicators? Scafato suggested a ‘user window’ for this area, which may also include life style indicators. How to deal with determinant-related diseases (e.g. alcohol)? It is important to use a consistent age, region and socio-economic classification. Are sheer absolute numbers also going to function as indicators? All person related indicators should be provided in principle only by gender. It was suggested that we needed a uniform spreadsheet with all proposed indicators and a series of criteria to judge them by. This would enable a transparent, uniform and defendable (expert judgement) process of decision-making. The end-product must show how we reached our recommendations for indicators. It looks like the material from HMP projects is not sufficient to fill all the needs of ECHI. In future the group wants to work with the Eurostat task force HIS/HES.

Remarks are made referring to relevant activities outside the HMP such as by the European Environmental Agency, other Commission work, and intercommission services. Some say that a WHO study on Health Behavior among School Children could be a good source.

Reporting back from the subgroup on health systems

The group did not talk about the tasks. There are not so many HMP projects on this field. Pieter Kramers has raised a discussion on whether the arrangement of issues and indicators should be updated according to (1) the system of health accounts, and (2) recent frames for health system performance assessment. Policy-relevant issues mentioned include: access to health care and poverty (also in the EU Committee on Social Policy, Wagener), the effects of ageing on the shift from cure to care, move of medical personnel, cross-border use of care, Aris Sissouras refers to recent discussions on high level within the EU on these issues, also including European co-operation for better use of resources, access and quality of care, and reconciling national health policies with European rules. This means that health care is coming into the picture more and more, although it is not officially in the EU mandate. It was suggested that this issue of health system performance measurement should be taken up in the new EU action programme. The participants were requested to send their thoughts on this issue to PK.

Summary on the subgroups

The subgroup co-ordinators will continue and enhance their work. For more complete information, Pieter Kramers will circulate a list of all HMP projects including the most recent ones. Gunter Brückner will send a pdf with the address to request a password for the IRC/CIRCA site where all the reports are. Brückner also stressed the importance of defining the purpose of the indicators more precisely. He also pointed out that indicators are a form of external input and that we must focus more on the actual data (items/sources), i.e. the linking of datasources and indicators.

8. *News from the Commission; the new public health programme*

Henriette Chamouillet mentions that for 2002 there is agreement on 8 projects in the HMP, but no contract signed yet. There are still more than 30 ongoing projects. 1 out of 56 is not extended in time.

Tapani Piha (Sanco) presents the future information system, i.e. strand 1 of the new public health programme. ECHI has an important influence on HMP. The results must function to underpin a Community Health Strategy. Working parties (under project contracts) will function to coordinate areas (network of networks approach; with some additional coordination). Larger, longer and multidisciplinary projects are intended (added value). Applicant countries need to be involved. Development of HIX (health information and knowledge system) will be central and an advisory panel on HIX will be set up. Organising a network of Public Health Institutions (or organisations having that function) is another issue. Annually topical health reports will be contracted on priority issues to be determined. Timing is a problem, however, as the first round will give '*calls for proposals*' in december already.

In the discussion, Raymond Wagener wants to see a balance and a coherent structure in the different programs. Gunter Brückner wants links between the Working Parties in order to harmonise the work. ECHI is such a link. R. Prochorskas would like more emphasis on efforts to help countries collecting data and to fill gaps in knowledge. Peter Achterberg stresses the need to get commitment from the Member States for the actual work to be done. Paulo Ferrinho has concerns about the network of public health institutes. How is this envisaged? Henriette Chamouillet reminds us of the old idea of a Health Observatory which is now perhaps coming back. The need of such a co-ordinated and sustained structure is stressed again by several participants. Tapani Piha says that the programme is agreed upon, but the related legislation is not yet in place. It would take 4 years to have the observatory. The interim period needs to be covered. So the first actions would be: building the network of PH institutes, and putting in place the Working Parties.

Gunter Brückner indicates that using ECHI-1 in the new programme has some problems: what is the legal status? Also, it would be useful to attach a price tag to each indicator, in terms of costs for regular data collection (note: this was never an objective of ECHI). Henriette Chamouillet says the general frame of ECHI-1 could be the basis for a legal status, but not the specific indicators.

9. *Discussion on the preceding project HMP co-ordinators meeting*

There was not much time any more for this agenda item. Quite some ECHI participants joined this meeting. Some projects give promises of forthcoming indicators for use in ECHI. Below is a complete list of projects discussed at the meeting and new projects started in 2001 or agreed on in 2002, with some specific comments.

Finished or ongoing projects discussed at the HMP co-ordinators meeting:

- Public health nutrition (Sjöström, 2000); preliminar indicator proposals; overlap with other projects has to be sorted out.

- Diabetes (de Beaufort, 2000); will propose core and secondary indicators, on risk factors, epidemiology of disease and complications; some overlap has to be addressed.
- Musculo-skeletal conditions (Bruusgaard, 2000); indicators will be proposed.
- Child health (Rigby, 2000); indicators will be proposed; ECHI is followed but in a child-centered way. Indicators are given with definitions.
- Health expectancies and health status (Robine, 1997, 2000); a comprehensive set of health status indicators is proposed.
- Health surveys (Aromaa, 1997, 2000); a data base (meta-information) on survey content. Recommendations are given for indicators and data collection.
- Food consumption surveys ('Dafne'; Trichopoulos, 1999, 2002); method-based (household budget surveys) database on food consumption. Overlap with other nutrition and food projects to be sorted out.
- Hospital data (Magee, 2000). Collection of hospital data and assessment of comparability. Definition of indicators is not an objective.
- European Health Promotion Indicators (EUPHID, John Davies, 2001); rather a theoretical framework on health and socio-cultural processes.
- Perinatal health (Zeitlin, 2000); review of existing indicators and selection for ECHI; need of further interaction with child health and reproductive health projects.
- Evaluation of public health projects (Brand, 2000); study for best practices of public health reporting; not meant to produce indicators.

New projects (funded by 2002)

- Producing a report on nutritional health in Europe (Ibrahim Elmadfa).
- Environmental health indicators (Krzyzanowski).
- Work-related indicators (Bödeker).
- Health in intellectually disabled (Noonan-Walsh).
- Eucomp-2 (Corcoran); standardised description of European health systems.
- Oral health indicators (Bourgeois).
- Emergency data (Krafft); focus on emergency service data, especially on cardiovascular and respiratory diseases.

Projects funded in 2001 not discussed at the meeting

- Indicators in the regions of Europe (ISARE-2; Ochoa); collection of data for a limited set of indicators in regions; fit to ECHI.
- Reproductive health indicators (Oliveira da Silva).
- Rasch conversion centre for indicators (van Buuren); ex-post harmonisation of data by statistical methods.
- Disease-specific morbidity data (Sue Davies).
- Report on mental health in the EU (Kovess).
- Indicators for monitoring cancer (Micheli).
- ECHI-2 (Kramers).
- Health information from primary care (Schellevis).
- Indicators for COPD and asthma (Duran).
- Policy health impact assessment (Scott-Samuel).
- Expenditure and utilisation of pharmaceuticals (Folino-Gallo).
- Health information systems in Europe (Gnesotto).

- Benchmarking health monitoring/prevention programmes (Weihrauch).
- Cancer monitoring programme (Parkin, IARC).

On the second day of the meeting, Hartmut Buchow presented the system on surveillance of communicable diseases. The need was raised for indicators in this field in the frame of a monitoring system. At this time this seemed a bridge too far. Pieter Kramers gave an overview of the status of ECHI-2. There was much discussion on links and overlaps between projects. There is already a history of inter-project discussion, namely the mental health consensus arranged by Reves and the mental health project, and the ECHI-morbidity meeting on disease-specific morbidity. Today new topics emerged as specifically prone for such a discussion:

- Nutrition.
- Mother & child health.
- Chronic diseases/health status/participation.
- Conceptual and theoretical issues (including health system performance assessment)
- (for development) user and patient satisfaction.

10. Draft progress report.

This item was not discussed. The project co-ordinator will finalise the draft with the comments received before September 25.

11-12. Discussion of further work; next meeting.

The chairman proposed, also based on a suggestion of Henriette Chamouillet, to enhance the interaction between the ECHI team and the HMP project co-ordinators by arranging the next meeting of ECHI-2 together with the co-ordinators meeting. We could make a mix of project result presentations, discussions of inter-project connections and consequences for the ECHI-2 list. In the project co-ordinators meeting, the dates of February 25-27 were proposed (three full days). There was a predominantly positive feeling about the idea. The chairman will timely take up contact with Sanco to further work out this idea.

There was a short discussion on a format distributed earlier by Sanco, in which each indicator should be defined and a rationale should be given. It was suggested further to include the purpose and possible data source. HMP projects could use this format. On the other hand, it was pointed out that a fixed format would bureaucratise the indicators and loose sight of the fact that in some areas (e.g. mortality) many indicators could be flexibly chosen and definition of the possibilities of the database can be more relevant than defining one or two indicators. Another issue raised again was the need of a smaller set of core indicators instead of a ballooning set which may be the result of adopting everything that projects come up with, how justified this can be for the particular field itself. This issue was not sufficiently discussed during this ECHI meeting.

13. Summary of agreements

For the future, the following things were agreed upon (already mentioned in mail of September 19):

- Those who did not already do so will react on recent health policy issues in their own country (lightweight, meant to be sure not too miss greater issues in the range of indicators; after the meeting three participants submitted material!); deadline December 15.
- Everybody reacts on the draft progress report included in the meeting documents; deadline September 25.
- Everybody sends reactions on any issue raised during the meeting on which he/she feels like contributing his/her ideas, including the subgroup work.
- I will distribute a shortlist of all recent HMP projects, with title and names of co-ordinators.
- Subgroup co-ordinators will continue their work; we should be in contact on short notice on further defining the precise frame of work, based on the discussions during the meeting. This includes the planning of the next February meeting.
- Rutger Nugteren will continue on ICHI-2, taking account of the discussions, and with taking up communication with WHO, OECD, and Eurostat during the coming months.
- **We keep the dates of February 25-27, 2003, free for a combined meeting of ECHI and the project co-ordinators; the exact form of the meeting will be worked out.**
- Sending the powerpoint presentations given by the Bilthoven team.
- Sending the letter of Vera Mallee on the reimbursement procedures.
- last but not least: after a complaint of the co-ordinator, we promised each other to be more accurate in replying to e-mails. This should also be noted by the ECHI participants who could not be present.
- Gunther Brückner will send the access prerequisites for the Circa site with HMP reports to all participants.

Version June 11, 2003

European Community Health Indicators; phase 2

ECHI-2

*Report of the third meeting
20 March, 2003*

Euroforum building, Luxembourg

Present:

P. Achterberg (the Netherlands)
A. Aromaa (Finland)
G. Badeyan (France)
E. Duran (Spain)
E. Hammerby (Denmark)
S. Holland (Sweden)
P. Ferrinho (Portugal)
R. Gisser (Austria)
P. Kramers (the Netherlands, chair)
H. Magee (Ireland)
H. Markowe (U.K.)
R. Nugteren (the Netherlands)
R. Prochorskas (WHO)
H. Strand (Norway)
E. Scafato (Italy)
H. van Oyen (Belgium)
E. van der Wilk (the Netherlands, report notes)
T. Ziese (Germany)
L. Mountford (Sanco)
F. Sicard (Sanco)
H. Friza (Sanco)

Excused:

A. Sissouras (Greece)
Z. Voko (Hungary)
R. Wagener (Luxemburg)
G. Lafortune (OECD)
G. Brückner (Eurostat)

Also present:

Several HMP project co-ordinators
Representatives of accession countries

1. Opening

The chairman welcomes the participants. The participants agree with the proposed agenda.

2. Reimbursement business

The chairman has reimbursement forms available. He stresses the need for everybody to fill in correctly all the required information on bank account, bank keys etc., and to send the form with the **original tickets** back to:

RIVM, National Institute of Public health and the Environment.

P.O. Box 1, 3720 BA Bilthoven

The Netherlands.

To the attention of:

Vera Mallee,

Department VTV

internal RIVM postal box no. 54.

A participants list is circulated, for correction and for signing for proof of presence.

3. Reflection on the past day's meeting

Badéyan notes some unclarities: Will ECHI remain central? How will the Working Parties evolve? What is the connection between EC, ECHI and the new Executive Agency? How to distinguish between indicator (ECHI) work and data collection? Also with regard to the workplan for 2004. Is there a draft?

Van Oyen: If ECHI wants to have a horizontal role, it should consult. Try to focus on what should be there (indicators) at the European level. The past days saw too large and too open discussions. It appears that the Commission still has even more questions than we do.

Aromaa: Six years ago we had the same stage of development. This is due to ignoring of expert proposals by the Commission, such as the need for a centre for co-ordination with the right expertise.

Magee: Agrees with former speakers. Wants also to know what will be done with the hospital data collected in his project. Doesn't know where to leave this data. What will be the relation with Eurostat (and HIEMS)? There is no formal way to inform projects about data, which leads to different interpretations. It is not even clear what kind of (information) system will be developed, i.e. indicator based or based on raw aggregated data.

Ferrinho: There should be a way to select indicators on the basis of criteria. We could focus on waiting lists, quality data, hospital data, human resources, pharmaceuticals, health accounts. Ambulatory indicators. Intermediate indicators. Corruption is becoming an issue in health system (in Portugal at least). Indicators used in financial sector could be useful. Links should be made to national indicator systems as well. The health systems group should focus on existing work.

Kramers: One problem is how ECHI will fit in the Working Parties structure. ECHI is not primarily dealing with aspects like collection of the right data. We have to deal

with the fact that the terminology used, i.e. 'core' indicators is still unclear. How can we best proceed to give the Commission the desired core set?

Van Oyen: What is urgent for the Commission?

Bruusgaard (project on musculoskeletal conditions): Who is in the end responsible? There used to be a HMP committee. ECHI has been put in this role. Who is to conclude on behalf of the projects, especially the ones that have ended already?

Krzyzanowski (project on environmental health indicators): The next step in the process requires answering the question of what is the use for the core indicator set.

Aromaa: Core indicators are important, but what is a core indicator? Quickly available indicator? Criteria not so important, but just pick indicators.

Magee: What is an acceptable number of indicators?

Ferrinho suggests that ECHI subgroup leaders attend the Working Parties.

Achterberg: There is a dualism between the Competent Authorities and the Working Parties.

Ziese: A Horizontal Working Party is needed (several projects do not fit in the Working Party structure). How should coordination of working parties be organised?

Aromaa: Balance is important. Select a few indicators that reflect the projects.

Kramers: We should not focus too much on availability, this creates data-drivenness.

Krzyzanowski (project on environmental health indicators): One could have different (core) sets of indicators, small, more extended, domain specific, developmental, etc. (note PK: this is the idea of user-windows!).

Magee: There has to be some sort of prioritisation also in developmental indicators.

Rigby (project on children's health): ECHI provides a very valuable first step. But let's harmonise now. Start a development programme for indicators that are nearly the same. Some projects provided inner list and outer lists, other did not. This creates disbalance. Also some topics are not represented in projects, such as the health of the elderly. Include this in the work programme for 2004.

Friza (Sanco): optimise and prioritise (according to scientific basis, political etc). Which set are we going to use? We have to get operational.

Folino-Gallo (project on pharmaceuticals): Again the question: what is the aim of indicator? We should assess the level of evidence of indicator. Then moving easy to selection.

Bruusgaard (project on musculoskeletal conditions): The problem is that some project leaders are not involved any more. Some projects finished months ago and they are not here to drop their ideas on indicators.

Van Oyen is not comfortable with the term 'imbalance', which has emotional connotation. We have to be able to think in a more structural way. We need a method on how to decide on choosing indicators.

4. Procedure for selecting core indicators

Kramers resumes that earlier during the meeting the group sessions did not lead to a satisfactory conclusion concerning the Commission's wish for a set of core indicators, due to the complexity of this question, combined with insufficient structure in the preparation of the meeting. He had stated that ECHI could take up this issue now since it was on the programme anyway. This would require action over the coming months. We should decide now on this roadmap, taking into account what has just been said by all the speakers.

Wildman (project on Perinatal health) gives a short account of a similar process they have gone through for selection of indicators. They adopted a Delphi process for consensus in three rounds.

1. Open discussions, to get a feeling of representation,
2. E-mail questionnaire. Experts are asked to rate indicators, after which a core set was formed. Analysis showed that there was 80% agreement among experts.
3. Then a shorter list was formed. If an indicator was proposed for deletion, others had a veto right with justification. This way they tried to be explicit and transparent.

Micheli (project on cancer indicators): The issue (again!) is why do we need core indicators? To reduce mortality, to reduce the chance of getting ill, to improve care. Likes to think about process. Not (never) a stable list. You need a good method to choose the indicators, not so much the indicators themselves.

Mountford (Commission): Why a core set? We should limit on the number of indicators, which has a relation with the funding of work. Also, when collection of data according to an indicator list will become a legal issue, the burden must not be too large.

Van Oyen suggests this may be in conflict with the public health needs, as put forward by the project results and the scientific evidence.

Ferrinho wants clarification of the concept of core indicators. Is it a set of indicators that help policy makers taking decisions?

Kramers indicates that this basically should be true for all indicators in the ECHI list. He explains again the principle of user-windows to give structure to the different possible points of view of policy makers and other actors in public health.

Rigby (project on children's health): The Child Health group used a structural matrix (strength of evidence, significance of burden, availability of data, need for decisionmakers) and a score (0-4) for their project's indicators. This cut out 90% of discussion.

Prochorskas: It is still not clear why we need a core set. We could take the practical approach. Use existing data sources and then do the next step. If the Commission needs the criteria to fill a database, the easy way is to collect the databases from which numerous indicators can be constructed, depending on the practical purpose (e.g. a report). Instead of core indicators the terminology phase 1 and phase 2 indicators could be used, pointing at those already available and those to be developed.

Badéyan points at the relation with the 'structural indicators', a very limited set selected under the heading of 'sustainability'. Here 'health expectancy' is the only health indicator.

Wildman (project on perinatal health) says 'core' is confusing; every one defines it differently. Suggests to introduce phase 1 (readily available) indicators and phase 2 indicators.

Giampaoli (project on cardiovascular health) says that in her project availability has been a criterion for ranking indicators.

Achterberg proposes, to avoid discussion about general relevance, to apply the user window concept now. Criteria (the Commissions criteria for the purpose of the indicators) are still essential, however. This is supported by *Aromaa*.

Krzyzanowski (project on environmental health indicators) produces a 2x2 table on the spot, showing the two dimensions: policy relevance versus availability, and how the action could be in the four resulting boxes. This is felt as a highly useful approach (see below).

	High relevance	Low relevance
Data available Yes	Core *	Extended
Data available No	Recommended * Development *	Research

* meet basic criteria (important PH issue, sensitive to interventions, public concern, policy concern)

Achterberg mentions that projects indeed have pointed at important data gaps. This should be taken on board.

Magee sees two sorts of ‘availability’: the easy ones and the ones which require much work.

Kramers then makes a proposal for a series of actions to be carried out under the ECHI project, to generate one or more ‘core sets’ of indicators during the coming months. He proposes a stepwise approach, somewhat like in the perinatal health project, involving first the circulation of a proposed protocol, receiving comments on this, then carrying out the actual selection, in order to have a result at the next ECHI-2 meeting in the third week of June, and after that to have something available for the meeting of Competent Authorities on July 10. He also proposes to have interim discussions on this with the Sanco staff in April.

People generally agree on the idea. *Wildman* says that from the projects all proposed indicators should be included in the list from which the core is to be selected. *Aromaa* stresses that the criteria burden to health and preventability should be the main ones, and that missing issues should be identified as well (e.g. health in other policies, social policies). *Achterberg* requests a clearer directive from the Commission as a basis for this process. *Mountford* says that on most issues EU bodies have not much formal say, but they have capacity and task to report.

5. Other issues; agreements

- *Kramers* will work with Sanco on the position of ECHI-2 in the Working Party structure.
- *Kramers* will circulate a draft of a selection procedure, within a few weeks, for comments.
- *All* will send their comments on these procedures.
- *All* will send their comments on the comprehensive ECHI indicator list to the project co-ordination.
- **The next ECHI-2 meeting will be on June 19 and 20.**

6. Closure of meeting

The chairman thanks all participants and wishes them a safe trip home.

Version July 2, 2003

European Community Health Indicators; phase 2

ECHI-2

***Report of the 4th meeting
19-20 June, 2003-07-02***

Euroforum, Gasperich, Luxemburg

Present:

ECHI team:

Gerard Badeyan,
Rui Calado (replaces Paulo Ferrinho)
Eva Hammerby,
Richard Gisser,
Else-Karin Groholt (new member, replaces Heine Strand),
Pieter Kramers,
Hugh Markowe,
Pieter Jan Miermans (replaces Herman van Oyen),
Rutger Nugteren,
Aris Sissouras,
Raymond Wagener (partly)
Eveline van der Wilk,
Thomas Ziese

Commission (partly):

Lindsay Mountford,
Frédéric Sicard,
Helmut Friza,
Ole Henriksen,
Didier Dupré

Absent:

Peter Achterberg,
Arpo Aromaa,
Enric Duran (no message),
Susanne Holland,
Hugh Magee,
Remis Prochorskas,
Emanuele Scafato

1. Opening, adoption of the agenda

Pieter Kramers welcomes new participants: Else-Karin Grøholt and replacers: Pieter Jan Miermans (for Herman van Oyen) and Rui Calado (for Paulo Ferrinho).

2. Reimbursement business; circulation of participant list

3. Report of the 3rd meeting of March 20 and of ECHI visits to Luxembourg of April 7 and 16

4. Recent developments in the Commission Services and the EU Public Health Programme: Working Parties, Networks and the place of ECHI

Lindsay Mountford apologises for John Ryan. It is a hectic time. Today is the last day for the evaluation of the proposals of the new programme. A reorganisation of commission services is going on. DG SANCO will have three new units in Brussels: Health strategy (Merckel), Health measures (no head yet), risk assessment (Wagstaff). Four units remain in Luxembourg: policy (no head yet), the other three corresponding to 3 strands: Information (John Ryan), Health threats (Hague), health determinants (Rajala). It will start from July 1st.

Under the recent call for proposals for the new programme, more than 400 proposals were received. Many are of high quality on the information side. Sanco will prepare a recommended list of projects for the Programme Committee which meets July 15-17. Around 10th of December all contracts have to be signed.

The ideas on the Executive Agency as permanent infrastructure have not developed very much. On July 10, the Network of Competent Authorities will convene. It will be attempted for next year to have the Work plan 2004 ready in time to send out call for proposals early in the year.

5. Relevant proposals submitted by ECHI participants in the EU Public Health Programme. Communication by participants

Only one proposal was sent in, i.e. one by Peter Achterberg on a structured information system like the Dutch Compass. Aris Sissouras suggests that ECHI should make a new proposal as a group. Helmut Friza states that for new proposals accession countries should be included as much as possible.

6. Selection of core indicators; discussion of procedures and results; discussion on follow-up.

Pieter acknowledges the valuable co-operation and support of some ECHI team members, but is disappointed about lack of response of some others. He plans to discuss this personally with those who did not respond at all for some time.

First there is a general discussion. Lyndsay would like to see the arguments for the scorings and pass it to the competent authorities meeting. She finds the result is neither elegant nor logical. She likes to see the results useful for health reporting.

Hugh Markowe finds that social indicators are underrepresented. In the UK the focus is shifting from 'old' indicators (medical model) to 'new' ones (new public health). He thinks we should follow this development. Helmut Friza thinks the number of 40 is the upper limit, to be seen as a first step. Aris does not agree on this. Frédéric Sicard finds it is a patchwork type of set: too little of everything. The corelist should reflect what is going on in the field of public health in the EU. Rui Calado says the availability of data is important. For Portugal he wants to see indicators that in the end improve health. Gérard Badéyan remembers that the corelist is the result of the agreed protocol. Why now complain about the result? Lyndsay says that although the protocol may be good, the result may need improvement. Hugh Markowe says that instead of developing new indicators, proxies could be chosen to cover the field. Ole Henriksen then says that ECHI did exactly as was asked by the Commission. Methods are transparent and the list is a good starting point for the commission. Good job!

Richard Gisser says it is useless to have general demography indicators in such a shortlist. It does not tell us anything about health. They are merely background information. Hugh Markowe says that the UK Ministry of Health, in its actions to improve public health, considers health inequalities as very important. It is considered that in the demography etc. chapter there are some indicators which are to be considered as (distal) determinants, influenceable by policy (e.g. education level, income differences). It was mentioned that such indicators are also included in EU listings on social indicators, and should be harmonised with choices made there. The point was raised where we see health inequalities. This should be covered by the stratification of indicators to SES wherever possible, in addition to having indicators on education and income differences. A few ECHI team members were of the opinion that the results of the ECHI project were corrupted by this exercise and the urge to restrict so much. On the basis of all these considerations, the group agreed nevertheless to consider the present version of the core list chapter by chapter.

The team made a number of suggestions for additions and deletions, mostly based on the general arguments given above. In the morbidity section, one felt there was too much emphasis on causes of death instead of on causes of chronic ill-health. Which would be the criterion for inclusion? Mostly burden of disease, but also avoidability (Markowe). In the determinant section, the team felt more was needed outside the classical field of cardiovascular and cancer risk factors. The team noted the absence of selections in the area of living and working conditions (environment and health), but did not suggest additions since the projects on these issues are still running. The team also felt more was needed in the prevention/health promotion section, being the prime field for public health action. In the area of health care facilities, utilisation and expenditures, very little was selected and the resulting selection was considered a bit weird. The team could not come to agree on changes in these areas. The general statement was made that many indicators here are rather related to the management of health care systems while we want indicators that are related to health, or to the performance of the system in relation to health.

It was agreed that Pieter would include the agreed changes in the list, with the arguments (see the core list (shortlist) version June 30). It was agreed to present the result in the context of the comprehensive ECHI list, to keep readers aware of the context. Lyndsay would prepare a discussion note stating the Commission's position. All this would be circulated first internally and then to the Network of Competent

Authorities. Pieter Kramers will give a presentation at their meeting of July 10, in which he will also stress the position of this exercise as one step in a process of further development. Aris Sissouras again states that the core list may be criticised and may do harm to the other work of ECHI and HMP projects. Thomas Ziese is afraid that people will stick to the shortlist and disregard the long list. Hugh Markowe is not too afraid of that, provided the background is explained, together with the philosophy and scope of the User-windows and the comprehensive list of indicators. Lyndsay says that Pieter should present his view on ECHI and share that with the commission so it can be reflected in the papers.

7. Comprehensive indicator list; discussion of comments from HMP project co-ordinators; discussion on the final follow-up

Pieter gives a short presentation on the status of the comprehensive ECHI list and some remarks made by HMP project co-ordinators.

As to the ECHI taxonomy (remarks by the health promotion indicators project), Hugh Markowe strongly suggests we should stick to what we have developed. Discussions about concepts are never finished, solve problems by creating user-windows. Aris agrees. He says we should continuously ask ourselves what we can do to help the MS, policymakers and the analysts to use the indicators?

As to the question how we envisage the final product of ECHI-2, all agree on the proposals. Richard mentions we are still waiting for HMP comments and results. Indicators on working conditions are lacking, e.g.. Thomas says we should invest in marketing efforts. Experts get disappointed because fine-tuning is not good yet and the ECHI-list is not official. But when will it be? Aris: we have a good matrix in which data sources are stated; this should work out as a valid reference. The question arises again how inequalities will be operationalised? By ethnicity? What will be the detail? Pieter says that we already followed the recommendations from the project by Kunst and Mackenbach recommendations. User windows can be worked out to deal with that.

For the coming period, the explicit formulation of user windows is an important item. Firstly, the sets recommended by HMP projects can be defined as user windows as such. In addition, important items might be selected for which we as ECHI team make a selection from the entire list. This could work like the core list selection but it is easier since the criterion is more clear. Pieter pointed out that the ECHI-1 report already contained some examples. Some such items were mentioned:

- health system performance,
- inequalities,
- elderly,
- Richard: working age population,
- Thomas: women's health and men's health.
- Eveline: dealing with emergencies.
- Thomas: teaching models for students about relations between indicators.
- Aris: everything related to health promotion activity (regulations)

It was agreed that the ECHI group could work on defining a short range of such user windows. This is work for the fall of 2003. Pieter will initiate the process.

Finally the question was addressed what the ECHI team members could do in the last year of the project. Apparently the subgroup approach has not worked too well. At this stage something else is needed. The following issues were agreed on:

- Team members will think of topics for other user-windows;
- After that, team members will assign indicators to the selected set of user-windows;
- Team members will complete or update the information on health policy priorities in their own country.
- Team members will communicate and seek feedback on ECHI in their own countries.

8. Progress on the ICHI-2 internet based indicator catalogue; short presentation by Rutger Nugteren and discussion on the follow-up.

Rutger gave a short presentation, and several people sat down with him behind the computer to play with the application. A number of useful suggestions were made. The question was raised whether the application could be made available to the ECHI team. A CD-ROM would be difficult, but an authorised access by the internet could be realised shortly.

9. Conclusion , summary of agreements, further action

These were referred to forthcoming circulations to the ECHI-team and the present meeting report.

10. Next meeting

We will try to plan the next ECHI-2 meeting in December of 2003. Pieter's first choice would be on Thursday and Friday 11 and 12 of December. 4 and 5 could be an alternative 18 and 19 is scheduled for the final meeting of the ISARE (regional indicators).

Some want to have the meeting elsewhere, but Frédéric says there was an agreement on having the meetings in Luxembourg. He wants to combine the next ECHI meeting with a possibly forthcoming meeting of HMP co-ordinators. Still Pieter does insist on having a meeting in December, irrespective of other issues coming up. He remains on the point that if not the December meeting than perhaps the next (last) meeting in May 2004 or so could be held elsewhere. This is definitely profitable for the working atmosphere of the ECHI team.

11. Other business, closure

Pieter closes the meeting and thank all participants for their committed and lively participation.

September 20, 2004

European Community Health Indicators; phase 2

ECHI-2

*Report of the 5th meeting
February 19-20, 2004*

Batiment Jean Monnet, Luxembourg

19 FEBRUARY MORNING SESSION; AGENDA ITEMS 1-5

ECHI TEAM AND COMMISSION ONLY

Present ECHI team:

Arpo Aromaa,
Gérard Badéyan,
Judite Catarino, replacing Rui Calado
Enric Duran,
Richard Gisser,
Else-Karin Groholt,
Eva Hammerby,
Susanne Holland,
Remigijus Prochorskas,
Hugh Magee,
Hugh Markowe,
Pieter-Jan Miermans, replacing Herman van Oyen,
Rutger Nugteren,
Emanuele Scafato,
Aris Sissouras,
Zoltan Voko,
Thomas Ziese

Apologies ECHI team:

Peter Achterberg,
Raymond Wagener,
Eveline van der Wilk

Present Commission:

Gunther Brückner (Estat),
John Ryan (Sanco),
Frédéric Sicard (Sanco)

**19 FEBRUARY AFTERNOON SESSION; 20 FEBRUARY ALL DAY;
AGENDA ITEMS 6-14.**

**ECHI TEAM, COMMISSION, HMP PROJECT CO-ORDINATORS, ESTAT
CORE GROUPS, WORKING PARTY REPRESENTATIVES**

Present from HMP projects, Estat Core Groups, Sanco Working Parties:

Karim Abu-Omar (physical activity)
Wolfgang Boedeker (workhealth)
Dag Bruusgaard (musculoskeletal conditions)
Stef van Buuren (ex-post harmonisation of data)
Marian Craig (Estat Core Group health systems)
Dafina Dalbokova (environmental health)
John Davies (health promotion indicators)
Carine De Beaufort (diabetes)
Pietro Folino-Gallo (pharmaceuticals)
Birthe Frimodt Møller (WP accidents/injuries)
Simona Giampaoli (cardiovascular diseases)
Frédéric Imbert (regional indicators)
Jürgen König (nutrition report)
Thomas Krafft (emergency care indicators)
Henny Lantman (health of intellectually handicapped)
Ville Lehtinen (mental health)
Dirk Meusel (WP on lifestyle)
Andrea Micheli (cancer)
Ada Naska (Dafne nutrition)
André Ochoa (regional indicators)
Miguel Oliveira da Silva (reproductive health)
Michael Rigby (child health)
Jean-Marie Robine (health expectancies)
Michael Sjöström (public health nutrition)
Jennifer Zeitlin (perinatal health)

Present (observer) from secretariat NCA and NWPL:

Walter Devillé
Evelien Spelten
Esmée Kolthof

Additionally present Commission:

Didier Dupré (Estat)
Ole Henriksen (Sanco)
Antoni Montserrat (Sanco)
Horst Kloppenburg (Sanco)

19 February, Morning Session

1. Welcome and introduction by Sanco

John Ryan welcomes everybody on behalf of Sanco. After underlining the importance of the ECHI project for Sanco, he gives some news on the progress of the Public Health Programme. Firstly, the contracts of the 2003 funding round are being finalised. Secondly, two calls for tender are being issued, on a community report on alcohol, and on health interview surveys. Thirdly, the 2004 call for proposals will be published soon. There will be an external evaluation of proposals this time. Fourth, a list of external consultants will be established. Fifth, the work programme for 2005 will be prepared and discussed in the Network of Competent Authorities of July. Sixth, there will be closer co-operation with OECD.

Hugh Markowe says the web-site (on the Europa site) of DG Sanco has improved very much. He asks how the commission selects candidates for the list of external consultants. The answer is that selection occurs on the basis of certain qualifications, CV's et cetera.

Arpo Aromaa addresses the problem of lack of continuity in projects, especially in those for which continuity is a basic success factor, such as the HIS/HES database. Delegation to other projects or to the new Centre for Communicable diseases, or contracting out were mentioned as options (feasible?).

2. Welcome by ECHI project co-ordinator

Pieter Kramers welcomes everybody and thanks Sanco for arranging the rooms and facilities. He reminds the participants of the participants list and of the further agenda.

3. Discussion on the ECHI long list

The updated version of this month (ECHI-2-33) was circulated before the meeting, by adopting new project results and quite a few comments from the ECHI team and HMP project co-ordinators. It has now over 400 indicators.

Hugh Markowe raises the question how we can control the list from getting ever longer.

Gunter Brückner reflects the concerns put forward by Member States, who expect ECHI to collect and contain data, which it is not meant to do. He also questions the status of the list at finalisation of the ECHI project. How 'final' 'will the list be? Should it be considered as a structured inventory or (just) for "agenda setting". Gunter suggests that it should not be considered as a recommendation for data collection. The short list could be a starting point for that. Are all indicators in the short list equally important?

Arpo Aromaa says the long list is far from ready. Yet, the next stage should be data collection. There should be "horizontal co-ordination" of different projects and/or different (health) specialists. This means that the work on information gathering

systems should be co-ordinated with the work of health specialists. He stresses the need for continuity and the room for innovation.

G rard Bad yan asks whether the short list is just a starting point or meant to set the political agenda. In France, recently a long list of health indicators has been established by law.

Zoltan Voko questions how the comments from different specialists are incorporated into ECHI? Could we figure out a mechanism to do this? Pieter Kramers replies that until now, he has done this himself, directly from the comments, with feedback to the specialists where needed.

Remis Prochorskas says we should have a ‘common sense’ view on public health reporting. Go back to the basics and look at what countries can produce. He suggests that the MS should aim for the collection of standard broad data-sets. The actual work to build a database should be done primarily on the basis of the shortlist. The long list is rather an inventory, not a basis for data collection. It is a problem that (in the shortlist) some indicators (e.g. in health promotion) cannot yet be expressed in numerical format. Pieter replies that the shortlist will be divided between indicators with data and indicators without data.

Gunter Br ckner mentions that Eurostat has changed its policies in a way that you can download information for free from New Cronos and that you are able to look at about 1000 indicators. He suggests that there should be hyperlinks to data and that the long list should be a bottom-up strategy. He noticed that there are no indications in ECHI on what time-scale to use for the presentation of indicators (yearly, monthly, etc.). Do not use ‘availability of data’ as a criterion for usefulness of an indicator (indicators for agenda setting etc.).

Emanuele Scafato mentions an Italian project on a national level, where ECHI is used for selecting indicators for data collection. He stressed that it is important to be flexible in choosing the indicators for the short list. Don’t let the (big) projects dominate the selection of indicators. The short list is the main user-window. Pieter replies that the selection of indicators is not dictated by projects but on the basis of certain criteria. Projects can give further specifications.

4. Discussion on User-windows

Hugh Markowe stresses that U-wins should serve specified purposes and specified people. Flexibility is essential. Hugh Magee likes the proposal for a ‘performance’ user-window, but wants to keep the public health perspective in. G rard Bad yan suggests that some ‘detailed’ indicators could be in a user-window while not being in the comprehensive long list. Zoltan Voko supports this idea, or to find a technical solution. Otherwise, the long list becomes too long. Also Eva Hammerby does not want the long list to be too long: this diminishes credibility.

Remis Prochorskas sees difficulties to fill a user-window on socio-economic health differences, for mortality. Hugh Markowe prefers a broader approach for age breakdown than e.g. a separate window on elderly as proposed.

Arpo proposes to have all indicators suggested by the projects in the final report of ECHI, and to make the difference clear between indicators selected as primary and secondary, by the projects themselves. Zoltan Voko supports this, saying again that the long list thus becomes an inventory rather than a straightforward recommendation for data collection. Arpo Aromaa stresses that many recommendations from projects do not reflect near-available data collection but rather address issues that have to be started almost from scratch. On the contrary, Aris Sissouras says ECHI is more than an inventory.

Emanuele Scafato is in favour of fixing a version of the list so that countries can use it and refer to it. Zoltan Voko, however, stresses that ECHI is a process, which has to be taken over.

5. Discussion on the follow-up of ECHI-2

Pieter Kramers points out that after finishing ECHI-2, he does not want to continue in the same manner. The work has been too much focused on his person and now it has to be carried on by others, and more than before by a group. He asks for ideas.

Thomas Ziese wants more of the indicator selection based on criteria and evidence. He pleads for quality control of indicators without clearly stating how this should look like.

Remis Prochorskas is worried about the availability of people to do future work for ECHI. He pleads for a working group (3-5 people from various countries including new member states) that should do the actual work. The group should include people with knowledge of data. Enric Duran wants more co-operation with universities, hospitals and others.

Aris says we should continue this successful way. The follow-up work should point in the direction of how to implement the indicators. Zoltan Voko discriminates three levels: (1) to maintain and develop the list, (2) to work on a manual for operationalisation, (3) to build this into information systems.

Arpo says we actually would need a 'health observatory' to continue the work. It should be done in a small core group. The Working Parties cannot do this.

Gérard Badéyan cites Toni Montserrat on three phases: (1) indicator definition, (2) indicator testing, and (3) hand over to routine data collection systems. The third phase would logically be done by Eurostat.

Hugh Magee stresses the role of ECHI in providing a logical structure or frame for many activities in the Public Health Programme. He challenges Sanco and Eurostat to maintain this. He doubts whether a Working Party 7 is sufficient to take care of this. Gunter Brückner says we need a bridge to RAD (raw aggregated data). What is leading, the RAD or the indicator definition?

Frédéric Sicard, finally, gives information on the Working Parties (WP) meeting approximately 2x per year. All WP's will have a secretariat. A WP no. 7 on indicators has been proposed by Sanco. Frédéric suggests to the meeting to submit a proposal for

the secretariat of WP 7, annex follow-up of ECHI, in the current round for the public health programme. He also says the legal basis of the shortlist will be an issue to discuss in WP7.

19 February, afternoon session

6. Second welcome

Pieter Kramers welcomes the participants joining and announces the agenda to be followed.

7. Presentations by four projects which are finalising

- Wolfgang Boedeker on Workhealth. Roughly following the structure of ECHI, they assembled a master list of about 300 potential indicators, mostly in the areas of determinants and health systems. Based on policy domains, a reduction of this number is now under way. Questions arise on the availability of data for all these new indicators.
- Dafina Dalbokova on Environment and health indicators. Their focus is now on housing, home accidents, traffic accidents, external environment. In the DIPSEA (shortly: cause-effect-action) cycle, focus is on exposure and effect indicators.
- Pietro Folino-Gallo on Euro-med-data (pharmaceuticals use). Their work notes a lack of adequate data and recommends to register data, by ATC group, on price per DDD, expenditures per DDD, and volume of use. He gives examples of large differences between countries for statins.
- John Davies on health promotion indicators. He emphasises his project as being different from all others, presenting a model of health promotion as the conceptual basis for selecting indicators in several settings such as school, workplace, etc. The conceptual model has been discussed with Pieter Kramers to reconcile it with the conceptual model lying behind the ECHI structure. There is a comment that health promotion is not always separate from the health services system but occurs within that system too.

8. Group discussions

Three groups are formed on: (1) Health status (chair Hugh Markowe, rapporteur Else-Karin Groholt), (2) Health determinants (chair Emanuele Scafato, rapporteur Richard Gisser) and Health systems (chair Pieter Kramers, rapporteur Susanne Holland). The groups are requested to address the following questions:

- Are the project results included in the ECHI longlist in the right way?
- How to proceed with harmonisation of definitions and data, and of data availability?

20 February, morning session

9. Feedback from group discussions

group 1: Health status (Chair: Hugh Markowe; rapporteur: Else-Karin Grøholt)

General comments:

- General support of the current work. The long list is improved.
- Split into “core indicators” and “recommended indicators” desirable.
- General support for finalising the long list.
- In a number of cases a simple indicator description is offered rather than an operational definition.
- Limitations of groupings currently presented with respect to:
 - age groups (need for smaller groups, need for more refined age standardisation, 65+ is too crude).
 - ICD codes (more specific codes desirable).
- Important to present ECHI-2 long list with full rationale to enable understanding of why individual indicators are selected.
- Will Commission badge the long list as “recommended”?
- Feasibility important. Long list may represent an ideal, but it may not be clear to readers which parts are ideal and which are practical now.
- Is the ECHI-2 list meant for internal or external use?
- Will the list be static or evolve? New work in different areas is developing (e.g. mental health).

Specific comments from the different projects:

Cancer

- Prevalence and incidence need to be included for all (main) cancer sites.

Health Promotion

- Need for more salutogenic indicators (instead of current disease focus).

Injury Prevention

- Project results reflected OK, though there may be issues concerning availability
 - data by intent and sector (eg. workplace) will be hard to substantiate.
 - reliability and validity of data (differences across countries).

Musculoskeletal

- Musculoskeletal pain included, but often need to consider pain more generally.
- Items such as fatigue included?

REVES

- ECHI-2 support of WHO work on DALY's, but important to recheck current status of the WHO work.

- A composite measure important, but WHO work may attempt to get too many things into one figure.

PERISTAT

- Identifying WHO/OECD as source of data ignores more sophisticated methodological work arising from the project.

EUROCISS

- Prevalence and incidence (reported as ‘attack rate/incidence’) need to be included for cardiovascular indicators.

Mental health

- Project results included OK.

Plenary discussion:

Pieter Kramers finds it difficult to give the full rationale for selection for each indicator. The projects often give these. In the ECHI list until now the rationale has been given by the group, since they often are similar within a group and at the same time show why some things have *not* been selected.

Frédéric Sicard says the list should not be static. Gradually, a legal basis is foreseen for parts of it.

Jennifer Zeitlin prefers more explicit reference to the projects and experts who made the recommendations for the various indicators.

group 2: Health determinants (Chair: Emanuele Scafato; rapporteur: Richard Gisser)

- Some of the proposed measures for certain indicators still need to be discussed.
- We should stress the importance of health surveys (interview *and* examination).
- It was proposed to circumvent the problem of cultural biases by comparing temporal changes in certain measures instead of actual differences.
- Furthermore it was discussed that some cut-off points were debatable.
- Questions were raised on how to deal with imbalances. No recommendations should be forced.
- There are gaps which are not covered.
- The format of the list is ok.
- ECHI-2 should be looked upon as a baseline that should be updated on regular bases (How and by whom? Concerns are expressed!). The work should continue because without implementation the work will be lost.
- For the new EU countries the data availability is not as good as for the old EU countries. Should ECHI be concerned with this?
- The intellectual disabilities project notes they find it difficult to fit in the ECHI scheme because not only the usual problems (e.g. sex, age) but also very subjective evaluation of intellectual disability and related dimensions are important. Try to document what the national definitions are and try to tackle them.

group 3: Health systems (Chair: Pieter Kramers; rapporteur: Susanne Holland)

Issues from the group:

- Eurostat is now also looking into the questions of effectiveness and efficiency of care. A project is going on (MDS-SHA: Minimal data set in the frame of the System of health accounts), trying to propose minimal data (and associated indicators) along the four goals of a health system: sustainability, effectiveness, equity, efficiency. These are the four 'Göthenborg pillars'.
- It seems worthwhile to reconcile this approach with the ECHI scheme.
- Another discussion point was how to harmonise the details of the collection and presentation of hospital data between international organisations. On the table was a proposal by Remis Prochorskas on this matter. Problems to carry this further included the uncertainty about the continuity of the Hospital Data Project (Hugh Magee) and the lack of capacity in Eurostat, although it could perhaps be taken up in the Core Group Health Systems by a task force. The group agreed on the basics but lacked a view on how to implement these.

Plenary discussion:

Remis Prochorskas stresses again that finding common formats for hospital data should not be too difficult. There are some practical problems but no big obstacles. Hugh Magee sees great potential for detailed data from hospital data projects. Large datasets are available. Data have now been collected from 13 different countries. There should be co-ordination to prevent duplicate effort. Didier Dupré says the Core Group will meet later this year. There is indeed more co-ordination now between Eurostat, OECD and WHO, he states.

Simona Giampaoli stresses the need to validate data sources. There should be more co-operation with other projects.

10. Discussion on User windows

Ville Lehtinen agrees with the proposal for the mental health field. He is concerned that the Working Parties will start all over again. Michael Rigby says that one of the purposes of the long list is to help countries to define priorities in data collection and to identify extremes in countries. He suggests that we should be aware that some countries would have extremes in certain data. We could therefore think of making country windows in which certain specific situations (e.g. extremes in data) are displayed.

11. The web-based ICHI indicator database

Rutger Nugteren presented the status of the ICHI database. It has been available online to the ECHI team only for test purposes, which provided him with useful comments.

Remis Prochorskas reminds the meeting that there was much interest in ICHI-1, produced by WHO. He points at the complication that the definition of indicators would need to include notes on country-specific features of data collection.

There were several positive reactions. Although updating of the system is technically not too complicated, it needs to be organised after finishing ECHI-2. Arpo Aromaa suggests that the versions for each year should be kept separately.

Michael Rigby suggests to provide links into the HMP project reports. For the ECHI indicators these are often the source of the definitions.

12. Discussion on the shortlist

At first, Didier Dupré gives a presentation on the availability of data in Eurostat for the indicators included in the shortlist. Problems include: several morbidity items, general musculoskeletal pain, pregnant women smoking, and several items in health systems. His good news is that the database of Eurostat is now accessible for free.

Miguel Oliveira da Silva suggests including teenage pregnancies. Arpo Aromaa stresses again the importance of both HIS and HES instruments in data collection. Andrea Micheli points out that for cancer, networks are existing which can provide the requested data routinely. Simona Giampaoli adds that for cardiovascular diseases this is also an important goal for the near future.

Remis Prochorskas says for the shortlist we should not be too sensitive to trends/fashion in data reporting or the choice of indicators. He gives the example of hospital bed data: it may seem 'old fashioned' but still is useful. He furthermore points out a few errors on what is and is not in the WHO database.

Ville Lehtinen and Michael Rigby point out that many data on mental health indicators or on breast feeding are available, often in a scattered way. Didier Dupré adds that in the new HIS modules devised by Eurostat there are mental health questions.

Toni Montserrat indicates that for much of the proposed data collection there is still no legal basis. If the projects deliver the tools and instruments, the survey developments in Sanco/Eurostat can gain quality and work towards a formal status. He is pleased with the fact that the co-operation between the WHO and Eurostat has improved and he is hoping for even better co-operation in the future. Gérard Badéyan has a problem with the status of the list because of the legally-based indicator list in France.

There are sometimes differences between what the commission wants and what the experts think is possible. This may lead to usage of data that may not always be as accurate as we want it to be. The Eurobarometer is an example of the above. It is mentioned that for some items the Eurobarometer is a reliable source but not for others.

Enric Duran and others think that the issues accessibility and equity should be defined more precisely. Equity/equality means a lot of different things in different countries.

This means it is very hard to measure. Dag Bruusgaard proposes that insurance coverage can take care of the issue for the time being. Arpo Aromaa says that also this will be difficult since countries differ very much in their insurance and social security systems. Pieter Kramers proposes still to include it with sufficient specification.

Frédéric Sicard adds that the definitions of the politically inspired indicators on patient and professional mobility are not yet ready.

Hugh Magee mentions that hospital data can sometimes be separated by SES or ethnicity class, also he finds that the proposed user window 22 (system performance) could include more of the kind of indicators provided by the hospital data project.

Enric Duran announces that his project will come with quite a few indicators for asthma and COPD, also clinical ones.

There is a question what daycases are (variable mentioned in hospital data project), especially in the case of mental health issues. Hugh Magee thinks the definitions are clear, and you can really measure trends from overnight hospitalisation to more daycases.

Zoltan Voko supports the inclusion of something on equipment (MRI etc.). Arpo Aromaa questions whether something could be included on integrated care. Gérard Badéyan proposes that mobility of professionals should be linked to personnel shortages.

Note: Pieter Kramers and Frédéric Sicard have replied to many remarks and issues raised in this meeting. These replies have not always been recorded. However, on the basis of these notes, they will try to make use of all the remarks made.

13. Follow-up of ECHI-2

Horst Kloppenburg gives the Sanco view on the position of Working Party 7 on indicators. Like in the past ECHI was discussing with the project co-ordinators, now WP7 will communicate with the WP leaders in the network of Working Party Leaders (NWPL). He sees WP7 as the logical continuation of ECHI and invites the meeting to submit proposals for the secretariat of WP7.

Pieter Kramers indicates that he is not very eager to go for a third round of ECHI as the principal applicant. The reasons are that this work should not be kept too much with one person or one country. He thinks it should be taken over by a consortium, in which he is willing to take part. He invites the participants to come up with initiatives.

Arpo Aromaa indicates that the actual work is done in the projects, and doubts whether a mere co-ordination activity will work. He proposes a relatively small project with a set of good people. Zoltan Voko adds that we have now to shift to implementation, i.e. a new activity.

John Ryan suggests the possibility that in the longer term the Agency in Sweden could take over the information work, and that Eurostat would play an increasing role in the routine implementation.

Arpo Aromaa rather sees a place for an indicator development project within the scope of WP7. Pieter Kramers suggests that the scope of WP7 would naturally be very similar to the one of the Network of Working Party Leaders, and asks why the two could not be merged. John Davies and Hugh Magee share this view. This is, however, apparently no option from the view of Sanco.

Generally, participants support the creation of a WP7, and agree to see that as the focus of continuation of the ECHI work.

14. Closure

Pieter Kramers urges all participants to send him, during the coming days, all their thoughts on the finalisation of ECHI-2 and the continuation of the comprehensive indicator work. He then thanks all participants for their active role in the discussions, and he thanks the Sanco staff, including the secretarial functions, for their great help in preparing and supporting the meeting.

Notes made at the finalisation of these minutes by August 27, 2004:

- *After the meeting quite some remarks were received by Pieter Kramers on the contents of ECHI, not very many on the follow-up.*
- *In the 2004 round, a project proposal was sent in by end of April by Arpo Aromaa, for the WP7 secretariat annex follow-up of ECHI, in which a consortium of people/institutes was proposed as a core team. The proposal was accepted 'subject to the outcome of negotiations'.*
- *In June, Pieter Kramers prepared an updated version of the shortlist, trying to accommodate all remarks made during the February meeting. In this version the proposed split between available and non-available indicators was implemented. It was presented in the NCA and NWPL meetings of July 5-6, 2004, and again analysed by Eurostat for availability. This June version of the shortlist was sent to all participants of the February meeting.*
- *On October 28-29, the last ECHI meeting will be held. At this meeting, Pieter Kramers hopes to present the draft for the final report, which he can then finalise by the end date of the project, being December 1, 2004.*

November 22, 2004; DRAFT

European Community Health Indicators; phase 2

ECHI-2

Report of the 6th meeting
October 28-29, 2004

Batiment Jean Monnet, Luxembourg

Present ECHI team:

Arpo Aromaa,
Gérard Badéyan,
Rui Calado,
Enric Duran,
Richard Gisser,
Else-Karin Grøholt,
Eva Hammerby,
Hugh Magee,
Hugh Markowe,
Herman van Oyen,
Rutger Nugteren,
Emanuele Scafato,
Aris Sissouras,
Magnus Stenbeck, replacing Susanne Holland,
Thomas Ziese.

Apologies ECHI team:

Peter Achterberg,
Remigijus Prochorskas,
Zoltan Voko,
Raymond Wagener,
Eveline van der Wilk.

Present Commission:

John Ryan (Sanco),
Zinta Podniece (Sanco),
Jürgen Schefflein (Sanco).

28 OCTOBER, AFTERNOON SESSION

1. Opening, welcome, Commission issues

Pieter Kramers welcomes everybody. He introduces the usual practical issues and welcomes John Ryan and Zinta Podniece, who join on behalf of Sanco.

John Ryan gives information on recent developments at the Commission services. First of all he emphasises the importance of the ECHI results for the work of Sanco, especially the shortlist. The follow-up and implementation must now be taken up in the Working Parties, together with Eurostat. For a quick first round the possibilities are being explored to use existing database software.

John also gives some details on the project cycle within the Public Health Programme. The contracts for the 2003 approved projects are now all signed. For the 2004 approved ones, a quicker procedure is followed, aiming at finishing all administrative stuff during a one-day session in Luxemburg. A list of all 2004 proposed projects with the selection outcome is on the table. The draft of the 2005 Work Plan is circulating and will be finalised hopefully during the Program Committee meeting of next December 1st. After that, it will be published with the new call for proposals. There will be calls for tender on 3 topics: Health interview surveys, mobility of professionals, and pharmaceutical products. There should be a link with a new Health Strategy Document. The establishment of the Executive Agency (EA) has been delayed by the dismissal of the new Commission, and the approval by the Budgetary Committee of the EP is still pending. The staff is proposed to have about 37 fte, about 1/3 scientific.

Herman van Oyen asks whether the EA will cover the entire project cycle. This will be the case, but the selection of projects and the decisions on what to do with the results remains in Sanco C2. Hugh Markowe asks whether the new Health Strategy Document will contain concrete targets. John says the Working Party 7 on indicators could address this point. This could also be part of the Work Plan for 2006. The Health Strategy Document is a lot on e-health, but the members of the Group preparing this document know little of the work in the Public Health Programme. Arpo Aromaa, Herman van Oyen and Magnus Stenbeck all stress the importance of maintaining and developing existing things such as ECHI, besides continuously inventing new parallel initiatives. Is the interaction with policy-makers sufficient? John recommends us to mention this in our final report.

2. Report of the 5th meeting

The report had already been circulated for comments. Nobody has additional remarks, so it is formally agreed.

3. Work done since february 2004

Pieter Kramers gives a short presentation of the progress of the work (see ppt file in meeting documents, annex ECHI-2-49, also attached here). Most issues will be followed up in the further items on the agenda.

4. Draft final report of ECHI-2

First there is a tour de table for major and general comments. Richard Gisser questions how complete we should have the Member State's policy priorities. Hugh Markowe states that the report should contain more of the actual output of the project. Texts on rationale and process are important but could be in an annex. Magnus Stenbeck also finds there is too much 'why' and too little 'what'. He likes to see something on what is 'public health', in relation to 'welfare' and 'systems', and on what is an 'indicator'. Herman van Oyen would like more of a strategic approach. The present text is too much for insiders. Emanuele Scafato adds that we should present guidance and reference for people in the Member States who want to use ECHI. He wants the long list on paper, not only in electronic form. The style should be more like the ECHI-1 report, but the front page should look more different. The affiliations of the ECHI team members should be included this time.

Arpo Aromaa also addresses the intended role and audience of the report. He suggests to separate the basic results from the more technical and historical information. Examples of the implementation and comparability of indicators could be useful. Rui Calado adds the question on the future of ECHI. How will it be used? Thomas Ziese stresses the fact that there are degrees of comparability of data or indicators, not just yes or no. Also, the report should be presented as final for ECHI-2, but otherwise as a point in time of an ongoing process. Hugh Magee supports this, and would like more explicit mention of age/gender issues. He also wants the long list in paper form, just like Gérard Badéyan. The latter would like to see a reference to the recent French law on indicators and on the (absence of a) legal status of ECHI. He also stresses the idea of working with RAD (raw aggregated data), which implies that from a defined data set a range of indicators can be calculated as required.

Else-Karin Grøholt hooks on to others by stressing the need of making clear what an indicator is, and how its relevance is assessed. She also wants to have the long list as a paper appendix, and again stresses indicator development as a dynamic process. Aris Sissouras finds the report well-structured, but likes to see more on the operationalisation as a policy tool. ECHI should be a reference. In Greece, he has used it for developing national initiatives. He also is in favour of a paper version of the long list. Emanuele adds that also in Italy ECHI-1 was used as a reference, and the added value of ECHI-2 should be explained. He mentions 'heavy drinking' as an indicator in the shortlist which has not precisely followed the long list and is not correct. He will provide Pieter with the right definition. Arpo Aromaa indicates that although there is growing agreement on how things should be comparably measured, there are still many differences in practice. Herman van Oyen states that regulations can help to improve this. He supports Aris in saying the ECHI report should have the status of a reference.

John Ryan is much in favour of an 'idiot-proof' executive summary, clearly stating what monitoring and reporting is in public health. The report should be used also at national levels, and he suggests to arrange for translations in various languages, e.g. by producing articles in MS professional journals. The position of the new Member States should be made clear. As to the legal basis, Eurostat has the tools to provide this and is at present looking at this issue. Arpo Aromaa remarks that this may not

work if information in the MS comes from other channels than the statistical agencies, which is sometimes the case. Herman van Oyen adds that this is the case in Belgium, but still regulations from Eurostat could be in force. John Ryan emphasises again that only Eurostat can provide a legal basis for data collection at EU level. Arpo Aromaa finally mentions that with the new MS there may be shifts in emphasis, e.g. on alcohol use and other lifestyles. He warns against too much emphasis on costs and expenditures.

Pieter Kramers thanks the participants for all their constructive comments and gives a short summary of what he picks up as the main message: make the report more basic on the central results instead of a technical progress report, and fit for a broad range of readers. Give the long list as a paper appendix. Stress indicator development as an ongoing process, with a view on where it should go. Include basic things like 'what is public health', 'what is an indicator'. Otherwise, he intends to follow up on all the detailed comments listed above.

5. State of the Shortlist

Pieter Kramers gives a short outline of the further evolution of the shortlist after the February meeting of ECHI, and the suggestions done by various meetings and Working Parties (see powerpoint presentation, sent annex to this report).

After the presentation, several comments are raised. Arpo Aromaa thinks that some of the recent additions are reasonable but some are not. The health promotion issues are still too generally stated. For alcohol dependence, the CAGE is not needed since this is also included in the CIDI. We should not be so specific here in indicating the precise measuring instrument. This is rather the next stage, especially when there are various views among experts. Herman van Oyen says that the indicator 'HbA1c' for diabetes regulation is not yet measurable in a standardised way, according to Belgian experience.

Hugh Markowe says it is now important to justify what is in the shortlist and why. At the size of 50 he was happy with some important things not included. Now he feels it has become longer in an unbalanced way, by some groups having been more vocal than others in suggesting changes. He has more trouble now to defend it to his Minister, e.g. why 'TB incidence' is not in and 'sense of mastery' is. Magnus Stenbeck is very hesitant on the indicator on job quality, which is a very difficult one in his experience. Enric Duran gives a plea for the IMCA proposals for COPD and asthma prevalence and the specific recommendations on COPD/asthma mortality, which differ from the Eurostat 65 list, for good reasons. Herman van Oyen again says the shortlist should be kept short and also makes the remark that the Eurostat 65 causes of death list cannot simply be changed or expanded.

Aris Sissouras argues that especially in the shortlist we should have clear definitions for the indicators. Else-Karin Grøholt adds that in Norway indicators work only if both definition and data are clearly described. Arpo Aromaa says that health expectancies based on perceived cannot be compared between countries, and they should preferably be based on disability-like measures. Hugh Magee adds that according to the initial criteria for selecting the shortlist (related to a significant health

problem) some of the newly added environmental health indicators should not be included. He also challenges the balance in the extended shortlist and recommends to make user-windows for some of these issues.

Pieter Kramers summarises the comments by saying that according to the team he has moved a bit too fast in accommodating the various suggested additions. He proposes that each of the team members gives more detailed comments on these recent additions, and that we want to present the shortlist as a consensus list from the ECHI team in its final report. The various suggestions from different sides then can be added to a waiting list for future extension, for which others will have responsibility. A difference will have to be made between real additions on the one hand, and specifications of topics agreed earlier on the other.

6. Dinner

At the end of this first meeting they the team had a very pleasant ECHI-2 farewell dinner.

29 OCTOBER, MORNING SESSION

7. ICHI web application

After a few introductory remarks by Pieter Kramers (see point presentation), a (slow) connection is made with the internet, to have 'live' access to ICHI. Rutger Nugteren successively demonstrates the various functionalities, including the access by the ECHI tree, by search function, the possibilities to select the WHO, OECD, Eurostat and/or ECHI indicator sets, the display of the definitions, and the user-windows. Several improvements have been realised recently, such as the possibility to read two different definitions at the same time for easy comparison. Some user-windows have recently been added by ECHI team members.

Herman van Oyen questions why ECHI definitions would be different from those of Eurostat. Pieter Kramers replies that ECHI definitions are not always as specific, may contain recommendations by HMP projects, and may even link to WHO-HFA definitions. Arpo Aromaa stresses the usefulness of the system as a library of indicators. Then the discussion focuses on the question who is providing the 'right' definition for a certain indicator. This problem does apply exclusively to the ECHI list, not to the WHO, OECD and Eurostat variables, since the ECHI indicators sometimes are rather 'topics' than 'operational indicators'. There are quite some examples of HMP projects proposing different definitions for the same topic, or different preferential data sources. These differences may represent innovative approaches versus current practices, or even conflicting expert views. Herman van Oyen states that it cannot be our business to solve all those problems. What we should do is refer to the different sources, without choosing ourselves. John Ryan suggests to provide hyperlinks to the respective sources such as project reports. John also addresses the language issue: now the application is in English only. How do we deal with the other 20 official EU languages?

Several discussants give suggestions for improvements in the screen lay-out of the application, such as having an overview of the number of indicators in particular selections, the possibility to add text or notes, the location of bars in the screen, the double appearance of certain indicators, the size of the heading, etc. Emanuele Scafato would like to have the application downloadable, like it can be done with WHO-HFA. Arpo Aromaa asks what can be printed and how. John Ryan finally addresses the problem of the sustainability of the system after the end of ECHI-2. Pieter Kramers says he hopes the maintenance can be taken forward in ECHIM/WP7, but a transfer to the Commission would be desirable anyway.

8. Status of the long list

Pieter Kramers gives a few introductory remarks (see ppoint presentation). The team generally agrees on his proposals to avoid the uncontrolled expansion of the long list. Several team members point out that quite a few recommendations from HMP projects are not really meant or fit for general monitoring purposes but rather for specific goals. Also, some HMP reports only produced general theories but no concrete measurable indicators. It was said the long list should contain more concrete links to the project sources. The issue of who decides on the right definition came up again. It was said that this could perhaps best be sorted out between the project subject experts and the data collection experts at Eurostat.

9. Presentation of the successor of ECHI-2, ECHIM/WP7

Arpo Aromaa gives a presentation on the plans for ECHIM/WP7 (see attached ppoint file). He emphasises the need of more co-ordination in setting up the information system: much of the work is liaison. His plans include a multi-center involvement, both in organising the Working Party 7 on indicators and in co-ordinating other activities aimed at the implementation of the information system.

Hugh Markowe stresses the need of a strategic approach. How will the further development of the shortlist from the longlist ingredients be structured? Magnus Stenbeck asks who is envisaged to do the actual data collection. Herman van Oyen's question is how the further development and operationalisation of the indicators is organised, who are the players? Hugh Magee pleads for the formulation of criteria and procedures for that, taking Eurostat on board in the process. Pieter Kramers indicates that Eurostat is a main player but some data come from other institutions or networks. Richard Gisser says that in Austria, data collected by others (e.g. insurance companies) may be channeled through the statistical institute. Emanuele Scafato suggests to include the implementation of the shortlist also in the Work Plan 2005 for the Public Health Programme (it is mentioned there). Herman van Oyen hopes that the proposed legal basis for some data collection will stimulate improvements. He expresses his concern that the broad scope of ECHIM/WP7 compared to ECHI-2 may imply a risk.

29 OCTOBER, AFTERNOON SESSION

10. Summary of the sessions, closure

After lunch, the main lines of the discussions and conclusions of the meeting are reviewed. In addition, some new issues are raised. It is noted that we should try to improve the coherence with the ISARE indicators. Pieter Kramers will be in the position to work on this as member of the ISARE steering committee. Herman van Oyen is not in favour of shifting indicators to other chapter of the ECHI structure (e.g. teenage pregnancies from demography to lifestyles) since it might generate more and not necessarily useful discussion. He prefers to be rather strict in the conceptual structure of ECHI.

In a final round, many of the team members find that ECHI-2 has made much progress compared to ECHI-1. The frame is beginning to be used in several Member States (Ireland, UK, Portugal, Germany, Norway, Austria). Many stress the need for continued co-ordination of all the projects and initiatives that occur in an increasingly scattered way within the Public Health Programme, and hope that ECHIM/WP7, together with the Network of Working Party Leaders, will be able to contribute to that. The team members thank the project co-ordinator for his work and patience, and wish him success with the final phase of the project.

Pieter Kramers, in turn, thanks the team members for their contributions and support, their commitment and their open discussions. He offers them a small present, a candle in the shape of the old church tower of Utrecht (near Bilthoven), being the tallest gothic church tower in Holland (110 m).

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