ANNEX 7

TO THE ECHI-2 REPORT, JUNE 20, 2005

THE ECHI SHORTLIST, SELECTION PROCEDURES, AS AGREED IN MAY, 2003

1. Background and history

Both Sanco and ECHI aim at a core set of indicators. At the 18-20 March 2003 meeting in Luxemburg, the ECHI team decided to launch a Delphi-like procedure to accomplish this. A draft procedure was circulated for comments on March 31.

At the meeting of HMP project co-ordinators in Luxemburg, on March 18-20, 2003, the Sanco G3 representatives put great emphasis on the need to show the beginning of an implementation of data in the indicator framework developed until now. For that purpose, they proposed to select a 'core set' of indicators that would enable a quick start. During the meeting, an attempt was made to make such a selection in group sessions, starting from the draft ECHI list. It was felt, however, that the rationale and the criteria were not sufficiently clear, and that the ECHI draft list was not yet well-fit for this purpose. Also, not all of the groups could finish their job. It was then decided that the ECHI-team would propose a procedure to carry out the selection in a more structured way, to deliver some result by 10 July, for the meeting of the Network of Competent Authorities.

On March 31, The ECHI co-ordinator circulated a proposal for a procedure to all past and present HMP project co-ordinators, to the ECHI team, to the Sanco G3 staff and to the Eurostat core group leaders. He also discussed the proposal with Sanco staff on April 16.

2. Reactions to draft protocol and draft ECHI indicator list

By April 18, quite some comments were received. Based on these, substantial changes were made to the proposed protocol. Also, they led to additions and improvements in the indicator list, as well as prioritisation within the work field of projects. Discussions with Sanco clarified the rationale for the core set, to some extent.

By April 18, many addressees had sent reactions. Many of these contained useful suggestions for changes to the protocol. These concerned, e.g.: the use or not of availability as a primary selection criterion, the separate use of disease burden and preventability criteria (or the separate selection by ECHI-chapter), the lack of balance

between generic and specific indicators (columns 1 and 2) in the March draft of the ECHI list, on what precisely a *user window* is (short answer: this is an indicator subset selected from a particular user's point of view; see below for further explanation), or the insufficient scientific basis of the indicator work until now. As a result, the present draft contains quite some changes, and is circulated as an intermediate draft on April 28 to Sanco and the ECHI-team.

Many addressees have sent suggestions and additions to the March draft indicator list from the viewpoint of their own projects. They sometimes sent a favourite set from their own project recommendations, not looking very closely at the boundaries between ECHI chapters, in line with comments that this should not be done. This will be taken on board for the next steps.

The fourth point of action in step 2 was the clarification by Sanco of the rationale for having the core list. As clarified during my visit, this was based much on the need felt to accomplish a beginning of a working information system on the short term, which is underpinned by the legal texts underlying the public health programme itself, but not on a policy action in a specified area.

In the present document, the ECHI co-ordinator has made an effort to take account of all these comments. This was not always fully possible. In these cases he has added some explanations, or responded to the commenters directly.

3. Rationale for a core indicator set and its status

The rationale for creating a core indicator set now is to set priorities for data implementation, and thus make a start with realising an information base on the short term. This will not hamper further development of other indicators outside the core set, to be realised in a long-term plan.

The first question is: *Why* do we want a 'core' set of indicators? One rationale was formulated in the ECHI-2 workplan, namely that the comprehensive indicator list would grow steadily by the input of all the HMP projects, and some restriction would be needed to effectively work on harmonisation of data collection but not on too many topics at the same time.

From the policy side (Sanco G3) the reason for wanting a 'core' set seems very much te derive from the need to accomplish a beginning of a working information system on the short term. This is underpinned by the legal texts underlying the public health programme itself, like: 'To improve health information and knowledge for the development of public health by .. developing and operating a sustainable health monitoring system to establish comparable quantitative and qualitative indicators at

Community level on the basis of existing work and accomplished results, and to collect, analyse and disseminate comparable and compatible age and gender specific information on public health at Community level concerning health status, health policies and health determinants, …… paying special attention to inequalities in health.'. These issues are further specified in the workplan for 2003 under items 2.2.2 and 2.2.3.

The main rationale for selecting a restricted set of topics thus seems to be to allow for a quick implementation of data with the indicators. There is no special direction on criteria except to be basically comprehensive and to include health inequalities. This means that the restricted list is intended for use in a short-term pilot implying the addition of data, from whatever source, to the indicator base. It also means that the *status of this core set is for the short term*, and is part of a longer term strategy for the gradual implementation of all the indicators that have been recommended in the various areas by the various projects, and the associated data collection. Therefore, the core set is named *'first phase set of core indicators'*. The longer term strategy still has to be specified.

4. Criteria for selecting core sets of indicators

For the first round of selection of the core set, the criteria will be (1) importance for overall health status and large health problems at population level, (2) strength of evidence for inequalities in health, and (3) importance for effective interventions and health policies. In short: the big problems and the big chances for improvement.

The second question is on the *criteria*. As the main rationale seems to be one of restricting the number of indicators in order to get something quickly done practically, there is no clear direction for criteria of content. This means that we should start from a *general public health policy perspective.* From such a perspective, one could say that health policy seeks (1) to address the big health problems, as well as (2) the unwanted health inequalities, and (3) the best opportunities to improve the health and inequalities situation by appropriate intervention.

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

Availability of data has been suggested as a criterion for selection. This looks logical in relation to the wish of producing quick results (in terms of quick implementation of the list with data). However, public health relevance and practical data availability are basically different dimensions, which we think are not wise to mix in the same selection procedure. In practice, when we select on the basis of the policy relevance, data will be available in most cases since most of these issues will have been policy-relevant for some time. Therefore, I expect that we will not end up with more than approximately 10% of 'core indicators' for which data are not available. At the same time, the selection process will point at a limited number of issues/indicators for which we think data development has high priority, and we avoid the trap of data-driven-ness. In short, the protocol implies a first selection round on the basis of policy-relevant criteria, after which in a second round, the data availability and the precise indicator definition will be established. The latter will be done by data specialists (Eurostat) and by the 'vertical'projects.

5. The ECHI list as the starting point for selecting user windows

The ECHI-2 draft list will be used us the starting point for the selection of the core set. On this basis, with new additions from HMP projects, a simplified list is presented, with maximum consistency in being 'medium-generic'. It will include recommendations for priorities in areas covered by specific HMP projects. Respondents may indicate missing issues.

The ECHI-1 list has been devised to comprehensively cover all issues of health status, health determinants, health promotion, health care, and background factors, that are of interest to actors in the public health field. It is not yet in balance since some issues have been specified better than others, due to work done in the past or in several HMP projects. Recent additions have enriched the list, but the lack of balance has not yet been solved, due to the fact that the presence or absence of a project on a specific subject is somewhat arbitrary. Further work in ECHI-2 will aim at improving the uptake of HMP project recommendations, and of indicator/database definitions. We think that at this stage, the list can be used as the starting point for a procedure for selecting the two user-windows mentioned, under the following conditions:

- The list should be as updated as possible, concerning the status of HMP projects; the ECHI project co-ordinator will attempt to take care of this by including recent results and current comments to the extent possible.
- The list should be consistent in the sense that all indicators mentioned have a somewhat similar status of being not too general and not too specific. To this end a modified list has is prepared for the selection procedure. This list is made up on the basis of the March draft and subsequent additions/changes. It contains the full list of indicators, at an 'average generic' level. This means that the wording will be specific enough to enable qualified choices, but not so specific that we end up

with e.g. lots of very precisely defined indicators. E.g., 'smoking behaviour' may be too generic since the problem is different e.g. for the young and for pregnant women, but something like 'smoking prevalence in 18-20 year olds' is too specific. This implies that the operationalisation of the selected indicators comes in the next step, on the basis of the involved project recommendations, and in connection with the assessment of data availability.

- The priority sets generated by the 'vertical' projects (i.e. those recommending indicators in a specific area) *within* their area, will be indicated in the list as such.
- The participants can raise issues that they find lacking in the current ECHI list and which they find important enough to include in the selection.

For details on some of these issues, further procedures and the time frame, see below.

6. Intended size of the core set and selection procedure.

The aim is a core set size of some 20-25% of the ECHI draft list. Participants select 50 first choice and 50 second choice. Playing with cutoff points in the resulting rankings can provide various sizes of core sets. Participants amend the results. Sanco and the ECHI co-ordinator have a final say. For a next phase, more precise indicator definitions and data availability will be assessed with the projects and with Eurostat.

Given the rationale of the present exercise, i.e. having a somewhat limited set for quick implementation (and priority development), as a first step in a larger strategy of indicator development, it seems reasonable (arbitrary!) to aim at a list containing some 20-25% of the total number of indicators in the present ECHI selection draft list, which is approximately 400.

This can be accomplished according to the following procedure (see also under (9) and time schedule)

- Each participant selects 50 indicators (about 20% of the total list) as his/her first choice, and another 50 as his/her second choice, from the overall ECHI draft list [*note: different from the 25 March draft we do not propose fixed numbers from each ECHI chapter*].
- From this, a ranking can be tabulated of indicators having e.g. 12, 11, 10 etc. votes. First choices are given twice the weight of second choices. This can be done for the whole list, but also for indicators within an ECHI chapter.
- From the overall ranking, larger or smaller core sets will be constructed, by choosing different cut-offs in the ranking.
- From the chapter rankings, combinations of cut-offs result in core sets which have emphasis on one or another chapter, e.g. on the health status chapter or the health determinants chapter.
- Along this line, several proposals for core lists will be presented, for discussion.

- All participants can suggest amendments to the results. Sanco and the ECHI co-ordinator have a final say in discussed items.
- For one or more of these variant proposals, indicator definitions and data availability will be assessed in the follow-up phase, with the HMP projects and Eurostat.

7. Indicator 'Core sets' and 'User windows'

User windows (as developed in ECHI-1) are core sets of indicators selected according to a specific user's perspective. The presently derived core set and its variants are examples of this concept.

In ECHI-1, the discussion on how to define a core set of indicators led to the conclusion that there may be many perspectives from which a 'core' set of indicators can be constructed. Each perspective has its own set of criteria and yields its own subset of indicators. Therefore we formulated the concept of 'user-windows' for subsets of indicators selected from a specified users perspective (for examples, see the ECHI-1 report, annex 7).

The present core set can be seen as a user window from the point of view of the '*general public health policy maker'*. We might, in addition, want to focus a core set on either health status or health determinants. These two would represent user windows from the point of view of either *'inspection of the health status landscape'* or of *'progress in effective health promotion'*.

8. Who takes part in the procedure?

The selection of core indicators is done by the more 'generalist' participants. The other participants comment on the procedures and results, and assess indicator definitions and data availability in the follow-up phase.

The procedure includes 4 groups of participants: (1) the ECHI team, (2) the past and present HMP co-ordinators, (3) the Sanco G3 staff and (4) Eurostat and the core group leaders. Their different roles are given in the time schedule table (see below). The selection of the core indicators will be done by set of generalists, being most representative of the *users* of the indicators. These include the ECHI team and the more 'horizontal' HMP projects (we propose: Isare (regional indicators), EVA (evaluation of health reports), Health promotion indicators, Health information systems, Health impact assessment, Socio-economic status and health). We would as a starting point not include co-ordinators of 'vertical projects' (e.g. cancer, nutrition) since they tend to be specialists, besides that they may be biased towards their own

topic. But if they can and want to act as generalists, they may join. All participants are involved in commenting on the procedures and on the results, and in the follow-up assessment of more precise indicator definitions and data availability. See below under time schedule.

9. Steps of the proposed protocol

Step 1:

- The ECHI project co-ordinator (Pieter Kramers, PK) sends the proposed protocol to all participants, with the March 12 version of the discussion draft indicator list. The participants include (1) the ECHI team, (2) the past and present HMP co-ordinators, (3) the Sanco G3 staff and (4) Eurostat and the core group leaders.

Step 2:

- All send comments on protocol to PK.
- All send comments on the indicator list to PK.
- Each project co-ordinator, notably of the 'vertical' projects dealing with a specific aspect of health, health determinant, and/or health system issue, selects the indicators which they find the most crucial ones from a general public health point of view (criteria see above). [*Note: In the 25 March version of this document it was not clear that this referred specifically to the indicators* ***within*** *the work area of the respective projects; most respondents however have taken it as such*]. The resulting favourite set will be marked in the overall list and will be a guidance in the overall selection in the next step.
- Sanco G3 staff clarifies the rationale for creating a core indicator set and indicates what the results will be used for.

Step 3:

- PK adapts the protocol and the indicator list according to the incoming comments, undertakes bilateral contact where needed, and circulates the protocol and the list for actual selection to the participants. Participants in this selection round will be a set of generalists, i.e. the ECHI team, the Sanco G3 staff, and the more 'horizontal' HMP projects.

Step 4:

- On the basis of the revised ECHI draft list, the participants select a fixed number of xxx indicators as first choice and xxx as second choice, from the overall ECHI draft list. Participants take account of the criteria and the conditions as set under

(4)-(6). They may add the reasons for their selection. Participants return their selections to PK.

Step 5:

- The results are tabulated by PK (see section 6 above). On this basis, he proposes a few variants for core sets or user windows. This analysis is presented in a transparent way and circulated to all participants.

Step 6:

- The participants study the results. They check for face-validity of the lists. They give comments to the variants. If they definitely disagree with the presence or absence of an indicator, they indicate this and qualify why. They can propose variant ways to deal with the obtained results. They send their comments to PK.
- The project co-ordinators (for their own field) and the Eurostat core groups comment on the data availability of the resulting indicator set, and where applicable on the preferred indicator definition. Thus the resulting user windows will show a gradient from easily available to developmental issues. They send their comments to PK.

Step 7:

- PK includes the comments, where possible, and after consultation if needed. Sanco and the ECHI co-ordinator may exert a last say in discussed items. The results so far are be presented to the meeting of the network of competent authorities (July 10) and will be circulated back to the participants. There will be a clear statement on the status of the result obtained until now, and on the need of putting this action into a longer term strategic plan on indicator and data development. The content of this will become clear during the process.