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# HEALTH REPORTING *in the* EUROPEAN UNION

Summary and Proceedings  
of a workshop  
organised by the RIVM  
in Bilthoven on 19 - 20 February 1998

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# **Health Reporting in the European Union**

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**Achterberg PW, Kramers PGN**

**SUMMARY AND PROCEEDINGS OF A WORKSHOP  
ORGANISED BY THE RIVM  
IN BILTHOVEN ON 19 & 20 FEBRUARY, 1998**

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## Executive summary

This Workshop possessed a unique feature as it brought together both the users, i.e. health policy makers, and the producers of health reports in Member States (MS) of the European Union. Added to these was the presence of major actors in the field of Community health information, i.e. the Commission and Eurostat, OECD and WHO. Several interesting developments in health reporting were noticed during the lively presentations and discussions.

In several MS health reports a shift has been noticed from the mere presentation of available data towards more integrative, comprehensive analyses, forging data into relevant information for Evidence Based Policy. This is supported by the growing political awareness that health is a broad issue and often in need of a broad dataset. Data on health determinants are needed to monitor prevention and health protection and data on the use, costs and outcomes of health care are essential to monitor its cost-effectiveness. Both a broadening of the focus of health reporting, as well as an increased awareness of the need for policy-relevance and international perspective have been observed. This has resulted in changes in health reporting towards:

- *growing attention for health care, i.e. variations in needs, use, costs and effectiveness*
- *increased awareness of potential effects of other policies on health*
- *more comparisons with other countries to provide an international perspective*
- *aiming at the exchange of views on national health with international peers*

Policy makers strongly favour the integration of health care information into health reporting in order to enhance its practical relevance. In countries where such changes in health reporting have taken place health reports are getting a more central position in planning and evaluation of health policy and in the health information policy cycle. In some MS health reporting has become a leading element in regional planning efforts for health care. The growing awareness of the broader ramifications and importance of health also includes the possible effects of other policies on health. Effective health reporting should therefore not be restricted to analyses of historically available data, but should also induce an active search for data in areas that are important for policy development and evaluation. Finally, it was repeatedly noted during this Workshop that international comparisons will provide a much wider context for and different perspective to national health status analyses. International comparisons may indicate the scope for improvements, contribute to target setting and point at possible future developments. A growing number of MS and regions have recognised the importance of international exchange of health assessments by publishing their health reports also in an English translation.

Sometimes quite different and often still evolving health reporting practices prevail in the Community. This makes mutual transfer of expertise and experience both valuable and feasible. Learning from other MS and exchanging and comparing information is desirable in the multitude of common areas of interest. A collaborating health reporting network may provide a central platform to define common interests and priorities for information exchange and monitoring to support a common Public Health policy for the European Union. Focusing the Community health reporting expertise, the core of which was present at this Workshop, can therefore contribute significantly to generating a critical mass that is needed to guide and direct Community health monitoring and reporting.



## Samenvatting

Deze workshop had als meest unieke kenmerk, dat gebruikers, d.w.z. beleidsmakers, en makers van gezondheidsrapporten uit lidstaten van de Europese Unie (EU) bij elkaar gebracht waren. Daarnaast waren andere belangrijke actoren in het veld van de Europese gezondheidsinformatie, zoals de Europese Commissie, Eurostat, de OECD en de WHO, aanwezig. Tijdens de presentaties en discussies konden diverse interessante ontwikkelingen opgetekend worden.

Er werd een duidelijke verschuiving opgemerkt in volksgezondheidsrapportages van het alleen presenteren van bestaande gegevens naar integratieve analyses, waarbij data geïntegreerd worden tot informatie die bruikbaar is voor 'Evidence Based Policy'. Deze ontwikkeling wordt ondersteund vanuit het groeiend politiek besef dat volksgezondheid een brede achtergrond heeft en dat een brede verzameling gegevens dus noodzakelijk is. Gegevens over determinanten zijn nodig voor het monitoren van preventie en gezondheidsbescherming en gegevens over gebruik, kosten en effecten van zorg zijn essentieel voor het beoordelen van kosten-effectiviteit. Niet alleen werd een verbreding gekonstateerd van het aandachtsveld van de rapporten maar daarnaast ook een toegenomen aandacht voor beleidsrelevantie en voor de toegevoegde waarde van een internationaal perspectief. Dit heeft geresulteerd in veranderingen in Europese gezondheidsrapporten in de richting van:

- *meer aandacht voor zorg, d.w.z. voor variaties in behoefte, gebruik, kosten en effectiviteit*
- *meer oog voor de mogelijke effecten van beleid in andere sectoren op de gezondheid*
- *meer vergelijkingen met andere landen om een internationaal perspectief te verkrijgen*
- *meer uitwisseling van visies op nationale gezondheid met internationale deskundigen*

Beleidsmakers zijn sterke voorstanders van de integratie van informatie over gezondheidszorg in gezondheidsrapporten om de praktische bruikbaarheid ervan te vergroten. In landen waar dergelijke veranderingen al hebben plaats gevonden krijgen de rapporten een meer centrale plaats bij planning en evaluatie van gezondheidsbeleid en in de beleidsinformatie cyclus. In een aantal lidstaten zijn gezondheidsrapporten sturende elementen geworden voor regionale zorgplanningsactiviteiten. De groeiende aandacht voor de bredere achtergronden en implicaties van gezondheid richt zich ook op effecten van ander beleid op gezondheid. Effectieve rapportages beperken zich daarom niet tot analyses van beschikbare data, maar dienen ook actief andere data te verzamelen die van belang zijn voor beleidsontwikkeling en evaluatie. Tenslotte werd er een aantal malen gewezen op het belang van internationale vergelijkingen, omdat deze een bredere kontekst en perspectief verschaffen voor nationale analyses. Internationale vergelijkingen kunnen aanwijzingen geven voor haalbaarheid en omvang van verbeteringen, bijdragen aan het formuleren van beleidsdoelstellingen en aanwijzingen geven voor mogelijke ontwikkelingen. Meerdere lidstaten, maar ook regio's, hebben het belang van internationale uitwisseling van hun rapportages onderkend door deze ook in een Engelse vertaling uit te brengen.

Gezondheidsrapportages in de EU zijn onderling nog behoorlijk verschillend en vaak ook nog sterk in ontwikkeling. Dit maakt uitwisseling van expertise en ervaringen zowel zinvol als waardevol. Leren van anderen en vergelijking en uitwisseling van informatie zijn wenselijk voor het grote aantal aandachtsgebieden, die van gezamenlijk belang zijn. Een netwerk voor gezondheidsrapportage kan daarbij een platform bieden om gezamenlijke interesses vast te stellen en prioriteiten aan te geven voor uitwisseling van informatie en monitoring ten behoeve van een Europees Public Health beleid. Bundelen van de expertise, zoals aanwezig op deze workshop, kan bijdragen aan het ontstaan van een kritische massa ter stimulering en aansturing van gezondheidsmonitoring en gezondheidsrapportage in de EU.



## **Summary of presentations, discussions and recommendations**

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### **General introduction**

The *High Level Committee on Health*, which advises the European Commission, has, in 1997, installed three special working groups. One of these, Working Group II (WGII: On Health Status), has produced an interim report with recommendations for future priorities for Community health status reporting (Annex 1) and its desired organisational approach. In addition to these recommendations, it was judged by WGII to be very worthwhile, if a meeting would be organised in which policy-relevant reporting expertise, which currently exists in Member States (MS), could be exchanged.

In February 1998 such a Workshop has been organised at the National Institute for Public Health and the Environment (RIVM) in Bilthoven, the Netherlands. The RIVM is the producer of the Dutch Public Health Status and Forecasts (PHSF) reports. Participants in this Workshop were the producers and the users (policy makers) of health reports from various MS, including representatives from a few large regions within MS. Also participating were representatives from the Commission (DG5: F1 and F3, as well as Eurostat), the members of WGII, as well as representatives from OECD and WHO (European region).

Denmark, Finland, the United Kingdom, France, Germany, Sweden and the Netherlands presented national health reports and the roles of these reports in the national processes of health policy making. Some countries presented 'regional' efforts (Northrhine-Westfalia and Catalonia). Other MS (Belgium, Portugal) were represented by their WGII members. Results from two European working groups (among which the earlier mentioned WGII) were presented as well, because these expert groups had focused on important health monitoring and reporting issues for the European Community.

The discussions that were held after the presentations and at the end of the meeting focused on process and products of health reporting efforts and on the effectivity for health policy making in MS itself and in the European Union. The potential roles and importance of international organisations, including the Commission in this area were brought into the discussion as well. The relevance of international comparisons for national health reporting and policy making was also discussed and the participants finally reflected on the potential importance of further exchange of information in this area.

A summary of the workshop proceedings is presented below. Annex 1 contains the earlier presented, slightly modified, interim report by Working Group II. The current report also contains full abstracts of the presentations during the Workshop and a list of names and addresses of Workshop participants (Annex 2). This report is the final product by Working Group II.

### **Summary of Workshop discussions**

Several Member States of the European Community highly value the exchange of information about their national health status, as they have published their public health report, or large summaries of it, in a second language (English). The availability of these reports has greatly eased and stimulated important exchanges of public health information. Still there are hardly any opportunities or fora for such exchanges. It is not surprising therefore, that there was a general feeling of positive excitement among the participants of the Workshop to be able to exchange

their views and experiences. During the presentations and discussions a generally shared feeling emerged that it would be important to keep this network of health report makers and users alive for the benefit of both individual Member States and the Commission. Below you will find an integrated summary of the presentations and discussions that went on during the two days of this Workshop.

### ***European Health Reporting: the product and the process***

Health reporting throughout the EU is, when looking more closely, a rather loosely defined set of activities, often involving the appearance of several public health reports within one country. Large differences are observed between health reports of various Member States and differences even exist between health reports for regions within one country. A number of European national health reports have recently been systematically compared and this comparison was published as an annex to the new Swedish Public Health Report 1997 (see the paper by *Lindberg*).

Some health reports have four-year cycles and are rather comprehensive, others are two-yearly or even yearly products and much less voluminous. Continuity of periodical health reporting is often fully guaranteed but not in all countries. In a number of Member States health reports serve a major government-supportive purpose and the production process is also strongly related to the governmental policy cycle. The desired link between health reports and the policy cycle may on occasion be disturbed as governments undergo rapid and/or substantial political changes. In a few Member States the national health reports are explicitly discussed in Parliament, which may enhance the possibility of arriving at a stable political base for national health policy.

A number of European countries, especially in eastern Europe, receive important support from activities by WHO-Europe in structuring data, indicators and activities within the Health For All 2000 (HFA 2000) framework. For several MS and regions that were present at the workshop it was made explicit that their reports were a follow up to these earlier efforts by WHO.

### ***Variability and similarity in health reporting***

The makers of national health reports most often operate in close contact with their policy makers, with data providers, and with other public health experts. The observed variations in organisation and approach are relatively easily explained by differences in aims and purposes of the reports or by differences in their target audiences.

As a major common point it can be concluded that for most MS there is very much, well-digested, information available on national health, albeit at various levels of abstraction and detail, and with often unknown international comparability. Workshop participants expressed the expectation that the new Health Monitoring Programme of the Commission would be able to enhance comparative, harmonising activities in areas of public health information where analysis and interpretation are lacking or need to be improved.

Many similar or even identical aspects of health status and determinants are discussed in the health reports that were presented at the Workshop. Examples are: developments in male and female life expectancy and in mortality patterns, i.e. for cancers and cardiovascular diseases, in morbidity patterns for chronic diseases and in the prevalence of their risk factors (life style factors, such as smoking, alcohol use and exercise, and endogenous factors, such as blood cholesterol levels and obesity). Other important recurring areas are health promotion and prevention, ageing of the population, accidents and suicide, mental health, AIDS and other (emerging) infectious diseases, abuse of drugs and alcohol, etc.

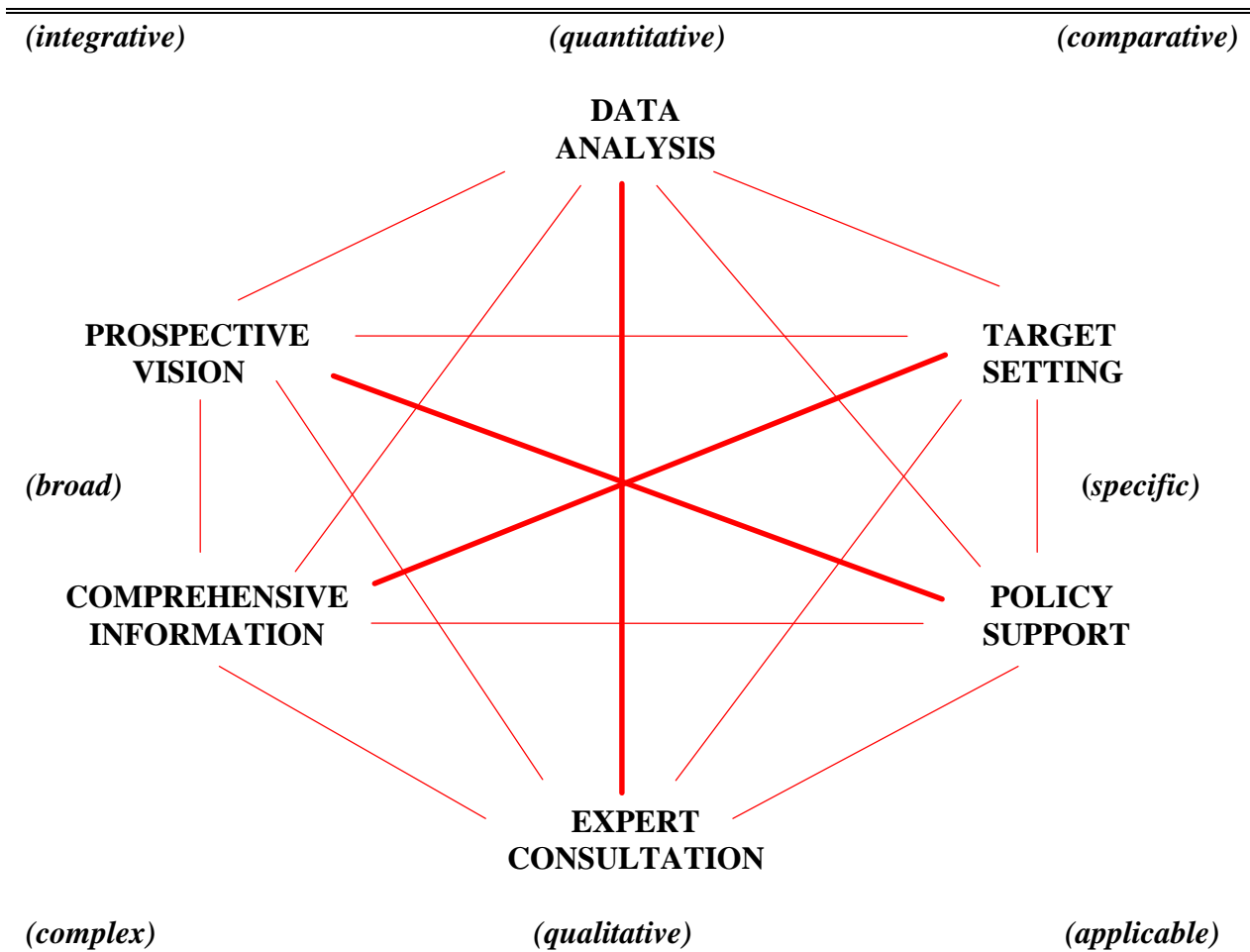
There appears to be a growing awareness of the broader ramifications and importance of health and its determinants, which also includes the possible effects of other policies on health. Apart

from health care policy, social, cultural, economical and environmental policies can all have significant contributions to improvements in health.

A general scheme of health information processing was presented at the Workshop and this can be used to explain how a range of reporting efforts will arise more or less logically, given a defined set of possible policy purposes (see abstract by *Achterberg*). A number of key features appear to be the recurring and essential elements in the processing of information towards policy-supportive health status assessment and reporting.

Figure A provides a multi-dimensional scheme for a number of key features that may be used as dimensions to classify health status reports in Member States of the European Union. Both national and regional health reports are found to be quite variable when judged along these dimensions. In a more general sense Figure A also provides some more general characteristics of the information that is contained in health reports (e.g., being broad, specific, complex, integrative, comparative, practical (applicable), qualitative or quantitative). Finally, Figure A gives interactions that may occur, indicated by dotted lines, e.g. the frequent co-existence of expert consultation with the presence of comprehensive information. Some of these key features, e.g. the inclusion of targets in a report, or the presence of prospective views, can vary between zero (absence) and one, while other dimensions, e.g. the use of expert consultation, are never zero, but may still be largely variable.

**Figure A: Health reporting: multidimensional features**



Finally, some additional variability between health reports is found in the ways that the production processes are organised, e.g. the distance of the organisation from the ministry of health.

The degree of detail of the data and analyses that is presented varies largely between reports, however, from rather qualitative and general analyses to comprehensive tables with incidence, prevalence and mortality by specific causes, age groups and sex and their analysis. In addition large differences are found between national health status reports with regard to the presentation of data on health care use, effectiveness and costs. Often these data were not included, but there appears to be a tendency to include them more systematically into health status reports, especially since policy makers think that these data play an important role in health policy making. A change was furthermore noted from mere 'data driven' reporting to more attention for the 'need to find relevant data' to analyse a particular problem.

### ***Indicators and targets***

The issue of using targets and/or indicators has been touched upon several times during the presentations and discussions, but needs much further and organised discussion. Some countries have elaborate indicator systems, others use targets and yet others have just started processes to arrive at target setting. The Health Monitoring Programme will deal with the development of indicators for the EU, but full MS involvement and commitment appears not to be automatically guaranteed, although it is very essential. The difficulty of existing targets without having appropriate data and indicators has been mentioned as a problem for Spanish regions. We already mentioned the important role that WHO and HFA indicators have (had) in various European countries. The use of health policy targets and/or indicators is not really common yet among MS, but, if present, it appears that having targets is associated with increased commitment by governments and the public health field.

### ***Policy relevance and imbedding***

Although policy-relevance is a key element of health reports in all countries, it was pointed out that for instance substantial changes in government (France, UK) may possibly influence the effectiveness and impact of health reports in a negative way. Health care and financing data are very important for policy makers, but have not always been present in health status reports yet. These data are increasingly getting attention, however, as it is known that large, unexplained, international variations exist in the organisation, volumes and costs of health care. It was stated that for health reports to be effective quick political action is necessary, without a guarantee for quick results, however. Moreover, the horizon of politicians, who are often concerned about quickly rising health budgets, is often (too) close by and desired returns on health policy investments may come too late for a particular health minister.

There are other ways of getting broad commitment for the conclusions and recommendations from health reports. A number of EU countries have involved relatively large groups of experts in the process of health report making. In some MS health reports are explicitly discussed in Parliament. Questions to be answered by health reports are now often generated in close collaboration with the government or with others involved in actual policy implementation (such as regional authorities).

The public health field and the general public currently function more often as important audiences for health status reports besides the government itself. Report makers have started to tailor their output towards these groups and/or have involved them more closely in the production and dissemination process. Several countries are changing their publication strategies

towards a more intensive use of electronic media (CD-ROM, internet publications) for the wider dissemination of their reports and conclusions.

### ***Impact, scientific and political independence***

The actual impact of health reports may be judged by a variety of effects or results (see abstract of the presentation by *Rosén*), all related to the actual use of the report, whether it be that the government has set up specific actions (programmes) in response to the report or the fact that universities use it for teaching purposes.

The scientific (and political) independence of health reporting has come up as an issue of some concern (see abstracts by *Achterberg* and by *Aromaa*). In a number of countries, the production of a health report has been institutionalised by law, which will make it an object of serious scientific and political scrutiny. The coverage of such a law may be extended (as in the Netherlands) by giving the producer of health reports, although part of the government, a legally defined scientific independence from that government.

Broad involvement of experts and others in the field is another way to add to scientific independence and gain both general and political, commitment as well as impact in the public health field.

Several times in the discussion it was noted that health reports may well function to signal a particular problem, but that, most often, several, repeated, signals of a particular problem (sometimes called: the 'law of three') are needed before it will actually reach the political agenda, or get 'big' media attention.

### ***Role of international organisations and the European Commission***

Subsidiarity is important within the Community as a general principle enshrined within the Treaty. This implies that most of the public health related policy responsibilities will remain with the Member States themselves. In addition there appears to be a shift within several MS towards an increase in regional responsibilities for public health. Therefore, the role for the Commission in public health, although growing after the Maastricht and Amsterdam treaties, will remain rather restricted in many areas. Other Community policies, however, may have a direct or indirect impact on health and this will remain an important aspect for the Commission and Member States to consider.

It was stated by participants that it does not appear to be a top-priority of the Commission to improve European health. However, improved exchange and comparison of health information, especially in areas where analysis and interpretation is scarce or lacking, may serve the interests of MS and their regions in some important ways and it is an existing EU priority to improve this exchange of information. This should in the opinion of workshop participants be a major target for the Health Monitoring Programme. Other international organisations and fora (WHO, OECD, G7) may contribute to policy making and stimulate exchange of information, for instance in the economic area, which may then become a major influence on health care financing and therefore on health policy in MS.

### ***Importance of international comparisons***

Several times it has been explicitly noted during the Workshop that international comparisons have given the final push to further investigate and deal with a particular national public health problem. During the discussions it has been noted that specific problems that were identified first in one country do actually also exist in other countries or will almost certainly emerge there in the future. This points at the importance of international comparisons. It was noted, however, in one of the discussions that politicians may not want to know in which area their country is doing

badly. There were counter-arguments heard then, that international comparisons may also be (and actually are) used to indicate positive health differences too. When used in a balanced way, international comparisons will provide a much wider context and a different perspective to national health status analyses and they have much to offer in terms of indicating scopes for improvement, highlighting unnoticed problems and pointing at future trends. In this way international comparison may also serve to inform national target setting.

By its sheer diversity in culture, lifestyle, economic development, age structure of the population and differences in health care organisation and financing, the European Union is in itself a huge 'natural experiment' and therefore also a potential goldmine for comparative health research (e.g. epidemiology) an area which may therefore be stimulated by the Commission. Comparative studies may also take place, and have already taken place, within Community research programmes, such as the coming 5th Framework programme on RTD (DG12). Results from comparative studies will give individual MS, but also the Community as a whole, more insight into existing and expected health trends and early indications for new developments which will prepare them all better for effective action.

### ***Health status reporting and health information systems***

Health reporting efforts in MS are closely related, of course, to health information collection and dissemination. A specific question is whether health reporting may lead to redefining health information systems, i.e. the system of collection of health data. Points made were the chaotic nature of some national information collection systems, which may need re-organisation and the danger (in some well-organised countries) that the existence of good data sources, e.g. cancer registries, would direct attention away from areas for which no good data exist, i.e. mental health. It was emphasised that a recent tendency is observed for health reports not to be fully 'data driven', but that data collection and analysis are more and more driven by the 'need to know'. The Finn's have made the decision, based on the outcomes of a similar discussion, for instance, to start their new public health report not with mortality, i.e. with the best data first, but with functional capacity.

### ***Geographical levels of health policy: international, national, regional***

An important area of differences between MS with regard to health policy and health reporting is related to the geographical level at which health issues are addressed, i.e. at the national or regional level. It appears that in a number of MS both policy implementation as well as health reporting are moving towards the regional level. Denmark and Sweden mention regional policy implementation and the new UK health policy (Our Healthier Nation) will recognise many local, besides a few national, targets. The presence at the Workshop of two large EU regions, i.e. Catalonia (6 million inhabitants) and Northrhine-Westfalia (18 million inhabitants) illustrates the importance of European regions, also because some of these regions cover areas or populations that are larger than some individual Member States.

Some concern was expressed with regard to this regionalisation of health information collection as local policy needs may lead to local data needs and to a subsequent increase in national and international data-chaos and an ever growing lack of comparability. Another problem that was signalled in this respect was that national and regional governments may at one time have different political 'colours' and will therefore adhere to different health targets and have different information needs. This may jeopardise the desired continuity between regional and national health policy and reporting. Finally, it was noted, however, that the regional perspective should be taken into account in further development of European health reports. This will not only allow for more accurate and realistic pictures of health states in Member States, but the further

development of a regional comparative perspective may also contribute to increased availability and harmonisation of national and European health data.

### *Using existing national experience for future European reporting efforts*

It was generally agreed that further exchange of experience between public health report makers in the EU could be very beneficial to both the Community and the Member States. It was not suggested, however, that national reports could be used as building blocks for future EU health reports. A specific Community focus for future Community health status reports was thought necessary, but its desired contents did not immediately emerge in full detail from the discussions. Among the important areas the effects on health of other policies were repeatedly mentioned. It was suggested that EU health reporting should really concentrate on that area as the EC has relatively large competence in these areas and less so in health. The new Finnish health reporting approach and its positioning within the government has led to an apparently much better integration of sectoral policy into general health policy.

In several instances it was pointed out that a clearly recognisable vision from the Commission with regard to the desired contents and purpose of European health status reports was still lacking. This was not only heard from several participants, but also emerged from a more theoretical analysis of the process of effective health report production and health policy making. The desired organisation and approach to European health reporting needs several clear organisational steps, to be taken by the Commission, such as drawing up a plan and agenda for health reporting (see paper by *Achterberg*). Another necessary step would be the organisation of a European facility for health reporting and analysis (see paper by *Aromaa*). It was also stated in the discussion, however, that no money from the Health Monitoring Programme, which has very limited funds to start with, should be diverted to a health observatory. Creating funds for a facility for health reporting and analysis (which may, depending on its form be called a 'Health Observatory') will have to be the responsibility of the European Council and Parliament. Without a clear purpose, well-defined users, a clear agenda and strong MS involvement effective European health reporting will have insufficient impact and European reports will be met by considerable scepticism in the various MS.

### *Some final statements*

It was proposed during the final discussion that the network for health monitoring and reporting that was convened in this Workshop should be continued as a logical and necessary follow up. Commission support should be looked for to shape this group into a **CO**llaborating **HE**alth **RE**porting **NeT**work (COHERENT), which can bring more cohesion into Community health monitoring and reporting. The network should aim at continuing the exchange of MS expertise in health reporting and to further analyse and compare what is going on in this area in MS. A second aim for such a network would be to organise a discussion on the desired development of health monitoring and reporting for the EU and possibly also to support EU activities relating to the definition of health indicators. Other potentially useful activities would be to generate an agenda for health comparisons and forecasts and create overviews of bilateral and also multilateral comparisons for specific aspects of public health and finally to discuss the desired uniform elements of an international paragraph in each national health report. It was strongly suggested by representatives of various MS that funding for continuation of this **COHERENT** network should be sought within the new Health Monitoring Programme of the EC.



# Workshop Summary

**Bilthoven, 19 & 20 February, 1998**

## **Health Reporting in the European Union**

### **ABSTRACTS OF PRESENTATIONS**

#### **Day 1**

#### **HEALTH REPORTS IN EU MEMBER STATES**



## Life expectancy in Denmark and health towards the year 2000

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In 1994 the Life Expectancy Committee (LEC) published their main report: *Life Time in Denmark*. LEC was established because international comparisons showed an unfavourable development of Life Expectancy (LE) in Denmark over a very long period. In 1990 Denmark was close to the bottom of the list among OECD countries with regard to LE.

The purpose of the work of the LEC was to describe and analyse LE and mortality and explain the deviant development of Denmark. The Committee was located within the Ministry of Health. The R & D Institute DICE, acted as scientific secretariat, the department acted as administrative secretariat. The Committee had representatives from a number of scientific institutes.

Initially, LE and mortality were described and analysed for the period 1948 - 1990. Data from WHO, OECD and Danish registers were used. European and international comparisons took place. Danish middle-aged women have up to 60 % excess mortality when compared to women in many European countries. Cancers, cardio-vascular diseases, chronic bronchitis, accidents and suicides generally dominate this excess mortality. Major problems were thus identified leading to in-depth analysis in specialist groups. Unique Danish registers were used in further research. Thirteen specialist reports were published. An explanatory model containing factors such as living conditions, health behaviour and life style, health care system and societal development was applied.

In the main report LEC acknowledges that illnesses and deaths have several simultaneous causes; lifestyle factors, particularly smoking, are important. Some living conditions, among these unemployment, are recognised. Increased social polarisation has been noticed. Health services as well as the health care part of GNP (%) apparently have not contributed to the stagnant LE in Denmark. LEC has recommended intensified health promotion and disease prevention and further research. Political actions were based on a number of the recommendations in the report.

In 1997 DICE (together with a scientific society) organised a follow-up conference on LEC and published a international Public Health Report: *Danish Health towards the year 2000*.

This health status reports mentions the following elements:

<i>Adding years to life</i>	The gap with Norway and Sweden has expanded. Still great problems.
<i>Adding health to life</i>	The goals (more years of living without disease, less longstanding illness in society, better self-reported health) have not been reached yet.
<i>Adding life years</i>	Denmark is slowly moving towards this goal.
<i>Ensuring equity in health</i>	Social inequity seems to have increased. The <i>new</i> social inequity is between those who are on the labour market and those outside.

### Reference

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## Lifetime in Denmark: a health policy issue

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The observation of a stagnating life expectancy in Denmark has over the last decade caused considerable concern. Both men and women have experienced a smaller improvement of life expectancy when compared to other OECD-countries. In 1992 the then Minister of Health appointed a committee to look into the causes of this poor performance. The aim of the report was to provide the information necessary for a meaningful discussion on what measures to take in order to improve Danish life expectancy.

The report made it clear that the poor performance was primarily due to an excess number of deaths among people still in their working ages. The report has also added to the increased awareness of the most important causes of death and how these are related to lifestyle. This increasing awareness has thus lead to the introduction of new disease preventing schemes. The primary focus has been on diseases caused by tobacco and alcohol consumption in addition to unhealthy diets.

Specific actions taken by the government in the area of disease prevention and health promotion include those given below:

<b>Contributing factor</b>	<b>Action taken</b>
Tobacco consumption	Intensified campaigns both nationally and locally. A report on the cost of tobacco consumption to the Danish society is being produced.
Alcohol consumption	Intensified campaigns. Tougher stand on the sale of alcohol to youngster. A report on the cost of alcohol consumption to the Danish society was published in 1997.
Accidents (part. poisoning)	Initiatives to reduce the frequency of medicine poisoning and drug related deaths.
Suicide	The National Board of Health has initiated a program to reduce the frequency of suicide.
Infant mortality	A campaign from the National Board of Health has lead to a remarkable drop in infant mortality caused by the sudden infant death syndrome. The Danish infant mortality is now among the lowest in the European Union.
Long-term unemployment	Improved economic conditions has reduced unemployment. But increased focus on the 80/20 problem.

An additional contributing factor is the female convergence to the male lifestyle. Danish women are thus characterized by a high work participation rate, heavy smoking and a relatively high alcohol consumption. No specific actions have, however, been taken which are aimed solely at women.

Promotion of healthy diets has gained importance. A report was published in 1997 on how to improve diets served in the public meals provision programs and public institutions. A study into children's diets has been initiated by the National Board of Health.

Administrative actions include:

- Increased funding for research in causes of diseases, new methods of health promotion and disease prevention in addition to the evaluation of the effectiveness of the utilized methods.
- A new division in the Ministry of Health with specific responsibilities in health status monitoring and the provision of data on disease prevention has been established.
- The creation of a health promotion register on lifestyle indicators, social conditions, employment situation, living conditions etc. has led to a vast improvement in the possibilities of comprehensive analysis.
- The introduction of compulsory health planning in the counties and municipalities including the making of a health profile of the area.

The initiatives taken since the report on life expectancy in Derunark is covered in the Review on Health Promotion and Disease Prevention published by the Ministry of Health in January 1998. This Review also includes considerations with regard to the health promotion schemes in the years to come. The main focus will be on nutrition to help reduce many of the lifestyle related diseases. Most important are the cardio-vascular diseases, but also the frequency of high blood pressure, diabetes and osteo-arthritis are influenced by dietary factors. Another important area is the promotion of health for the weakest in society.

The Ministry of Health will evaluate the result of the health promotion efforts undertaken in the last decade towards the end of 1998. The improvements in the data gathered in the health promotion register will bring about more comprehensive results than it has been possible till recently. Moreover, the Ministry of Health is considering to revive the Life Expectancy Committee to evaluate the initiatives directly relating to the actions proposed in the original report.



## **Health in Finland 1996: surveying national health**

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Several developments contributed to the process which resulted in the first Finnish national health status report (*Health in Finland 1996*) published in 1997. Evaluation had been an integral part of health policy since the 1960s. There was a long-term research tradition in epidemiology and health services research and Finland had good national statistics and registers.

The 1990s brought about a change from centralised planning and direction to local (municipal) decision making. Management by information is becoming increasingly important. A concise social indicator system was expected both to help the social and health sectors define their own goals and assess their achievements and also to be an aid in the competition for resources. On the national level there were and are several agencies holding relevant data and registers and carrying out research and monitoring. An integrative approach was needed for comprehensive national health monitoring and health reporting.

In 1995 a law was passed calling for the government's Public Health Report to the Parliament to be presented every two years. The legislation was changed in 1997 and as of 1998 the Ministry of Social Affairs and Health presents to the government a Social and Health report every two years. The first and only Public Health Report was published in 1996 and the new report is in preparation in February 1998.

The main basis for the above policy documents are scientific and evaluative reports: 1. *Health in Finland*, 2. Report on social and health services, 3. Report on social security, and other health, health care and health policy relevant reports. The data and information bases shall be updated and the reports themselves repeatedly published. In addition, the Social and Health Report draws information from other Ministries.

### **Information needs**

Health reports should contain policy relevant information about health and its determinants. The latter comprise the physical and social environment and living conditions, behaviour (life styles), health care and related social security, and also health and other policies. The analyses should consider the level of health and its determinants, distribution (equity), trends, future outlook including societal consequences and assess the possibilities for influencing the future.

National statistics and registers as well as national population surveys are the main data sources. Relevant registers, research data and other information is held by e.g. Statistics Finland, The National Research and Development Centre for Welfare and Health (STAKES), The Social Insurance Institution (SII), The Central Pension Institute (CPI), The National Public Health Institute (KTL) and several other organisations. The registers and statistics comprise information on mortality and causes of death, some diseases, occupational diseases and accidents and traffic accidents, hospital discharges, reimbursements for medication, daily sickness allowances, pensions, population census data, sales and consumption, health services and social security, and health care costs. National population health surveys using interviews, mailed questionnaires and health examinations cover many aspects of health, but only some are carried out at regular intervals.

### **Organisation of the work**

The need for comprehensive analysis and reporting on health coincided with a need to develop information systems and social indicators at large. In 1993, an informal group chaired by the

chief official of the Ministry of Social Affairs and Health started a series of meetings to develop social indicators and reporting in the fields of health, health and social services, and income security. Experts came from the Ministry, national research agencies, the Social Insurance Institution, and the University. The KTL was responsible for the health report. Two group members drew up the plan, initiated compilation of data and information and created a network of about 70 experts who wrote drafts and/or final texts. All holders of national data contributed.

### **Health in Finland 1996**

The first national health report contains information and analyses on health determinants, the level of health, the distribution of health, past and future developments and public health impact. It contains international comparisons. The health determinants considered are population, living conditions, natural environment, living habits and risk factors. The comprehensive health section is divided into three main parts: (a) Mortality, morbidity and functional ability, (b) The most important diseases, disorders and other health problems, and (c) Health in some population groups. A section on health services and related social security is followed by a summary of the population's health and its determinants. Some of the main end-conclusions are:

- the ageing population needs more care, high priority should be given to improvement of the ageing population's functional and work ability and more rehabilitation is needed,
- preventive efforts should be more comprehensive, they should be focussed on health threatening lifestyles, and on the control of growing health problems,
- health inequalities should be reduced,
- access to health care should be further improved and the current high quality health and social services and the universal social security should be retained, and
- a comprehensive health information system should be developed.

### **Proposals for the future**

The system of information gathering should be improved to obtain comprehensive and relevant information at suitable intervals. An outline has been developed. In addition to the present contents the scientific and evaluative health reports should contain regularly updated information also on healthy and disability free life-expectancy, systematic forecasts and estimates of future trends, estimates of public health impact and societal costs of the major health problems, and policy relevant assessments of the feasibility and consequences of alternative health policies. The reporting process should be improved using current information technology. Main products being:

- (1) comprehensive relevant data updated yearly
- (2) a national health report at an interval of 2 to 4 years,
- (3) regular updates to the above and occasional special reports and
- (4) data, statistics and reports in electronic form

In addition to national analysis and reporting new processes and products should be developed for the benefit of local, regional and other users. Plans for these developments have been drafted.

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## Public Health Reports in Finland as Policy Tools

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### The 1996 Public Health Report

The 1996 Public Health Report was initiated by the Parliament, compiled by a task force and promoted by the Ministry of Social Affairs and Health. It contained a description of the health situation in Finland and of recent policies as well as a section for future challenges. This Public Health Report was backed by two other health reports: the Health of Finns (a comprehensive health status report by the National Public Health Institute) and the Overview of Social and Health Services (by STAKES). These were completed on the basis of agreements between the institutions and the Ministry of Social Affairs and Health. The Report was based on a special act on public health reporting (1238/95) which envisaged a public health report every two years. The aim of the act was to discontinue previous regular reports on alcohol and alcohol-related harm which were considered to be too narrow in their scope.

The Report was not the first health policy review in Finland, but a logical continuation of health policies. Health policy got strong backing in 1972 with the Primary Health Care Act. At the same time the prevention of cardiovascular disease was a very topical issue. In 1977, health policy was strengthened by a pioneering, comprehensive Tobacco Control Act which also signalled the start of more emphasis on health promotion. The development continued in 1978 with the Occupational Health Care Act. In 1985, the national health policy was codified in a national Health for All programme which was subsequently revised six years later.

### The purpose

The purpose of the Public Health Report was to give a compact overview of

- development of public health at the beginning of the 90s (prerequisites for and actual state of health of the Finns)
- main lines of the health policy
- health promotion action by different branches of administration, and
- major health challenges and trends

The Report did not intend to cover all aspects of health but to highlight the principal challenges and potentials in the foreseeable future. The aim of the Report was also to evaluate the impact of different measures and explore possibilities for the future health policy. Because of the history of the Report, it was to draw special attention to the development of alcohol situation.

The Report was intended to be a new instrument in promoting the discussion about health policy. In order to do so, it included success stories and challenges. The impact of other policies on health, which at the beginning was only one of the tracks in the Report, got more and more visibility during its preparation. Equity (equality) in health was identified as a key challenge already at the time of the preparations for the Report. This issue was closely related to an analysis social determinants of and the impact of the economic recession (1991-1993) on health. Finland's new membership in the European Union led to a specific question: what are prerequisites for a national health policy in an integrating Europe.

### The process

The Ministry of Social Affairs and Health appointed a task force that consisted of representatives of all ministries (except the Ministry of Foreign Affairs). The previously mentioned two

background reports were used as a basis for the descriptive health status part of the Report. All ministries provided a description of their policies and action that they considered to have had an impact on health. The Ministry of Social Affairs and Health drafted the section on future challenges.

The whole Report was approved by the task force. After a minor finalization it was submitted to the Cabinet (State Council) which in turn submitted to the Parliament for political discussion. Copies of the Report were distributed to municipalities, professional groups and non-governmental organisations. For administrative reasons, the task was given to the task force at a very short notice and it had only three months to complete its task.

### **Major messages**

The Report identified *six areas* in which future challenges for health policy should be met:

1. Promotion of equity in health
2. Promotion of health of the young
3. Improving the functional capacity of the population
4. Development of the service system
5. Co-ordination of the national health policy
6. Strengthening of the international operations

However, the main message turned out to be the involvement of other ministries in the work. The enthusiasm of other ministries actually caused that their contribution to the Report was not cut as much as was initially planned. The task force did not only passively receive contributions from different ministries but also actively pointed out issues that should be discussed.

### **Policy impact - expected and achieved**

At the time of the completion and dissemination of the Report several consequences were predicted:

1. The duration of the policy impact of the Report was expected to be 2-4 years, or until the end of the century and of the political term of the Cabinet. This proved to be too optimistic. The Report was not the first of its kind. The policy environment is also changing very fast.
2. An intensive discussion took place, as expected, at the Parliament's social and health committee. In addition, the Report was analysed and debated by various professional groups and non-governmental organisations active in the field of public health. The promotion of the Report was not as intensive as it could have been. However, an unpredicted use of the Report has been its popularity in different educational institutions. As the Report is concise and cheap, it has been introduced as learning material in many schools teaching public health .
3. The Report was believed to help to put health policy more visibly onto the political agenda. This was partly achieved but the official and non-controversial style of the Report did not fuel heated debate, especially as there has been a decade long consensus on the basic health policy in Finland.
4. The Report was a new means of guidance for municipalities. The Report also advocated local public health reports. Indeed, the Association of Municipalities ran a series of seminars based on the idea. Management by information cannot of course rely on one report but the guidance is created by a multitude of messages, studies and reports.
5. The Report was to describe the state of public health and health services for use at many levels. Regional and social differences in health were also highlighted. This was undoubtedly achieved.
6. The Report was to be a tool for municipalities and other actors. The popularity of the Report proves that it has been useful.

There was an interesting aftermath in relation to public health reporting. As a part of the rationalisation of policy reporting of the Finnish Government it was proposed that all separate reports, including the public health report, should be discontinued. However, the Parliament insisted on getting a report regularly. Therefore at the end of 1997 the Parliament enacted a new law that mandates a report on social welfare and health to be drawn up every two years. The new report is a logical continuation of public health reporting in Finland, which started in 1985:

1985 Public health policy report

1986 National Health for All policy

1993 Revised national Health for All policy

1996 Public health report

**1998 Report on social welfare and health**

Until 1992 there was also a regular report on alcohol and related harm. It was replaced by the public health report in 1996. The public health report will in 1998 be replaced by an even wider report on social protection.

### **Conclusions**

1. The Public Health Report was not an epidemiological or scientific report but a policy document supported by epidemiological and scientific efforts.
2. The Report was not a one-off effort but a part in a chain of policy developments.
3. In a stable policy situation, without a crisis, any policy report can only enhance the existing trends and policies.
4. The main significance of the Report proved to be the involvement of other sectors in its preparation. The Public Health Report highlighted the health impact of other policies than health policy. This was partly a consequence of the European Union's interest in the issue but also enforced by the Union's action.
5. Selection of the broad areas of challenges is vital. Broad concepts may influence the politics in the longer run much more than narrow issues.
6. Tackling the equity in health is difficult.
7. In an information society, any message or report must be systematically promoted or marketed.

In 1997, there were discussions in Finland on how to produce the 1998 public health report as it would not be useful to repeat the 1996 exercise. The two possibilities suggested were to

- concentrate on health forecasts; or
- base the report on international comparisons.

However, the political developments led to broadening the scope of the report to include social welfare. An other development in the 1998 report will be that the contribution of other sectors will not be presented as a separate section but integrated under common subtitles.



## Health reporting in England: a national perspective

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### Introduction

A wide range of mechanisms exist in England (and Wales, Scotland, etc.) for the reporting of health status. Each has its own purpose, objectives and target audience. The presentation of health status information figures most importantly in the context of the *Health Survey for England*, in the *Chief Medical Officer's annual report* and in various publications associated with the now former health strategy: *Health of the Nation* and recently with the present health strategy, which is called: ***Our Healthier Nation***.

A key message is that output must be "tailored" to its target audience. For example the results of the *Health Survey for England* are being made available via a popular summary, via the Internet and on CD-rom, as well as in a large published volume. Another key message from the Health Survey is that if policy makers can be involved in the planning stages they are then likely to gain maximum value from the output. The *Chief Medical Officer's annual report* (yearly, since 1858) is intended to act as a catalyst for policy development as well as to provide a simple description of the current state of health. Areas of concern have in recent years been identified explicitly and progress reviewed in subsequent reports.

In Summary: Health status assessment has been a central element of each stage of development of the English health strategy - planning, formulation, implementation, monitoring and evaluation.

### Conclusions

From English health status assessment and reporting it may be concluded that:

- available information can and should be exploited
- output should be tailored to its target audience
- graphical output often gets messages across more effectively than text
- international data provide a *wider context* and a *different perspective*
- *repeat* assessments give substantial added value
- users should be involved throughout the process wherever possible
- reporting on health status is a means to an end and not an end in itself

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## **Health reporting: policy issues in the UK**

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*No abstract available; short summary by workshop organisers*

Functions of health reports were discussed from the viewpoints of politicians and governments. Health reports may become the bringers of bad news or function to signal problems which cannot be tackled in the short run, which however is politically the most realistic one. The other extreme may occur too, i.e. health reports may be used by politicians to give the impression that a particular problem is already being addressed. Keeping a good balance between good and bad messages is essential, as is timing. Political instability may be a major cause of lack of impact of health reports. Politicians are also very interested in additional information, of which information about the financial costs of health care are very important.

## Health in France: goals, approach and results

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### Introduction and positioning

Health reporting in France is not assigned to an institution but to the Haut Comité de la Santé Publique, an advisory council for the Ministry of Health. The first report (*La Santé en France*) was published in 1994. A second, interim, report was launched in 1996. A three-year frequency of publication has been adopted since.

### Methods and process

The 1994 report contains two parts: the *health report*, which is a synthesis of specific reports from 8 working groups and the *health goals* issued result from a DELPHI-type survey among 100 consulted experts. The 8 specific reports were also published in full detail in a second volume. A (perceived) health survey in the general population was undertaken (phone interview) and its results were included in the first health report.

### Contents

Items and health indicators were proposed by 5 working groups: life expectation, health quality, frequent diseases, health of specific population groups and health determinants. The other specific reports dealt with health concepts and their social construction, health monitoring and information, health care use and costs. In part two, fourteen specific goals were proposed for priority health problems and four specific goals for health determinants with priority.

### Main Messages

A challenge for public health will be:

- to reduce premature morbidity and mortality,
- to improve care for chronic diseases and handicaps,
- to reduce health inequalities,
- health costs make health choices necessary,
- health priorities to be proposed to the population and its representatives.

### Future reports

- Developing comparative work at international, national and regional levels
- Emphasis on trends and forecasting.

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## **Health in France: the 1994 General Report. Its Use for the French Government**

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### **Introduction**

The 1994 report "Health in France" was used by four successive governments. It remains in fact essentially a common reference for many people involved in public health.

The purpose, from the principal user's point of view, namely the General Directorate of Health, was not only to analyse the nation's health, but also to set priorities and objectives for a national health policy. It is the reason why Part 11 of the report, which contains the proposed targets and indicators and the proposals for implementing the public health approach, was achieved in close collaboration between the High Commission of Public Health (HCSP) and the Ministry of Health Services.

### **The process and methods**

About 300 experts and decision-makers were brought together to develop the report. This kind of collaboration had probably a great importance for further use of the report.

This target approach was clearly influenced by the W.H.O "Health for All" targets, by the report "Politique de la santé et du bien être" from Québec and by the English report "The Health of the Nation".

The main principles of the process were to place population health at the center of concern, to involve policy makers and actors in the health system in identification of problems and solutions, and finally to initiate a debate that could lead to the adoption of a national framework for health policy.

Four major messages captured the policy maker's attention in my opinion:

- Good news : the health status in France is rather good if compared with other european countries and it is particularly true for women and elderly.
- France suffers from an excess of premature mortality namely in men. The determinants of which are well known, but rather neglected.
- Health inequalities are very important between men and women, between social groups and between regions.
- The medical care sytem is not the health system and a copernician revolution is necessary to give priority to public health as health of the population and also as an organisational and ethical approach.

This last affirmation is now commonplace, even among medical-care professionals; all inferences have, however, not yet been drawn from it.

### **Effects and impact**

The theoretical way for a report to impact the national health policy is very simple. The High Comission for Public Health edits a report. The report is given to the Minister (who is also the President of the Comission). The Minister includes all those very interesting propositions in its health policy. On the basis of this policy the health administration gives instructions to all

institutes concerned. And the institutions of course, put immediately those instructions into action.

In reality, things have been quite different. The direct effects of the report on the health policy were at first time rather light. One of the major impacts of the report has been in fact cultural through the progressive integration of its main messages in the mind of numerous key actors of the health system. The second way was not through a public health law, as requested by the report, but by including important propositions of the report in the social security reform two years later. This reform created new structures for policy making.

### **Health policy**

At the national level a national health conference, composed by representatives of health institutes, professionals and users, advises the government and the parliament on the priorities of health policy. Each year the parliament now votes, not only on the budget for social security, but also on the framework for health policy. At the regional level, regional health conferences are committed to set regional priorities and a partnership is implemented within regional health programs. The priorities proposed by the report are now widely shared, namely by the national health conference and the regional health conferences. It is interesting to consider that the corresponding targets have, however, never been adopted formally. Year after year more importance is given to health promotion by increasing financing with special attention for smoking and alcohol consumption. Changes are occurring in health data collection systems with more importance given to health priorities and prevention. A regional network is to be created to improve data collection at this level. Finally, inequalities in health have been for the past two year and continue to be an important topic in health agendas.

In conclusion, the users of the 1994 report on health in France get probably more than what they first expected and this is most likely because the report became an essential common reference. The report is, however, not perfect and three public health issues were not properly explored. Economic aspects of health and care organisation were superficially studied. Important issues of health protection and safety were also missed.



## Health Reporting in Germany

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### Main objectives of Health Reporting in Germany

The main objectives are: to collect and distribute information on:

- the health of German population or population groups
- the influence of life-style, environment and social situation on health
- prevalence and impact of diseases
- facilities and utilisation of health care
- costs, expenditures and resources of health care, in order to provide a scientific basis for an active Public Health policy.

### Federal Health Reporting at present

With the financial support by the Federal Ministry of Education and Research and the Federal Ministry of Health a German Health Reporting System under the leadership of the Federal Statistical Office was initiated. The conceptual framework dealt with the following questions:

- What topics are to be covered by the report (rating criteria: public health relevance, time course dynamics, complexity, scientific consensus)?
- Which structure of chapters is favourable?
- Who should write the chapters of the health reports?

Accordingly, about 100 topics were identified. Each topic (chapter) should contain a comprehensive and action-orientated overview, written by an expert in the field. The experts were selected by ratings of their proposals after a 'call-for-papers' published in relevant journals. A scientific committee supervised this process of health reporting. In mid-1998 three main products of the Research Project "Federal Health Reporting" will be available:

- Basic Health Report (100 topics, 600 pages)
- Health Information System, offering health data via the Internet to users
- Special report about *allergies*.

### Federal Health Reporting in the Future

German health reporting has a pluralistic approach. For Health Reporting on a routine basis the responsibility for *Federal* Health Reporting has been transferred to the Robert Koch Institute (Berlin). One of the main partners is the Centre for Information and Documentation of Health Data at the Federal Statistical office. Funding is provided by the Federal Ministry of Health.

Next steps to be taken by RKI are:

- Evaluate of the first federal health report using feedback from the target groups or users
- Organise regular workshops to promote the comparability with the health reports from the "Länder" and also at the European level
- Continuous up-date of the report including new developments in science and public health
- Modify data collection to serve the information needs of health reporting and its users
- Develop procedures to improve the use of administrative data, especially regarding outpatient health care service
- Use information technology to facilitate cost-effective distribution of health data and reports.

## **A regional German Health Report: Nordrhein-Westfalen (NRW)**

### **Birgit Wehrauch**

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The process of health reporting in NRW started in 1986 when the NRW Ministry of Employment, Health and Social Affairs commissioned the NRW State Institute (former 'IDIS', now 'LÖGD': State Institute of Public Health) to develop health reporting and a first pilot report. In 1990 and 1994 NRW health reports were published with a comprehensive approach. The structure was as follows: health status and quality of life, health risks, health protection, health care, health institutions and health expenditure and financing.

Important principles of NRW health reporting were right from the beginning:

- the health political relevance of the subject
- the evaluation of the data situation, and
- the involvement of expert knowledge

The concept of the health report system in Northrhine-Westphalia was building on a process that involved actors from different fields.

At the beginning of the nineties, the data basis was not yet satisfactory. This has improved much after 1991 when the 16 German Länder had agreed on the first common (core) indicator set (11 categories, 140 indicators). More than 200 indicators have been built up since then in NRW and they are provided on the internet since 1997.

In recent years, in addition to the above-mentioned NRW health reports, series of nine volumes have been developed in connection with the implementation of the indicator set of the German Länder as well as some reports on specific subjects (e.g. health promotion, children's health).

NRW has also during the last years supported the development of health reporting on the local level and been involved in different international projects on health information, one official of the Ministry now being one of the two German representatives in the commission that is accompanying the implementation of the EU Health Monitoring Programme.

To integrate health reporting into health policy and in this way promote the process of evidence-based policy, the NRW State Health Conference was set up in 1991, involving all relevant partners of the NRW health system. With the project on 'Local Coordination of the Health and Social Care' a comparable process implying the setting up of Local Health Conferences has been initiated in 27 out of 54 cities and counties.

The recently passed NRW law on public health services has made health reporting a duty task for the land NRW and the local level - involving parliament/county council. This law also stipulates the establishment of the State Health Conference and the Local Health Conferences in all 54 cities and counties. Keeping the process of health reporting flexible and adjustable to the health political developments we are right now in the discussion process of further development of our concept. E.g. the European integration process and the question of compatibility of the further development on all levels, the integration of new techniques and methods but also the running process of target setting in health policy are to be considered in this context.

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## Sweden's Public Health Report 1997

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### Introduction and positioning

Sweden's Public Health Report 1997 is the fourth in the series of national reports on public health commissioned by the Swedish government. It was produced by the National Board of Health and Welfare, which reports to Parliament and the Government. The Board compiles information for Parliament and the Government, but also for other national and regional authorities and employers of nursing and care professionals and for a large group of other organisations and persons. The Swedish public health report is intended to give an up-to-date overview of how health problems and risk factors for ill health are changing over time in different sectors of the population and to analyse possible causes of these changes. The aim is for the report to serve as a basis for discussion of future health policy in Sweden and to identify population groups with serious health problems. The next public health report is scheduled for spring 2001.

### Methods

The report was produced by a project group at the Centre for Epidemiology of the National Board of Health and Welfare in collaboration with a special editorial committee. Special material for the report was produced by a number of experts, and three background documents were specially written:

- Hur görs folkhälsorapporter i Europa? (What do public health reports in Europe contain?)
- Konsekvenser av ohälsa för sociala kontakter och ekonomiska resurser (The consequences of ill health for social contact and economic resources)
- Hur påverkar biologiska och sociala förhållanden tidigt i livet hälsan i vuxen ålder? (How do biological and social circumstances in early life affect health in adults?)

There has been collaboration with the National Institute of Public Health regarding a large number of questions.

The strategy for dissemination included copies to certain important target groups such as the Cabinet Office, the Minister of Health and Social Affairs and a few other members of the government, the Standing Committee on Social Questions and the Standing Committee of Social Insurance and to other concerned authorities. A four-colour folder was produced for use at relevant conferences and the like and a simpler sales letter was mailed to many different groups of interest. A special sales letter was sent to members of the Riksdag (Parliament). Articles were published in different periodicals. A summary of the report is on the Board's web site. A press conference was held when the report was published. Several speeches were, and are being, given to many different kinds of audience. An information poster on the report is being made for use at conferences and exhibitions. Finally, the report has been translated into English.

### Criteria for inclusion of material

The ambition was to analyse health and well-being in general as well as major public health problems. What are considered as diseases causing major problems at national level varies among countries and cultures and over time. Whether a health problem should be considered as major is connected with how common it is, its degree of severity, whether it is on the increase or declining and how it is distributed among various population groups. The consequences for individuals and the community, and the opportunities of doing something about the problem, must also be considered.

In Swedish national public-health reports, primarily six groups of condition have been considered as major health problems: cardiovascular diseases, mental ill health, tumours, diseases of the locomotive organs, injuries and allergies. In addition, dental health, certain infectious diseases and certain other health problems, varying between reports, have been treated in more detail in some years.

Sweden has unique opportunities of conducting epidemiological research and following the health circumstances of the population thanks to our long tradition of population registers and our PIN numbering which make it possible to follow up the effects of different exposures. We sought to use mainly data from national registers, including survey data, but also research and other kinds of investigatory work that serve to elucidate the topics described. The analyses required data not only on the development of health and health problems but also on social conditions and determinants of health.

No evaluation is as yet planned for the 1997 report. The 1994 report was evaluated by an independent researcher commissioned by the producer.

### **Contents**

The report covers health status, mortality and length of life in general, major health problems (see above), their frequency and development in the population as a whole and in different population categories. Data sources were national and other registers, surveys, research and investigations. Determinants of health such as social conditions, habits of life, work environment, physical environment (in- and outdoor), and the contribution of medical care to public health are treated. Data sources were national and other registers, surveys, research and investigations. Use and cost of health care are not covered except for "Care on equal terms?" The direct effects of prevention and health care are covered only marginally, but the contribution of medical care to the peoples health is outlined in one chapter. Health monitoring and health information needs are briefly commented on in a chapter on the need for data and research. The difficulties in following up children's physical and mental health as well as risk factors for various large health problems at national level are examples pointed out. No suggestions or options for health policy are given. Prospective views are discussed only in the form of possible major trends considering today's conditions.

### **Conclusions**

#### *Main summary message and general message*

Swedes are healthier and are living longer, but this does not apply to everyone to the same extent. Social differences in health remain large and are tending to increase among women though decreasing among men. More and more people experience anxiety and have other mental trouble, which may be because social change and unemployment generate increased insecurity. Risk factors and social problems tend to accumulate throughout life and more so in lower social groups. Thus, in a vicious spiral, the risk of ill health in these groups is gradually increasing.

#### *Aspects of public health policy*

Important target groups for the report are politicians at national and regional levels and organisations and authorities in various sectors of society whose decisions may affect the preconditions for the development of the people's health.

Better possibilities to make international comparisons would certainly add to the quality of future reports. Today little more than causes of death and length of life can with reasonable quality be compared between countries. Comparable measures of morbidity and of all kinds of health risk are desirable as are measures of social background variables. But it is also important not only to

compare one parameter at a time between countries, but to consider their overall situations and to analyse health outcomes on this basis. The next report, which will be published in spring 2001, will follow up most of the topics covered by the present one. There are no conclusions on international comparisons and European policy.

*Feedback to those who ordered the report*

Partly as a consequence of the Public Health Report 1994, a National Public Health Commission was set up. Its terms of reference include deciding on national public health targets. The commission is using Sweden's Public Health Report 1997 as a starting-point for its work. Later on, public health reports will be a forum for following-up on national targets.

**Reference**

*Sweden's Public Health Report 1997*. Socialstyrelsen; EPC, Stockholm. 1998



## **The Health Plan for Catalonia. The view from the report producers**

**Emilia Sanchez**

*Health Plan and Evaluation Unit, Catalan Health Service, Barcelona, Spain.*

Catalonia is a region with six-million-inhabitants, located in northeast Spain which holds health responsibilities since 1981. After the Spanish General Health Law and the Catalan Health Reorganisation Act (LOSC) were passed in 1990 the Catalan Health Service (CHS) was created, which is a body with a role in health planning, funding and purchasing health services and the conditions for the formulation of the Health Plan for Catalonia were established.

The Health Plan for Catalonia (HPC) is the guiding instrument and the reference framework for all public actions in the health sector in Catalonia. It defines policies on health and services and involves several different sectors. The LOSC set the lifetime of the HPC at three years. The first HPC covered the period 1993-1995 and currently the 1996-1998 Health Plan is in force. The HPC is based on a positive approach to the concept of health and incorporates the principles of the LOSC and the targets of the WHO's *Health for All by the Year 2000* strategy. Therefore, the interventions and operational targets that are proposed are based on health promotion and disease prevention; equity, efficiency and quality of the services, and users' satisfaction.

The health planning process in Catalonia is decentralised. The HPC incorporates the drafts of the health plans for the eight health regions which Catalonia, for health administrative purposes, is divided in. Such a characteristic is aimed to improve the quality of both planning process and outcome, allow for the identification of territorial-specific features, enhance the development of interventions, and assure the participation of health professionals and, to some extent, the citizens. The process begins with the analysis of the health situation, its determining factors and the relevant services; it goes on to identify priority problems and to define targets and interventions, and finally proposes the evaluation of the targets achievement. A wide range of health professionals, including doctors, nurses, social workers, health economists, etc., from different levels of care and with some experts leading the working groups, have been involved in the identification of health problems and the design of interventions. The final report has been submitted for approval to the Catalan Government to be passed by the Parliament of Catalonia.

The current HPC covers the following areas:

- Evaluation of the 1993-1995 period
- Health of the population: health status and determinants of health based on the analysis of demographic and epidemiological data as well as the Catalan Health Survey (ESCA94)
- Priority interventions: healthy lifestyles; health problems (22); use of medicines; users' satisfaction
- Strategies for developing health policies and services
- Operational targets and evaluation

The HPC has proven to be a good tool to establish priorities and to distribute the resources of the publicly financed health system in Catalonia in a more efficient and equitable way. Moreover, its messages can be found in the contracts for purchasing services and in health professionals' daily practice. However, some of its contents make the incorporation of the HPC at hospital level quite difficult. Finally, implementation and evaluation of the proposals have to face the limitations derived from the short lifetime of the health plan.

### **Reference**

*Health plan for Catalonia: 1993-1995.* Generalitat de Catalunya. Departament de Sanitat I Seguritat Social. Barcelona, 1993.

## **Health Reports in Spain: critical considerations from a users point of view**

**Rosa Gispert**

*Institutie of Health Studies, Barcelona, Spain*

The aim of this presentation is to discuss the advantages and limitations of health reports from the user's point of view. Three main uses have been identified: ***Health Policy, Public Health and Planning, Research.***

In the field of health policy, results of a review of all the regional health reports elaborated in Spain are currently available. The formulation of these documents has been widely influenced by the adherence of Spain to the "2000 Health for All Strategy" of the WHO. The Spanish General Health Law defined the structure and content of an "Integrated Health Plan" at national level and established the development of regional health plans. Although some limitations can be identified, the process has contributed positively to introduce the public health perspective into the political framework.

In the area of Public Health and Planing some of the contributions and limitations of the Catalan health plan have been analyzed in more detail. The collaborative (huge participation) process of its development is one of its more successful achievements. The large number of targets, its uncertain epidemiological basis, the lack of well-defined indicators and the unclarity of ist conclusions with regard to desired interventions are some of the challenges for further, future development. The problems that have been encountered might hinder its full implementation and evaluation and could discourage the health professionals.

From the point of view of evaluation and research the positive consequences of the health plan are the increase of health data sources and the introduction of continuing education activities related to health targets. The main shortcomings, however, are: the ambiguous health policy, the lack of available or comparable data in some important areas and the still weak relationship between targets, interventions and indicators.

Some conclusions arise from this critical review. Different requirements for a health report exist at different levels of use, but there are also some common aspects. These are: the need of a comprehensive analysis of health status, of comparability of data, of few but relevant health problems that are prioritized and the need to define useful interventions to face those problems.

From these conclusions we can see that the relevance of a future European health report will depend on its ability to put together a picture of the health status of the EU and its regions, to define priority areas in which the European perspective is an added value to the national ones and to promote effective, evidence-based interventions that could be practically evaluated.

## **The Dutch Public Health Status and Forecasts report 1997**

**Pieter Kramers, Dirk Ruwaard**

*Dept. for Public Health Forecasting, National Institute of Public Health and the Environment (RIVM), Bilthoven, the Netherlands.*

### **Introduction**

The general objective of the Dutch Public Health Status and Forecasts (PHSF) project is *to provide an overview and analysis of the available data in the field of public health, once every four years, with explicit identification of any gaps in the information supply.* Thus PHSF intends to contribute to the realization of 'Evidence-Based Policy' in the Netherlands. This means that, in the policy cycle of the Ministry of Health, Welfare and Sport, PHSF provides the basic information for use in the *evaluation* of current policy and in the *preparation* of new health policy. PHSF is prepared by many national experts, at the National Institute of Public Health and the Environment (RIVM) in a joint effort. The RIVM is the scientific institute supporting the Ministry of Health. In an alternating four-year cycle, the Ministry compiles a policy document which sets out the broad principles and goals of health policy.

PHSF-1997 builds on the knowledge that was presented in the first (1993) PHSF report (English translation of the summary: 1994). In this first report the following questions were addressed: How healthy or unhealthy are people living in the Netherlands? What are the reasons for this? How is the situation developing over time? and: How does all this tie together? Considerable use has been made of information derived from PHSF 1993 in drawing up the policy document *Healthy and Sound*, which was published in Dutch in 1995 (English translation: 1996).

### **PHSF 1997**

In accordance with the wishes of the Ministry, and based on the results of an evaluation of PHSF 1993, the general objectives for PHSF 1997 have been defined as (1) a general update of the figures given in PHSF 1993 and an improvement of the attempts at forecasting, and (2) the addition of five specific themes, i.e. : health inequalities, composite measures of public health, effects of prevention and of health care interventions, and the consequences of health status for health care consumption.

The thematic approach of PHSF 1997 has been implemented by closely involving the Dutch scientific community. To this end, Expertise Groups have been set up for each of the themes. A Consultant Group was appointed to ensure that the work on the various themes was soundly interconnected. More than 250 experts have contributed to investigations and papers under each of the themes. For every theme, a separate 'theme report' was published (in Dutch). Thus, PHSF can be considered a 'National Effort'. The summary report 'Health, Prevention and Health Care in the Netherlands until 2015' will be available in English in the summer of 1998.

The key message of PHSF 1997 covers five areas of actual findings:

(1) life expectancy, (2) quality of life, (3) inequalities in health, (4) developments in health services use, and (5) health gains, to be attained by health care and prevention. On the basis of the findings recommendations were made on (a) the planning (and funding) of health care services, activities in (b) prevention and (c) the health care sector, (d) initiatives towards specific target groups and (e) in monitoring and research.

### **Short summary of findings of PHSF 1997**

In 1994 *life expectancy* was 74.6 years for Dutch men and 80.3 years for women, and it is still increasing. There is a gradual reduction however in the difference in life expectancy between men and women, from 6.7 years in 1980 to an expected 4.2 years in 2015. The developments in life

expectancy are mainly due to a continuing decrease in mortality by ischemic heart disease and stroke. Mortality due to lung cancer has declined for men but has increased for women.

What about *quality of life*? According to the calculations for 1994, both men and women enjoy a health expectancy (expectation of healthy years) of about 60 years. For their remaining years (more than 14 for men and 20 for women), they will suffer impaired health. Over the period 1983–1994, the improvement in male life expectancy was accompanied by an increase in the number of healthy years. This was not the same, however, for women. With a correction for the severity of the ill-health, the ratio between healthy and health-impaired years has remained more or less constant, but the trend has been more favourable for men than for women. Of the groups of diseases and disorders that were covered in PHSF, the main causes of health impairment (calculated as the years lived with disabilities according to the DALY approach) are chronic physical disorders, such as sensory disorders (sight and hearing), chronic lung disease, diabetes mellitus, and disorders of the locomotor system (arthrosis and rheumatoid arthritis), which account for around 40% of health impairments, and mental disorders such as depression, anxiety disorders, alcohol dependence, and dementia, which also account for almost 40% of the total.

*Health inequalities are not declining.* The greatest disparities between population groups are based on differences in socio-economic status (measured on the basis of education, income and occupational status). People in the Netherlands with a low educational level die, on average, 3.5 years earlier and have almost 12 years less in good health than people with higher education. Health inequalities based on socio-economic status are not declining, and in some respects they have actually increased. However, health inequalities are not restricted to groups with lower socio-economic status. We have to remain alert to avoid a further increase in the extent of health inequalities, since most of the population groups that now suffer a health deficit, such as ethnic minorities, divorcees, the aged and those living alone, are expected to increase in size more rapidly than the general population. These health deficits are partly due to the greater prevalence of risk factors in these groups, such as smoking, immoderate alcohol consumption, lower intake of fruit and vegetables, less participation in sports, hypertension, unfavourable serum cholesterol levels and obesity. People in these groups also suffer more psychosocial stress, and some aspects of their living and working conditions and their access to health care and prevention are less favourable as well.

*More and different health care will be necessary in the future.* The expected rise in the number of cases of diseases by the year 2015, taking only population growth and ageing of the population into account, will not only necessitate more health care, but also large shifts within the health care system (both within and between health care facilities) in order to maintain the level of health care at the 1994 level. Because of these demographic developments and assuming a continuation of past trends in other aspects, an annual growth in the volume of Dutch health care of about 2.1% will be required (irrespective of the question whether the current volume of health care can be regarded as adequate). In 1994 about 60 billion guilders went into Dutch health care. Of this, about 23% was spent on mental disorders (including mental retardation and dementia) and more than 10% on cardiovascular diseases. Of the various health care sectors, the most important contributors to the total costs were hospital care (about 32%), care for the elderly (18%) and primary health care (more than 16%). These areas are supplemented with a large amount of informal health care which, however, cannot be quantified in detail.

*There is a considerable potential for improved health through prevention.* In recent decades considerable health improvements have been achieved by prevention, mainly through vaccinations, legislation and regulation in fields such as food safety, safety of consumer products and working conditions, and through integrated structures such as child health care. On the other hand, it is still

possible to achieve considerable health improvements by eliminating important risk factors. Of the 133,500 deaths in the Netherlands in 1994, many may be attributed to smoking (about 23,000), to high blood pressure (about 17,000), to unfavourable cholesterol levels (more than 12,000), to physical inactivity (more than 8,000), to glucose intolerance (almost 7,000) and to obesity (about 6,000). Moreover, there have been unfavourable developments in the exposure to some risk factors (smoking, immoderate alcohol consumption, high-risk sexual behaviour, physical inactivity, obesity, insufficient consumption of fruit and vegetables), not least among young people. Except for vaccinations and a number of screening programmes many preventive interventions have in practice achieved less than the maximum possible effect (i.e. the actual effectiveness of programmes falls short of the efficacy of these interventions). In other cases, there is a lack of evaluation of the interventions. The most important problems in prevention interventions are difficulties in reaching the right target groups, the reluctance of professionals to implement interventions which have proved to be effective, and a lack of integration of the various activities.

*Too little is known about the effectiveness of health care.* From a study of ten diseases, it appeared that the efficacy of many health care interventions that are currently in use has been proven in scientific clinical trials. But there were only a few instances, such as for tuberculosis, rectal cancer and acute heart attacks, in which Dutch health care records make it possible to evaluate the actual effectiveness of interventions in practice. The obstacles to greater practical effectiveness are in different steps of the treatment process, i.e. the contact with the health care system, diagnosis, medical indications for intervention, treatment and patient compliance may all show shortcomings, which are specific for each intervention or disease.

### **Summary and recommendations**

The above summary implicitly carries a series of recommendations for Dutch policy makers. The explicit *recommendations on monitoring and research* include: the need for improvement of systems which continually collect valid epidemiological data on a nation-wide or representative basis; the need to enhance the coherence among data sources; and to increase our knowledge about the efficacy, effectiveness and efficiency of interventions in prevention and health care; the need to enhance our insight into the causes of chronic physical and mental disorders, in order to open avenues for the prevention of these disorders; and the need to increase our efforts to monitor health inequalities and to do research to explain these differences.

### **References**

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Ruwaard D, Kramers PGN, van den Berg Jeths A, Achterberg PW. ***Public health status and forecasts: the health status of the Dutch population over the period 1950-2010.*** The Hague: RIVM, 1994.

## Two Dutch Public Health Status and Forecasts and their health policy impact

Wendy Reijmerink

*Min. of Health, Welfare and Sports, Rijswijk, The Netherlands*

Dutch health policy has in recent years focused on being 'Evidence Based', i.e. getting 'best evidence' for 'best policy'. Important aims are the three A's: **A**vailability of 'best evidence', critical **A**ppraisal of this evidence and **A**pplication of best evidence in everyday practice. To enhance evidence based policy it is essential to strengthen the links between researchers and policy makers. On both sides this requires scientific as well as political sensitivity and a good sense of timing and focusing. A good information system, which is based on good interaction between scientists and policy makers is therefore essential.

The current Dutch health policy information system uses a four-year planning cycle in which a number of documents supply relevant information for the formulation of health policy, which is described in a separate, also four-yearly, report. Two of these policy-supportive reports (The State of Health Care, by the Health Care Inspectorate and The State of Health Protection by the Health Protection Inspectorate) describe quality aspects of the health care and prevention systems every four year. A third, four-yearly, report, the Public Health Status and Forecasts is produced by the National Institute for Public Health and the Environment (RIVM). The first (1993) PHSF report served to evaluate current policy, to set new policy priorities and identify new areas for health policy and research and for the quantification of future health care needs. The data presented by the first PHSF report were analysed (using multi criteria analysis by a panel of policy makers) to determine measures and criteria for urgency of health problems, to rank types of interventions and to specify effective policy interventions. In 1995 the Framework for Health Policy in the Netherlands ('Healthy and Sound') appeared as a result. This report has made extensive use of the information gathered in the first PHSF report.

Major objectives of public health policy in the Netherlands were defined as:

- increasing health life expectancy
- preventing avoidable deaths
- improving quality of life of sick and disabled people

Important conditions, that should also be maintained, were that socio-economic differences should not increase, cost containment should take place within health care facilities and collective health expenditure should also be contained. The following basic policy-principles were formulated: intensifying anti-smoking policy; improving eating and drinking habits; encouraging physical exercise; increasing safety; reinforcing the prevention of chronic diseases; introducing programmatic prevention into the extramural health care system; intensifying prevention in the fields of social security and labour and reinforcing the financial and organizational basis of prevention.

In addition to actually using the relevant information that was presented by the first PHSF report, the Ministry has asked for its evaluation. The first PHSF report was evaluated by the Ministry and by the RIVM itself and by the Dutch Health Council and by participants of a specially organised seminar. Based on the results of these evaluations, the Ministry has asked the RIVM to prepare the second PHSF (1997), which has aimed to cover some areas that were identified by the Ministry as in need of additional attention. New areas involved paying systematic attention to: health differences, effectiveness of prevention and care, consequences for the need for and use of health care and estimates for future developments. On the Minister's request the publication of the 1997 report has been accelerated in order to be used for the policy preparations for 1998.

Important policy outcomes that were (also) based on the 1997 PHSF-report were:

- adaptation of the fixed annual growth limit for the Dutch care sector from 1.3 to 1.5 %
- additional budget for care and prevention
- proposal for raising the age-limit for free sale of alcohol and tobacco (from 16 to 18 years)
- improving information provision for waiting lists through creating extra budget for better ways to manage waiting list procedures

More policy decisions, based on the evidence and information contained in the 1997 PHSF-report, will be presented by the Ministry during 1998. Major criteria for the actual use of available information for Dutch health policy making are that the information should be:

- science-based (facts)
- with proven or credible benefit for policy making
- changeable by policy action
- having priority
- socially and politically acceptable
- practical (effective, efficient, affordable)
- maintainable (no quick relapse after stopping the prevention effort)

The major 'spin-off' of the 1997 PHSF-report can in general terms be typified as increases in:

- information awareness
- synthesising effect
- health outcome orientation

Important remaining questions for the Dutch health policy information system remain:

- What do we know?
- What do we need to know?
- What do we want to know?
- What can we measure?
- How do we measure?
- Within which conditions?

With these basic questions in mind the system of Dutch health policy documents and their various roles will be constantly evaluated by the Ministry in order to arrive at a proper trade-off between the efforts to gather and analyse policy-relevant information on the one hand and the actual use of that information by policy makers on the other hand.



## Comparing European Public Health reports

**Gudrun Lindberg**

*National Board of Health, Stockholm, Sweden*

To initiate a discussion on what a public health report really ought to be like an overview of a dozen European public health reports has been presented in Sweden's new Public Health Report 1997. It deals with the following questions:

- *How do the reports describe national policy?*
- *Do the reports suggest how to achieve better public health?*
- *What areas or topics are covered?*
- *How are the people's health and its development described?*
- *How are differences between groups described?*

While Sweden at present has no explicit, official national health policy and no set of national health targets, England and the Netherlands do. Goals, directions and suggestions for action within public health work are available in many countries, but are presented chiefly in publications other than the public health reports.

Traditional risk factors are mentioned in *all* the reports. Living habits, living conditions and sometimes biological factors are treated. The roles, difficulties and opportunities of medical care are relatively well described. Some reports comment on the role of the medical insurance system. Many maintain that chiefly factors outside medical care have led to improvements in health. Detailed analyses of these factors and how they have affected health are mostly absent. It is manifestly hard to report and analyse determinants in a manner that is easy to grasp. Different factors work together and it is difficult, sometimes impossible, to specify health effects. It may be meaningless to report certain factors without showing how their effects accumulate in population groups and environments. Almost all the reports choose the classic epidemiological indicators focusing on (above all somatic) ill health. A long tradition of recording mortality and causes of death makes comparisons possible over time and between ages, sexes, and parts of a country and countries. Existing data regarding consumption of medical care, sick listing and so on is also much used. A majority of the reports, however, stress that causes of death give a limited picture, and knowledge is also needed regarding both the diseases people die of and the diseases they suffer from.

The time-frames vary. The Dutch report seeks to describe developments 40 years back in time and assessments 15 years into the future. Prognostications are absent from practically all the other reports. It is not easy to describe the population's health in positive terms. The Dutch report expresses a desire to report "positive indicators of health". Sweden's public health report uses a combination of health and life expectancy measure. All the reports include comparisons between population groups. Regional comparisons and comparisons with other countries are generally made. Age and gender are natural bases for division in all the reports. Descriptions of differences in health by occupation, ethnic background, unemployment and different functional impairment also occur. Most of the reports make the classical division of social groups defined through education or profession. Thorough analyses of social differences are, however, few. Factors such as low income; small cash margins and limited freedom of action may also affect health. This is of course a complicated area and some reports raise the methodological problems of interpreting social differences.

### Reference

*Sweden's Public Health Report 1997*. Socialstyrelsen; EPC, Stockholm. 1998.



# Workshop Summary

**Bilthoven, 19 & 20 February, 1998**

## **Health Reporting in the European Union**

### **ABSTRACTS OF PRESENTATIONS**

**Day 2**

**INFORMATION FOR EU HEALTH POLICY  
AND REPORTING NEEDS**



## **Eurostat, EU health information and reporting**

**Marleen DeSmedt**, *European Commission, Eurostat, Luxembourg*

*No abstract available; short summary by the workshop organisers*

A summary was presented of the legal responsibilities of the Statistical Office of the European Commission: Eurostat. Its role was explained in the information collection for the Community and more specifically in the area of Social Affairs, which includes Health information. Ongoing activities, current and future tasks were presented in relation to activities that are planned for the Health Monitoring Programme. Several networks, which involve various national statistical bureaux in Member States are active with harmonisation activities in the area of mortality, morbidity and health care.

## **OECD and Health Information for the European Union**

**Jean-Pierre Poullier**

*OECD, Paris, France*

The main line of this presentation, which presented a view from the OECD perspective on international health reporting and health information needs went along a series of points for discussion:

- Recurrent reporting by OECD: Existing database: *OECD Health Data* (quadrilingual, CD-Rom)
- Short and longer-term perspectives: *'reporting, while constructing instruments'*
- Relationship with data producers: *'importance of intellectual co-responsibility'*
- An enlargement of the democratic process: *'deepening of the effectiveness criterion'*
- Distinct information and analytical roles
- In-house expertise: selection process, quality improvement
- An implicit production of a health model: *'from health status to health outcomes'*
- Inputs - throughputs - *'non medical determinants are important'*
- Organisation (including public health) and financing variables
- The relevance of a non-EU tier to EU health reporting: *'Complementarity or distinct roles?'*
- Relationships with WHO, WHO-Europe, EUROSTAT, DG-V
- Do international comparisons matter?
- A possible policy follow-up perspective in an age of globalisation
- Health policy: who decides?

## WHO and Health Information for Europe

**Arun Nanda**

*WHO Regional Office for Europe: the Unit of Epidemiology, Statistics and Health Information, Copenhagen, Denmark*

The overall objective of the Unit of Epidemiology, Statistics and Health Information (ESI) is to make information on health in Europe widely available in a form that allows the health situation to be readily summarized, and areas for public health action to be pinpointed.

A public health report describing the state of health in Europe which is a synopsis of the Health for All (HFA) monitoring and evaluation reports of European Member States is published every three years as "The Health in Europe" series. The statistical information is collated and maintained in the HFA database which is updated annually and widely disseminated via a user-friendly PC presentation system, also accessible via Internet. A project to develop common protocols and instruments in Health Interview Surveys (started jointly with Statistics Netherlands) has been successful in the BIOMED2 call for proposals. A second project is the development of an Atlas of "Avoidable Mortality" for countries of central and eastern Europe (CCEE) and the newly independent states (NIS).

Countries are encouraged to produce 'Public Health Reports' that pinpoint areas for public health action. To complement these, Highlights on Health in countries are available for all the NIS, some CCEE and all the EU (supported by the EC) countries. It is planned to update the NIS and CCEE Highlights in 1998. A number of Member States have adapted the HFA database principles and software to develop national health databases for their own use at national and subnational levels.

### **Networking and telecommunication**

The main providers and users of health information from each of the 50 Member States were assembled for the first time at the Joint EU/UNICEF/WHO meeting 'Information for Health for Europe' (6-8 Oct. 1994). Recommendations included starting a process of collaboration between international agencies. It is planned to use the ECE/WHO meeting (Italy, October 1998) to continue this process; this being the second Europe-wide meeting of providers and users of health information.

The EU Health Monitoring Programme aims to set up a consistent and coherent information system for the EU. WHO has been closely involved with the development work which has led to its formulation.

The joint WHO/EU telecommunication project ENS CARE (1992-1994) developed the concept of 'distributed' databases, with a "Care Network Node (CNN)" in each of the 12 EU countries.

The G-7 Ministerial Conference (Brussels, 25-26 Feb. 1995), endorsed several projects to demonstrate the benefits of the Global Information Society. The G-7 Global Health Care Applications Project (1995-1996) developed as part of a subproject, *Towards a Global Public Health Information Network* (GLOPHIN), a special G-7 prototype adaptation of the HFA on-line database. With the support of the EU INCO-COPERNICUS Programme, a **European Public Health Information Network for Eastern Europe - EUPHIN-EAST** is being implemented (1997-1998) for 23 CCEE and NIS based on the concepts developed in ENS CARE and GLOPHIN. Each country will have national integrated health databases for wide use within the country. These will also form the basis for the national "distributed" databases for telematic connection via the network. It is intended that this will interconnect to a similar network being developed by the EU [(EU-IDA (HIEMS))].

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## **International comparative health information for Europe**

**Daan Kromhout**

*Division of Public Health Research, RIVM, The Netherlands*

*No abstract available; short summary by the workshop organisers*

On the basis of examples from international comparative epidemiological studies, such as *the Seven Countries Study* and the *FINE studies*, it was demonstrated that the European Community can be a goldmine of policy relevant public health information. International, comparative epidemiological data is an essential source of information for national health policy making. The need for standardised collection of health data was emphasised.

It was also noted that important public health messages, i.e. regarding the very deleterious effects of smoking on health, do not match international (European) policy actions, e.g. in relation to subsidies on growing tobacco.

International comparative data can provide both different as well as common perspectives for a public health problem and can point at possible strategies for national improvement and international collaboration and priorities for exchanging experience.

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## **Health policy and the European Union**

**Hans Stein**

*Ministry of Health, Dept of International Affairs, Bonn, Germany*

*No abstract available; short summary by the workshop organisers*

A short overview was given of the political history of the Community and the role of health policy in that, from the perspective of a national policy maker. Special attention was paid to the important aspect of subsidiarity, i.e. the division of responsibilities between MS and the Commission. The place of Community activities and the role of the Health Monitoring Programme was pointed at.

## **The experience of the European Commission with health status reports**

**Michael Hübel**

*European Commission, DG5/F/1; Luxembourg*

*Short summary statement by the author*

When adopting its Framework for action in the field of public health in November 1993, the Commission commissioned itself to publish regular reports on the state of health in the Community. A first report, based on work done by WHO-Europe, was put forward in 1995. It is intended to present similar general reports on a regular basis. In between, reports covering specific population groups and health determinants are being prepared. A first of these, on the State of women's health, was presented in 1997. The intention is to publish further reports on migrants and on young people.

The reports are designed as review documents, covering mortality, morbidity and some specific health determinants. They do not include policy recommendations, which would in most cases have to be targeted at Member States. Their presentation as Commission reports gives them a certain political weight, but may lead to false expectations.

Work on health status reporting will in future be informed by the Community's Health Monitoring Programme, the aim of which is to create a Community health monitoring structure. Activities on health information and analysis will remain a main priority with the Community's future public health policy. A Commission communication on the future policy is about to be published (now available - COM (98) 230 final of 15.4.1998).

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## **Health data: the Health Monitoring Programme**

**Matti Rajala**

*European Commission, DG 5/F/3, Luxembourg*

*No abstract available; short summary by the workshop organisers*

The three pillars of the Health Monitoring Programme, i.e. health status analysis and reporting, health indicator development and the development of an electronic data-exchange network were explained in some detail. A workprogramme is currently being drawn up. The amount of available money is very, very little if compared with many other programmes funded by the Community.

## **The Organisation of Health Monitoring in the European Union**

### *Report of the expert group on feasibility analysis on the organisation of health monitoring.*

**Arpo Aromaa**

*National Public Health Institute (KTL), Helsinki, Finland.*

### **Background**

During the 1990s the need for European Union health monitoring has increased as a result of the increasing responsibility for health protection reflected also in the Maastricht Treaty. The broad range of Public Health Programmes and the need to assess the health effects of other policies further stress the need for systematic health monitoring. The five year Health Monitoring Programme (HMP) initiated in 1997 was one response to this need. During negotiations between the Parliament and the Commission about the HMP Parliament requested that the Commission should investigate the feasibility of a health observatory, which would carry out the tasks of EU health monitoring. A feasibility study on the organisation of health monitoring in the European Union was carried out in 1997 on the basis of a contract between the Commission (DG V) and the National Public Health Institute (KTL) of Finland<sup>1</sup>. Its main outcomes are summarised here.

### **Goals of health monitoring**

Health monitoring should provide relevant, comparable and high quality health information to (1) monitor and compare current health status, its determinants and consequences, (2) focus on existing health policy priorities, (3) evaluate the effectiveness of public health actions, and (4) identify new priority areas for public health in the European Union. It shall also assess the health effects of other policies.

### **Current situation in Europe with regard to health information collection**

Many actors and actions in the field of public health, health statistics and health monitoring already exist in the European Union, internationally and in the Member States. Examples are the Eurostat, DG V and several other Directorates, various EU Programmes and EU Agencies, which amongst other tasks monitor different aspects of health. In Europe there are also many non-governmental organisations (NGOs) and networks active in the field. Furthermore, international organisations, especially the WHO and the OECD carry out health monitoring activities in close collaboration with national governments. The EU has initiated a five year Health Monitoring Programme (1997 to 2001) which comprises three main tasks (A) establishment of community health indicators, (B) development of a community-wide network for sharing health data, and (C) analyses and reporting.

### **Elements of health monitoring and requirements for the monitoring capacity**

Health monitoring comprises:

- (1) the definition of health information needs, indicators and products,
- (2) information gathering,
- (3) analysis and interpretation, and
- (4) information dissemination.

Central products of a capacity for health monitoring are policy relevant reports and information.

The European Community health monitoring capacity should be organised in a way, which ensures that it has the public health and scientific competence needed to meet its objectives, that it is acceptable to the Member States and European Institutions, is able to be objective which requires scientific and professional independence and is cost-effective. Central coordination and

leadership of health monitoring should be combined with networking to focal points in all Member States and intense collaboration with the relevant organisations in the European Union and at the international level. Close involvement of the Commission, in particular DG V and Eurostat, as well as strengthening the Commission's public health expertise are needed regardless of how health monitoring is organised.

### **Evaluation of organisational alternatives**

The expert group evaluated four main alternatives for the organisation of health monitoring, which are all based on a core capacity and extensive networking. The alternatives differed in regard of the core capacity and they were (1) DG V and (2) Eurostat within the Commission, (3) a new EU body, i.e. a Health Observatory and (4) an alternative based on existing national public health institutes or comparable organisations in the Member States. Other alternatives were also discussed but not evaluated in detail. The group developed a set of criteria which were used as an aid in the evaluation. The criteria were grouped under (1) ability to reach objectives, (b) acceptability, (c) objectivity and (d) costs.

### **Recommendations of the expert group**

The expert group recommended that the long-term goal should be the creation of a new European body for health monitoring (a 'Health Observatory'). The new body should have close links with a suitable expert institute such as a strong national public health institute and would work in close collaboration with networks of focal points in the Member States. The group recognised that setting up the new EU body requires major new resources and will take a number of years to be fully operational. However, the need to start developing a European health monitoring capacity is urgent.

Therefore, the expert group recommended that as an immediate solution the Commission takes steps to set up a European Community health monitoring capacity, which during the current Health Monitoring Programme comprises a consortium of 3-4 national public health institutes (or comparable organisations) of Member States. They should work with (and indeed establish) a network of focal points in all Member States and with other relevant organisations and so form a functional health observatory. The expert group also recommended that further preparatory work for the permanent implementation of European Community health monitoring should be initiated and that this should, in part, be carried out within the framework of the Health Monitoring Programme.

### **What to do next?**

The Commission should take immediate steps to develop a networked solution with adequate central steering based on a competent and suitable core capacity. Well-coordinated projects should be initiated which support the establishment of coherent, permanent, EU health monitoring.

### **Reference**

*Aromaa A, Achterberg PW, Bellach B-M, Gentle P, Salmi R, Sans S and Manderbacka K. **The Organisation of Health Monitoring in the European Union.** Report of the expertgroup on feasibility analysis on the organisation of health monitoring, September, 1997 (to be published).*

## A Framework and Strategy for effective Community Health reporting

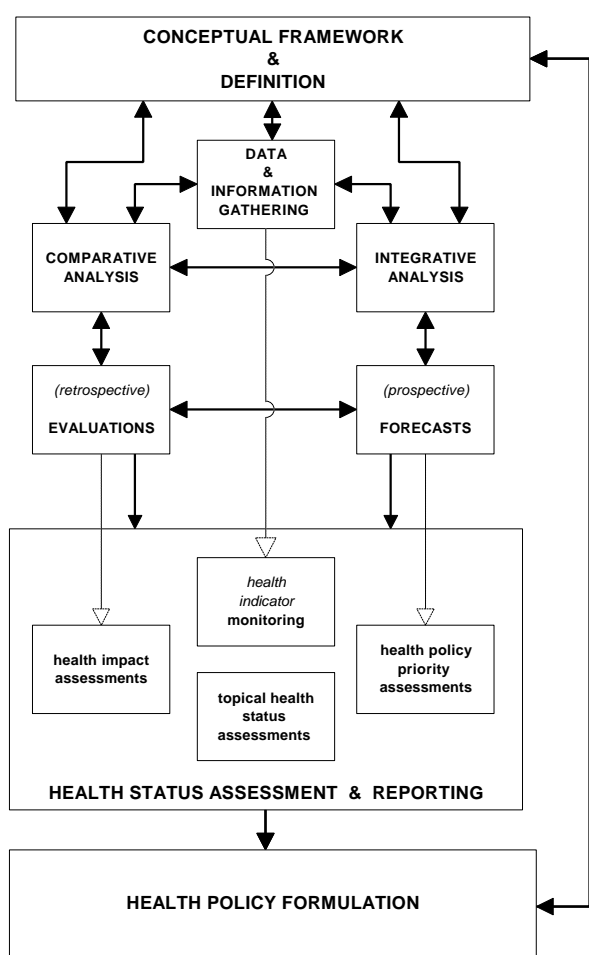
*Report from Working Group II (On health status) of the High Level Committee on Health.*

**Peter W Achterberg**

*RIVM, Dept for Public Health Forecasting, Bilthoven, The Netherlands*

A summary has been presented of the interim report by Working Group II (WG II) under the High Level Committee on health <sup>1</sup>. After a short discussion of the Terms of Reference the main questions that were addressed by WGII were summarised. These are: which are the desired key features of health reports and what organisational approach should be taken for future effective Community health reporting? This in relation to the new Health Monitoring Programme and to the future policy Framework for Health that is soon to be drawn up by the Commission.

Critical factors for effectivity of health reporting are the ability to provide a relevant answer to a specific policy question, the acceptance of the outcomes (by the end users and the public health field) and the intrinsic quality of the reporting effort.



**Key features for health status reports are:**

- *policy-oriented,*
- *conceptual,*
- *integrative,*
- *collaborative,*
- *quantitative,*
- *consistent,*
- *prospective,*
- *evaluative,*
- *comparative, and*
- *comprehensive.*

Not all key features need to be present in every health report, however, depending on the specific purpose of the health report in question. Important **purposes** for Community health reporting and (*related reports*) are:

- **to identify new priority areas**  
- *prospective, comprehensive reports*
- **to focus on existing priority areas**  
- *focusing (topical) reports*
- **to monitor current health status**  
- *monitoring reports*
- **to evaluate health-related EC Actions**  
- *health impact assessment reports*

These purposes may be served by a variety of health reports, as indicated in **Figure 1**. Nearly all different kinds of reports may be identified here, except for the comprehensive report, which is a combination of the others. Nearly all key previously mentioned key elements can be identified in Figure 1 too. Different reports have different time-frames and periodicities, however, and this needs drawing up a reporting agenda.

One key element of health reporting, however, cannot be immediately identified in Figure 1, i.e. the need for the process of health report production to be **collaborative**.

To ensure maximum support and commitment, future EU health reporting should be undertaken in a collaborative way, actively involving many different partners, such as:

- ◇ Member States and/or Federal Agencies, through their Health Ministries, national statistical bureaux (and Eurostat) and public health institutes with relevant reporting experience
- ◇ International health data-collecting organisations (WHO, OECD, Eurostat), which have a dominant role in the harmonisation of European health data and information
- ◇ Community Public Health Programmes (and their committees)
- ◇ International research networks which cover specific areas of public health
- ◇ Concerted Actions or Centres in the public health area that are supported by EC funding

It was stressed that being collaborative is an essential element with serious consequences for the desired organisational approach to health reporting, paving the way for scientific and political acceptance and independence.

Another important function related to international health reporting, but one which does not imply actual health report production, is the collection and publication of *summary information on health information systems in Member States* and on the availability and comparability of health data and methods of collection and validation.

It has furthermore been emphasised by WGII that several reporting tasks should involve the incorporation of *prospective views or forecasts*. In addition, separate prospective studies may be called for, which analyse the health effects of potentially important developments, i.e. ageing, migration, environmental changes and selected socio-cultural developments

### **Summary of recommendations**

The final recommendations of Working Group II are that in order to arrive at effective future Community Health Reporting:

- *implement the above indicated key elements of health reports*
- *organise a capacity for Community Health Reporting*
- *draw up a Community health reporting plan and agenda and*
- *bring continuity to Community Health Reporting.*

### **Reference**

*Kramers PGN, Achterberg PW, Robine JM, Cambois E. Priorities in European Health Status Assessment.* Interim report. Report of Working Group II of the High Level Committee on Health: On the feasibility and implementation of future European health status reporting. (EU project: EU SOC96 210 860 05 F01//96CVV F1-438-0) (unpublished: available from first authors: RIVM, VTV, P.O. Box 1; Bilthoven, The Netherlands).

## Critical factors for effective health reporting

**Måns Rosén**

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### Introduction

It is important to stress that health reporting must, in order to be effective, be a comprehensive system of different products and measures aiming at creating knowledge and awareness of important public health problems and their determinants among policy-makers and others involved in organisations that can influence the health of the population. Examples of such measures are: publishing national public health reports, annual up-dating of easy accessible data bases for health monitoring, R&D reports on specific policy relevant topics, efforts to implement health reporting in education, building networks with regional-local decision-makers, etc.

### Effects and impacts of health reporting

In general several potential *effects and impacts* of health reporting can be identified:

- Statements in government policy documents or in regional - local political forum
- Political initiatives, e.g. government bill, commissions or committees, motion proposals
- Administrative changes or allocation of resources
- Research programmes initiatives
- Use for educational purposes (university course literature etc.)
- Coverage in mass media
- Citations in scientific articles
- Recognition among decision-makers, etc.

The effects of health reporting are not easy to evaluate, but the Swedish Public Health Reports have most likely contributed to government bills in 1987 and 1991, setting up of a government public health group, the commission to produce national Social Reports, the establishment of the National Institute of Public Health in 1992 and in 1997 the setting up of a Commission on national targets of public health and a government research bill with a commission to the Council for Social Research to draw up a national programme of health inequity research. The national public health reporting has also stimulated many county councils and municipalities to publish their own regional-local reports. The data used in these reports are also to a large extent based on data from the national data base "How are you Sweden?" which consists of regional and local health data.

### Impact of the 1994 Swedish Public Health Report

An external review of the 1994 Swedish Public Health Report has been conducted by telephone interviews to representatives of parliament, ministries, county councils, universities etc. Within ministries, 76 % of the respondents had knowledge of the existence of the report and half were aware of the content of the report. For those responsible for health, social affairs and labour market issues nearly 70 % had read the report. The report was widely used as education material in universities. Within faculties of medicine, nursing and public health 35 % used the report as course literature, 17 % used it as reference literature and 35 % of those faculties had the report available in their libraries. The report was judged to have very high credibility and quality among respondents from all sectors.

### **Critical factors for effective health reporting and potential for improvement**

In general, the following factors are identified:

- Trustworthy decision-making documents and organisation
- Political and management support
- Local data creates local involvement
- Adjust the language to the target groups
- Concentrate marketing efforts to few messages
- Built networks
- Focus on identified and relevant problems

### **Potential for improvement**

- Political formulated targets to follow-up
- Develop epidemiological models for analysing health consequences of social changes

Our experience gained so far indicates some critical factors for effective public health reporting, e.g. the need for political and management support, that reports are based on a high scientific ground in order to be trustworthy, the importance of realising that local data creates local involvement, the need to focus on policy relevant issues and the need for building networks between national and local administrations and between policy-makers, researchers and those involved in implementing the strategies. The health reporting process would be more effective if there were political and operational formulated targets to be followed-up. There is also a demand to develop epidemiological models for analysing health consequences of changes in society.

# Workshop Summary

**Bilthoven, 19 & 20 February, 1998**

## **Health Reporting in the European Union**

### **ANNEX 1**

**Report of Working Group II of the High Level Committee on Health  
On the feasibility and implementation of  
future European health status reporting**



**Report of Working Group II of the High Level Committee on Health  
On the feasibility and implementation of  
future European health status reporting**

**PRIORITIES IN EUROPEAN HEALTH STATUS REPORTING**

INTERIM REPORT

from EU project: EU SOC96 210 860 05 F01//96CVV F1-438-0

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Presented as draft paper to the High Level Committee on Health meeting; March 18-19, 1997.

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### **Summary: Report from Working Group II to the High Level Committee on Health**

#### **Feasibility and implementation of future European health status reporting**

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Based on the work of an expert group under the High Level Committee on Health

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## **Summary: Report from Working Group II to the High Level Committee on Health**

At its meeting in Madrid in October 1995 the High Level Committee on Health decided to set up three subcommittees to provide a basis on which the HLCH will advise the Commission on:

- a new European framework for health (Working Group I)
- health status assessment (Working Group II)
- a strategy for integrating health aspects into other policies (Working Group III)

Working Groups I and III have worked in parallel and decided to submit joint reports to the High Level Committee on Health in March 1997. Working Group II follows the format chosen by the other Working Groups and is presenting its summary report concurrently.

**The report of Working Group II** addresses future health status reporting that will aim to both support future health policy priority setting and to evaluate current and past policies, as foreseen in the proposed Health Monitoring Programme and with a view towards priorities for a new Framework for Health.

With the expansion of the Communities responsibilities and programme activities in the public health area, including the growing need to assess the effects of health policy and other policies on health, a new and more complex mission for Community health reporting is emerging.

Looking forward in time, from a European policy perspective, and considering past experience of health reporting in Member States, Working Group II has identified a proposed set of reporting tasks. In addition to these tasks a series of quality prerequisites and critical factors for future reporting are presented. Criteria for selection of priority issues for health reporting are discussed and a number of priority issues are identified.

It is emphasised that, in order to be scientifically relevant and acceptable to Member States, to the European Community, Parliament and Council, and also to the public health sector a future approach to Community health reporting, should be well-planned and properly organised. This will enable the incorporation of demands for quality and effectiveness, including the active inclusion of expertise that has accumulated in Member States and international organisations. Recommendations are then put forward to implement a future Community health reporting system which will have sufficient impact on European health policy.

**Working Group II** commends this report to the High Level Committee on Health for discussion and for approval.

### **Working Group II further recommends that the High level Committee on Health:**

- should advise the Commission of a growing demand for health reporting, with policy relevance both for the Community and for the Member States. This involves the need to establish a well-organised health reporting capacity, to draw up an agenda for health reporting, establish continuous participation of experts within Member States and elsewhere and, finally, consolidate a health reporting capacity within a new Framework for Health.
- should offer the services of the High Level Committee to further advise the Commission on planning, implementation and agenda building for a future health reporting capacity that aims to serve the Community with effective, policy-relevant products and activities.



## Feasibility and implementation of future European health status reporting

### 1 Introduction and Terms of Reference

The High Level Committee on Health (HLCH) has, at its meeting in Madrid (October 1995), decided to set up three Working Groups, one of which is the Working Group on Health Status (WG II), which has been presented with the Terms of Reference (ToR) given below.

- i. To make proposals for the undertaking of analyses of health status, health determinants and specific health problems as foreseen in the action programme on health monitoring;*
- ii. To arrange for forecasts for important public health issues in the EU also taking into account the future enlargement of the EU and the specific health situation of the potential new Member States;*
- iii. To contribute to the definition of health objectives and priority setting for the future framework on Public Health;*
- iv. To make proposals for the selection of themes in future Health Status Reports;*
- v. To contribute to the development of appropriate methodologies for health impacts of other Community policies;*
- vi. To make proposals concerning Public Health information policies in the EU.*

The actual start of the activities by Working Group II was postponed until contractual arrangements for Commission support were finalised. In addition, the initial time-planning for the activities of the working group has been restricted. The ToR have been approached in an integrated manner. The link between future health reporting, a new Framework for Health, and the proposed Health Monitoring Programme is addressed in some detail. Criteria are indicated for the selection of priority issues for health reporting. Suggestions are given for future health reporting tasks and recommendations for themes for actual health reports. The final outcome is a set of recommendations for a well-organised, effective approach to policy-supportive health reporting, a first priority for health information policy for the Community.

The conclusions and recommendations from Working Group II build upon both previous and current efforts of the Community and Member States in this area. Activities of other EC committees and working groups and the tasks and roles of international organisations in the area of public health information are taken into consideration.

Working Group II has been presented with a systematic comparison of national health status reports in Member States, which has been carried out by two public health institutes, the French INSERM (Demography and Health, Montpellier) and the Dutch RIVM (Centre for Public Health Forecasting, Bilthoven). A more comprehensive background report is in preparation and this report will be supplemented with the outcomes of a workshop planned for September 1997. This workshop will bring together end users and producers of health status reports and aims for a further exchange of experience and practical information about critical factors that give a health report actual impact on health policy.

In the next chapters, the purposes of health reporting are discussed from a Community perspective, followed by an analysis of essential elements of national health reports. The outcomes are shown to have specific implications for a quality approach to European health reporting. The factors that are critical in reaching actual impact on policy by health reporting are also discussed and, finally, the broad scope and potential for European health reporting are presented. A short summary with recommendations is presented in the last chapter.

## 2 Purposes of health status reporting from the perspective of the European Union

### *The European perspective*

Article 129 of the Maastricht Treaty on the European Union (1992) has extended the mandate of the European Community in the public health sector. The Community now has an explicit obligation to 'ensure a high level of human health protection by encouraging co-operation between Member States and, if necessary, lending support to their action'.

The possible consequences for Public Health policy development at the European level have been discussed by the Commission, the Council and the European Parliament. They stress the need for co-ordination and collaboration among Member States, and for improving consultation and participation mechanisms. In the current Framework for Health, 'Major Health Scourges' are identified as well as important 'Influences on Health and Disease':

- ageing of the population
- increasing population mobility
- environmental changes and conditions in the working place
- rising public expectations concerning health
- socio-economic problems, in particular social exclusion

In the area of health information, data and indicators the Commission has issued a proposal for a programme of Community action on Health Monitoring, aiming to:

- > establish Community health indicators
- > develop an electronic health data network
- > establish health status analysis and reporting

### *Purposes of health status reporting*

For an increasing number of Member States health status analysis and reporting has become an important instrument to support national health policy cycles. Health status reporting in the European Community does not yet fulfil this purpose. Basically, such health reporting should support the preparation, planning, implementation and evaluation of health policy, i.e. of programmes and actions at the Community level and at the Member State level. General health policy questions deal with priority setting for health policy and with past and possible future effects of policy actions and programmes. In addition, effective health status reporting can lead to the identification of health data needs and of health research priorities.

Health status reporting activities can, if undertaken effectively, contribute significantly to the expanding mission of the Community in the public health sector. Some examples of the purposes of health reporting, which may be elaborated in more detail later, are:

- ◇ define common public health objectives, priorities and strategies
- ◇ focus and co-ordinate the compilation, analysis and evaluation of health information
- ◇ foster the mutual exchange of health information, expertise and experiences
- ◇ create networks for information and consultation in the area of health information
- ◇ contribute to making data collection mechanisms more comparable
- ◇ improve health information systems and disease monitoring and surveillance activities

To be fully effective, health status reporting and the process by which it is performed should possess a number of essential characteristics. Working Group II has looked at experience of health reporting in various Member States to identify these key characteristics.

### 3 Key features of health status reports

Essential characteristics of health status reporting at Community level may be derived from an analysis of national health reports at Member State level. A number of important attributes of broad, policy-oriented national health status reports have been described based on an analysis of the Dutch '*Public Health Status and Forecasts*' report. A comparative analysis of other national (and regional) health reports has contributed to composing the list of characteristics that is presented here as key features of health reporting. We mention, for instance, Denmark's '*Lifetime in Denmark*', the English '*Health of the Nation*', the French '*Santé en France*', and the Spanish '*Health Plan for Catalonia*'. The set of essential features that is presented here has been discussed at meetings of the working group.

#### *Essential elements of health status reports*

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<i>policy-oriented</i>	pose a clear central question, designed to support health policy
<i>conceptual</i>	start from a conceptual model, not merely from available data
<i>integrative</i>	interrelate health status, determinants, care, costs and policy
<i>collaborative</i>	broadly based on expert opinions; broad acceptance
<i>quantitative</i>	as much as possible: based on actual data and research results
<i>consistent</i>	handle all data in a uniform manner for maximum comparability
<i>prospective</i>	looking towards the future; use of trend extrapolations and models
<i>comparative</i>	regional, international comparisons/differences between groups
<i>comprehensive</i>	health is a broad issue; many kinds of data are relevant

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The identified key elements are related to the *purpose and process* of health reporting, point at desired characteristics of the *contents* and at the effects that the *main results and conclusions* may have on health policy, both from a prospective and retrospective (evaluative) point of view. A detailed analysis of national health reports along these lines will be presented in a background report that will be published at a later stage. This may lead to some rephrasing of the above key elements or to the identification of additional essential characteristics.

The key elements that are presented here will be analysed in more detail in the next chapter. Indications will be given of how they may be used to focus and implement effective health reporting for the European Union. Practical, organisational consequences are given and conclusions are drawn as to when and how these key features should be applied in European practice.

## 4 Key features of effective health reporting at the Community level

### *Relevance for health policy*

Community health reporting should first of all provide an answer to a specific, policy relevant, question, posed, for instance, by the Commission. Relevant answers are built around an analysis of health facts, which aims to provide starting points for explicit, identifiable policy actions. These analyses may also provide the Community with an evaluation of the progress of implemented health policy activities. In addition, Community health reporting should provide Member States with the comparative information and analyses that they need to develop their own health policies.

Health reports may answer several kinds of policy-relevant questions. The answers may point to new (future) health policy areas, focus on current health policy areas, or discuss the effects of past health policy efforts. In all cases the relevance for health policy can be focused by subdividing health policy, for instance, into prevention policy, health research policy or health information policy. If desired by the Community, health reporting can also focus its policy orientation by aiming to identify realistic health targets.

When focusing health reporting on health policy highest priority should be given to the perspective of the European Union. The subjects of health reports should fit in with the competence of the Community in the public health area and should have relevance for Community programmes and policies, including the framework for health. Furthermore, compliance with the principle of *subsidiarity* is essential as is the need to provide *European added value*, i.e. the need for policy initiatives from the Community that supplement or replace initiatives from individual Member States must be demonstrable.

In order to have an explicit impact on health policy and other policies, European health status reporting should ideally be part of a functioning health policy cycle, as is the case in some Member States, where health reporting is implemented according to a plan and guided by explicit policy-oriented objectives and central questions.

### *Using a conceptual model for European public health*

Health reporting for the European Union should consistently follow a well-defined set of concepts and definitions, called a conceptual model, to be shared by the Member States. Individual health reports should use identical conceptual elements to assure comparability. The conceptual model for public health should contain demographic factors, determinants of health (risk factors), and health policy, relating these, where possible, to indicators of health status (in a broad sense) and to data for health care utilisation and costs. This model can also serve as a framework for the development of health indicators and electronic data dissemination as foreseen in the Health Monitoring Programme. A conceptual model is furthermore important for a consistent approach to the evaluation of the effects of other policies on health. At this conceptual level an ambitious starting point is necessary to present a comprehensive framework within which more specific studies can be carried out.

### *The need for integrative and explanatory analyses*

In addition to presenting statistical data, European health reporting should analyse and explain differences and similarities in health status and thus make connections between data sets. The collected material is to be presented as coherently as possible, explaining the observed differences and trends in health status by identifying relevant determinants and policy options and indicating important consequences (for health care utilisation and costs), including trends

and developments. This may result in the attribution of major causes of ill health to a variable set of risk factors, i.e. different causes and different risk groups in different countries.

European health status analyses should focus on health in its broadest sense, from mortality to morbidity, disability and quality of life. A full integrative analysis will enhance the possibility to arrive at 'evidence based' health policy making in the European Union. Specific, integrative, indicators such as compound health measures (health expectancy, disability adjusted life years) may be used to provide a comparative, integrative assessment of health status in the Community.

#### *The need for a collaborative approach*

A successful approach to European health reporting requires full Member State involvement from the outset, i.e. during the planning phases, for instance by involving a network of public health institutes with expertise in national health reporting. A collaborative approach must also involve constant consultation of the end user (the Commission, Council, Parliament) by the producing organisation, and calls for consultation of professional experts and of other users of the report, such as Member State governments. In the process, consultation with international organisations may be necessary or even essential. European health reporting should closely interact with ongoing efforts (e.g. by Eurostat, WHO, OECD) to make European data in the health information area more comparable.

The close involvement of scientific expert panels with health reporting will ensure scientific quality, credibility and independence. The involvement of experts from Member States can assist the validation of national data and lead to increased political acceptance of European health reporting. In order to ensure this scientific and political independence and acceptance, report production should be organised at an appropriate distance from the end user, which may be different for different reports.

In summary, health reporting efforts for the EC should build upon expertise and data found in:

- ◇ Member States and/or Federal Agencies, their Health Ministries, public health institutes that have experience of policy-oriented health reporting tasks and national statistical bureaux (including Eurostat);
- ◇ International, health data collecting organisations (WHO, OECD, Eurostat, etc.);
- ◇ Community Public Health Programmes (and their committees);
- ◇ International research networks which cover specific health areas;
- ◇ Concerted Actions or Centres in the public health area supported by EC funding.

Setting up permanent expert networks for health reporting supports one of the Community's policy objectives, i.e. sustaining network development in the area of health information.

A further positive contribution from health reporting to European health policy may result from an increased awareness of sharing the responsibility for health in Europe and from an increased sense of belonging to the Union, stimulated by a fully collaborative Community health reporting process.

#### *Analysis of health differences must be quantitative and consistent*

As far as possible European health reporting should be quantitative, offering quantitative explanations of health differences and trends by making use of existing, valid and comparable data. Where quantitative information is lacking, however, or forms an important supplement, this should also be collected. Health reporting must aim to handle the material as uniformly as possible to ensure maximum comparability.

Health analyses by socio-economic subgroups are broadly felt to be necessary for European health reporting. Analysis of health differences by age, sex, country and/or over time should, of course, always be a part of any comparative health status report.

A European health reporting system that aims at consistency and quantification can operate directly in line with the development of a health indicator system and with a strategy for the electronic dissemination of health information. Currently, activities by Eurostat and some national statistics bureaux are underway to enhance the scope and comparability of European health data. The choices for future expansion of a European data set should be guided by the outcomes from previous, policy-relevant health reporting.

#### *The surplus value of prospective views*

Health reporting may gain in policy relevance when a view of a possible future is enhanced by including forecasts or scenarios. This approach can 'predict' future developments, but not in the sense of inevitable consequences. It rather indicates what might happen if certain assumptions prove valid or if they are changed. Such indications may provide possibilities for feedback and policy evaluation and can be used to test alternative strategies. Forecasting supports strategic policy development or can warn against potentially threatening developments. For the purpose of forecasting several different methodologies may be used.

*Trend extrapolation*, through time series analyses, after correction for 'statistical' noise and, if necessary, for 'seasonal' influences, is a first technique that may provide relevant information for the future. This approach implicitly takes into account a complex, possibly variable, set of changing exposures to determinants. *Demographic projections* are based on expected changes in the future age and sex composition of a population and the central assumption that the age and sex distribution of a specific aspect of health (disease prevalence, health care use) remains constant. Estimates may thus be derived for the future number of patients or volumes of disease-specific health care. *Dynamic forecasts* use mathematical models, of varying nature and complexity, which describe interactions between health status, its determinants, health care use or costs and, less frequently, health policy. Complex sets of data are generally required for such analyses. In addition, more qualitative analyses (such as so-called *Delphi methodology*) can also provide relevant health outlooks. The nature of the question that must be addressed, as well as data availability and specification, determine which of these methodologies will be used.

Relevant outcomes of forecasting for the EU may include indications of differential future developments, such as increasing health differences and differential control of health threats, and these may point to opportunities to learn from each other or suggest the need to enhance collaboration. Expected changes in certain autonomous, health-related factors (ageing, socio-cultural changes) provide possible topics for policy-relevant prospective analyses. Other expected changes, for instance in the geographical scope of the Union may also call for prospective health status analyses. If possible, integrative reports should try to incorporate quantitative or qualitative, prospective elements, as they provide surplus value with specific policy relevance.

#### *Comparative analyses*

European added value will be provided by the introduction of international comparisons, not only of health profiles by state, region or district, but also by the integration of health status data with risk factor data and by aiming to introduce links with potential prevention outcomes or with the presence, use and accessibility of health care facilities and their costs. Here choices as to the level of comparison, i.e. by country or region, should be influenced by Member States, as responsibility for health policy is sometimes located at the level of regional authorities. Future

Community members should be included in comparative health reporting efforts as soon as possible. As considerable differences exist between countries with regard to the availability of comparable health information a first comparison may by necessity be rather crude and this may be refined in the longer run.

Comparative analyses depend to a large extent on the presence of comparable health data. Both the scope and methodology of health data collection differ considerably among Member States. There is a need for a good systematic overview of European health information, which compares national health reporting systems and includes a full, comparative description of data availability, collection methodology and data definitions.

#### *An appropriate degree of comprehensiveness*

The comprehensiveness of a health report refers to the degree of completeness and detail with which the public health sector is covered by a health report, or, in other words, the degree of coverage of a conceptual model. Such coverage is directly linked to the central question that must be addressed by a report. A broad central question will imply a broad coverage of the public health sector. Narrowing or focusing of question and coverage occurs when a specific topic is selected, i.e. a disease group (infectious diseases) or a set of risk factors (life style related health risks). A reduction in comprehensiveness can also result from narrowing the policy relevance, for instance, by focusing on prevention policy or even on a specific area of prevention, such as cancer screening.

Working Group II has indicated various reporting tasks for the Community, with a variable scope, and resulting in the production of reports with a variable degree of comprehensiveness.

#### *Conclusions*

Any operationalization of 'effective' health reporting must ensure policy relevance, i.e. by *linking health reporting to European programmes*, and by *stimulating networks in the health information area*. European health reports should, moreover, *provide added value* in comparison with existing national and other health status reports. The need to be collaborative implies drawing *the Commission, scientific experts, and Member States' expertise* into the health reporting process. Implementation of the key features identified above will provide the required quality and effectiveness. Several key features, i.e. being policy supportive, using a uniform conceptual model and being consistent are essential for all health reporting. The need for some of the key features, i.e. being fully quantitative, prospective or comprehensive depends on the specific purpose and central question of a health report.

In addition, however, there are other critical factors that determine the *actual impact* of health reporting. These are discussed in the next Chapter.

## 5 Critical factors for effective use of health reports by policy makers

For a health report to have a real impact on health policy it should be used effectively by policy makers. In this chapter we examine several critical factors that determine the actual impact of health reporting on health policy and perhaps on public health itself. The available experience from Member States, as provided by the working group members, has been the main input for this chapter.

### *Effects and impact of a health report*

Effectiveness of health reports can be measured at various levels. Eventual outcomes in terms of health changes would be the most tangible measure of impact, of course, but actions that are initiated by a health report, e.g. policy changes, as well as information that has been passed on to people, that may in turn influence public health, are considered relevant effects as well.

We may differentiate between *official impact*, i.e. recognised effects on governmental policy making or administrative changes and *unofficial impact*, such as publicity, scientific impact, use for educational purposes or influence on political parties or pressure groups. Among the impacts valued most by the working group were: the follow up of a report by an official governmental policy document, or by a policy initiative, and the discussion of a health report in parliament. Some experts highly value the use of a comprehensive national health status document in public health curricula, while others lay great value on the actual introduction of a health research programme in response to a particular health status report.

### *Achieving policy-relevant impact from health reports*

We have indicated measures or criteria by which the effectiveness or impact of health reporting may be judged. Some of these impact measures, such as the follow-up of a health report by an official policy report, can be embedded within the health policy process. It is obvious that setting up a policy cycle for the Community with a clear place for health reporting in the preparation and evaluation phases is a good way to achieve policy impact.

Most important is the ability to provide a relevant answer to a central question. This implies a very close and frequent interaction of producer and end user, but from a situation of scientific and political independence. Fine tuning of the central questions and checking of tentative answers for their practical value for the end user are essential requirements in this process.

The impact of health reports may be focused by the introduction of health targets or specific indicators and by evaluating these targets at regular intervals. To enable a long-standing impact on policy in the EU, a future health reporting effort should not be implemented for a short period, but must become a specific, continuous, activity in a new Framework for Health.

In summary the critical factors for effective health reporting are: the ability to provide a relevant answer to a specific policy question; the acceptance of the outcomes by the end user and by the public health sector and, last but not least, the intrinsic quality of the reporting effort, such as: the validity of the data, the presence of integrative power and scientific and political independence.

As it may be important for both Member States and the Community to share further experience in this area, a workshop will be organised by this working group in which producers and end-users of health reports can exchange practical lessons and address the question of how health reports may achieve policy impact in the European Union.

The question remains, however, which health reporting tasks and priority areas for health reporting can be identified and by what criteria new themes are to be selected.

## 6 Scope and realisation of health reporting for the Community

In Chapter 4 we indicated that a health reporting system might produce more than one kind of health report. The changing outlook of the Community, i.e. a broader orientation on effects of other policies on health, already indicates one *evaluative* health reporting topic, i.e. *health impact assessment*. This area does still need, as indicated in the report by Working Groups I and III, considerable further development of methodology.

An analysis of recent health reports from Member States has led Working Group II to conclude there is a need for *comprehensive, prospective, policy-supportive* health status reports for the Community. Reports with such a broad scope need not be published annually, however, but can be produced in a planning cycle of between 4 and 6 years. It is desirable to set up such a cycle for the Community. These reports, which are the most comprehensive ones, can serve the purpose of explaining the current situation and main developments and identifying future health policy options. They can provide an indication of areas for which comparable data are lacking and identify geographical areas, or specific sub-populations which show large deviations from the average for health status or for exposures to health threats.

The production of less integrative (1-2 year cycle) health reports for the Community is also considered useful. These reports can contain comparable statistical data, collected routinely and consistently. This would fulfil a need for the *general monitoring* of and reporting on the mainstream of health status, but with rather limited relevance for priority setting or policy evaluation. A primary 'statistical' data set (mortality) may be used to start this monitoring function, to be gradually extended with other data (morbidity, disability), e.g. from nationally representative (HIS/HES) surveys. The data contained in these annual (or bi-annual) reports may contain the first Community health indicators and be among the first to be spread via the newly planned electronic networks as foreseen in the Health Monitoring Programme.

A first health report from the Commission '*On the State of Health in the European Community*' was largely based on existing, comparable data from the 'Health for all' database (WHO), from Eurostat and OECD. This report classifies as fulfilling the *broad monitoring* need.

In addition, the working group concluded, other, *focusing*, health reports may be needed, i.e. for evaluative purposes, as indicated above, or for an *in depth, integrative, analysis* of a restricted part of public health with special relevance for the EU, e.g. diseases for which Community Public Health Programmes exist. Currently, a second health status report by the Commission is in preparation, focusing on the state of *women's health* in the EC, which classifies as a *focusing* report. Finally, the working group indicated the need for *prospective studies*, which may either be part of integrative studies or fully separate reports that focus on potentially important developments with uncertain health effects.

It was also suggested by the working group that it would be an important, comparative task for a health reporting system to collect and publish summary information on health information systems in Member States and on availability and comparability of health data and methods of collection and validation.

After the above identification of, at least, five different reporting tasks, the question arises, however, as to what priority issues a European health reporting system should deal with, or, according to what criteria European priorities for future health reporting should be selected.

### *Criteria and priority issues for health status reports - a preliminary view*

Priorities for health status reporting coincide, almost by necessity, with priorities for health policy. Criteria for selecting priority issues in European health policy are:

- Health problems (mortality, morbidity, disability) and health threats (risk factors), which are, or are likely to become, important in all or most EU countries
- Health problems that may cross boundaries (e.g. infectious diseases, air pollution, food and trade-related health threats, etc.)
- Aspects of health (e.g. mortality and morbidity) for which wide and/or unexplained differences exist between countries or regions.
- Health threats which by the nature of their causes and/or control are considered of particular relevance to the EC and to existing Community programmes, including relevance for other policies, e.g. the potential health effects of changing EU regulations.

The following preliminary list of possible topics has been drawn up after discussions within the working group. Some topics fulfil one criterion, others may fulfil several criteria. Areas that were already indicated by the Community as future priority areas are also found in this list. Strongly overlapping or otherwise closely related topics have been grouped by adding secondary, more specific, topics in brackets. This list has clearly a preliminary character and needs a systematic, further elaboration.

- ⇒ Environment and health [Pollution-related diseases]
- ⇒ Life style and health [Nutrition and health]
- ⇒ Rare diseases [Creutzfeld-Jacob disease/BSE]
- ⇒ Cancer [Cancer screening] [Breast cancer screening]
- ⇒ Accidents and injuries [Traffic accidents]
- ⇒ Social inequalities in health [Regional inequalities in health] [Social exclusion]
- ⇒ Avoidable deaths
- ⇒ Mental health [Alzheimer/dementia] [Suicide] [Drug abuse/Addictions]
- ⇒ Emerging infectious diseases [HIV-infection and AIDS] [Tuberculosis]
- ⇒ Diabetes Mellitus
- ⇒ The use and distribution of medical technology, including medical devices and drugs
- ⇒ Unplanned pregnancies
- ⇒ Care for the elderly

Some areas call for comprehensive, integrative reports, while others require a more specific approach. For areas in which rapid changes may occur (infectious diseases, the spread of unhealthy behaviour, etc.) or where quantitative predictions, such as demographic projections, are relatively reliable, prospective studies may be useful. For areas where anticipation may be important (e.g. new technological developments) prospective analyses are called for as well.

### *Conclusions*

Several necessary health reporting tasks have been indicated alongside a need for the production of various health reports for the Community. These may differ in scope and timing, but have a similar need for inter-report consistency, conceptual comparability and quality control. A preliminary list of priority topics is presented. As these topics may overlap and cannot be dealt with simultaneously, drawing up a programme or plan for health reporting seems logical, including a health reporting agenda. This is of major importance to ensure constant quality, conceptual continuity and consistency. The execution of this task could be given to a centralised capacity, for instance to a co-operating network of public health institutes with appropriate reporting expertise.

## 7 Summary and recommendations

Working Group II has analysed, in line with its terms of reference, priority issues and quality requirements for future European health status reports. The aim of the analysis was to enhance the impact and policy relevance of health reporting both for the Community and the Member States. In this summary, Working Group II presents its considerations and recommendations.

First of all, health reports should provide policy-makers with the required information. Two kinds of health reporting are necessary to serve policy making: (1) assisting in the preparation of new health policy by identifying new priorities, including the need and ability to identify health threats, and (2) analysis and evaluation of current and past health policy activities. Priority setting requires a broad, prospective view on public health, while analysis and evaluation focuses on a particular health aspect, i.e. an established policy priority.

Based on the experience of national experts involved in the preparation of health reports, Working Group II has identified the prerequisites for a scientifically sound approach to health reporting with a proper policy impact. These can be formulated as: *conceptual, integrative, collaborative, quantitative, consistent, prospective, comparative and comprehensive*.

In the European context this means that we should agree on a common conceptual approach to the public health sector, including definitions of indicators and determinants of health. These concepts and definitions should be used as consistently as possible. The necessary activities are foreseen under the proposed Health Monitoring Programme. A part of these activities may involve working towards comparable health data as is currently under study in Eurostat's Working Groups on Health Statistics and associated task forces.

The requirements placed on health reporting also imply, however, that health reporting should attempt to go beyond the presentation of sets of statistical data and offer explanations for observed differences and trends. A further necessary step is to adopt practices for prospective views, i.e. to apply methodologies for exploring possible future developments, e.g. scenarios and models.

The central element of EU health reporting, providing the *added European value*, is the comparison between regions and countries and between subpopulations of any kind, and, of course, comparison between different points in time. This may also highlight areas with a need for future data collection.

Finally, to ensure maximum scientific support and consensus, future EU health reporting should be undertaken in a collaborative way, actively involving different partners, such as:

- ◇ Member States and/or Federal Agencies, through their Health Ministries, national statistical bureaux (and Eurostat) and public health institutes with relevant reporting experience
- ◇ International health data-collecting organisations (WHO, OECD, Eurostat), which have a dominant role in the harmonisation of European health data and information
- ◇ Community Public Health Programmes (and their committees)
- ◇ International research networks which cover specific areas of public health
- ◇ Concerted Actions or Centres in the public health area that are supported by EC funding

Health reporting will have a sufficient policy impact if it succeeds in providing a relevant answer to a specific policy question and if the outcomes of the reports gain acceptance by the end-user (the Commission, Council and Parliament), by the Member States, and by the public health sector. It is possible to organise the production of health reports so as to optimise the chances of this acceptance of the product, and simultaneously guarantee consistency and quality. This has been achieved in Member States by setting up a health reporting capacity at an appropriate

distance from the end user, which operates according to a plan, remains under expert supervision, and co-operates closely with both the end user and the public health sector.

In practice, a future European health reporting system will have to accommodate a number of different reporting tasks, which can be specified as follows:

- **identify new priority areas** through the cyclical (4-6 years) production of a comprehensive, prospective report. This should cover the full public health sector and contain an integrative, comparative analysis of health status, its determinants and consequences, including trends and expectations for the future
- **focus on existing priority areas.** Integrative, comparative health reports designed to analyse specific topics, as presented by Community Programmes (e.g. cancer, AIDS)
- **monitor current health status** through regular (1-2 year) publications. These should have a broad health monitoring purpose, presenting routinely collected, fully comparable data. This activity has strong links to the development of a set of health indicators and of an electronic health information network, as indicated in the Health Monitoring Programme
- **evaluate the effectiveness of health-related EC actions.** Reports that include analysis of health data and the use and development of *health impact assessment* measures and indicators to evaluate past and, if possible, future policies. This area may need a separate approach as methodologies are still developing.

Another feasible function for a health reporting capacity, but one which does not imply actual health report production, is the collection and publication of *summary information on health information systems in Member States* and on the availability and comparability of health data and methods of collection and validation.

It is emphasised that several reporting tasks should involve the incorporation of *prospective views or forecasts*. In addition, separate prospective studies may be called for, which analyse the health effects of potentially important developments, i.e. ageing, migration, environmental changes and selected socio-cultural developments

Within the above reporting tasks a variety of themes for individual health reports can be elaborated and several themes have been identified in this report. These are related to health problems, health threats or uncertain, potentially health threatening, developments, which may cross boundaries, with a 'shared EU priority' and/or identifying large, growing health differences in the Community. The complexity of the tasks and themes requires setting up a plan and reporting agenda and a proper organisation of the production process. This translates into a number of practical, recommendations for future European health reporting:

- ◇ be organised within a '*capacity for health reporting*', which operates in a scientifically and politically independent way, with close involvement of the Commission and the Member States from the outset and initially associated to the Health Monitoring Programme (HMP)
- ◇ operate according to a plan of action, including a *European health reporting agenda*. This calls for a *health reporting plan* to be drawn up, with specific aims, objectives and quality specifications for reports and involving health reporting expertise from Member States in both planning and production
- ◇ A European health reporting capacity should not be implemented temporarily, as in a programme of restricted duration, such as the Health Monitoring Programme. Health reporting should eventually become a well-defined part of a Community health policy cycle and an explicit part of a new Framework for Health.

# Workshop Summary

**Bilthoven, 19 & 20 February, 1998**

## **Health Reporting in the European Union**

### **ANNEX 2**

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