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SESSION I: Problems associated with the lack of coordination in national and international health statistics

"Health for all" indicators for the WHO European Region and the HFA database

Invited paper submitted by the WHO Regional Office for Europe,
Unit of Epidemiology, Statistics and Health Information

Introduction

1. The purpose of this paper is to describe the role, concept and use of the European HFA indicators and its associated database presentation system. It is this experience that has determined WHO's strategy for strengthening national health information systems with its emphasis on greater use of existing data rather than more data *per se*. It is also this experience that has laid the foundation for the concept of National Integrated Statistical Health Databases (as set out in Paper 2).

2. However, it should be noted that many countries have been using similar concepts and databases to make comparisons, by geographic areas and health care institutions, of health and health-related information to analyze the effectiveness and efficiency of their structures and actions. In recent years, such comparisons have become increasingly important and are being complemented by the use of international databases to identify areas where sharing other countries' experiences and good practices may be beneficial.

3. Furthermore, like WHO, OECD have also developed and maintained a health database since the mid-1980s. Other international agencies working in health,

such as UNICEF and the World Bank, have also begun to do so in their particular technical and geographical areas. Moreover, as the European Community starts to implement the Health Monitoring Programme, it too, will develop and maintain a Health database.

The European HFA Policy and Targets

4. The global strategy for attaining the goal of health for all by the year 2000 (HFA 2000) was launched after the World Health Assembly's historic HFA resolution (May 1977). To support the global strategy, a regional health for all strategy specifically for Europe, was endorsed by the European Member States in 1980 as the collective expression of all their health aspirations. The strategy called for a fundamental change in health policies in Europe with concerted action to give, higher priority to health promotion and disease prevention and to give greater stress to the role individuals, families and communities can play in health development.

5. In pledging themselves for the first time ever to one common regional health policy, the Member States also recognized that in order to achieve practical change something more concrete was needed. Therefore, they agreed to establish specific targets to support the implementation of the strategy. In 1984, after extensive analyses and debate 38 specific and formidable but not unrealistic regional health for all targets were adopted by the Member States at the 34th session of the Regional Committee for Europe. Described as a "wonderful blend of today's realities and tomorrow's dreams", the HFA targets set the challenge to achieve certain improvement levels in the health status of populations in Europe and in health determinants such as lifestyle hazards, environment and health services. Member States also agreed to update the HFA policy and targets every 7 years. The last update of the European policy and targets was in 1991 and the update for the 21st century (HFA 21), with its proposals for 21 targets for the 21st century, will be finalized in 1998. In this way, Member States morally pledged themselves to constantly work together across political and national borders to improve the health of the people of Europe.

The HFA Statistical Indicators

6. Together with the 38 regional HFA targets, the Member States also adopted a set of statistical indicators for use on a routine basis to assess progress or lack of progress towards the HFA targets. The indicators are more formally used during the regular triennial HFA monitoring and evaluations. The last HFA evaluation was in 1997 and its results are presented in the report Health in Europe – 1997, which has been widely distributed. Copies will be available at the Sixth WHO/ECE meeting on health statistics. Prior to each of the formal triennial monitoring and evaluations, the list of HFA indicators is reviewed in a process of consultation with internal and external experts, to take into account the changing requirements and availability of data. The list of indicators is also reviewed as part of each update of the HFA policy. No significant changes to the list of HFA indicators were necessary during the 1991 HFA policy update, as the number and essence of the HFA targets

remained relatively unchanged. The available data on HFA indicators had been continuously collected by the WHO Regional Office for Europe since 1984 and have been widely disseminated via a PC based presentation system which is known and used as the HFA database.

7. The 1998 update of the health for all policy for Europe, with its 21 targets, is more extensive than that carried out in 1991 and reflects the needs of the twenty-first century. Accordingly, a major review of the present HFA indicators has been undertaken. This included (i) reassignment of the present HFA indicators to the newly formulated targets, and (ii) the definition of new indicators wherever necessary. The opportunity was also taken to streamline the existing system of indicators based on the experience of the past 15 years, in order to provide a more efficient HFA monitoring and evaluation mechanism as called for by the Member States. At the same time the continuity of the HFA indicators as an international framework for health monitoring has been preserved. The targets and associated indicators presented to the forty-eighth session of the Regional Committee in September 1998 will be made available at the sixth WHO/ECE meeting on health statistics as a Conference Room Document.

Coverage of HFA indicators

8. Since 1984, the HFA indicators have become widely used and known as a common framework for international data collection, harmonization, dissemination and use of basic health statistics in the Region. This framework also serves as a backbone linking, at the HFA indicator level, different data sets which at least in WHO/EURO were previously compartmentalized in different units or programmes.

9. Relating to the HFA policy targets, HFA indicators "by definition" cover not only the whole of the health sector but also the health-related aspects of other sectors, being of course more detailed with regard to health status and health services. The HFA indicators and some supporting background statistics, as they are used in the HFA database, can be grouped under the following broad headings:

10. Basic demographic and socio-economic indicators.

11. Health status indicators:
12. mortality-based indicators
13. morbidity indicators
14. disability and other measurements of health status.
15. Health care indicators:
16. resources and cost related input indicators
17. utilization related process indicators
18. health care quality and outcome related indicators.
19. Lifestyles related indicators.
20. Environment related indicators.
21. Sources, quality and reporting cycle

22. Data availability and quality vary between the different indicators. The data are relatively good for the indicators which are based on routinely collected and available statistics in the countries. However, even in the case of most commonly used health statistics, these are not always fully comparable between countries due to the differences in national definitions and registration practices. Less data are available for indicators which are measured by means of population surveys and censuses or are not part of the usual statistical data collection and reporting in the European countries. Nevertheless, these indicators are retained as part of the HFA indicator because this “blend of today’s realities and tomorrow’s dreams” will help to motivate and stimulate countries to extend their routine systems to cover such indicators in the future.

23. Not all indicators are collected directly from the countries. Data which were already reported by countries to WHO or other international agencies are used first and only missing data are requested from the countries. This is to lessen the task of reporting for Member States and, at the same time, the use of one common source (as far as possible) increases comparability. For example, most mortality-based indicators are calculated by WHO from the detailed mortality data which have been routinely reported to WHO for many years. In general, there are three groups of data sources: (i) data reported to the specific WHO units (e.g. mortality, infectious diseases, immunization); (ii) data from other specialized international agencies/secondary sources (e.g. health expenditures from OECD, food consumption from FAO, etc.); (iii) national counterparts for health statistics.

24. For practical reasons, the HFA data collection from countries is divided into two parts: (i) annual collection of health statistics which in most countries are part of the routine national statistical data reporting; (ii) 3- or 6-year special requests to countries (as part of the regular HFA monitoring and evaluation in the European Region) for the data which are not covered by the above annual collection. The latter are usually data which are derived from census and health interview surveys which even at country level are in general only likely to be updated every 5 or 10 years.

25. Annual letters requesting data with detailed guidelines and definitions are sent to the national counterpart for health statistics which, in most countries, has been officially nominated by the Ministries of Health. Recommended working definitions for annually collected HFA indicators are included in the guidelines in order to improve international comparability of data. It is expected that countries will make efforts to re-group their raw data to comply with the recommended definitions. When this is not feasible or acceptable, the available data are requested to be provided as they are, together with a description of national definitions or differences from the recommended common definitions.

26. The majority of countries in Europe are reporting in computer readable form and some of them have computerized the retrieval of data for reporting to WHO/EURO from their national health databases. This makes the preparation of standard data files with updates of the HFA indicators almost a matter of

"press a button". Experience from recent years shows that reporting from countries of central and eastern Europe is generally more complete and timely as compared to most western European countries. However, the description of the national definitions is still a problem for almost all the countries. Presumably one of the reasons is that the national definitions and registration methods of most statistical indicators are not fully documented and generally known in the countries. Usually it is assumed that national indicators follow common international definitions. However, there are often country-specific registration practices in different countries causing a bias in the statistics which are only known to a small number of national experts.

27. The schedule of the data collection and dissemination cycle is as follows:

January-April

28. WHO/EURO collects available data for selected indicators from secondary sources (e.g. other international agencies) and loads it into the HFA database.

May-June

29. WHO/EURO sends data request letter and guidelines to the national counterparts for health statistics. The HFA database and prefilled data sheets are also included with the data already available for the respective country, which were reported to WHO in previous years or obtained from secondary sources. This allows countries to identify which data are already reported to WHO and to provide only new, missing or corrected data.

August-September

30. Countries are expected to retrieve the appropriate data items from the national health database and to forward these data to WHO/EURO in a standard computer-readable form, according to the recommended specifications given in the guidelines.

October-November

31. WHO/EURO processes the reported data and loads it into the European HFA database presentation system.

December

32. All accumulated data, in the form of the user-friendly HFA database presentation system, are sent back to the countries and made available for international use.

33. Whenever possible, countries are encouraged to establish procedures for automatic retrieval of appropriate data from their national health databases in the form of standard files for further transmission to WHO/EURO. After the

initial effort and investment, subsequent periodic provision of data becomes a relatively minor task.

The HFA database presentation system

34. Although originally the HFA database was established as a tool to monitor progress towards the HFA targets in Europe, it now also has an increasing value as an international source of key health data for the European countries which is easily accessible to everybody throughout Europe. The HFA database is now frequently used by a wide range of users, such as national health administrations for assessment and comparisons of health in their country vis-à-vis other European countries, schools of public health for teaching purposes, individual researchers for writing papers on international health, pharmaceutical and medical equipment companies for market research, students doing their projects and a variety of other users. One of the reasons for this relatively good success is that the HFA data are distributed together with a user-friendly data presentation software. It allows easy and fast access to the data and its display in graphical form even by less computer "literate" users. This significantly expands the range of potential users of the HFA database.

35. The first version of the HFA database was produced in 1987. Initially, data updates were made only as part of the triennial HFA monitoring and evaluations. Since 1992, more regular data updates were initiated; already in April 1992, the HFA database was the first and only readily available source for detailed data (initially mainly mortality) on the Newly Independent States. Since 1993, both a Windows and a DOS version of the HFA database have been available and since then, the software and presentation possibilities have been periodically improved in response to users' comments and requests. Many Ministries of Health have made the HFA database available on their LANs and in 1995, WHO/EURO made the HFA database available on their website so that it could be downloaded via the Internet. This coincided with the initiation of annual data updating and in 1996 an "on-line" Internet version was developed.

36. Now, as mentioned above, the HFA database is updated and made available twice a year: in June-July (after the data from secondary sources are included) and in December-January (after the data reported by countries are included). It is placed on the WHO/EURO web site (www.who.dk, Country Information page) and FTP server (ftp.who.dk\HFA), from where it can be downloaded at any time. The data of the issue is indicated on the opening screen of the HFA database. An "Internet on-line" version, with fewer data display options, is also available at the above web site. The next development of the HFA database will take place as part of the development of the European Public Health Information Network for Eastern Europe (EUPHIN-EAST).

Developments at country level

37. The power of comparative information and its feedback to aid decision-making, as exemplified by the HFA database presentation system, has been recognized by countries in Europe since the beginning of the 1980s. Many countries have developed such systems, some of which will be presented at the joint ECE/WHO meeting on health statistics in Rome. Some of the systems known to WHO are the UK Health Service Indicator system, the Danish Indicator System for Community Physicians, the Finnish SOTKA database, the Norwegian "Wheel", the Lithuanian indicator system for its health districts, the Swedish system for its "Kommunes", the French "Health Observatory" and the German Internet-based health and health services system.

38. Many of the above have been based or inspired by the WHO HFA database system and the WHO Collaborating Centre in Vilnius, Lithuania, has been a key resource. In some cases, the systems have been developed with WHO. For the eleven central and eastern European countries and the 12 newly independent states, this was started with the support of the UK (1992-1994) and continued as part of the joint EU/WHO projects COPERNICUS CARESUPPORT (1995-1996) and EUPHIN-EAST (1997-1998). Appropriate selection of indicators and training in their use for policy and management was a key element of this development.

39. WHO has, as part of the above projects, developed a "developer's version" of the HFA database system which can be easily and very cost-effectively adapted (including translations into their language) by countries for use by their health districts and managers. Those countries in Europe which did not already have such systems (e.g. Switzerland, Ireland, Spain, Portugal, Italy, some Lander in Germany, Austria) have used, or are using the developer's version of the HFA system to build a database presentation system for themselves.

40. Independently, there has also been interest from outside Europe. Requests for such developments have come from as far afield as Hong Kong, Bhutan, India, Pakistan, states in Canada, Australia and the USA.

Conclusions

41. The HFA policy and targets set the goal to be achieved for health in Europe. The set of internationally approved HFA indicators provides a framework and system to monitor and evaluate progress towards that goal. The HFA database presentation system enables countries to use the HFA indicators to compare themselves to other countries and seek answers to the differences they find. Such systems that allow ready comparisons are invaluable and many countries in Europe are developing or have developed such systems. Some countries have and are using the "developer's version" of the WHO HFA database presentation system software to cost-effectively create their national versions.