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STIMULATING INTERNATIONAL CO-OPERATION ON HEALTH STATISTICS

Submitted by Eurostat and CBS-NL

1. The document CES/1999/11 on 'Health statistics – Questions of priorities and co-ordination' of 30 March 1999 submitted by Statistics Canada for the 47th plenary session of the Conference of European Statisticians (CES), mentions the need for more co-ordination in the area of health statistics in general and in some areas in particular.

2. In the present document Eurostat and CBS-NL present a practical example of co-ordination of work within the European Statistical System (ESS), leading to a comprehensive and consistent system for health statistics covering all relevant areas, as well as a proposal for better co-ordination of the work between international organisations.

Increasing interest in the EU for health statistics

3. Within the European Union the issue of public health has been given a boost, since as part of action under Art 129 (on public health) of the Maastricht Treaty, reinforced by the new public health provisions of the Amsterdam Treaty, the Community had to address the issues of preventing disease and protecting health. A prerequisite for such action is knowledge about existing problems, their nature and their extent and evaluation of results of specific programmes.

4. In June 1997 the Council and the European Parliament, following a proposal[1] made by the Commission, adopted a Decision on a programme of Community action on health monitoring (1997-2001)[2]. This programme is now being executed by the Commission and the Member States (steered by DG V supported by Eurostat). The statistical activities required for health monitoring are explicitly outlined in the Community Statistical Programme 1998-2002.

5. The programme of Community action on health monitoring (HMP) includes in its annexes a non-exhaustive list of areas in which health indicators may be established, ranging from health status (including disability, morbidity, accidents and mortality by cause), life style and health habits, living and working conditions to areas such as health protection, demography and social factors.

6. It should be noted that the wide range of areas proposed (see Annex), matches with a number of existing statistical projects undertaken in the European Statistical System (ESS). For example, data on costs and financing of health care are linking in with the System of National Accounts (SNA), the causes of death statistics are closely linked to demographic data in general and statistics on the health care sector tie in with business statistics. For many of these statistical projects, Community legislation is in force.

Organisation of the work within the ESS

7. Already at the stage of its preparation, this programme of Community action on health monitoring has given useful inspiration for the work of the three Eurostat Task Forces (TF) on public health each covering one of the three major domains of health statistics: health and health related survey data, causes of death statistics and health care data. For each of the TFs the Eurostat Working Group on 'Public Health statistics' (15 EU Member States and EEA/EFTA countries as members, WHO and OECD as observers) agreed the specific Terms of Reference and all participants expressed their great interest to participate actively in the Task Forces.

8. In 1997, the Statistical Programme Committee (SPC) decided to put the LEGs (Leadership Groups) idea into practice. LEGs are 'a form of partnership in which the responsibility for developing (parts of) new Community statistical projects in fields not (totally) covered by legal acts, is delegated for a defined length of time to one Member State which co-ordinates the activities of a limited group of Member States together with Eurostat, under the basic assumptions of shared responsibilities and control of the SPC'.

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1 COM(95)449 final of 16.10.1995
2 OJ No L 193, 22.7.97, p. 1
(texts available from Eurostat/E/3 – M.De Smedt Tel : 352/4301-33673)

9. In March 1997, a protocol on a LEG Health was agreed in order to strengthen the capabilities at EU level, to speed up the work under the TFs and to assist in the development of a general framework for health statistics at Community level. The LEG Health partners agreed to advise and support Eurostat within the readily available means and feasibility, in particular for:
- the preparation and chairing of TF meetings,
- implementation of Eurostat projects,
- expert and technical advise .

10. The LEG Health involves a direct participation of a group of leading partners :
-Statistics Netherlands (CBS): co-ordinator of the LEG Health;
-Institut National de la Santé et de la Recherche Médicale (INSERM) - after consulting Institut National de la Statistique et des Etudes Economiques (INSEE) in France,
-the Office for National Statistics (ONS) in the UK and
-the Statistisches Bundesamt (StBA) in Germany.

11. It should be emphasised that National Statistical Institutes (NSIs) and government authorities from other Member States are also members of this new form of partnership, in particular as members of TFs. Many of them, and also OECD and WHO, have taken an active role in the TFs, e.g. in preparing documents. At its 29th meeting on 27 May 1998 in Stockholm, the SPC welcomed the work achieved during 1997 by the LEG on Health statistics and decided to continue its mandate.

12. And so Eurostat is actually establishing, together with the authorities responsible in the Member States for public health statistics and through the LEG Health, the infrastructure for a permanent and durable system for public health statistics at Community level. This system, which will provide the statistical data needed primarily for health monitoring, builds mainly on three domains: health and health related survey data, causes of death statistics and health care data.

13. The SPC has in September 1998 endorsed and supported the achievements made in these three domains as well as the main objectives for the short and medium term planning. The ultimate goal is to have – by the year 2002 - a system, which could adequately respond to the need for changing priorities on health data for establishing and monitoring of programmes and actions in the field of public health.

Co-ordination with international organisations

14. Significant international experience has already been gathered in the field of health data and the use of health indicators, in particular by the World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD). Co-operation between these organisations

and the Commission (DG V and Eurostat) on health monitoring and public health statistics is fostered through their participation at the meetings of the Eurostat TFs and their attendance as observers at meetings of the WG on Public Health statistics and of the HMP Committee.

15. In addition, regular exchange of information on the activities of the respective organisations is given through the Economic Commission for Europe (ECE)/CES, who designated the OECD as the focal point on health statistics.

16. When common interests are involved in the domain of public health statistics, Eurostat would prefer a collaboration with international agencies on the basis of 'use of common questionnaires' or on the basis of 'territorial division'. These two models are preferred rather than a division of work, by which each organisation would be responsible for a number of 'subjects', such as 'mortality', 'surveys', 'cost of health care'.

17. The 'subject' model would not be feasible since each organisation has – according to its mandate – its own ways of accountability for preparing reports and documents on health issues, and therefore needs to have the flexibility for specific analysis, if needed via specific indicators. Such mandates cannot be transferred between inter/supra –national organisations and Eurostat's comprehensive approach requires regular and appropriate primary data for all components.

18. The 'territorial' and the 'common questionnaire' model are already applied successfully for several domains, e.g. statistics on agriculture, education, population, ESA). These models are already including other UN agencies, such as UNESCO and UNSD and they could also be applied for health statistics, including reporting by EU Member States to WHO and possibly to other agencies, via Eurostat.

19. A further step could be to seek practical working solutions for avoiding duplication of efforts and creating transparency. Working relations between the organisations could be further improved according to three technical pillars:

a) development and maintenance of the methodology, e.g. establishment of standards and instruments for data collection, definitions and classifications;

b) the data collection as such, transmission and validation;

c) use of data for management, planning, analysis and publications, research.

20. For development and maintenance of the methodology e.g. on standards and instruments (point a) the international focal point should be – per subject or cluster of relates subjects - where expertise can best be mobilised, e.g. International Classification of Diseases (ICD) in WHO, health expenditure

classification in OECD, panel survey methodology and statistics on disability in Eurostat. This does not prevent other agencies from working together with the focal point.

21. The data collection (point b) should follow the two above-mentioned models (already adopted by OECD, Eurostat and some other organisations). The actual data transfer between countries and inter/supra national organisations is not a problem as such: for health data, it is expected that in the future the data exchange will be realised through the telematic transfer system being established by the HIEMS-EUPHIN project of the European Commission. Ideally this will lead to a unique set of data accessible to all relevant inter/supra national organisations attached to the network. However validation at international level will be needed even more; and this could be arranged via the territorial model.

22. With respect to analysis and reporting (point c) every organisation must be free to act according to its mandate, for the preparation of specific reports e.g. World health reports (WHO), Annual report on the status of health in the EU (DG V- Eurostat) or for further in-depth analysis if needed even with specific indicators. This principle of flexibility should be guaranteed so as not to hamper the organisations in the execution of their mandates. Countries will then be given the opportunity to discuss the analytical results in the existing consultative structures of the respective organisations. The results of these discussions will also be presented at the regular co-ordination meetings between the organisations (see below).

23. In addition to these three pillars, support is needed for strengthening the frameworks for statistical systems in the Member States. This should be pursued by all organisations according to their proper means and resources and could be subject of ad-hoc collaboration and joint efforts, e.g. common training through Training of European Statisticians (TES) or the joint OECD-Eurostat Workshop on Health Accounts.

A practical way forward

24. Building on the document presented by Statistics Canada, we suggest at first to widen the scope so that attention is given not only to measures of health status, but also to the whole area of health care data and to health outcomes (defined as the effects of health care on health status), the latter being of increasing importance at political level.

25. It would also be preferable to distinguish the discussions on the scope and content of the different domains in health statistics (such as on ‘health status measurement’ as suggested by Statistics Canada) from the practical arrangements for implementation to be made afterwards on the organisation of the work and on the co-ordination of the activities between the different inter/supra-national organisations.

26. We welcome to have at regular intervals, e.g. twice a year, an exchange of information between the relevant organisations and agencies involved. Instead of assuring this through the establishment of a formal Inter-secretariat Working Group we would rather consider the possibility of having these regular meetings in the context of the existing structure (via the focal point, which is OECD) and still leaving the possibility open for the organisations to make ad-hoc practical arrangements on specific topics to maximise efficiency.

27. As a practical way forward we suggest that it is the focal point that takes the initiative for establishing contacts between the inter/supra-national organisations. A group of three representatives from National Statistical Institutes (NSIs) would also be invited to participate at these meetings. As participating NSIs we suggest that one for the EU (e.g. the co-ordinator LEG health), one OECD member country (non-EU Member State) and one WHO/Europe member country (non-EU MS and non-OECD member country) are chosen.

28. It would be preferable to have each inter/supra national organisation – for a period of two years – in the focal point's role; the secretariat would then be assumed by the focal point together with one of the participating NSIs on a rotational basis. Meetings could either be organised by teleconferencing or in one of the organisations' or NSIs' premises. According to the existing procedure it is then up to the focal point to report to the ECE/CES.

Annex

NON-EXHAUSTIVE LIST OF AREAS IN WHICH HEALTH INDICATORS MAY BE ESTABLISHED

(Annex II of DECISION No 1400/97/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 30 June 1997 adopting a programme of Community action on health monitoring within the framework for action in the field of public health (1997 to 2001)

A. Health status

1. Life expectancy:
   - life expectancy at certain ages,
   - health expectancies.
2. Mortality:
   - overall,
   - causes of death,
   - disease-specific survival rates.
3. Morbidity:
   - disease-specific morbidity,
   - co-morbidity.
4. Functioning and quality of life:
   - self-perceived health,
   - physical disability,
   - activity limitations,
   - functional status/ability,
   - health-related work loss,
   - mental health.
5. Anthropometric characteristics.

B. Life style and health habits

1. Tobacco consumption
2. Alcohol consumption
3. Illegal drug consumption
4. Physical activities
5. Diet
6. Sex life
7. Other

C. Living and working conditions

1. Employment/unemployment:
   - occupation.
2. Work environment:
   - accidents,
   - exposure to carcinogenic and other dangerous substances,
   - occupational diseases.

3. Housing conditions.
4. Home and leisure activities:
   - accidents at home,
   - leisure.
5. Transport:
   - car accidents.
6. External environment:
   - air pollution,
   - water pollution,
   - other types of pollution,
   - radiation,
   - exposure to carcinogenic and other dangerous substances outside the work environment.

D. Health protection

1. Sources of financing.
2. Facilities/manpower:
   - health resource utilization,
   - health care personnel.
3. Cost/expenditure:
   - in-patient care,
   - out-patient care,
   - pharmaceutical products.
4. Consumption/uses:
   - in-patient care,
   - out-patient care,
   - pharmaceutical products.
5. Health promotion and disease prevention.

E. Demographic and social factors

1. Gender
2. Age
3. Marital status
4. Region of residence
5. Education
6. Income
7. Population subgroups
8. Health insurance status

F. Miscellaneous

1. Product safety
2. Others
