



**Minutes of the ECHIM Extended Core Group meeting  
Luxembourg 1.-2.3.2010  
Jean Monnet M4**

**List of Participants**

|                 |  |             |
|-----------------|--|-------------|
| Austria         | Jeannette Klimont                          |             |
| Belgium         | Jean Tafforeau                             |             |
| Cyprus          | Pavlos Pavlou                              |             |
| Czech Republic  | Jiří Holub                                 |             |
| Estonia         | Liis Roováli                               |             |
| Finland         | Arpo Aromaa                                | (chairman)  |
| Finland         | Mika Gissler                               |             |
| Finland         | Marja Lampola                              |             |
| Finland         | Ari-Pekka Sihvonen                         |             |
| Finland         | Antti Tuomi-Nikula                         |             |
| Finland         | Kari Kuulasmaa                             |             |
| Finland         | Jari Kirsilä                               |             |
| Finland         | Johanna Mäki-Opas                          | (secretary) |
| France          | Gerard Badeyan                             |             |
| Germany         | Jürgen Thelen                              |             |
| Germany         | Nils Kirsch                                |             |
| Greece          | Aris Sissouras                             |             |
| Greece          | Elpida Pavi                                |             |
| Greece          | Demos Bartsokas                            |             |
| Ireland         | Hugh Magee                                 |             |
| Ireland         | Grainne Cosgrove                           |             |
| Italy           | Silvia Ghirini                             |             |
| Italy           | Emanuele Scafato                           |             |
| Lithuania       | Rita Gaidelyte                             |             |
| Lithuania       | Ausra Zelviene                             |             |
| Lithuania       | Ieva Uogintaite                            |             |
| Luxembourg      | Guy Weber                                  |             |
| Malta           | Miriam Gatt                                |             |
| Netherlands     | Pieter Kramers                             |             |
| Netherlands     | Marieke Verschuuren                        |             |
| Norway          | Cassie Trewin                              |             |
| Poland          | Roman Topor-Madry                          |             |
| Portugal        | Jose Luis Castanheira                      |             |
| Serbia          | Jasmina Grozdanov                          |             |
| Slovak Republic | Mária Chemelová                            |             |
| Slovenia        | Polonca Truden-Dobrin                      |             |
| Slovenia        | Katja Kovse                                |             |
| Spain           | Mónica Suarez Cardona                      |             |
| Spain           | Maria De Los Santos Ichaso Hernandez-Rubio |             |
| Sweden          | Susanne Holland                            |             |
| United Kingdom  | Joanna Newton                              |             |
| United Kingdom  | Hugh Markowe                               |             |

WHO  
DG SANCO  
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Eurostat  
Eurostat

Enrique Loyola  
Nick Fahy  
Guðrún Guðfinnsdóttir  
Bart De Norre  
Albane Gourdol

## **Monday 1<sup>st</sup> of March 2010**

### **Opening of the meeting**

*Nick Fahy and Arpo Aromaa*

Nick Fahy welcomed the participants to the meeting. The role of the Commission is to support Member States in developing the health information system. Fahy addressed that comparable health information is important and is one of the most powerful ways to influence to the health policy. This is why the Commission wants to support the Member States in the actions related to the ECHI Indicators. This meeting was arranged to get all or at least nearly all the Member States around the same table, so that the implementation work could really begin.

Arpo Aromaa also welcomed the participants and noted that it is great to notice that the project has the Commission's support. Work with the health indicators has reached the point where it is time to move from the defining the indicators to the implementation phase. This meeting should support the implementation work in the Member States. He gave thanks to the Commission for organizing this meeting. In this meeting agenda there are also two workshops. During these workshops it is possible to share experiences about the implementation work between countries.

A short introduction round was held among participants. From this meeting forward Albane Gourdol will replace Lucial Agafiteil as the representative of Eurostat.

### **Adoption of the agenda**

The agenda was accepted. The timetable is quite tight, but when possible time for discussions will be arranged.

### **Minutes of the previous meeting**

Arpo Aromaa went through the minutes of the previous meeting (29–30 September 2009) and they were accepted without any changes.

### **Recent developments in the health information activities**

*Guðrún Guðfinnsdóttir*

Guðrún Guðfinnsdóttir started by informing that a new Commissioner for Health and Consumers, Mr J Dalli from Malta had recently taken office.

She told about the main objectives of the Second Programme of Community action in the field of health which are to improve citizens' health security, to promote health and to generate and disseminate health information and knowledge. Joint actions are emphasised in the work plan 2010. It includes calls for 10 joint actions including healthy life years, injury data and monitoring, rare diseases, congenital anomalies, cancer and Alzheimer's disease and other dementias. Eurobarometer surveys during 2010 will concentrate for example on visual health and impairments, hearing health and impairments, knowledge of rare diseases, patients' rights, tobacco, mental health and sleeping disorders.

She described briefly the progress on the European Health Examination Survey (EHES). Piloting of the EHES will be conducted through Joint Action. Full scale surveys will be implemented in 2011–2013 if funding can be ensured.

EU alcohol indicators have been developed by a special Committee on Alcohol Data Collection, Indicators and Definitions. The Committee identified key indicators on volume of consumption, pattern of consumption and alcohol-attributable health harm as well as some indicators to address the priority themes identified in the EU strategy to support Member States in reducing alcohol related harm.

New EU Public health website ([ec.europa.eu/health](http://ec.europa.eu/health)) has been remodelled. The new website contains the ECHI tool, which is under development.

## **Eurostat actions related to health indicators**

*Albane Gourdol*

Albane Gourdol introduced the Eurostat actions which are related to the health indicators. She concentrated mainly to the EHIS (European Health Interview Survey). The first wave of EHIS has been implemented in 18 MS and in TR, CH and NO whereas in 6 MS EHIS modules have been only partly covered and 9 MS did not participate. Currently Eurostat keeps microdata files from 7 countries. By the end of 2010 Eurostat should have 17 microdata files. Validation rules of the results from the first wave have been finalised in September 2009 but there is constant update. Dissemination of the EHIS results via Eurostat website will happen in October 2010 and in April 2011; microdata files will be available for research purposes also during the year 2011.

The second wave of EHIS will be implemented during the year 2014. For this the assessments from the 1<sup>st</sup> wave will be done and the questionnaire will be slimmed down. Filling in the EHIS questionnaire can take one hour. Some encountered problems will have to be solved (e.g. on mental health, alcohol and physical activity questions). The new EHIS questionnaire should meet the needs of several policy-driven indicator systems. Fieldworks in 2014 will be held under an Implementing regulation. There will be an EHIS workshop in Berlin in September 2010. The aim is to share experiences between HIS experts and find out solutions to the problems faced during the 1<sup>st</sup> phase.

There was discussion about the new implementing Regulation. Gourdol pointed out that by 2014 MSs will be obligated to carry out EHIS. Eurostat received compliments about the dissemination of the results and a statement that ECHIM and Eurostat should collaborate closely also in the future. There is a lot of work to be done.

## **Summary of the EU health survey actions EHIS, EHES and EUHSID**

*Arpo Aromaa*

Arpo Aromaa briefly described the other EU actions related to ECHIM. He pointed out that many ECHI indicators can only be derived from health interview and health examination surveys. The projects close to ECHIM are EHES, EHIS and EUHSID. EHES (European Health Examination Survey) is expected to go into full-scale after it has been piloted in 2010 in 14 countries. The first round of full-scale EHIS (European Health Interview Survey) has been completed in 21 countries and some results will be released next year. However, it has become clear that a large part of the EHIS questions need to be revised. Therefore, the wave starting 2014 is expected to be the first covering all EU countries. The survey system has been supported by the EUHSID database comprising HIS and HES methods from EU and OECD countries. Currently, the structure and user-friendliness of the database is being improved. Since ECHIM implements indicators, its main goal is to use the data from existing and these new sources. A lot of work has been put into defining indicators to be derived from EHIS and EHES.

## **Overview of the progress of the ECHIM**

*Mika Gissler*

Mika Gissler gave an overview of the status of the ECHIM project. The main achievements of the previous phase of ECHIM (2005–2008) were the formation of the extended network of health indicators specialists, the release of an updated ECHI shortlist of indicators, including a set of partly finalised documentation sheets and the collection of country specific information on the availability and comparability of the ECHI shortlist indicator data. The next step is the implementation, which is the core issue in the Joint Action for ECHIM.

The Joint Action is funded by the EU Commission and runs until end of 2011. There are five partners (THL, RIVM, RKI, HI, ISS) and liaison with EU Commission, Eurostat, Member States and International organizations in health monitoring. Main objectives are to consolidate and expand the ECHI indicator system towards a sustainable health monitoring system in Europe and to collect and disseminate comparable health data and information based on the ECHI shortlist. The prospective outcomes from the Joint Action for ECHIM are: a new release of the ECHI shortlist, including a complete and finalised set of documentation sheets, an updated description of the methods for improving the ECHI shortlist, guidelines for implementing the indicators at national level and EU level, the initiation of an ongoing process for implementing health indicators in most Member States, realization of a pilot data collection and the creation of the electronic presentation of the gathered health data based on the ECHI shortlist indicators and the final report.

There is overall eight Work Packages through which the work in the project has been organised.

At the moment the Guidelines for the national implementation have been published and 12 countries belonging to the Core Group already drafted their national implementation plans. Most of the Core Group countries have filled in the Communication Survey and the indicator updates will be ready soon. Most data are taken from existing international sources. It is important, however, to test the data flow as well as to collect additional data, because not all indicators are in the existing international databases and some of them have to be collected from the member states directly.

## **Development and documentation of ECHI shortlist indicators**

*Marieke Verschuuren*

RIVM and THL are responsible for the development and documentation of the indicators. For the most of the indicators the decision of definition and preferred source has been made. The remaining tasks are to solve the pending definition and source problems, update the documentation sheets and to make a summary list of operational indicators.

For 7 indicators decisions on pending issues were already made during the CG meeting in Ljubljana and for 9 indicators there are still minor problems for which WP1 partners proposed a solution and asked opinions from the CG in January 2010. Also two CG work groups were established: one to work with the indicators 13, 67–70 and 73, and one for working on indicators 15 and 16. ISS will work with the indicator of alcohol attributable deaths and RKI on smoking attributable deaths.

Currently there are 75 indicators in the implementation and 13 in the development section of the shortlist. In the implementation section 21 indicators' definitions are not finalized. There are outcomes expected soon for 10 of these (from work of two GC work groups and also for indicators 55 PM10 exposure and 77 Expenditures on health).

There are 6 EHIS based indicators with obvious questionnaire problems. These are 36. Physical and sensory functional limitations, 38. Psychological distress, 39. Psychological well-being, 47. Hazardous alcohol consumption, 52. Physical activity and 54. Social support. In order to solve these operationalization problems, ECHIM need to collaborate closely with Eurostat. There are also 5 indicators that need still lot of work. These are 45. Pregnant woman smoking, 51. Breastfeeding, 74. Medicine use, selected groups, 81. Waiting times for elective surgeries and 82. Surgical wound infections. It was proposed that these 11 indicators are moved to the development section and will be discussed more closely and decisions should be made during the next CG meeting how to proceed with them. It was also pointed out by Marieke Verschuuren that the Commission may consider adding topics to the Work plan 2011 that require substantial development work, like health promotion and patient mobility. There were also some pending questions to Eurostat. These were about the indicators 6, 7, 15, 16 and 73. These will be solved in bilateral discussions between the ECHIM Partners and Eurostat.

Work with the Documentation Sheets has also progressed. First the Documentation Sheets for indicators in data collection pilot will be updated by RIVM, THL and RKI and these should be ready in April 2010. After that the rest of the indicators in the implementation sections will be updated. For all the 64 indicators in the implementation section, the Documentation Sheets should be ready in the beginning of June. Updated sheets will be published on ECHIM products website [www.healthindicators.eu](http://www.healthindicators.eu).

During this presentation there was much discussion. There was agreement on the proposal to move 11 indicators to the development section. Hugh Markowe stressed the need to develop a plan how to proceed with the work needed for the development section. Hugh Magee pointed out that in EHIS there are some major problems with mental health and physical activity. Some surprise about this was expressed, since especially the mental health questions have a long history of use and validation.

Hugh Magee explained the status of the work with indicators 13, 67–70 and 73. A document on this work was distributed among the Core Group prior to the meeting. He asked to send the comments on these indicators in two weeks to Marieke Verschuuren. One point that was brought up for discussion was related to the cancer indicators. The definitions of indicators 20 and 78 do not fully coincide with the Eurostat 65 CoD. It should be decided how to deal with this.

Gerard Badeyan was worried about the breakdowns by sex, age and socioeconomic status. It was stressed that the Health surveys are the only source of socioeconomic statuses.

Pavlos Pavlou pointed out that before starting the implementation of the indicators the definitions should be finalized and also the one data source should be chosen, because otherwise it might interfere with ongoing implementation work.

## **Implementation of health indicators in MSs and the EU: Overview of the National Implementation Plans**

*Ari-Pekka Sihvonon*

Ari-Pekka Sihvonon told about the implementation process of health indicators in the EU.

During the previous project period (2005–2008) the implementation work was started by checking data availability in the international databases (Eurostat, WHO-HfA and OECD Health Data) and by compiling the country reports. Then the ECHIM Survey was conducted in order to check possible additional national data sources. In addition, Bilateral Discussions between ECHIM secretariats and MS experts were organised in order to gather deeper information of the country's situation. All the above mentioned information has been pulled together and published in the Final Report of ECHIM. All these country specific documents are also available in the ECHIM extranet.

The implementation of the ECHI indicators will be carried out in two phases. The ECHIM Core Group countries started first and the non-Core Group countries will

follow later. Implementation of the ECHI indicators means that (1) they are introduced to the local administrators, decision makers and data collection professionals, (2) data sources are created and modified where needed, (3) a temporary system for data flow from MS to an EU-ECHIM database is created and tested, (4) a central presentation system has been set up and (5) the results have been analyzed and interpreted for health policy and planning.

The three key elements in the implementation work are: the Communication Survey, the National Communication Plan and the National Implementation Plan. The purpose of the Communication Survey is to get an overview of the challenges countries typically may have when planning and carrying out the implementation, and to help to overcome those common problems. The aim of the National Communication Plan is to detail the communication with the key stakeholders (e.g ministries, statistical officers, public health institutes) concerning the ECHI Indicators and national implementation work. The National Implementation Plan includes all the concrete steps needed to be taken when implementing the indicators, eventually indicator by indicator. The National Implementation Team should be set up to organize the implementation work. Concrete actions that should be taken include filling the gaps in data availability, to improve the quality of the data and to improve the data flow (within the county, and to the central EU-ECHIM database).

The timetable and deadlines for the implementation activities in Core Group countries:

- Communication Survey: deadline Sept 2009
- National Implementation Plans: deadline Sept 2009
- National Communication Plans: deadline Dec 2009
- National Implementation Plans, 2nd drafts: deadline Jan 2010
- Indicator Data Availability Sheets: deadline April 2010

Timetable and deadlines for the implementation activities in non-Core Group countries:

- Communication Survey: deadline 30.4.2010
- National Implementation Plans: deadline 30.6.2010
- National Communication Plans: deadline 30.6.2010
- Indicator Data Availability Sheets: deadline 30.9.2010

It is expected that all countries will prepare each of these plans. The countries have been divided into four groups and each group have a one ECHIM Partner Institute as a responsible organization. The drafts of the Implementation Plans are available in the ECHIM Extranet <https://www4.ktl.fi/wiki03/>. Countries can update their own implementation plans to the Extranet by themselves or email it to Helsinki Secretariat. It is important to acknowledge that countries are in different state of the implementation process and the variations in implementation process are acceptable. Guidelines for drafting the Implementation Plan as well as the Communication Plan are available at [www.echim.org/ext1.html](http://www.echim.org/ext1.html).

There is a lot of work to do so it is recommended that everybody starts to draft these plans quite quickly.

## **The ECHIM Leaflet**

*Antti Tuomi-Nikula*

Antti Tuomi-Nikula presented the new ECHIM Leaflet. The purpose of the leaflet is to promote, visualise and popularise the idea of ECHIM, and to back up the implementation work in MSs. The idea is that the leaflet has two sides. The one side tells what kind of information is already available at EU level and the other concentrates on the missing information. It is highly recommended to disseminate the leaflet in countries to relevant stakeholders and perhaps even translate it to the national languages. Helsinki Secretariat will send maximum 50 leaflets to the MS. The leaflet is also available [www.echim.org/leaflet](http://www.echim.org/leaflet) in different formats, ready to be edited and printed. Questions on technical issues can be addressed to [antti.tuomi-nikula@thl.fi](mailto:antti.tuomi-nikula@thl.fi).

## **Mapping and description of the data flow regarding the ECHI shortlist indicators**

*Jürgen Thelen & Nils Kirsch*

Jürgen Thelen summarized recent developments concerning the ECHI database and data flow.

It is now agreed to use the ECHI@EC as a permanent solution for the ECHI Database, which shall be presented in the context of the Health-Portal (but currently redirected to SANCO site). In this context he reported on the adaptation of ECHIM tasks concerning data base (WP5) and presentation (WP2). The working group's draft proposed, inter alia to adapt the ECHI@EC user interface in order to integrate indicator presentations (in terms of texts, graphs and source information), and to establish a permanent unit at European Level responsible for ECHI after the Joint Action. This unit should safeguard future data collection and the required quality checks as well as coordination of the production of health information based on ECHI data.

No amendment of the contract is needed for WP5 since both the pilot data collection and the validation of sources and data to be integrated in ECHI@EC will be performed as foreseen.

For WP1 it was concluded that indicator presentations can be structured according to the EUPHIX concept with options to use also other output formats (e.g. PDF). The dissemination of results will be presented via the ECHI@EC system. Minor corrections seem necessary only if an amendment would be needed. Subsequently, Thelen threw a glance at ECHI@EC which was relaunched at the DG SANCO website in December 2009 ([ec.europa.eu/health/indicators/echi/index\\_en.htm](http://ec.europa.eu/health/indicators/echi/index_en.htm)), but unfortunately without consultation of ECHIM Joint Action.

As learned from Buniet (DG SANCO/A4) ECHI indicators from international sources are integrated automatically into the ECHI@EC database. However, Thelen presented a number of screen-shot examples that illustrated several indicators to be incorrect in terms of figures (data/calculations obviously wrong), sources (not specified by ECHIM) and graphs (not useful). Additionally, the download feature resulted in tables

which lack any information (title, sources, data explanation, context, etc). Furthermore ECHI shortlist indicators have been mixed with other health indicators which are regarded problematic (no documentation for these indicators).

He emphasized the need for a clear concept for the presentation of indicators and information via the DG SANCO website. This includes a scheme for quality control of data to be integrated as well as presented at ECHI@EC.

Nils Kirsch commenced the presentation by giving an overview of the basic aspects and concept of the ECHIM pilot data collection. He emphasized that MS will only be addressed to provide data for indicators not yet covered by routine collection procedures. Since the focus will be laid on indicators that shall be derived from EHIS, the pilot collection will target on those MS which did not participate in the first wave of EHIS, also exploring the availability of suitable national data (e.g. SILC, microcensus) for ECHIM purposes.

The latter resulted in the approach also to include alternative data sources such as registers or projects (e.g. for diabetes, depression, asthma, COPD, injuries, etc). Due to the state of EHIS and to operationalization problems encountered, it was proposed to exclude some ECHI-indicators from the pilot collection, e.g. indicator 36 (physical and sensory functional limitations), indicator 52 (physical activity) and indicator 54 (social support).

SILC data will be used and can be obtained from Eurostat for indicator 33 (self-perceived health), indicator 34 (self-reported chronic morbidity) and indicator 35 (long-term activity limitations).

On the other hand it was discussed to collect interim (auxiliary indicator) data on national tobacco and alcohol consumption prevalences which could be the basis for ECHI indicators 15 (smoking-attributable deaths), 44 (regular smokers), 16 (alcohol-attributable deaths) and 47 (hazardous alcohol consumption).

With regard to indicators' relevant dimensions it was concluded to confine on sex, age groups (three at max) and socio-economic status by educational level (ISCED 97, aggregated to three groups: 0–2; 3–4; 5–6). Kirsch listed several options regarding the questionnaire form and presented a Microsoft<sup>®</sup> Excel sheet with macro programming as an example of a standardized software file.

Ultimately, a tentative timetable for the pilot data collection was proposed.

May 2010: To finalize questionnaire and instructions, up-date respective documentation sheets, establish contact with MS's NIT, define data flow and processing

June 2010: Send out questionnaire to MS

Sep 2010: Requested return of questionnaires, collection and processing of data, compile data related information, some feedback to MS

Jan 2011: Transfer data sets to ECHI@EC and RIVM for web-based presentation

There were a lot of discussion concerning the database and pilot data collection. There are some major problems with the database which the Commission also realises.

These shortcomings need to be solved through co-operation in order to create a functional data presentation system.

The timetable for pilot data collection was seen quite tight, but it was remarked that in the pilot there will be only a limited number of indicators. There was also discussion that countries do not want to collect data which can be collected from Eurostat, but again Kirsch explained that MS which implemented (the full) EHIS will not be asked to repeat EHIS based calculations and that register based indicator data is a new approach for the pilot. This is only a pilot and will not be a permanent solution.

The remark was made that there should only one recommended data source from which the data should be derived. But if for example there are no EHIS data available in a country some other data source can be used in pilot.

It was decided that the indicators that will need further development will be removed from the pilot data collection.

The question was asked put for Commission whether they have already sent the promised letter to the Member States in order to advance and support the implementation work. This letter has not been sent yet because of the exchange of Commissioner.

## **Tuesday 2<sup>nd</sup> of March 2010**

### **Drafting a National Implementation Plan**

*Antti Tuomi-Nikula*

Antti Tuomi-Nikula told more about drafting the Implementation Plan. It is recommended that in the National Implementation Team (NIT) there is wide range of experts and various institutions represented. There should also be a member from the HIC who has contacts with the Eurostat, WHO and OECD. The task of the NIT is then checking the availability of international and national data sources. Implementation includes listing missing indicators and their sources and drafting a realistic timetable for gathering the missing indicators, organising the NIT meetings and also a plan for needed resources and contacts. The recommendation is to document all information on indicator availability as well as implementation actions in the Indicator Data Availability Sheet.

The Indicator Availability Sheet is an Excel file divided in two worksheets: Indicator data in international sources and in national sources. There are two information entities: one for basic availability information and the other for implementation actions for each indicator. The purpose of the Indicator Data Availability Sheets is to sum up availability information and also summarise the implementation activities by indicator. If the sheet does not fit to country's purposes, it is possible to modify it. The first NIT meeting in Finland was held in January 2010. It was discovered that it is quite demanding to build up an implementation team and get people around the same table, because everyone has so much duties.

It is also important to update the National Implementation Plan regularly. The most important documents and templates (Implementation Guidelines, Indicator Data Availability Sheet, Communication Survey questionnaire and Communication Guidelines) are available at [www.echim.org/meetings.html](http://www.echim.org/meetings.html). Also in the ECHIM Extranet (<https://www4.ktl.fi/wiki03/>) there are documents per country from the previous phase of ECHIM as well as all National Implementation Plans, Communication Plans and guidelines. To access the Extranet you need a username/password. You will get it from [antti.tuomi-nikula@thl.fi](mailto:antti.tuomi-nikula@thl.fi).

## **Experiences from the implementation in Italy**

*Silvia Ghirini*

Silvia Ghirini gave a presentation also on behalf of Emanuele Scafato about the implementation of ECHI indicators in Italy. The implementation work in Italy has progressed quite nicely. The NIT was created in September 2009 and the first meeting was held. The Italian NIT has members from the Public Health Institute (ISS), the Ministry of Health and from the National Institute of Statistics (ISTAT). Other experts will be contacted for specific issues. Also the Communication Plan has been drafted.

There are also some obstacles with the implementation in Italy. For example the delegation of health issues from central government to the regions, the lack of resources, and lack of motivation, poor record linkage possibilities and the absence of a HES in Italy. However, something can be done in order to improve the situation. The co-operation at national level in order to obtain standard available health data for the monitoring system at national and regional levels should be improved, as well as the conditions for record linkage possibilities. Also, a letter from the Commission to the national organizations in order to get the commitment on ECHI indicators implementation would help. Finally, the European Commission could be some financial support for the implementation.

For the implementation, Italy has divided the indicators into four sections: indicators readily available and delivered to international organizations, indicators readily available from national databases for which (E)HIS is the preferred data sources, indicators not available in international databases but available in national databases and indicators not yet available.

The audience of the meeting was really pleased to see some implementation actions in practice. It is important to note that countries appear to have differences in their implementation plans as well as in their implementation process. There was also discussion about the funding of the national implementation. Arpo Aromaa asked how Italy will proceed with the indicators that are not available at all. Silvia Ghirini replied that there are no plans with these missing indicators. It was also pointed out that before implementation can go further in countries the updated Documentation Sheets should be available. Marieke Verschuuren told that the finalized Documentation Sheets will be available in June 2010. In Cyprus the initiation has been quite difficult because they started really from scratch. Now there is many new registers and close co-operation with the statistical office. Hugh Magee pointed out that when countries have filled in their Indicator Data Availability Sheets it would be beneficial to check

if from many countries the same indicators are missing. Emanuele Scafato said that as co-funders of ECHIM, each partner and Member State representative has the obligation to have some indicators tested particularly for those, such as the alcohol indicators, that are linked to some priority in terms of EU policy. Losing this peculiar ECHIM characteristic and added value would compromise the 'filling-the-gaps-approach' which only an EU project can follow, to realise a renewed health monitoring system. It would be good to discuss with the Commission how to gain the missing information.

## **Experiences from the implementation in Slovenia**

*Polonca Truden-Dobrin*

Polonca Truden-Dobrin presented the implementation work in Slovenia. She stated that the challenges are probably the same as in other countries. The main problems are lack of resources, the rigidity of existing health information system because of the legislative framework, lack of IT support, lack of cooperation between the main stakeholders, and limited awareness of ECHI in health administration, health professionals and in general public.

The NIT has been established and there are members from the National Institute of Public Health (NIPH), the Ministry of Health, the Health Insurance Institute of Slovenia, the Statistical Office of the Republic of Slovenia and the Institute of Oncology (National Cancer Registry).

A working group on ECHI indicators has been established at the National Institute of Public Health. This group will be involved in proposing and setting-up improvements in availability and quality of data for ECHI and establishing procedures for regular collection and processing of ECHI data and its provision to the central ECHI database.

The EHIS survey has already been completed in Slovenia, but there were several problems e.g. small sample size and low response rate to alcohol questions. The work has been started in order to make a law to change on personal data collection in health care. Related to this a working group has been set up at the NIPH to prepare the list of the national data sets and the content of the data sets.

The NIT will also finalize the Communication plan. Various activities have been considered for different target groups, e.g. web based presentation, articles in professional journals, presentations at conferences, press conferences and press releases, meetings with key persons and dissemination of information about ECHI indicators.

The ECHIM Joint Action was presented to the media at the press conference on 29th of September 2009 during the ECHIM Core Group meeting. This was a very successful. ECHI indicators and ECHIM joint action were also presented at the national conference 'From data to information in health care' in November 2009. The conference was attended by persons from all key institutions and other partners.

## **Main outcomes from the group discussions**

Four discussion groups were established. Chairs were Pieter Kramers, Marieke Verschuuren, Hugh Magee and Mika Gissler. These groups discussed for one and a half hour about the need for health indicators and about the implementation work.

Even though there can be seen growing interest towards indicator work, the ECHIM project still needs publicity in the Member States. For that purpose the new ECHIM leaflet was seen as a good tool. It is important that in the countries the important stakeholders really understand the need for and the benefit of ECHI indicators. The remark was made that especially in countries with a long history of health monitoring it was not easy to explain the unique selling point (or added value) of ECHIM over existing international data collection schemes (WHO, OECD). ECHIM has to give this issue careful thought. It was also pointed out that the implementation of the indicators varies a lot from country to country. Every country has its own special challenges. For example in countries comprising autonomic areas makes the implementation work may prove more difficult. The formality of the NIT may vary between countries, for example. The lack of resources is a problem in many countries. The communication within the project and the collaboration with the related projects is regarded as important.

There were some concerns related to the database; these acknowledged problems need to be solved as soon as possible. There were also discussions about the continuity of the project. Will there be a new Joint Action or some other kind of solution after 2011? The Commission's support in this indicator work cannot be addressed too much.

## **Responding to the Communication Survey**

*Jari Kirsilä*

The goals of communication in the ECHIM Joint Action are to demonstrate the force of health indicators as a solid basis for efficient health policy, to ensure the support of policymakers and administrators to the long-term work and to strengthen the brand of ECHIM. The key messages in the Core Group meeting in Vilnius last spring were the lack of information on the health of Europeans. An efficient health policy requires comparable information from all MS. This long-term work needs support from the EU health authorities.

The ECHIM Communication Survey was conducted during the summer 2009. It aimed to get an overview of the challenges in the implementation in different countries. There are some common problems in implementation in many MS.

In the communication ECHIM should concentrate more on the positive than negative aspects; for example what is known about the health of Europeans instead of what is not known and what have been achieved instead of what is missing. And to emphasize that ECHIM is more than just a single project.

The timetable for the actions in the field of communication is the following:

#### Core Group Countries:

- Communications officer/contact person of NIT identified asap
- Communication plan first draft outlined asap

#### Non-Core Group Countries

- Communication Survey, deadline 30.4.2010
- Communications officer/contact person of NIT identified, deadline 30.4.2010
- Communication plan first draft, deadline 30.6.2010

The goal is that a network of communication officers is established, one person from each MS. The idea is to have a next press conference in Berlin during the next Core Group meeting in September.

There was a lot of discussion about the need for press conference. There were opinions for and against. Some members supported the idea while other members argued that there should be a press conference when there is something more to tell. But it was also seen that there is a need to communicate to stakeholders and other relevant persons about the project at this point. It was also said that different target groups need different messages at different stage and that the communication needs are different in different countries.

### **Next steps in ECHIM**

*Johanna Mäki-Opas and Marja Lampola*

Mäki-Opas went once more through the timetable for the implementation work of Core Group Countries as well as of the other countries in the project. It was addressed that participants will be informed by email if there will be any changes in timetables or other issues. Pieter Kramers added that to his view the coming year would be the crucial year for the Joint Action's success, and he hoped that that the cooperation with DG Sanco would develop as fruitful again as it used to be in earlier years.

Marja Lampola told briefly about the travel expenses policy related to this meeting and that she will take contact to the persons who will be reimbursed from the ECHIM central funds. She also reported that the first interim report has been sent to the EAHC and the ECHIM is awaiting response.

### **Closure of the meeting**

DG SANCO promised to organise the Extended Core Group meeting also next year. Arpo Aromaa thanked the participants and closed the meeting.

