

**Minutes of the ECHIM Extended Core Group meeting
Luxembourg 16.–17.3.2011
HITEC building**

List of Participants

Albania	Enver Roshi	
Austria	Erika Baldaszi	
Belgium	Jean Tafforeau	
Cyprus	Pavlos Pavlou	
Czech Republic	Jirí Holub	
Czech Republic	Sarka Dankova	
Denmark	Anne Illemann Christensen	
Estonia	Riina Tilk	
Estonia	Maali Köbin	
Estonia	Kristina Köhler	
Finland	Mika Gissler	(chair)
Finland	Marja Lampola	
Finland	Antti Tuomi-Nikula	
Finland	Johanna Mäki-Opas	(secretary)
France	Gerard Badeyan	
Germany	Jürgen Thelen	
Germany	Nils Kirsch	
Germany	Lothar Janssen	
Iceland	Guðrún Guðfinnsdóttir	
Ireland	Hugh Magee	
Italy	Silvia Ghirini	
Kosovo	Naser Ramadani	
Latvia	Dace Mihalovska	
Lithuania	Neringa Madeikyte	
Lithuania	Ausra Zelviene	
Lithuania	Romualdas Gurevicius	
Malta	Miriam Gatt	
Netherlands	Pieter Kramers	
Netherlands	Marieke Verschuuren	
Netherlands	Peter Achterberg	
Norway	Heidi Lyshol	
Poland	Roman Topor-Madry	
Portugal	Jose Luis Castanheira	
Slovenia	Polonca Truden-Dobrin	
Spain	Pedro Arias Bohigas	
Switzerland	Renaud Lieberherr	
Turkey	Fehmi Aydinli	
United Kingdom	Carolina Hall	
United Kingdom	Hugh Markowe (17.3)	
WHO	Enrique Loyola	
OECD	Gaetan Lafortune (16.3)	
DG SANCO	Stefan Schreck (16.3.)	
DG SANCO	Sigurlaug Hauksdóttir	
DG SANCO	Federico Paoli	
DG SANCO	Tuuli-Maria Mattila	
DG SANCO	Fabienne Lefebvre	
Eurostat	Bart De Norre (16.3)	
EAHC	Dirk Meusel (17.3)	

Day 1

Opening of the meeting and adoption of the agenda

Stefan Schreck

Stefan Schreck opened the meeting and welcomed all the participants. He told that he has recently started as a head of the DG SANCO Unit C2 and previously worked in EAHC.

ECHIM is a first joint action, and thus regarded as a kind of the test round. DG SANCO intends to evaluate the impact of ECHIM on Member State level. This is good practice for organizing the health policy in EU. This JA will be a very encouraging experience and the outcomes will most likely be positive.

Everyone was satisfied with agenda, so no changes were needed.

Importance of ECHIM

Pieter Kramers

Peter Kramers introduced 'the importance of ECHIM'. He started by giving a short overview of the history of indicator work by earlier ECHI(M) projects. The work has already started in 1998 and by 2008 there were available, for example, first version of documentation sheets for all shortlist indicators, a first assessment of the availability of data connected to the ECHI shortlist, and a network of indicator experts in the Member States. The ECHI shortlist became an important element in DG SANCO documents and it was a guiding principle for new research projects and for Eurostat work on improving data collections.

By the end of the Joint Action for ECHIM 2009-2011, the up-dated documentation of indicators and the Pilot data collection will be finalised. The National Implementation Teams in Member States (MS) should have a stable structure so that they are able to continue the indicator work also after the Joint Action. The first joint analysis and report on data based on the ECHI shortlist should be published. There also should be a plan for the future maintenance of ECHI in the frame of a solid European Health Information System.

ECHIM makes use of earlier work by WHO, OECD, etc., but it adds the EU perspective, and puts extra efforts in comparability problems and their solution. ECHIM provides evidence base for policy making, and is not a primary database. ECHIM has selected the most relevant health policy topics and it also shows areas where there is information shortage. ECHIM is seen as a natural complement of Eurostat.

The former (until end of 2010) head of DG SANCO C2 unit Nick Fahy commented quite positively on ECHIM during the last EUPHA meeting in November 2010. Among other things he stated that this is the moment when the DG SANCO should take up the ECHIM work and make it permanent.

Overview of the progress of ECHIM

Mika Gissler

Mika Gissler summarised the current status of the project as well as goals to be achieved before end of 2011. The specific objectives for the project are to improve, document and maintain the ECHI Indicators, to develop guidelines and Member State specific plans for ECHI shortlist indicators implementation at national, regional and EU-level. In a co-operation with the MSs ECHIM will implement ECHI shortlist indicators in Member States, to maintain a network of national health indicator experts for ECHI Indicators and the needed data collection, to map, design and test the data flow between Member States and a central

capacity for health monitoring and to present health data based on the ECHI shortlist. The ECHIM project will produce the first joint analysis and report on data based on ECHI shortlist indicators.

The biggest challenges have been in implementation of indicators in Member States, whereas the indicator development work and pilot data collection has proceeded well. Mika Gissler pointed out that because ECHIM project have some budget left and also work to be done we could discuss about the possibility to continue this work for example the first half of year 2012.

ECHIM and DG SANCO – ECHIM as a tool for DG SANCO and related developments *Sigurlaug Hauksdottir*

Sigurlaug Hauksdóttir presented the role of the ECHI indicators in DG SANCO's work and gave a brief presentation of the HEIDI data interface. In their work the ECHI indicators are a core set of indicators used and the ECHI indicators are seen as well defined and high quality indicators. DG SANCO uses the indicators in most of their briefings and in consultations when possible. The indicators are also promoted in HEIDI. Sigurlaug Hauksdóttir assessed that the ECHI indicators are well known in the field of health.

According to Hauksdóttir EHIS is and will be the main source of the ECHI indicators. The next EHIS will be conducted in 2014 under the regulation.

DG SANCO has promoted the ECHIM by sending a supportive letter to all Member States' permanent representatives. Almost 10 countries have replied and all of them have been very positive. According to the replies from MSs, they have already integrated the ECHI indicators in their national indicator work or are planning to do so.

There was discussion about who will make the conclusions whether the data in HEIDI is comparable. Sigurlaug Hauksdóttir replied that when the data is from ESTAT, WHO, OECD or other EC or EU institution and the breakdown of the data is in accordance with the recommendations of the ECHIM, the data is considered to be comparable. It was suggested by the MSs that the group of ECHIM experts shall also in the future take the responsibility for the quality of the information.

HEIDI has now two sections. This was remarked as bit confusing among the participants. Hauksdóttir addressed that the HEIDI will be the place for all EU health information in the future.

During the discussion, Enrique Loyola (WHO) recommended that, when the Commission would take over the data work, they should use the ECHIM group as having years of experience in data quality; this would improve credibility to the users.

Progress of ECHIM related projects *Bart De Norre, Jean Tafforeau, Johanna Mäki-Opas*

Bart De Norre from Eurostat told about the current status of their work related to ECHIM. Recent ESSC (European Statistical System Committee) decisions reflect the need of tuning the restricted resources within Eurostat and the ESS to the policy priorities (including the audit mandate following the financial and economic crisis) and the reengineering of the statistical production method. Examples are the definition of negative priorities and the restriction of the number of meetings. For public health statistics the focus should be on consolidation and implementation and less on development work. Priority domains remain Health care (expenditure and non-expenditure), Causes of death, Health status, health

determinants and health care utilisation (EHIS and SILC-MEHM), Disability – health and social integration. A task force will be set up in 2012 for Morbidity statistics.

EHIS is progressing well. The new EHIS questionnaire will be discussed in the next EHIS Technical Group meeting end of March 2011. EHIS wave II will be executed in 2014 under a specific implementing regulation (linked to the framework regulation 1338/2008 and only for this wave). According to Bart De Norre the way how the EHIS wave III in 2018 can be executed, is not yet decided.

Jean Tafforeau told about the current status of EUHSID. The aim of the project is to collect to the database information on health interview and health examination survey methodology. The database, which is available via Internet includes questions and examination protocols used in national health surveys. This is seen as very important project, which is about to end this spring. Hope was expressed that Eurostat and/or DG SANCO will continue to support this work. Federico Paoli mentioned that no decisions have been made how the EUHSID will be continued.

Johanna Mäki-Opas went quickly through the current status of EHES. The EHES pilot surveys will be finalized in 13 countries during this spring. In the future at least the data for BMI and blood pressure indicators are recommended to be collected through EHES.

There was discussion about who will own the EHES data. Even the EHES Partners do not know this yet, so it will need further discussions. EHIS data of wave I are delivered by the participating countries to Eurostat under a gentlemen's agreement. EHIS wave II data will be delivered under regulation. Eurostat foresees also a legislation to deliver micro data of EHIS to the research community.

Status of the ECHI shortlist

Marieke Verschuuren

Marieke Verschuuren presented the current status of the ECHI shortlist and work still to be done until the end of the project. One of the deliverables of the Joint Action for ECHIM is the release of an updated version of the ECHI shortlist.

A proposal for the procedure for updating the shortlist was developed and discussed during Berlin ECHIM Core Group meeting in September 2010. Main conclusions were that the shortlist should stay as stable as possible, be in line with the implementation focus of the Joint Action. Therefore stricter and more explicit eligibility criteria than before should be applied for the implementation and development sections of the shortlist. Moreover, some indicators should not stay in shortlist as there are still a lot of problems to overcome before they can be implemented. As a result of the application of these new criteria, it is proposed to move 8 indicators from the implementation to development section; smoking-related deaths, alcohol-related deaths, attack rates of AMI and stroke, and register-based prevalence of diabetes, depression, asthma and COPD.

It was suggested to add a new element in the ECHI indicator documentation; the ECHI innovations list. This list includes those indicators that have policy relevance but for which still major problems related to definition, methodology and/or data collection exist. It was suggested to move the following 8 indicators from the ECHI shortlist to the ECHI innovations list; excess mortality by extreme temperatures, suicide attempt, mobility of professionals, waiting times for elective surgeries, cancer treatment delay, policies on healthy nutrition, policies and practices on healthy lifestyles, integrated programmes in settings, including workplace, schools, hospital.

Marieke Verschuuren also presented the updated ECHIM products website www.healthindicators.eu. Now it is possible for example to see from the homepage the recent updates and the related date of those. Each documentation sheet has the same structure. Excel sheets with the operational indicators (indicator definition(s) combined with breakdowns according to e.g. sex, age, SES) were added to all the documentation sheets.

There was discussion about the differences between the innovation list and the development section. Marieke clarified that already quite some developmental work has been put into the indicators in the development section, and/or that there are indications that data collection for these indicators will become part of regular international data collections. For the indicators in the innovations list this is not the case.

In the proposal for the 2011 version of the shortlist the disease prevalence and injuries incidence indicators, which consist of a self-reported and register-based estimate, have been split into two separate indicators. It is still long way to receive register-based information on for example diabetes. On the other hand, Eurostat will continue their activities related to morbidity statistics, so European effort in this field is taking place.

For some indicators the preferred source is EHES, but because EHES has not been widely implemented yet, EHIS has been appointed as interim source for those indicators.

The conclusion was that the rationale for the proposed division of the shortlist indicators over the implementation and development sections of the ECHI shortlist and the ECHI innovations list is quite difficult according to the meeting participants. The structure will be considered once more. Several decisions have been taken during prior Core Group meetings, however, which should also be taken into account.

Spain has proposed to add four new indicators to the ECHI shortlist; condom use, health care-associated infections, organ donation rates, and user satisfaction/experience. The RIVM team proposed not to add user satisfaction and health care associated infections, as these overlap with existing indicators on the shortlist. Rather it should be investigated whether these existing indicators should be adapted. Condom use and organ donation rates seem policy relevant and these topics are not yet covered by existing indicators, so their addition could be considered. All the MSs will be given the opportunity to comment on this issue after the meeting.

Future of ECHIM and the European Health Monitoring System after the end of the ECHIM Joint Action

Stefan Schreck, Pieter Kramers

Stefan Schreck pointed out the key points of the future of ECHIM. According to him the structure of Joint Actions will not remain the same in the future. Applicants have to make sure that there is true added value for working on issues on and for the EU level. With regard to ECHIM, it needs to be demonstrated that the ECHI indicators are needed and used in Member States and that they really make a difference in the decision making of policy makers. It is hoped that they will be useable also after ten years. It is really important at this point that all the deliverables that has been promised in work plan of the project are delivered. In the future the ECHIM needs a permanent structure. HEIDI is a step towards this; ECHI indicators are already there. The financial framework will of course also have an affect on the future of ECHIM.

Peter Kramers continued with some reflections from the side of ECHIM. The discussions on ECHIM's future started at the ECHIM Core Group meeting in Berlin (September 2010) and are to be extended during this meeting. ECHIM's long term vision basically implies having in place a sustained central health monitoring and reporting capacity, being used for EU and

MSs' health policy making. For the proper continuation of current indicator work, we need to have a permanent structure within the DG SANCO. As a starting point for the continuation of ECHIM work, we will have for use by the end of the current Joint Action: the fully documented ECHI shortlist, the HEIDI data tool updated and filled with data and metadata (contents checked and validated), the collected pilot data accessible and entered in HEIDI data tool, National Implementation Teams in place in most MSs, a vision in DG SANCO on the status of the ECHI shortlist and use of ECHI indicators in Commission public health products, Commitment in Eurostat to maintain and expand data collection according to the ECHI shortlist and a guide on how to maintain and improve ECHIM.

The minimum set of tasks to maintain ECHI work after the Joint Action as seen by ECHIM are: maintaining the ECHI shortlist (maintain indicator doc sheets/comparability sheets, work on development section, update the shortlist every 3-4 years, coordinate with related indicator work, integrate outcomes from relevant EU-funded projects), supporting the HEIDI data tool: (check, validate, update data & meta-data; focus on data available only from national sources), maintain network of MSs' experts, collaborate with WHO, OECD, to increase synergy in indicator work.

Expanding on the current Commission investments in ECHI work (HEIDI etc.) a clear view is needed of what professional expertise (public health, IT, data handling, coordination) we need to perform these tasks, and how this should be embedded with DG SANCO and possibly also elsewhere. What can be done to ensure professional quality as well as sustained financing?

After the introduction, there were discussions in four groups, focusing on the following questions:

- What are the tasks that need to be continued after the Joint Action to ensure sustainability of the ECHI system?
- What are the different scenarios for organizing this work (short term and longer term solutions), and what are the pros and cons for each of these scenarios?
- What can be recommended to the Commission regarding the use of the ECHIM products, e.g. ECHI indicators by the Commission?

The outcomes of these group discussions were presented during the second day of the meeting.

Day 2

Mika Gissler opened the second meeting day.

Federico Paoli presented the ECHIM contact persons in EAHC and DG SANCO.

Mr Dirk Meusel (Executive Agency for Health and Consumers, EAHC, Dirk.MEUSEL@ec.europa.eu) is a project officer in charge of administrative and financial issues and overall project management of ECHIM.

Ms Sigurlaug Hauksdottir (DG SANCO Unit C2, "Health Information", Sigurlaug.HAUKSDOTTIR@ec.europa.eu) is a policy officer in charge of technical contents, overall overview of activities and policy framework.

Ms Tuuli-Maria Mattila (Deputy Head of Unit, Tuuli-Maria.MATTILA@ec.europa.eu) in charge of overall coordination of HEIDI data tool.

Pilot Data Collection

Nils Kirsch

By the deadline of the Pilot data collection 21 countries sent their data. There were some delays and the deadline was postponed three times. But the response rate (66%) is pretty good.

As an overview can be stated that some ECHI dimensions (i.e. educational level) and subgroups (i.e. age bands) are partly not available and there has been problems with age-standardization for register-based indicators. Several problems were reported from MS due to fragmentation of national data holders (e.g. accessibility, reluctance, unclear responsibilities) and lack of resources. Conceptual differences among national HIS often prevent ECHI conform computation.

The quality of the data and the validation cannot be performed from remote by ECHIM. Only face validity checks are possible. Accuracy of data and final indicator processing incurs the liability of MS. Perhaps there could be a workshop for interested MS with ECHIM (and possibly Eurostat) experts to elaborate statistical “SOPs” for inherent QC _ preparatory work.

The pilot data collection was a successful first exercise. Drop-outs reflect lack of appropriate data, manpower and/or political commitment. Face validity checks call for further analyses of data processing and to enforce harmonized operations of the National Implementation Teams. Success of ECHI depends greatly on future developments of EHIS & EHES and close liaison with DG SANCO & Eurostat.

The data collection will be prolonged a bit more so that for example Switzerland, Norway and Denmark can send their data.

ECHI Database

Jürgen Thelen

The initial plan was to have an own ECHI Database (EHCI@EC), but now the ECHI database and presentation tool will be included to the HEIDI system (Health in Europe: Information and Data Interface), which is a wiki and data tool of DG SANCO. HEIDI is an interactive application to present relevant and comparable information on health at European level.

HEIDI Data Tools will keep the functionalities implemented with the ECHI@EC tool. In HEIDI there are two separate sets of Health indicators (ECHI Indicators and EUHI - European Health Indicators). The question remains are these two sets separated sufficiently, even though there is explanations in the introductory page.

HEIDI will be one of the main outcomes where the ECHI Indicators will be presented in the future. Commission is aware that there still is a lot to do with the HEIDI. They are continuously working with it in order to improve the system. HEIDI should also be improved so that the countries could use it for their own purposes.

The collection of the Pilot data was a good experience for those who delivered the data, for Eurostat and also for those who we not able to send the data. This is more complicated than for example collecting EHIS data and perhaps Eurostat will collect ECHI data regularly in the future.

Implementation of ECHI Indicators in Europe

Antti Tuomi-Nikula

Antti Tuomi-Nikula went through the main components and documents related to the implementation. These are:

- Communication Survey
- National Implementation Team
- National Implementation Plan
- National Communication Plan
- Indicator Data Availability Sheet

In the implementation activities it is recommended to first set up a National Implementation Team (NIT). The NITs should include a wide range of expertise, like member from EGHI, Communications officers and representatives from various institutes. The deadline for setting up a NIT is 31.5.2011.

The NIT should plan how the ECHI Indicators will be implemented in the country. They should first check existing data sources: both international and national and check the relevant earlier exercises/reports. And check what indicators are available by filling in the Data Availability Sheet by 31.5.2011.

After that the NITs have time to prepare the Implementation Plan until 31.7.2011. The plan should include concrete actions how to fill the gaps in data availability, how to improve quality of data and how to improve the data flow.

National Communication Plan aims to detail the communication with the key stakeholders like ministries, statistical offices and public health institutes. The plan should include the key messages that are essential to obtain support for the implementation work in the country. This can be a separate plan or it can be part of the Implementation Plan.

The documents are collected to assist countries in progressing in the implementation work.

All the documents should be send to johanna.maki-opas@thl.fi or upload them to ECHIM extranet <https://www3.thl.fi/wiki03/login.action?>

Country example: Implementation in Spain

Pedro Arias Bohigas

Pedro Arias Bohigas gave an example on the implementation activities in Spain. Spain has established a National Implementation Team, which has meetings approximately two times a year. In the NIT there are many experts and representatives from various instances and organizations.

Communication is also important part of the implementation. In this area quite much is happening in Spain. For example they have a communication officer in their NIT, they have a dissemination plan and they are drafting a paper on ECHI and National Key Indicators.

Spain has a long tradition on health information and is working on improving accessibility to this information. A Health Statistic Webportal has been developed and new efforts to promote and distribute information to a wider audience are ongoing.

Spain is able to provide data for most of ECHI indicators however there are also some challenges in implementation work. For example the lack of funding and manpower, no

national version of ICD-10 CM in Spain, primary care registers are not integrated at national level, poor record linkage and breakdown for some indicators is not feasible.

After this presentation, the issue of the progress of implementation in the countries was discussed in four groups. These groups were assembled according to the division made in the Joint Action, and led by Finland, Germany, Italy and Lithuania.

Conclusions from the group discussion on implementation activities in MSs

Antti Tuomi-Nikula, Ausra Zelviene, Silvia Ghirini, Jürgen Thelen

In Norway many national indicators are quite close to the definition of ECHI indicators, so the situation is quite good. But they are just now starting to report them. They will take part to the ECHIM Pilot collection, even though they are a bit late. Ministry does not hinder the indicator work but they do not offer any concrete support either. The ECHI shortlist contains some indicators which will never be available in Norway.

In Denmark the situation is quite similar to Norway: most of the ECHI indicators are available, even though they have not been reported yet and Denmark did not participate in the Pilot data collection, but they consider the possibility to deliver the pilot data now. The challenge in implementation work has been that because three organizations own the data, the decision who will be responsible for ECHIM has took a while, but has been now determined. In the future the EHIS should be included to the national surveys; this would help the situation even more.

In Iceland many indicators are available, but EHIS has not been conducted. But the future of the indicators looks quite good and there are good registers. The biggest challenges seem to be lack of resources and the organisational changes of health ministry.

In Ireland the progress of implementation is quite good. The ECHI indicators are well known. The survey base new data is lacking, because the previous survey was conducted in 2007 and the next one will most likely be in 2014. The letter which was sent by Commission will most likely be beneficial. Perhaps more should be still addressed the added value of ECHIM.

United Kingdom has long traditions in health surveys, which complicates a bit the comparability of the data with the ECHIM. Each region has their own health systems and unifying them is difficult. In UK they have a NIT which meets four times a year.

Finland has also long traditions in health surveys, but EHIS has not been incorporated in the health information system yet. The challenge is to have comparable information, because of long series of surveys. The registers are quite good. In Finland there is portal called "Our Health" which will include the ECHI indicators in the future.

In Malta the small size of the country is seen as a big advantage for the implementation work. Overall the work is progressing quite well. Joining to the EU has helped the indicator work. The EHIS and EHES provide lot of data for the ECHIM. Some indicators have been produced in other health projects. There are some minor problems with some indicators: perhaps health expenditure data is a biggest one, because it has not been assigned importance in Malta.

The Czech Republic has participated in the indicator work for a long time and it is very active and motivated. The country has a long tradition in health statistics and lots of data exists; almost all ECHI data is available. In the Czech Republic the cooperation between institutions is very good and also data from health insurance companies is available. As a challenges can be seen that changes in the health information system, which are often difficult and expensive. The question which remains: whether there will be somebody responsible for comparing data sources and choosing the best one? In the future the Czech Republic will

implement regular collection of ECHI indicators and add ECHI indicators to the national DPS system (Data Presentation System).

Estonia has a national database and is working on comparison of national and ECHI indicators. At the beginning of 2011 Estonia began to implement e-health, which will improve health statistics greatly. The ECHI work has had some delays, but at the moment the work is progressing quickly. For the Pilot data collection some data sources did not match with ECHI definition; some breakdowns (e.g. age groups and socioeconomic status) were different. Also the register linkages are not possible and not likely in the nearest future.

Poland is in the phase of planning the national implementation of ECHIM. Many work groups are planning the future health information systems, but no concrete decisions have been made so far. In general, the key stakeholders have positive attitude towards ECHIM, but no concrete actions have been done. Poland has problems with data quality from hospitals and primary health care centres, but are planning to improve it. They did not participate in the pilot data collection, so no concrete remarks could be pointed out about this subject.

Latvia joined the project 6 months ago. During that short period they filled in data availability sheets and drew conclusions that data availability is very good. They have good patient registers and they also participated EHIS in 2008. There are some challenges like problems with interpretation of some indicators (e.g. smoking prevalence, alcohol consumption) and with coding of death causes. There is positive attitude towards ECHI, willingness to implement ECHI indicators and incorporate them into national DPS –based system.

Albania participated in an ECHIM Extended Core Group meeting for the first time. They are interested in developing a national ECHI indicator system in future according to indicators developed by ECHIM, but more time is required for implementation work.

In Lithuania the reorganization of the Ministry of Health didn't allow sending the pilot collection data as requested by the Joint Action for ECHIM. They have a complicated situation in developing the ECHI indicator system due to data protection issues and the necessity to improve the possibility of data linkage. They also suggest the necessity of more collaboration between OECD, Eurostat and ECHIM JA.

Portugal does not have a NIT, and they do not see it necessity in the future. There is a National health indicators monitoring system, which will not be replaced with a new one (ECHIM) in order to maintain the exiting time series. They have difficulties in finding new resources for the development of new registers and HES. The national health system is divided in public sector and private sector. Data developed by the private sector are not well identified and they are probably underestimated. There are excessive requests of data (from Eurostat, OECD, WHO) and it is not possible to satisfy also the ECHIM JA requests without a political mandate (EU) because the decision of new HIS or HES is under political control. There are also data protection problems which are to be solved.

In Cyprus, there is a gap of information and a national health monitoring system is to be created. Work done by ECHIM and ECHIM JA is seen as a good starting point for the development of the national system and they are interested in following the EU recommendations. At this moment an informal NIT exists. Data necessary for the ECHI short list are available in some cases from national HIS survey and from cancer register. The biggest obstacles are the financial crisis and the very strong private sector of public health, without quality control, because they often don't give data to the MoH. The communication on ECHIM progress is part of their daily work.

Austria aims to implement the ECHI shortlist for the purposes of public health reporting and public health monitoring. An advisory board consisting of members of the statistical office (Statistics Austria) and the Austrian Ministry of Health has been established. Austria was

amongst the first countries to perform the European Health Interview Survey (EHIS) in 2006/2007. The calculation of the ECHI shortlist indicators has been performed by Eurostat, which has started to disseminate the results in February 2011. It is regarded advantageous that all ECHI relevant data are administered by one unit while the lacking possibility to link patient records from different domains is seen as one of the main obstacles. Further information regarding the implementation of the ECHI shortlist can be found on the http://www.statistik.at/web_de/statistiken/gesundheit/europaeische_gesundheitsindikatoren_e_chi/index.html

In France an expert team has been set up to initiate the use of the ECHI shortlist indicators in a national report comparable to the “Dare to compare” report published by the RIVM (Netherlands). Together with an advisory board the expert team is regarded as the National Implementation Team. While France underpins the necessity for international comparisons in public health reporting, the current focus lies on the fulfilling of the reporting obligations for the French national public health law, which has defined 99 national public health objectives. The latest indicator-based report was published recently (L’État de santé de la population en France, Rapport 2009-2010). Regarding the availability of data, France has decided to use only selected modules of the EHIS-Questionnaire. Therefore the availability of French data for the calculations performed by Eurostat was limited.

The National Implementation Team in the Netherlands now benefits from the enhanced engagement of the central bureau of statistics (CBS) which has provided valuable input in the ECHIM Pilot data collection. While there are no difficulties to report ECHI data under the regular reporting scheme for Eurostat, scattered data and unclear/overlapping responsibilities for other data sets interfere with a coherent approach towards specific ECHI shortlist indicators. Regarding the Pilot data collection data ownership has sometimes proven to be problematic. Due to organisational changes the coverage of some routine data sources has decreased. Overall the presentation of the ECHI shortlist indicators in the national public health compass has clearly enhanced the visibility of ECHI in national health reporting.

Due to the absence of a regular contact person over the past six month Switzerland was not included in the Pilot data collection. Recently a contact person has been nominated at the federal agency for statistics (Bundesamt für Statistik) who received the ECHIM pilot data questionnaire. Because the Swiss Health Survey has been developed with a view on the European Health Interview Survey, a national team should be set up to explore the possibilities for data delivery. Overall the Swiss representative underpinned the interest to enhance the international cooperation and explained that he will examine the possibilities to set up a national ECHI team.

In Germany a national ECHI team consisting of relevant national stakeholders (Federal Ministry of Health, Federal Statistical Office and Robert Koch Institute) has been set up. Additional expertise will be gathered in the team if needed (e. g. federal state representatives). The German ECHI has started its work with a view on the pilot data collection, for which the relevant data sources have been identified. The national health monitoring system that has been set up only two years ago and that has been developed with a view on the requirements of European health data has proven to be a very valuable source of data that is directly comparable to the data gathered with the European health interview survey (EHIS). Though Germany lacks specialised national registers for acute myocardial infarction and stroke the register-based indicators included in the ECHIM Pilot data collection could be delivered by the Federal Statistical Office. The Federal Health Monitoring and reporting units at the Robert Koch Institute are preparing publications to inform their users about the ongoing developments in the ECHIM Joint action. For this purpose Robert Koch Institute will produce an issue of “Health Reporting Compact”, which is their new publication. Now that the first results of the EHIS wave 1 are disseminated via Eurostat, the online information system of

the Federal Health Reporting will be developed in close cooperation with the responsible administrators at the Federal Statistical Office.

In Belgium no specific implementation team has been set up. Instead the task has been assigned to the national focal point responsible for the delivery of health data to international organisations. For administrative reasons the Scientific Institute for Public Health (IPH) has finalised its formal application to become a member of the European Statistical System (ESS) which is required for officially nominated data holders under the statistical law of the EU (EC/223/2009). Belgium has compiled an inventory of data sources for the ECHI shortlist which has been submitted to the ECHIM secretariat. There is a clear interest of the different Ministries of Health in Belgium (national, regional) and IPH has received the mandate to engage in the international developments.

The Belgian representative expressed his concern about the latest developments regarding the plan to adopt the implementing regulation for the European Health Interview Survey for the EHIS wave 2 in 2014 only. It was questioned if such an approach will be successful in the adoption under the comitology procedure. Several participants agreed that the needed consent for the implementing regulation will be difficult to obtain if it refers to a single survey only. Moreover, the initial considerations to implement modules of the health interview survey as rolling modules of the SILC-Survey after 2019 were put into question. This would especially affect countries where health surveys (interview or examination surveys) are performed by institutions different from that conducting the EU-SILC Survey.

General points:

In many countries it is seen good progress in implementation work, but ECHIM still need more visible political commitment.

Lack of manpower and financial support delays the implementation work.

There are challenges in data protection and data linkage. Commission should have more clear vision how to improve the situation.

Enrique Loyola again stressed the importance of bringing together more the efforts of ECHIM, WHO and OECD.

Future of the ECHIM: Results from the group discussions held on the first day

Mika Gissler, Antti Tuomi-Nikula, Marika Verschuure and Jürgen Thelen

The future ECHIM system has to be sustainable and worth to keep. Therefore, it is essential to ensure its sufficient quality.

The tasks in the future are:

1. Maintaining the short list: documentation, developmental work, coordination with other indicator systems (OMC, SPC, Eurostat)
2. Data collection: data flow from international and national data sources
3. Processing and reviewing the data effectively before entering the data: quality assurance, outliers, post-harmonisation
4. Development of HEIDI data presentation tool
5. Analysing , reporting and creating links to HEIDI system
6. Networking with international and national counterparts
7. Supporting the member states in their national implementation

The ECHIM implementation work must continue in the future. A lot of work has already been done and there is a vision about on the tasks that still need to be done. An EU Regulation would of course be the best thing to enhance the ECHIM, but it is highly unlikely to be

achieved. Moral support from the commission especially for countries with limited resources would be important. In the future the maintaining the network of national focal points is seen as a key issue as well as existence of national implementation teams with adequate understanding and knowledge in collecting and handling the data.

At the national level in countries, the role of the ECHIM indicator work must be clear: political commitment must be strengthened (Ministries of Health need to be involved), structure clarified and media coverage tried to gain. Working together is the key. ECHIM should also be strongly promoted at international conferences. It should also be noticed that ECHIM has already had many positive effects to the national health information systems. It has for example helped to discover data problems in them. It helps to assess these systems and to identify priorities.

The long term scenario would be a one European Health Information System, one entity to cover different aspects, an umbrella under which EU, WHO and OECD would work together.

According to the Member States representatives ECHIM need to have better visible status as a Core Sets of indicators at EU level. The status of the ECHI shortlist should be made clearer, communication is a key here. There should be more presentations at conferences and publications. There should also be closer collaboration between other European level organizations like OECD and WHO. It should be clear that ECHI indicators can already be used and they have added value. The focus of work should be on improving the comparability of the data, because there is the added value of ECHI. The ECHI shortlist should not become too long and it should respond in policy needs also in future (e.g. inequalities). Also in the future the technical data skills are necessary, this is why the logical future partners might be OECD and Eurostat.

It was also seen important that the work which has been done with the indicators in the development section should not be wasted. It should be decided how the work will be continued. A continuous support or "Help-desk" functionality must be maintained also after the Joint Action for Candidate countries that will need central guidance for their national measures regarding the implementation of ECHI.

Federico Paoli presented the future of ECHIM from DG SANCO's the point of view. A concrete action which was taken recently by DG SANCO to enhance the implementation work was the ECHIM letter. It was sent to all Members States, Candidate countries and EFTA countries as well as Serbia and Moldova in the beginning of this year. Quite a few countries sent replies with useful comments. These Included

- A more systematic and sustainable approach to the health monitoring system after the termination of the joint action should be ensured. It is important that indicators have a practical value to MSs. Branding the ECHIM in MSs and letting the ECHI be well known among the users are the key factors. Harmonisation of primary data collection, analysis and reporting at national and European level is essential.
- Better promotion/continuous political marketing of ECHI and national and EU level.
- Creation of a user-friendly presentation system: interactive, functional, flexible and accessible.
- Compilation of analytical reports at EU level - whose core ingredient should be ECHI indicators - which should be tailored to their target audiences (primary target should be policy makers).

- Details of the data collection and calculation methodology accompany all indicators, give a possibility to assess comparability issues.
- Keep the indicator set focused and limited, and of high quality (a smaller high-quality indicator set is more valuable than a large variable-quality indicator set).
- Ensure that any further development is consistent with constrained resources faced by MS: Avoid unnecessary additional data collections.
- Don't reinvent the wheel: build on existing indicators and existing collections.
- Indicators should be constructed to assess offer insights into health inequalities.
- The length of the ECHI shortlist should be kept feasible.

Before the summer holidays a paper should be drafted to suggest how the ECHIM work should be continued in the future. It was decided that ECHIM Partners will draft this paper.

Possible extension for the ECHIM JA and discussion about the future of ECHIM

EAHC (Dirk Meusel) and DG SANCO (Tuuli-Maria Mattila) saw it possible that ECHIM JA request an extension period. An official amendment is needed. At least the data analyses need more time and the extension also give time to plan the future of the EHCIM after the Joint action.

The Extended ECHIM Core Group meeting is needed also in the future, so hopefully DG SANCO will be able to organise it during the spring 2012 also in Luxembourg.

Many projects are facing the same situation were the financing is coming to an end. The continuity of the overall work should be ensured and perhaps it should be planned together with OECD.

Commission, WHO and OECD should work more closely together in the future. It is difficult to rationalise all the different data collections to Ministries.

Next steps and goals by the end of the project

Antti Tuomi-Nikula

Antti Tuomi-Nikula reminded about the deadlines.

Deadline for establishing the National Implementation Team and filling out the Indicator Data Availability Sheet is 31.5.2011 for all countries. And deadline for the Communication Survey questionnaire, draft Implementation & Communication Plan is 31.7.2011.

Administration issues

Marja Lampola

Marja Lampola told briefly about the financial issues.

Final payment from the previous ECHIM project period has been received from EU last year. 1st and 2nd year of the Joint Action has been reported to EAHC. There will be a need for amendment. This will be prepared by the THL with the help of Partners. Related to this meeting, the reimbursements will be paid by EU, THL or own organization. Marja Lampola will send related documents by email.

