Working Paper No.4
30 April 2004

ENGLISH ONLY

STATISTICAL COMMISSION and UN ECONOMIC COMMISSION FOR EUROPE

CONFERENCE OF EUROPEAN STATISTICIANS

STATISTICAL OFFICE OF THE EUROPEAN COMMUNITIES (EUROSTAT)

WORLD HEALTH ORGANIZATION (WHO)

Joint UNECE/WHO/Eurostat Meeting on the Measurement of Health Status
(Geneva, 24-26 May 2004)

Session 1– Invited paper

TOWARDS A COMMON FRAMEWORK TO MEASURE HEALTH STATUS

Submitted by Eurostat/European Commission*

I. INTRODUCTION

1. The subject of this meeting - the measurement of health and how to come to a common framework for this measurement - is certainly not a brand new topic. Over the past years there were several international meetings dedicated to this topic:
- for *health status* in general : the Joint UN-ECE and WHO meeting on measuring Health status, held in October 2000 in Ottawa and
- for *disability* : the UN International Seminar on Measurement of Disability, held in June 2001 in New York and the three meetings of the Washington City Group on Disability Measurement, held respectively in February 2001 in Washington, in January 2003 in Ottawa and in February 2004 in Brussels.

2. It is only during the last two decades that reasonable results have been achieved, although the issue is far from being resolved. One of the most important problems is on how to reach a consensus on *common instruments to measure health status,* which could be used for regular measurements in time at national and international level.

3. The aim is to establish instruments for (modules for) surveys, which could be executed at regular intervals and in such a way that they will provide reliable and comparable results whilst being executed in an efficient way and at reasonable input of both financial and human resources. Surveys which are acceptable both for the interviewer and the interviewee and which give,

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although carried out in different languages and in different cultural settings, results that could be compared within and across countries.

4. One of the most difficult issues to overcome is how to combine the aim to arrive at optimal results which could easily be realised in practice in regular surveys on the one hand and the aim to use scientifically complete and accurate instruments on the other hand.

II. HEALTH SURVEYS AS AN ELEMENT FOR THE MEASUREMENT OF HEALTH STATUS

5. But what do we actually mean when we refer to the measurement of the health status of a population? What should be measured? What are possible instruments and data sources?

In general *four building blocks* could be identified which provide the basic data for the measurement of health:
1) health and disability interview surveys (HIS/DIS);
2) diagnosis-related morbidity data (MORB);
3) causes of death statistics (COD); and
4) health examination surveys (HES).

6. Each of these building blocks has its own characteristics, advantages and draw backs.

Diagnosis-related morbidity data are mainly provided by health professionals in and outside hospitals and this within a certain health care struc ture. It is the organisation of the health care system, which determines the accuracy and the completeness of the data provided. The differences of the national health care systems are a complicating factor for the use of this data source for intercountry comparisons.

Health Interview Surveys/Disability Interview Surveys (HIS/DIS) provide data on the perception of the individual of his health status and level of functioning, maybe not with all the medical details, but not so much determined by the (national) structure of the health care system. HIS/DIS indicate how people feel, what consequences people experience with respect to individual and social activities. Special attention could be given to special groups, such as disabled people.

Health Examina tion Surveys (HES) provide data on physiological and psychic identifiable and measurable characteristics. For these data there is not yet a harmonised methodology at international level. HES are also very expensive and may as such be an extra financial burden.

Causes Of Death (COD) give data on the final outcome of health, in casu death.

7. These four building blocks to measure the status of health are as such part of a larger group of data, with links to other domains such as demographic and socio-economic characteristics.

8. This meeting is mainly focussed on the intention to come at international level towards a common framework of health status measurement through surveys.

III. A COMMON FRAMEWORK FOR HEALTH STATUS MEASUREMENT IN THE EU

9. Since more than a decade now Eurostat has gradually established a framework for common efforts to measure first with 12, then with 15 + 3 and now with 28 countries the health status of our European population.

10. The emphasis is to provide a comparable set of data which gives information for policy and general information purposes and this for a group of 28 countries with their different cultural and language characteristics. So the challenge is to minimise the bias these cultural and language characteristics might have on the data set and to come to truly inter-country comparable data.

11. This framework has been gradually built taking into account that 'health status' is one element amongst a variety of social variables. One could look at health either as a separate item or as a supporting element in a wider 'social' context. This has practical implications for the execution and reporting on health status.

12. The measurement of health status in relation to socio-economic aspects and in the context of social protection is an important aspect for policymaking, such as in terms of measurement of needs and outcome. Health status is also an explicatory and supporting element in terms of distribution of and access to health care resources.

13. At the level of the European Union, indicators on health status are included in wider sets of indicators such as indicators on *sustainable development* and *social indicators*, and in the future also in the package of *structural indicators*, which the Commission has to provide yearly to the European Council.

14. So within Europe 'health' is looked at within a wider context; health statistics in general and statistics on health status in particular are part of a larger group of social statistics. The advantage of this is that for a number of other socio-cultural-economic variables which are determinants for health such as education or occupation, classifications are well established. The restriction might however be that one could not fully benefit of the luxury of scientific freedom for developing instruments independently for the single aim of health status.

15. Building on national experiences we are working supranationally on bringing together data on health status an its determinants gathered according to a common framework and using as much as possible commonly agreed and tested instruments.

16. There is a common policy within the EU and in particular within the European Statistical System (ESS) to give special attention to the use of common standards and instruments and to avoid that the comparability of data sets is blurred by language and cultural specificities.

17. Further in this conference there will be different presentations highlighting the methodological approaches used in this common policy in the ESS.

IV. TOWARDS A EUROPEAN HEALTH SURVEY SYSTEM

18. Within the context of HIS a common framework has been agreed in the group of Directors of Social Statistics (DSS) at their meeting in September 2002.

19. The *European Health Survey System (EHSS)* may be tentatively defined as a comprehensive and coordinated set of surveys, allowing inter-country comparisons, that is built around an essential core survey, according to a flexible and modular implementation, aiming to monitor potential changes in health and in relation to other - mainly lifestyle and socio-economic - variables over time.

20. The *EHSS* is composed of three pillars:

a) The European Core Health Interview Survey *(ECHIS)*, which is the core survey – consisting of different modules - in the System for general statistical measurement in the framework of health statistics;

b) The European Special Health Interview Surveys *(ESHIS)*, which is a complementary set of special surveys (targeting to specific age groups, disease groups etc), which should deal with specific user-oriented topics and which could be run by special networks of researchers and/or institutes;

c) A compilation of reference instruments and other recommended instruments, which is compiled in an online database and is regularly updated.

21. For the ECHIS, there is already in place the annual minimum European health module in the Statistics of Income and Living Conditions (SILC) and at least every five years Member States should include – in their national surveys and during the same period - four harmonised modules constructed around common concepts for which reference instruments are or will be available:

- the European module on health status
- the European module on disability and social integration
- the European module on health determinants
- the European module on health care
- the European background module.

Further details will be given by my colleagues during other presentations at this meeting.

V. SOME IDEAS FOR COOPERATION AT A WIDER INTERNATIONAL LEVEL

22. The EU Member States agreed to go forward with the EHSS as a usefull complete, feasible and stepwise approach. One could think of a similar approach at a wider international level, although some might say that the differences between the various regions in the world (Africa, Asia, America, Europe…) make this an unrealistic approach.

23. A feasible approach might be to seek at first *consensus for general measures* such as to be used in censuses or general population surveys and, as a next step, to develop at world level more specific longer sets for health status. A similar approach is used for disability measurement in the Washington City Group (WCG) and in line with the approach taken in the WCG, Eurostat and its partners in the ESS have developed a general measure for disability (track A) and will now embark on the development of a larger set of measures (track B).

24. Following these lines, international organisations and bodies working at the global level could focus more on the development of standards such as concepts and classifications, frameworks and methodology by way of preparing « toolboxes » for data collection and analysis.

25. For their routine statistical data collection, the international organisations and bodies should only make use of secondary sources, such as aggregates as provided by the different countries.

26. International organisations working in specific regions in the world, such as WHO-Euro and the EU as a supranational organisation, could concentrate more on the adaptation of the global toolboxes according to different regional situations. The regional organisations could strengthen their support for the global level with respect to the toolboxes.

27. At the national level, the focus should be on the implementation of common concepts and reference instruments in the context of cultural and language differences. Countries should be the primary data collectors, and should themselves provide the aggregates to the international/supranational organisations.

28. In this short keynote address I have given a short outline on how Eurostat has set up a framework for the measurement of health status, in particular on how a common approach is reached on health surveys and I have given some suggestions for international cooperation in the field of health status measurement.

29. All elementary elements to make a step forward are available. As for instruments there is considerable progress made, but there is still a lot to be done when it comes to implementation of these instruments and this with the available financial and human resources. This means that we have now to concentrate on setting *priorities* and on preparing *a practical and feasible action plan*.

All ingredients are available, it is no up to us to establish the common menu.

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