PARALLEL SESSION 6

Saturday 8 November, 09:00–10:30

A.6. Workshop: Overcoming the incomparability of European morbidity data

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Issue/problem

In order to monitor population health in the European Union (EU) relevant, valid and comparable health data are needed from Member States (MSs). But how do MSs know what data to collect? They make decisions based on sources like the European Community Health Indicators (ECHI) shortlist and Eurostat's new strand: Diagnosis Specific Morbidity Statistics. Using the data from different MSs, the needs of health policy and public health can be served better, which helps anticipate on certain public health trends, such as ageing and health inequalities.

Description of the methodology

In the workshop four topics will be presented. The first is to introduce the ECHI shortly and to present the latest developments in the ECHI shortlist. The second presentation is to illustrate the practical application of the newly developed indicators. The third is to introduce Eurostat's Diagnosis Specific Morbidity Statistics (design and methodology), and the fourth is to present preliminary results from pilot studies on the Diagnosis Specific Morbidity Statistics from several MSs.

Aim of the workshop

The aim of the workshop is to provide insight in the world behind EU health data. How are decisions made on what data to collect? What can different MSs do for assuring data quality, and how can country-level data be translated to EU-level data?

Developing and implementing European community health indicators to advance health monitoring in the EU and all EU Member States

Arpo Aromaa

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Issue/problem

There is a great and ever growing need for a common set of comparable indicators to monitor health in the EU and many such indicators are not available. Joint vision of their development and implementation is needed.

Description of the policy

The project European Community Health Indicators and Monitoring (ECHIM) develops and implements health indicators to advance health monitoring in the EU.

ECHIMs main activity is to start the implementation process in each Member State (MS) in collaboration with the national contact persons and organizations. The work is long term.

Results (effects/changes)

(1) A revised list of the ECHI-indicators with precise definitions and data sources has been prepared.

(2) The availability and comparability of the indicators in international databases and national sources have been assessed.

(3) The key issues for successful implementation of the indicators have been identified in each MS.

(4) Country-specific strategies for the implementation have been outlined in collaboration with the national contact persons.

Lessons

The final report of ECHIM makes recommendations for data gathering, quality assurance, analysis and reporting as well as proposals regarding the functions and structures of the permanent health information and knowledge systems. The guidelines are also a starting point for the MSs to consider how to close the gaps and implement indicators.

Developing the core set of European community health indicators

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Issue/problem

Valid and public health-relevant indicators and comparable and valid data for them are a prerequisite for all health monitoring, information dissemination and reporting.

Description of the policy

The European Community Health Indicators (ECHI) projects have proposed a shortlist of 82 indicators as a common conceptual structure for health information and monitoring in the EU. One of the key aim of the current European Community Health Indicators and Monitoring (ECHIM) project is to further develop the ECHI indicators and their definitions.

Results (effects/changes)

A new release of the ECHI shortlist is available. The definitions and the preferred data sources of the indicators have been determined. Also, the availability, comparability and quality of data have been assessed. The Documentation Sheets present the complete information on each of the ECHI shortlist indicators in a condensed form. They have been published online on the ECHIM website.

Lessons

A set of valid, comparable and public health policy and health care relevant indicators with definitions and interpretations is needed, and it is now available for health monitoring in the EU. Documentation Sheets present the overall guidelines for implementation of the ECHI indicators and are the necessary base for the countries to able to implement the indicators. But further development of health indicators and their definitions must be continued.

Eurostat's methodology for diagnosis-specific morbidity statistics

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Issue/problem

Next to the cause of death statistics and the data from health interview surveys, statistics on diagnosis-specific morbidity are another important element for providing a comprehensive description of the status of health of European populations. The overall aim of diagnosis-specific morbidity statistics is to achieve a sustainable data provision for a selected set of diseases within the European Statistical System (ESS), in order to provide a general picture of diagnosis-specific morbidity at population level.

Description of the policy

In the context of the Community Statistical Programme, a group of experts focused its efforts on establishing a morbidity shortlist (taking into consideration other existing shortlists and required indicators) as well as on the best measures (incidence, prevalence) according to the shortlist items, quality criteria according to these measures and most appropriate sources. In 2007, a final shortlist together with recommended measurements and guidelines for data collection were agreed by Member States for starting pilot data collection exercises.

Results (effects/changes)

The work on diagnosis-specific morbidity statistics is in a developmental stage, i.e. a methodological approach has been proposed and first pilot data collection exercises started to test the feasibility of this approach. In 2008, the results of these pilot data collections will be evaluated with a view to establish a regular data collection within the ESS.

Lessons

Hurdles in the development of the methodological approach have been identified as well as caveats for feasibility. Anticipating on the upcoming evaluation we propose some ways to overcome them.

Results from pilot studies on diagnosis specific morbidity statistics

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Issue/problem

The Eurostat Pilot Project on Morbidity Statistics was carried out by following three countries: Estonia, Germany and Lithuania. The aim of the project was to assess the feasibility of using routine data for morbidity statistics at the European level.

Description of the methodology

The countries identified and evaluated potential data sources. Special emphasis was given to the health insurance database, a new innovative data source. Pilot data collection from the health insurance database and other potential data sources identified was carried out in all the countries. To validate the health insurance database, deeper quality analyses were performed for tuberculosis, lung cancer, diabetes, hypertension and myocardial infarction.

Results (effects/changes)

Using the health insurance database, different morbidity statistics can be computed (incidence and prevalence for Estonia and Lithuania, prevalence for Germany). The best data source was suggested for each diagnosis. An algorithm for the selected disease estimate developed on the basis of documented diagnosis differed between the countries. More similarities were observed for Estonia and Lithuania.

Lessons

Using different data sources, distinctions were found in morbidity statistics between the countries and within a country. No single general algorithm can be applied to all diseases. Utilization of health insurance database necessitates special methodological strategies.

B.6. Session: Obesity 2

The challenges of gathering data on the behavioural determinants of the child obesity epidemic in Europe

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Obesity is one of the major child health challenges and causes of morbidity in Europe. The problem is internationally recognized, but there is no coordinated or standardized way of monitoring the epidemic, and even more importantly no consensus on how to measure causal nutritional and physical activity behaviour.

A year-long project in 2007 by the EU funded Scientific Platform Project on Lifestyle Determinants of Obesity attempted to establish the data collection mechanisms used in 31 countries in Europe for assessing childhood obesogenic behaviour using nutrition and physical activity as the essential determinants. A systematic literature review and analysis led to structured data availability assessment by in-country agents. The results showed the complexity of the issue.

For example, there is no absolute agreement on the definition of when a child becomes overweight, and then obese. Using a life course method of study is essential as it allows for the fact that children at different ages act differently and are affected differently. Collecting and analysing data about children are sometimes challenging because of ethical concerns coupled with the need for the data to be reliable and valid even though in many cases, particularly for younger children, indirect or proxy measures must be used. Policy issues and legislation (within and beyond the health sector) influence children's and parental behaviour. Similarly, environmental determinants including places to play: walk to school; gain access to affordable healthy food; and even fashion have a profound effect on children's behaviour and lifestyles.

The project established data collection parameters for measuring childhood nutritional and physical activity behaviour that took into account these considerations and revealed the great disparity in data collection surrounding childhood obesity in Europe. Both the life-course-based set of measures, and the availability of these data items across EU Member States, will be presented.

Mothers' social background and risk of eating disorders in daughters

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Introduction

Eating disorders (EDs) are becoming more common among young women. EDs are associated with severe somatic and psychiatric complications as well as higher risk of premature death, but their aetiology is still poorly understood.

Material and methods

We studied incidence of ED among Swedish females born 1952–89 ($n = 14\,338$), the third generation descendants from the Uppsala Birth Cohort (UBCoS). Register-based data on grandparental and parental social characteristics, school marks at age 15 years, hospitalizations for ED (ICD-8: 306.5; ICD-9: 307.1,307.5; ICD-10: F50.0–F50.9), deaths and emigrations were obtained by linkages through unique personal identification numbers and covered a follow-up period from 1960 till end 2002. Associations of social characteristics and school performance with incidence of ED (first hospitalization for one of the above diagnoses) were studied in multivariable Cox regression, adjusted for year of birth.