
3rd PHMR Newsletter

EUPHA Section on Public Health Monitoring and Reporting

February 2016

News from Europe

Status Quo of the negotiations on the EU General Data Protection Regulation

In December 2015 the trilogue between the European Commission, The European Parliament and the Council of Ministers came to an end. They adopted a compromise text that includes safeguards to enable public health research. Comprehensive information on the results of the trilogue and the upcoming activities can be found on the website of the European Data in Health Research Alliance – www.datasaveslives.eu.

Reorganization of DG SANTÉ (former DG SANCO)

The unit responsible for public health monitoring and reporting issues is located in [Unit C2](#) (Country knowledge and scientific committees) – Head of Unit: Philippe Roux.

News on the DG SANTÉ funded project BRIDGE Health

The BRIDGE Health project (**BR**idging **I**nformation and **D**ata **G**eneration for **E**vidence-based Health policy and research), that aims to prepare the transition towards a sustainable and integrated European health information system, was introduced by Petronille Bogaert and Herman van Oyen in our [past newsletter](#).

In the meantime the project has launched a [website](#) and published a first [newsletter](#). To receive regular updates you can subscribe to the newsletter or follow [@bridge_health](#) on Twitter.

New public health monitoring tools

The European Commission has launched a new tool for monitoring health in Europe. The [ECHI data tool](#) replaces the former HEIDI tool. About 50 indicators from the 88 European Core Health Indicators are integrated in the data tool. As a new feature graphical and tabular visualization of more than one indicator is possible.

Eurostat provides regular updated statistical information in their series [Statistics explained](#). One of the series topics is focused on [Health](#). The link to [Health in the European Union – facts and figures](#) provides also some infographics on population health.

The [European health statistics app](#) of WHO-EUR allows accessing the Health for All database via smartphone.

World Health Organization Regional Office for Europe (WHO-EUR)

During the WHO-EUR's 65th Regional Committee for Europe the objectives, principles and modalities for continued cooperation between the European Commission and the WHO Regional Office for Europe were outlined.

The document includes also a paragraph on health information:

Modernizing and integrating the public health information system

19. Robust, high quality and comparable data are essential to improve health outcomes and health systems. The European Commission and the WHO Regional Office for Europe endeavour to continue to collaborate with each other and with the Organisation for Economic Co-operation and Development (OECD) on information related to public health and health systems; in particular, in relation to the achievement of harmonization of health indicators. In this context, the European Commission remains engaged in the European Health Information Initiative ([EHII](#)) and its six elements, led by the WHO Regional Office for Europe, including the development of information for health and well-being with a focus on indicators, improved access to and enhanced dissemination of health information, capacity building, strengthening of health information networks, support for health information strategy development, and communications and advocacy. The WHO Regional Office for Europe remains engaged in the Commission's efforts in setting up a sustainable EU Health Information System, including a more formalized governance of health indicators, collection and analysis of country specific information, and establishing a sustainable solution for providing technical and scientific support for health information in the EU. Both institutions aim at creating favourable conditions allowing the Member States to take decisions on health indicators leading to as high a level of integration as possible under the respective legal, financial and governance systems; this should be based on existing indicator systems, including the European Core Health Indicators ([ECHI](#)), [Health 2020 indicators](#), among others. The two institutions intend to continue to collaborate

through this cooperation process as a vehicle to arrive at coherent and complementary health information reporting in the European Region. The European Commission and the WHO Regional Office for Europe through this cooperation process endeavour to reduce the burden put on Member States in terms of data collection and reporting.

PHMR Section News

ANNUAL REPORT 2015

The annual report summarizes the 2015 activities of the EUPHA-PHMR section, please [click](#) for more information.

European Health Information Initiative (EHII)

[Brochure](#) on the European Health Information Initiative

EUPHA was invited by WHO Europe through the Chair of the Steering Group of the WHO European Health Information Initiative Drs Annemiek van Bolhuis to become a member of the EHII and its Steering Group. EUPHA's Executive Council has approved EHII's invitation and has requested the PHMR Section President to fulfil this task.

The EHII Steering Group will meet in March 2016. We will report in the upcoming newsletter about the meeting.

EUPHAnxt

PHMR section members younger than 35 years are cordially invited to join EUPHAnxt.

Contact: info.euphanxt@eupha.org

NEW: Questions and news from PHMR section members

Small Area Estimation for Policy Makers in the Netherlands

Carolien van den Brink, Jan van de Kasstele, Oscar Breugelmans, Laurens Zwakhals, National Institute for Public Health and the Environment, the Netherlands

Introduction: In the Netherlands as well as in other countries, local policy makers and health care services increasingly require information on health-related indicators at smaller geographical scale, like municipalities, neighbourhoods or postal codes areas. However, indicators about health and health-related behaviour at smaller geographical level are scarce. Especially when using questionnaires to collect data, it is very expensive to oversample. Reliable statistics of interest cannot be produced due to these limitations of the available data. A solution to this problem is to use small area estimation (SAE). In a few words, SAE uses a model to borrow strength from

auxiliary variables or neighbouring regions to predict the statistics of interest for a specific area.

Methods: There is a broad literature about SAE methods. Pfeffermann (2013) provides a good overview. The method we employ is a unit level mixed effects logistic model. The response variable is binary, taking the values 1 or 0, in which case the small area statistics of interest are proportions. The model relates the outcome to age, sex and ethnicity at the unit level, and several other auxiliary variables at the area level. Any variation in the outcome that is unaccounted for is modelled by area specific, possible spatially correlated, random effects. The expected response of the unobserved individuals can accordingly be predicted and the area level proportions can be calculated.

Data source: In recent years more large data sources on health related indicators have become available, such as several registrations and survey data on health indicators. One important new data source in the Netherlands is the Public Health Monitor. Together with Municipal Health Services and Statistics Netherlands, the National Institute for Public Health and the Environment has worked on the standardization of questions and methods that are used in the Public Health Monitor. The Public Health Monitor, carried out in 2012, contains more than 384.000 respondents, distributed over 400 municipalities. The Public Health Monitor is repeated every four years. We will apply the SAE model to this dataset to make small area estimates for e.g. self-rated health, smoking and overweight.

Other relevant developments?

We would like to know from other researchers that are working on similar models. We are interested in the models that are used and in the predicting variables that are put into the model. It would be interesting to share our experiences.

Please contact Carolien van den Brink (carolien.van.den.brink@rivm.nl)

Summary of PHMR workshops at the EPHC 2015 in Milan

On the following pages we would like to disseminate our impressions and summaries of the three workshops with PHMR section involvement.

1. Observe the gap: Possibilities and approaches for routine monitoring of social health inequalities

Organized by the EUPHA sections on Public Health Monitoring and Reporting and Public Health Economics

Chairs: Nicole Rosenkötter, Tek Ang-Lin

Report provided by Marja van Bon-Martens

The reduction of health inequalities was the main theme of the EPHC 2014. By taking this theme

up, the workshop aimed to discuss approaches for routine monitoring of social health inequalities to observe the gap and to inform public (health) policy.

Inequalities in life expectancy by socioeconomic status in the EU

Presenter: Veronica Corsini, European Commission, Eurostat

Indicator: [Life expectancy by educational attainment](#)

In 2007, Eurostat was requested by DG Employment, Social Affairs and Inclusion to develop comparable information on mortality by socioeconomic groups to be available on a regular basis for all EU Member States.

Methodological issues that needed to be addressed were the choice of socioeconomic group characteristic, the choice of the health indicator, and the approach for connecting social and health information. It was decided to use educational attainment for the determination of the socioeconomic group and life expectancy as health indicator.

Information on deaths by sex, age and educational attainment group (based on ISCED1997 first and ISCED2011 after) is derived from Eurostat annual demographic questionnaires. For some countries also information on the population by sex, age and educational attainment could be derived from this data source; for the other countries information on population characteristics is derived from the EU Labour Force Survey. For all countries, Eurostat applies the same methodology to calculate life expectancy.

Life expectancy by educational attainment differs largely between EU Member States. Within countries gaps in life expectancy by educational attainment can be observed, mainly for men. The higher the education, the higher the life expectancy: at any age, life expectancy is shorter among persons with the lowest educational attainment and life expectancy increases with educational level. Moreover, women with low education have higher life expectancies than men with high education (58% of the countries in 2013). Gaps in life expectancy (at age 30) between high and low educational attainment groups have increased between 2007 and 2013 in 33% of the countries for men and 61 % of the countries for women.

Monitoring the gap in perinatal health in Europe: can we use routine datasets for cross-national comparisons of social disparities?

Presenter: Mika Gissler, Euro-Peristat

National rates on the impact of socioeconomic status on stillbirth are not routinely available in Europe. Therefore, Euro-Peristat aimed to assess the impact of social inequalities on stillbirth rates by using indicators generated by routine monitoring systems. The network used aggregated population-based data from 2010 of 29 countries. As socioeconomic indicators maternal educational level, maternal occupation, and paternal occupation are used. Stillbirth is defined as

death at the gestational age of 22 weeks or more per 1000 live and stillbirth in that year. If gestational age is not available stillbirth are determined by birthweight (500g or more).

Of the 29 investigated European countries, 79% provided stillbirth rates by at least one of the three socioeconomic indicators. Mothers' education has better availability and comparability than mothers' or fathers' occupation. Stillbirth rates by mothers' education is available in 19 countries, and by mothers' and fathers' occupation in 13 countries. Based on the calculations of PAR%, 1,606 (25%) out of 6,337 stillbirths in the investigated countries could be prevented if all women have the stillbirth rate of the most educated in their county.

It is concluded that routine data are available. Since data are aggregated, it is not possible to explore the contribution of other demographic or behavioural factors. They concluded that substantial health gains can be achieved from acting on social inequalities in still birth, but that more research is needed to develop effective policies. Routine monitoring of social inequalities of stillbirth is required.

Monitoring SES differences in health life expectancy in the Netherlands

Presenter: Marjanne Plasmans, RIVM, the Netherlands

Socioeconomic inequalities remain high, even in western countries with universal access to health care. To avoid the confusion about different figures that are used to describe socioeconomic inequalities, the RIVM wanted to develop a new indicator that could be monitored over time and describes socioeconomic inequalities in the total population. This indicator should reflect socioeconomic inequalities in the total population, should be sensitive to changes, should be relevant for public health and health policy, and should make comparisons between countries possible.

For this new indicator educational status, life expectancy and healthy life expectancy (based on self-perceived health) are used. Since the concept of SES is rather related to the position in the social hierarchy within a society, a relative approach is applied, given each person a rank that he or she has in the population based on the educational status. This approach enabled the analysis of the difference in healthy life expectancy at age 25 between the 90th and 10th percentile of education from 2001 to 2013.

Results showed that both, life expectancy and health life expectancy, are higher in high SES groups. The difference in healthy life expectancy between the low educated and the high educated is about 14 years for women as well as for men. Life expectancy has increased over time (2001-2013) for men and women. The difference in life expectancy between low and high educational levels is significantly declining for women. For low educated groups healthy years gained are less than gain of years in life expectancy, indicating that the years gained might be partly unhealthy.

The main advantage of the new indicator seems to be that it takes into account the changes of the

distribution of education over time. The combination of monitoring trends in life expectancy and healthy life expectancy per educational level is recommendable.

Surveillance of social inequalities in health in France

Presenter: Daniel Eilstein, French Institute for Public Health surveillance (INVS), France

In France, social inequalities in health are known in life expectancy, Healthy Life Years, in most diseases, from childhood to older age. Therefore, policy makers need to know how inequalities develop and how to intervene. The French Institute for Public Health Surveillance aims to optimize surveillance of the French population by taking the social determinants of health into account and to provide evidence to support decision-making and actions in public health. Specifically, they aim to integrate the socioeconomic dimensions routinely at the individual and geographic levels and in surveys and surveillance systems.

They have worked on the identification and use of socioeconomic variables on the individual level, on deprivation indices for the area level, and on a common definition of the concept of vulnerability, with the following results:

- Different categories for socioeconomic variables have been identified, e.g. education, employment, income, household, housing, health insurance.
- Deprivation indices: EDI European Deprivation index (individual), Fdep (French deprivation index, ecological index). Fdep uses census and tax data on the commune level, which is the smallest administrative unit. To calculate this index, the method of Principal Component Analysis was applied to a set of four variables.
- Vulnerability to disease of a population (an individual) is defined as the propensity to increase the risk for a health event to occur.

The challenge now will be to combine surveillance and research on social health inequalities, and research on interventions.

2. Health assessments: Status and perspectives of basic and advanced approaches

Organized by the EUPHA sections on Public Health Policy and Practice, the EUPHA section Public Health Epidemiology, the EUPHA section Public Health Monitoring and Reporting, the EUPHA section Health Impact Assessment and the EUPHA section Health Technology Assessment

Chairs: Giuseppe La Torre and Piedad Martin-Olmedo

Report provided by Nicole Rosenkötter

Health information systems and assessment tools in public health practice and policy

Presenter: Kai Michelsen, Maastricht University, the Netherlands

Kai Michelsen provided some reflections on the value of health information and assessment tools in public health policy and practice. He applied the UNDP Capacity Assessment framework to discuss (1) assessments as capacity to inform decisions and (2) assessments as objectives of capacity development. Moreover, he raised several questions to guide further thinking: Statistical analyses are only part of the policy process. May health assessments always take a backseat to politics as policy is made? Political power is legitimated by elections, how do health assessments come into play? Is communication and advocacy underdeveloped within the various health assessments? What implications does evidence-informed policy making have? Which model of persuasion do we apply, a rational-democratic model, a totalitarian model, a polis model? Are there cultural differences between the different assessment types?

Public Health Monitoring and Reporting - a collaborative process with multiple stakeholders

Presenter: Nicole Rosenkötter, NRW Centre for Health, Germany

Nicole Rosenkötter introduced basic and advanced approaches of public health monitoring and reporting (PHMR). Routine PHMR tasks are (1) data collection and indicator development/maintenance, (2) analysis and monitoring, and (3) reporting.

The collection of data and the maintenance of the indicator set require continuous exchange with various data owners. Data and indicators can be based on basic civil registration and vital statistics systems, or can include a wider variety of (health-related) data across different health domains and policy sectors. Applied analytical and monitoring approaches can range from rather basic descriptive analyses, age-standardization, time series and spatial comparisons to more sophisticated analyses that link health data with data from other sectors, include forecasting approaches, use Geographic Information Systems, summary measures or measures of deprivation. Public health reporting activities can be directly based on the presented data or incorporate scientific evidence, communicate policy priorities and, add a policy relevant perspective to the data. To disseminate monitoring results, approaches can range from generic paper reports and targeted publications for different audiences, to active involvement in committees, or comprehensive online documentation, including advanced graphical or audio/video approaches.

This rough overview shows that PHMR comprises several tasks and approaches. Their application depends on existing resources, knowledge, or specific needs on local, regional, national or international level. To improve public health monitoring and reporting in Europe it is essential to support infrastructure development (e.g. workforce, health information systems) and regular good practice exchange.

Prospective Impact Assessment: Taking stimulation from, and giving it to, other types of assessment

Presenter: Marco Martuzzi, WHO Regional Office for Europe

[Report](#)

Based on the observation that health is often not covered adequately in impact assessments, Marco Martuzzi reported from an initiative of the EUPHA section on Health Impact Assessment (HIA) to foster HIA development, for the benefit of population health. He presented results on the assessment of HIA practices in different countries and regions in Europe that can be used to support proper implementation.

Data from 22 countries were available for the analysis. Most countries started HIA in 2000 to 2010, in the UK HIAs were already conducted in the 1980s. Infrastructure projects were the main focus of the assessed HIAs. The assessments were mostly commissioned by the health authority of project proponents and were funded mostly by project proponents which might induce a conflict of interest. Most of the respondents reported that health assessments are integrated in environmental assessments, separate HIAs were reported by almost one quarter of the respondents.

In order to further develop HIA implementation, capacity building and the provision of resources, e.g. in terms of national guidelines and databases seem to be required. Moreover, increased political stewardship and involvement as well as legislation are seen as facilitators for HIA implementation.

The contribution of HTA to health policies

Presenter: Chiara de Waure, Institute of Public Health, Catholic University of the Sacred Heart, Italy

Health Technology Assessment (HTA) is a well established assessment approach about the medical, social, economic, and ethical issues related to the use of a health technology. It provides decision makers with a multidisciplinary and thorough evaluation. However, reaching a policy impact is one of the challenges and was discussed in the presentation.

The involvement of relevant stakeholder groups can be one factor relevant for improving the impact of HTA. The type of approaches for stakeholder involvement can range from regular routine meetings, to public meetings, to public consultations. Even though HTA aims to inform reimbursement and pricing decisions and to support the development of clinical practice guidelines and health service standards it is not guaranteed that information derived from a HTA is applied in decision making. Policy impact could be improved by early and constant involvement of stakeholders, timeliness and appropriateness of the evaluation, transparency of the process, proper communication and dissemination, and an institutional framework. Another study summarized facilitators in four groups: (1) Healthy stakeholder relationships, (2) Well-intentions, (3) clearly defined governance and leadership, (4) available organizational infrastructure.

Differences in the objectives of stakeholders, lack of commitment to HTA and changing political situations can act as barriers for HTA impact. The same holds true for the existence of heterogeneous HTA assessments, different health priorities, lack of a holistic approach to implementation, lack of reinforcement of compliance, or accountability.

3. Quality health information systems in small European countries and regions

Organized by the University of Malta, WHO (IHD), EUPHA (PHMR)

Chairs: Julian Malmo and Francesco Zambon

Report provided by Marieke Verschuuren

The chairs introduced the workshop by underlining the importance of sound health information and explaining its usages. They touched upon some of the problems small countries face like the problem over-surveying and a high data request burden for its citizens. On the other hand, there are also advantages for small countries like the fact that it costs relatively little effort to achieve a good coverage and the closeness of health information experts to policy makers.

EHII: recent developments and relevance for small countries

Presenter: Claudia Stein, WHO Regional Office for Europe

[Link to the EHII brochure](#)

Small countries face several health information challenges, like small number of deaths and cases, resulting in high fluctuations in rates from year to year, and having small health information agencies/departments. In Europe, the small countries in general have good population health and good health information systems. Sometimes the numerous data requests by the international organizations are not appropriate for small countries; they can be overwhelmed. WHO is working on improving their internal coordination regarding data request to the Member States. WHO Regional Office for Europe, the European Commission and the OECD have been cooperating in the field of health since several years. To support this collaboration by means of strategic advice [the WHO European Health Information Initiative \(EHII\)](#) was established in 2012. EHII focuses on six key areas, one of which is the strengthening of health information networks. EVIPnet and CARINFONET are examples of health information networks that already operate under the umbrella of EHII. The South East European Health Network (SEEHN) is currently discussing the establishment of a health information network. During the Regional Committee in September, the ministers of the small countries met, chaired by Malta, and agreed to establish a health information network. The benefits for countries to organize themselves in health information networks are that such a network can provide a platform for joint capacity building, exchange, reporting and mutual support. The Regional Director calls upon other countries to join the EHII. Chairs of health

information networks are invited to become part of the Steering Group of EHII. WHO defines small countries as countries with a population of less than 1 million inhabitants. Other organizations use different definitions. It was discussed that sub-national regions in federal states face similar problems as small countries.

Factors affecting data availability in the European Region - does population size matter?

Presenter: Natasha Azzopardi-Muscat, University of Malta, Malta

A study was performed to explore potential predictors influencing data availability in WHO's Health for All database (HfA). All indicator domains in HfA were included. As predictor variables population size, GDP, and EU membership were used. Population size was divided into three categories: < 3 million, 3 – 30 million, > 30 million. In total 504 indicators were included in the analysis. EU membership was a determinant of data availability in 317 indicators. This is probably a consequence of EU legal data delivery obligations. GDP was a predictor, in particular for life style indicators, probably reflecting the availability of means for carrying out population surveys. Population size was a predictor only in 27 indicators, related to e.g. rare diseases. Therefore, it was not a main predictor. The results of the study raise the question how WHO can further assist non-EU countries. There seems to be scope for projects, funding and capacity building. Also the development of peer support, e.g. in the form of networks, will be important. The problem of survey fatigue is getting stronger in small countries, and is expected to have an influence on data availability in the future.

A web based system for rare diseases - the experience of the Veneto region, Italy

Presenter: Paola Facchin, Italy

There are many challenges related to the monitoring of rare diseases. For example, it is difficult to calculate the impact at population level. Only 500 rare diseases are listed in ICD-10, and only half of these have their own code. Usually databases for single diseases exist, while integrated databases are needed. In 2001 in Italy, a law was passed on regional rare diseases registries. The example of the registry developed for the Veneto region (4.9 million inhabitants) was presented. A comprehensive web-based information system was developed, connecting with the health professionals. Currently there are over 100,000 patients in the system. Next to information on diagnoses (N.B. not only pediatric diseases), the system also contains information on costs, treatment and prescriptions. The prevalence of rare diseases in the Veneto region appears to be lower than the European average. Nevertheless, rare diseases have many consequences, like years of life lost. Information collection is only sustainable if imbricated with the care process. The data collected should be beneficial to care givers, patients and policy-makers. Interoperability is not a technical issue; it is an attitude. Future perspectives relate to the application of telemedicine and a

revision of the legislative framework.

Promoting health: from data to decisions

Presenter: Ottavio Beretta, health promotion and evaluation office, Cantone Ticino, Italy

[Link to the presentation](#)

A health information system has been developed in the Cantone Ticino region in Switzerland. The system is not just about quality of data, statistical methods, technology or money. In Cantone Ticino a stepwise approach is applied for system development:

1. Define the problem and define whether it is your problem: National issues do not need to be local problems.
2. The target: Who are the people involved and concerned?
3. Analysis: Keep it simple. Do not torture the data. Is this difference really a difference? Increase statistical rigor.
4. Interpretation: Interpretation should not be based on opinions but on data. This is not an error proof process. Perceptions of different stakeholders play a role, and can be used as a reality check. The region is trying to collect these perceptions through social media, like Facebook. This is an innovative element.
5. Visualization: Visualization should transfer knowledge, not tables.
6. Sharing: Recipients of health information should not just be experts or politicians, also the general population should be informed.

Commitment is essential for all steps. Involving professionals is very important.

A qualitative study of the experiences of health information practitioners in a small European country

Presenter: Sanne Gathoni Tijssen, Maastricht University, the Netherlands

A qualitative study of the experiences of health information practitioners in a small European country (Malta) was carried out. The Health Metrics Network (HMN) framework was used for the content analysis. Eight health information professionals (HIP) were approached; one dropped out. The HIP feel that they are important for policy making. There is a close collaboration with the policy makers. The HIP are well able to meet the data requests by the international organizations. However, small countries struggle with limited resources and population survey fatigue. Also, there is a small numbers problem. The HIP recommended using moving averages and aggregate data to overcome this problem. The experiences of HIP are important for improving health information systems.

Reflections

Presenter: Neil Riley, EUPHA section on Public Health Monitoring and Reporting

There are many shared issues, which reflect opportunities for working together. We can jointly work on technical issues and capacity building. There seems to be a particular need for training policy makers and journalists how to use data. However, the new EU Data Protection Regulation might hamper setting up joint registries. We can learn from each other, and we need to discuss how we can best share experiences. The use of peer networks seems particularly of importance here. Maybe we should consider establishing 'slightly-bigger-than-small-countries' network as well. In addition, there seems potential in linking sub-national regions with similar population sizes. In EUPHA section Public Health Monitoring and Reporting (>900 members), there is a huge expertise that can be drawn on.

New publications



WHO-EUR Regions for Health Network

Regions for Health Network Twenty-second annual meeting report.

[Report](#)

From 14 to 15 October 2015, the 22nd annual meeting of the Regions for Health Network (RHN) was held in Milan, Italy. The main theme was improving health and equity across regions and sectors. Capacity-building sessions addressed important scientific evidence and practical efforts to improve health and equity:

- joining forces – citizens and regions for better health;
- starting people on a healthy life course – evidence, policy and advocacy; and
- tackling health inequities at subnational level – grounding actions on data.

These were put in the context of the WHO European health policy framework, Health 2020, and efforts to translate it into practice at regional level. The RHN business meeting provided its Steering Group and members with an opportunity to describe and discuss their main activities during the previous and coming year, including the revision of the terms of reference, a programme of publications

and new ways of extending RHN's effectiveness.

In addition to the meeting, members also had the opportunity to organize and attend three sessions as part of the Conference programme. These are also covered in this publication.



WHO-EUR

European Health Information Initiative: First meeting of the Steering Group

[Meeting report](#)

The WHO European Health Information Initiative (EHII) Steering Group held its first formal meeting in Copenhagen, Denmark, on 24–25 March 2015. Launched in 2012 with start-up funding from the Ministry of Health, Welfare and Sport of the Netherlands, EHII is a multimember network committed to improving the health of the people of the WHO European Region by improving the information that underpins policy. This involves fostering international cooperation to exchange expertise, build capacity and harmonize data collection. Through these objectives, EHII contributes to integrating health information activities and developing a single integrated health information system for the Region. A number of countries and institutions, including an independent foundation, have contributed to specific EHII activities through funding and/or contributions in kind. The Steering Group received and discussed background information and updates, and reviewed and offered advice on EHII's scope, terms of reference and action plan for 2015–2017.



WHO-EUR

The case for investing in public health. A public health summary report for EPHO 8.

The economic crisis has led to increased demand and reduced resources for health sectors. The trend for increasing healthcare costs to individuals, the health sector and wider society is significant. Public health can be part of the solution to this challenge. The evidence shows that prevention can be cost-effective, provide value for money and give returns on investment in both the short and

longer terms. This [public health summary](#) outlines quick returns on investment for health and other sectors for interventions that promote physical activity and healthy employment; address housing and mental health; and reduce road traffic injuries and violence. Vaccinations and screening programmes are largely cost-effective. Population-level approaches are estimated to cost on average five times less than individual interventions.



European Journal of Public Health (2016), 26(1):65-70

Key features of an EU health information system: a concept mapping study

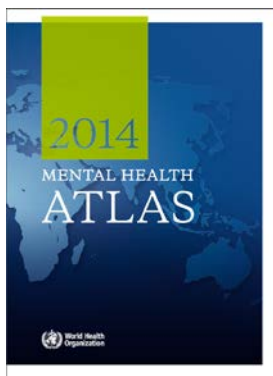
Rosenkoetter, N., Achterberg, P. W., van Bon-Martens, M. J. H., Michelsen, K., van Oers, H. A. M., Brand, H

[Paper](#)

Background: Despite the acknowledged value of an EU health information system (EU-HISys) and the many achievements in this field, the landscape is still heavily fragmented and incomplete. Through a systematic analysis of the opinions and valuations of public health stakeholders, this study aims to conceptualize key features of an EU-HISys. Methods: Public health professionals and policymakers were invited to participate in a concept mapping procedure. First, participants (N = 34) formulated statements that reflected their vision of an EU-HISys. Second, participants (N = 28) rated the relative importance of each statement and grouped conceptually similar ones. Principal Component and cluster analyses were used to condense these results to EU-HISys key features in a concept map. The number of key features and the labelling of the concept map were determined by expert consensus. Results: The concept map contains 10 key features that summarize 93 statements. The map consists of a horizontal axis that represents the relevance of an ‘organizational strategy’, which deals with the ‘efforts’ to design and develop an EU-HISys and the ‘achievements’ gained by a functioning EU-HISys. The vertical axis represents the ‘professional orientation’ of the EU-HISys, ranging from the ‘scientific’ through to the ‘policy’ perspective. The top ranking

statement expressed the need to establish a system that is permanent and sustainable. The top ranking key feature focuses on data and information quality. Conclusions: This study provides insights into key features of an EU-HISys. The results can be used to guide future planning and to support the development of a health information system for Europe.

- Check also the other papers under the Health Monitoring header of the EJPH

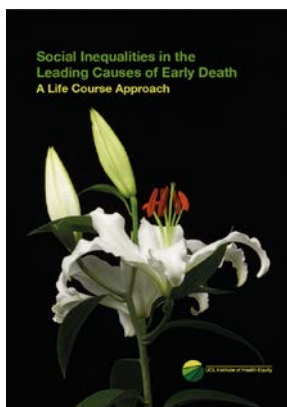


WHO

Mental Health Atlas 2014

WHO's [Mental Health Atlas](#) series has established itself as the most comprehensive and widely used source of information on the global mental health situation.

This new edition of Mental Health Atlas, carried out in 2014, assumes new importance as a repository of mental health information in WHO Member States because it is providing much of the baseline data against which progress towards the objectives and targets of the Comprehensive Mental Health Action Plan 2013-2020 is to be measured.



UCL Institute of Health Equity

Social Inequalities in the Leading causes of Early Death. A life course approach.

This [evidence review](#) analyses data from the World Health Organisation's Detailed Mortality Database, and summarises the literature to show that:

- the leading causes of death change across the life course
- there are marked social inequalities in each of the leading causes of death (within top 5 broad causes), by total number of deaths, across the life course
- social and economic circumstances from birth accumulate and impact a person's likelihood of an early death
- different mortality rates for the leading causes of death are evident across comparative European countries

This evidence is summarised for specific age groups across the life course.



WHO-EUR

The European Public Health report 2015. Targets and beyond – reaching new frontiers in evidence

The [European health report](#) is a flagship publication, published every three years. The 2012 report set the baseline for monitoring progress towards the six targets of the European policy framework, Health 2020.

The 2015 report presents the progress made since the baseline. An assessment of the available data on all the targets reveals that the European Region is on track, but much potential remains for further health gains and reductions in inequalities.

The 2015 report gives an update on the challenges in measuring and reporting on progress towards Health 2020, particularly in measuring well-being, and proposes new sources of qualitative evidence to describe and monitor well-being.

Facts and figures are not enough to report meaningfully on what it means to be healthy and well in Europe. The 2015 European health report argues that new forms of evidence are necessary to fully capture this. Stronger international collaboration is required to advance the agenda for health-information research and development in the Region. [Video](#)



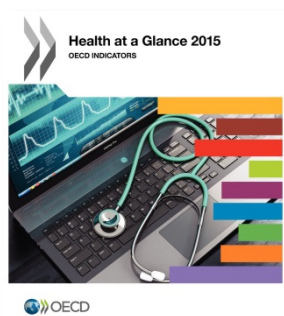
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Health Data Governance. Privacy, Monitoring and Research.

[Link](#)

All countries are investing in health data. There are however significant cross-country differences in data availability and use. Some countries stand out for their innovative practices enabling privacy-protective data use while others are falling behind with insufficient data and restrictions that limit access to and use of data, even by government itself. Countries that develop a data governance framework that enables privacy-protective data use will not only have the information needed to promote quality, efficiency and

performance in their health systems, they will become a more attractive centre for medical research. After examining the current situation in OECD countries, a multi-disciplinary advisory panel of experts identified eight key data governance mechanisms to maximise benefits to patients and to societies from the collection, linkage and analysis of health data and to, at the same time, minimise risks to the privacy of patients and to the security of health data.



OECD

Health at a Glance 2015

This new edition of [Health at a Glance](#) presents the most recent comparable data on the performance of health systems in OECD countries. Where possible, it also reports data for partner countries (Brazil, China, Colombia, Costa Rica, India, Indonesia, Latvia, Lithuania, Russian Federation and South Africa). Compared with the previous edition, this new edition includes a new set of dashboards of health indicators to summarise in a clear and user-friendly way the relative strengths and weaknesses of OECD countries on different key indicators of health and health system performance, and also a special focus on the pharmaceutical sector. This edition also contains new indicators on health workforce migration and on the quality of health care. [Video](#)

Conference Announcement

27-28 April 2016, Newcastle-Gateshead, UK

Third [Fuse International Conference](#) on Knowledge Exchange in Public Health “Evidence to impact in public health”

9-12 November 2016, Vienna, Austria

9th [European Public Health Conference](#), All for Health - Health for All

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