EU Health information system

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Article 168

*A **high level of human health protection** shall be ensured **in** the definition and implementation of **all Union policies and activities**.*

***Union action**, which **shall complement national policies**, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health...*

Our goal

Improve health, reduce inequalities

Health determinants

nutrition and physical activity

[addictions (alcohol, drugs)

socio-economic and environmental factors]

Why?

Most of the staggering burden of chronic diseases (13 of the top 15 causes of years of life lost in the EU) is preventable

Healthier lifestyles increase life expectancy and quality of life, sustainability of health and social systems and workforce productivity

But

At present, health information covers communicable disease (much) better…

…but the burden of disease, health expenditure and productivity cost comes mostly from NCDs

Good policy requires good data

Obesity (7 yrs boys): Italy 27% vs Sweden 7%
(different regions need different approaches)

Dentures least common in Sweden and Romania
(quality of oral healthcare vs unaffordability)

Obesity/inactivity show steep social gradient
(grand public campaigns may not be adequate; taxation's regressive impact should be accounted for)

Opportunities for improvement

Increase comparability

(common definitions and methodologies)

Regular collection

(instead of fighting for the inclusion of topics in surveys)

Opportunities for savings

Reduce burden of reporting

(no duplication of reporting to Eurostat, EFSA, WHO, FAO, OECD)

Increase predictability and sustainability

(merge/revise current expedients, such as WHO funding for COSI and NOPA)

Opportunities for impact

Improved geo-referencing of obesity, physical inactivity and NCDs

(linking hotspots to political constituencies will increase likelihood of action)

Wish list

(not the point for today but…)

screen time, energy drinks, sleep patterns, breakfast, trans fatty acids, breastfeeding, affordability of the food basket, breakdowns by socio-economic group…

Alcohol Policy

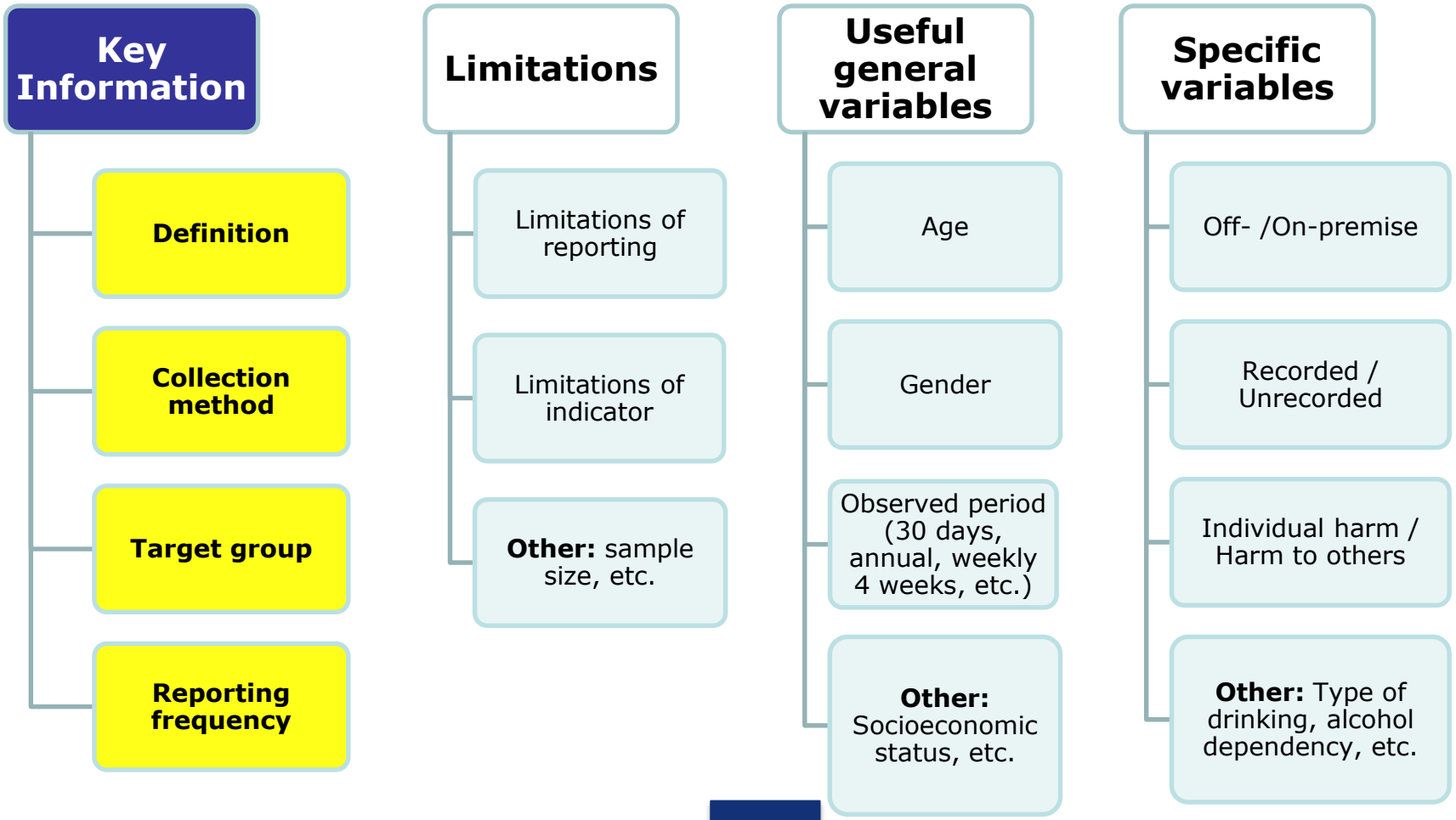
- **EU Alcohol Strategy (and the shaping of the future EU policy on alcohol and health)**
- **Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) 2014-2016**
- **Coordination at EU level**
  - Committee on National Alcohol Policy and Action (CNAPA)
  - Committee on data collection, indicators and definitions
  - European Alcohol and Health Forum (EAHF)
- **Joint Action on Reducing Alcohol Related Harm (JA RAHRA)**

"Any amount of alcohol can be dangerous during pregnancy and when driving. Young people are particularly at risk of short term effects of drunkenness, including accidents and violence, with alcohol-related deaths accounting for around 25% of all deaths in young men aged between 15 and 29." (EC, 2014)

General requirements for policy making, monitoring and reporting

- Well defined indicators based on scientific evidence and agreement by all concerned parties
- Standardized data collection mechanisms
- Comparability
- Disaggregation of data if needed
- Regularly updated
- Sustainability
- Solid governance and management
- Compliance by data providers (burden of reporting)

Crucial points of indicators for policymakers on alcohol and health



Key alcohol-related sources

WHO

OECD

ESPAD

ECHI

EUSAH

EUROBAROMETER

ESPAD

The European School Survey Project on Alcohol and Other Drugs

hbsc

Limitations of existing data

1. **Definitions** (indicators, collection method)
   - Definition of hazardous drinking, terminology, of indicator, of estimates, measurement (recorded, unrecorded, both), template size, etc.
2. **Link between indicators/overlaps/duplication**
   - Total consumption does not give an idea of harmful patterns without knowledge on the average numbers
3. **EU level data**
   - Lack of solid EU level data; e.g. not all EU Members states are OECD members, not all provide data
4. **No standardized collection method**
5. **Number of respondents**
   - Sample size differs, smaller size can be seen as less
6. **Estimates & projections**
   - Based on different standardized value and statistical methods
7. **Financial constraints, burden of reporting: gap in data provision**
   - Contribute to unequal availability of information among EU member states

Differences among available data

SOURCE	INDICATOR	DEFINITION
WHO	*Total alcohol per capita (15+ years) consumption of pure alcohol = combined recorded and unrecorded APC*	Recorded and unrecorded – tourist consumption
EURO BAROMETER	*Alcohol consumption prevalence (15+ years)*	"Respondents were asked whether they had consumed any alcoholic beverages in the past 12 months"
ECHI	*Total (recorded + unrecorded) adult (15+ years) per capita consumption.*	Recorded and unrecorded – doesn't mention taking into account tourist consumption.
ESPAD	*Use of any alcoholic beverage during the past 12 months.*	Does "Any" cover beverages bellow 0.5 percent of alcohol in volume?
OECD	*Alcohol consumption in litres per capita (age 15+)*	"Methodology to convert alcoholic drinks to pure alcohol may differ across countries. Typically beer is weighted as 4-5%, wine as 11-16% and spirits as 40% of pure alcohol equivalent." "Data cover all beverages containing more than 0.5 percent of alcohol in volume." (OECD Health Statistics, 2014)

Conclusions

- Solid **governance and management needed in order to achieve:**
- **Standardized methodology** among Member states
- **Quality** vs quantity (real policy needs)
- **No overlapping /duplication of work**
- Logical **linkages** between indicators: coherence, synergy
- **Coordinated** development of new indicators in order to avoid potential additional burden i.e. monitoring, reporting, etc.
- **Coherent, systematic, integrated and sustainable approach – governance of health information is best placed at health authorities (DG SANTE at EU level)**