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Evaluation of the use and impact of the European Community Health Indicators ECHI by Member States

Executive summary

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Written by: "Public Health Evaluation and Impact Assessment Consortium" (PHEIAC)

*Health and
Consumers*

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Evaluation of the Use and Impact of the European Community Health Indicators

Executive summary

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1. Introduction

This Executive summary is based on the final report "*Evaluation of the use and impact of the European Community Health Indicators (ECHI) by the Member States*" undertaken on behalf of the European Commission (EC) – Directorate General for Health & Consumers (DG SANCO).

The purpose of the Study is twofold. First of all is to assess the extent to which the ECHI indicators have been used in the countries participating to the ECHIM Joint Action (JA), either to monitor and evaluate health policies or to assess the responsiveness and efficiency of health systems, or in other steps of the policy-making process. In this sense, it involved an analysis of the limitations and possible reasons for non-use as well as of the driving forces behind their actual use.

Secondly, the Study is to provide indications on how to reach a high level of consensus on the use of the ECHI indicators in the participating countries, in order to ensure the long-term sustainability of the mechanism.

The geographical scope of the Study covers all the current EU 28 Member States (i.e. including Croatia), as well as Iceland and Norway.

The Study is based on five main sources of information, namely:

- a detailed review of all the relevant project deliverables released by the ECHIM Joint Action;
- an extensive in-depth interview programme (ca. 70 interviews carried out) inclusive of (i) EU-level informants, (ii) national-level key expert and (iii) European-level stakeholder organisations active in various fields;
- a questionnaire-based survey addressed to policymakers of various types (including regional level staff) from 30 countries. An overall 431 potential respondents were contacted and a total of 114 valid responses were received;
- a bibliometric research and analysis carried out in the *PubMed* and OVID databases, complemented by an impact factor analysis via the *Web of Science*;
- an extensive complementary desk research of country-level policy document and scientific and grey literature on ECHI.

In line with evaluation best practices, findings and conclusions are based on a triangulation of sources. Analysis of certain sustainability issues (legal aspects, governance, etc.) that required insider knowledge about the subject matter are naturally based mainly on interviews with key informants and could not be cross-checked with other external sources.

2. Main findings

ECHI helped structuring the National Health Information systems. ECHI has had a notable impact in helping certain countries to better structure their health information systems and favour the creation of a clearer legal framework for the collection of health indicators where this was needed. In particular, it played for latecomers a similar lighthouse role and a source of inspiration and reference as that played by WHO Health for All database or the OECD Health Performance Quality Indicators initiatives in the past, although probably on a smaller scale. Also, as a result of this, all European countries nowadays have envisaged a system to regularly collect health indicator datasets. This has had an enabling impact as most of these countries are now in a position to use these health indicators for strategic health policy steering purposes or for health system performance assessment, although with a variety of approaches, and the few who do not, reportedly have plans in the pipeline to that aim.

Moderate effects in terms of creation / stabilization of new indicators. The impact above has not necessarily materialized yet in the creation of new indicators at the national level except for sporadic cases where the investment needed was limited and data could be simply recalculated or extracted from existing registries. Most of the work done by 'latecomers' has focused on the creation or improvement of registries, and this will take time to return tangible results. Legislation on regulating data flows with healthcare services is often still pending. Resource issues also linked to the recent economic crisis have generally hindered the gathering of new data. In a few cases ECHI was not given the legal status to modify the existing agenda. As a result, little indicators have been added to existing international data sets and the indicators currently collected by means of temporary PHP projects have hardly stabilized in a clearer and more sustainable institutional framework which can be a particular matter of concern for users of these indicators as Commission PHP financing is not supposed to be on a permanent basis.

ECHI contributed to foster cross-country benchmarking. ECHI has certainly contributed to fostering systematic health benchmarking across Europe, which however remains at its early stages. Much of this benchmarking has had so far little tangible and documentable impact on the policymaking process, also because it is often poorly institutionalized. The bulk of all policy-related benchmarking activities takes place at a sectoral level in a sporadic and often informal and undocumented way. In many instances, ECHI indicators when used are hardly recognized as such, and more often than not are used 'unconsciously' since they were present in pre-existing data sets.

There is a relatively high but skewed knowledge of ECHI. Awareness about ECHI can be assessed on average as high but also rather skewed in both geographical terms and among categories of users. It can be considered even very high among health information services (such as public health institutes, statistical offices and the like), health study departments and academicians involved with the policymaking process, but it is much less so among the staff responsible for planning and monitoring of policies or for policy evaluation and the assessment of healthcare services, and particularly in countries that joined late the ECHI process and were not part of the ECHIM core group. This is likely to be the cumulated impact of ECHI information and communications activities over time. The HEIDI data tool, which is a quite recent instrument, is still far from reaching the dissemination potential of other similar tools, and does not seem able to redress this skewed pattern of awareness, but

possibly contributes to it, as it appears more frequently used by certain categories of policymakers than others.

ECHI has had a mixed bibliometric impact. ECHI has had a certain echo on the scientific literature although it difficult to assess at this stage the impact on the scientific debate. Most of the articles published however are of a descriptive nature and aimed at advocating a wide use of the instrument among public health experts. There is a notable shortage of articles on the concrete use that can be made of these data and examples of the policy lessons that can be drawn with them.

The ECHI uptake in policymaking is skewed. The patterns of uptake of ECHI in the policymaking process appear rather skewed and broadly follow the same considerations already made for awareness. Documented instances mainly relate to benchmarking reports and dedicated health information databases. ECHI-based benchmarking reports have been published in three countries and are reportedly in the pipeline in another. A dozen countries have included ECHI as a recognizable component of their health information systems, although in a couple of cases, the sustainability of these initiatives appears uncertain. Formal uptake in general strategies and planning documents has been more limited so far and amounts to a handful of cases, although it seems bound to increase in the near future also because such kind of impact takes longer to materialize. All other instances of use are largely informal and undocumented or, as in the case of sectoral plans, often largely 'unconscious' because ECHI indicators are often perceived there as pre-existent.

ECHI individual indicators are generally widely used. There is some variability in the level of use of the different ECHI indicators (either named as such in the national inventories or not formally acknowledged as ECHI but equivalent to them) across Europe. This partly depends on the availability of the indicator or the sheer awareness about its existence, but also relates to intrinsic features of the indicator and its suitability to local policymaking needs. However, there are just very few instances of indicators in the implementation section that appear as limitedly or very limitedly used across the board. The majority of them appear as fairly widely used, particularly for descriptive or benchmarking purposes. Use for policy planning or monitoring purposes or for health system assessment and evaluation is more limited. This typically depends on competition with other sources, limited time series available, insufficient frequency of data collection, and lack of data breakdown at the regional level. The indicators classified for use for health inequalities or HIAP purposes are actually used in line with expectations.

ECHI individual indicators are often deemed as highly useful for policymaking. The ECHI indicators used in the past have generally been deemed very useful and only few specific cases are registered of partial dissatisfaction. The overall usefulness of ECHI shortlist would have been even higher if some of the indicators currently in the work-in-progress section had been actually implemented.

EHIS-based ECHI brings added-value to national sources. A quarter of ECHI indicators are to be implemented by means of EHIS. In those Countries with a longer tradition of health information systems and where health indicators are more developed, EHIS faces competition from both longer and more detailed HIS series or better quality registry-based data. Their only source of added value would therefore lie in increased scope for data comparability and their usefulness for internal policymaking purposes more limited. However this competition with other sources is expected to be mitigated by the fact that not only do EHIS data enable better European comparison, but they also often represent the only source available for health inequalities purposes, as registries face in a number of countries privacy or

contractual limitations hindering the feasibility of such kinds of analyses. In those countries where no pre-existing HIS were available or registries are still underdeveloped the added value of EHIS for internal policymaking purposes is more obvious, but conversely mitigated by the fact that data are available only every five years.

Some EHIS-based ECHI are however not useful for comparisons. It is acknowledged that there are also a few EHIS indicators that can be particularly dependent on cultural factors and therefore do not lend themselves very well to cross-country comparisons. In these cases much of the informational added value would be related to their use for domestic vertical comparisons over time, and would be also mainly justified for health inequalities purposes and other forms of cross-sectional analysis with other EHIS data. And it is recognized as such by users themselves. Needless to say, the perception of added value attached to these indicators is much lower in all those countries where the demand of indicators for health inequality purposes is less developed and the need for cross-sectional analytical work less sophisticated.

EHES-based ECHI are not usable yet. EHES would provide additional added value in terms of data quality for a few ECHI indicators (body mass index and blood pressure as currently already envisaged and diabetes prevalence, not envisaged yet but in the future pipeline) whose usefulness is however already deemed relatively high even in their EHIS-based version. There are broader cost considerations hindering for the time being EHES mainstreaming into the health information systems of a number of countries, and the incentives provided by the ECHI shortlist in its current format do not appear as sufficiently strong to really influence decisions in this respect. Much of the added value of EHES would continue to lie in providing more detailed information for research purposes than that required for strict policymaking needs. It remains an open question what could eventually happen one day if the number of EHES-based ECHI indicators were actually larger and resource constraints lower.

There is general consensus on having a system of European indicators like ECHI in place. There is considerable consensus among stakeholders on establishing a permanent health indicator system like ECHI at the European level particularly under a clearer institutional and legal framework, and possibly with the joint involvement of other international organizations and European institutions such as the OECD, WHO, and Eurostat. This would allow to capitalize on the results achieved so far, the methodological work already done and to keep the networking of a group of relevant competent experts across Europe alive and operational.

ECHI governance may be improved. As far as governance aspects are concerned there is a widespread consensus about the need to move away from a project-based approach and pursue the embedding of ECHI into a permanent, institutional mechanism at EU level although not necessarily embodied by means of EU legislation. The abovementioned mechanism should preferably involve all the relevant public authorities of the MS, and not be governed by a group of institutes as in the case of ECHIM, since this would give ECHI a more formal recognition. The ECHI shortlist should also be given a clearer legal status, as this has represented a barrier to its uptake in a number of countries. It is widely recognised that the European Commission should play a leading role in this mechanism as the primary coordinator of activities. This could mean a stronger involvement of DG SANCO or Eurostat although the various options should not be seen as mutually exclusive, since a strong coordination between these two services is deemed at any rate necessary. Other possibilities that might be examined include the coordination of this mechanism by another EU agency, e.g. JRC or ECDC. Finally there is

overwhelming consensus that enhanced coordination and synergy with the work of OECD and WHO should be sought.

Financing constraints may hinder ECHI sustainability. While there is consensus among stakeholders on the need to have a European system of indicators like ECHI in place on a permanent basis also in the future, there is also evidence of growing financial constraints on the health information systems of several countries, which have in some cases already impacted on ECHI maintenance. The fact that much of the use made of ECHI indicators for benchmarking purposes appears to materialize in highly fragmented, uncoordinated and poorly documented initiatives whose pay-off is not always visible to outsiders does not certainly help build its case vis-à-vis budgetary authorities. Also, its poor visibility and recognition in the formal policymaking process does not bode well in this respect, and should be further strengthened to provide a critical mass of evidence about the cost-effectiveness of having the ECHI instrument in place at the national level.

3. Recommendations

Minor modifications of the ECHI shortlist are possible. The ECHI shortlist could be considered as reasonably complete enough and without any obvious missing parts particularly if a higher implementation rate of its work-in-progress section could eventually be reached. There might be some scope for the restructuring of the section on health intervention and health services that could be made clearer in its purposes and benefit from the work carried out in parallel at the OECD on the same subjects. If the added value of ECHI is to be further increased by filling information gaps as was the case with health inequalities, then there is clear evidence of an increasing demand for age-specific indicators and in particular child and adolescent health indicators and strengthen data on avoidable mortality that is not fully met by the international databases.

Simplification / streamlining of the shortlist may be considered. If the ECHI shortlist is to remain an instrument for broad health descriptive purposes mainly aimed at fostering general benchmarking, then there is no major need to simplify and streamline it, but eventually for budgetary reasons. In such case, some of the indicators in the development section appear as likely candidates for downgrading, both because of difficulties in their implementation and their unclear relevance in certain countries' policy contexts. However, these would represent only marginal adjustments. If the ECHI shortlist is to become an instrument to steer the strategic policy planning and monitoring process across Europe and provide a common framework for reference, then a substantial simplification and shortening would be required in line with current trends. This would imply the selection of a few indicators per policy priority and a clear selection of the key policy areas to be included as core. And the sheer way the shortlist is built should move away from incorporating the results of PHP projects to mirroring the agendas already decided in the different areas. There are compromise solutions between these two extremes that could eventually be considered, depending on political decision.

ECHI legal status should be clarified. While a joint action is certainly a good instrument to pilot a newly introduced tool and spread its use, it also has some notable limitations when it comes to mainstreaming it into common practice. At present, the unclear status of the ECHI shortlist as a fully EU-backed document represents a barrier to its uptake and implementation and the governance mechanisms of a JA would no longer be perceived by certain countries as fully legitimate. A more formal governance could also help foster MS commitment to indicator implementation.

There is a need for increasing ECHI awareness among certain categories of policymakers. Since any newly introduced information instrument is more likely to attract the attention of related experts, researchers and academicians, awareness about and use of ECHI appear still exceedingly skewed towards these categories of early users. Therefore there is a need to complement the information and communication effort with instruments more specifically targeted at policy practitioners that are sometimes unaware even about the existence of indicators already concretely implemented and potentially available for use. Better cross-referencing in the Eurostat database is the first obvious measure. But this could also include reports and studies on the use that could be made of these data and the concrete lessons a policymaker could draw from using them. Collaboration with the OECD and ECHI inclusion in *The Health at a Glance* report already represents a first step in this direction.

The work-in-progress section of ECHI should be finalised. The overall perceived usefulness of the ECHI shortlist would increase remarkably if some important indicators still in the work-in-progress section were eventually implemented.

Cross-country benchmarking should be encouraged. Any increase in the added value of ECHI from benchmarking implies a parallel growth in policy evaluation and health assessment practice. So far, benchmarking and international comparisons have been institutionalized as a stable and recognizable component of the policymaking process in a fairly limited number of countries, although there is clear evidence that also this process is slowly gaining ground across Europe. This should be further encouraged. In this sense, the limited policy evaluation capacity and the limited role played by health assessments in informing policymaking in a number of countries emerge as major barriers to a full exploitation of ECHI's benefits, and consequently to countries' investments on its implementation. It has however to be considered that in a number of countries internal benchmarking aimed at explaining wide domestic variance already attracts considerable resources.

To increase the usefulness for policy planners should become a priority. Throughout the implementation of the various ECHI projects, a great emphasis has been attached to ensuring data comparability and the overtime stability of the shortlist. However, if ECHI is also to become a common framework for coordinating policy planning and monitoring to better address the evolving information needs of policymakers other important features of indicators should also receive greater attention in the future when it comes to their selection and identification, such as their sensibility, i.e. their capacity to indicate changes over a relatively short period of time, their specificity in reflecting the results of specific policies and their concrete actionability by policymakers, i.e. the fact that values can be really influenced over a reasonable period of time by policy action. This could include further research on which indicators of health outcome are more sensible to policies and less affected by or correlated with other external factors outside of policymakers' control.

Address financing issues. For the time being the financial sustainability of the mechanism appears still dependent onto EU financing. More than half of national experts interviewed rules out that participating countries could allocate financial resources to it, in addition perhaps to the own costs for participating to activities (human resources, travel expenses etc.). On the other hand, about one third of country experts surveyed do not exclude a priori the possibility of MS co-funding to this mechanism, thus indicating that there is already a good recognition of the advantages that such mechanism could bring at country level in the long run. Moreover, no sources of financing are currently available to ensure the sustainability of some of the indicators currently included in the shortlist.