Experts Group on Health Information

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Updates Eurostat

Eurostat - F5 – Education, health and social protection

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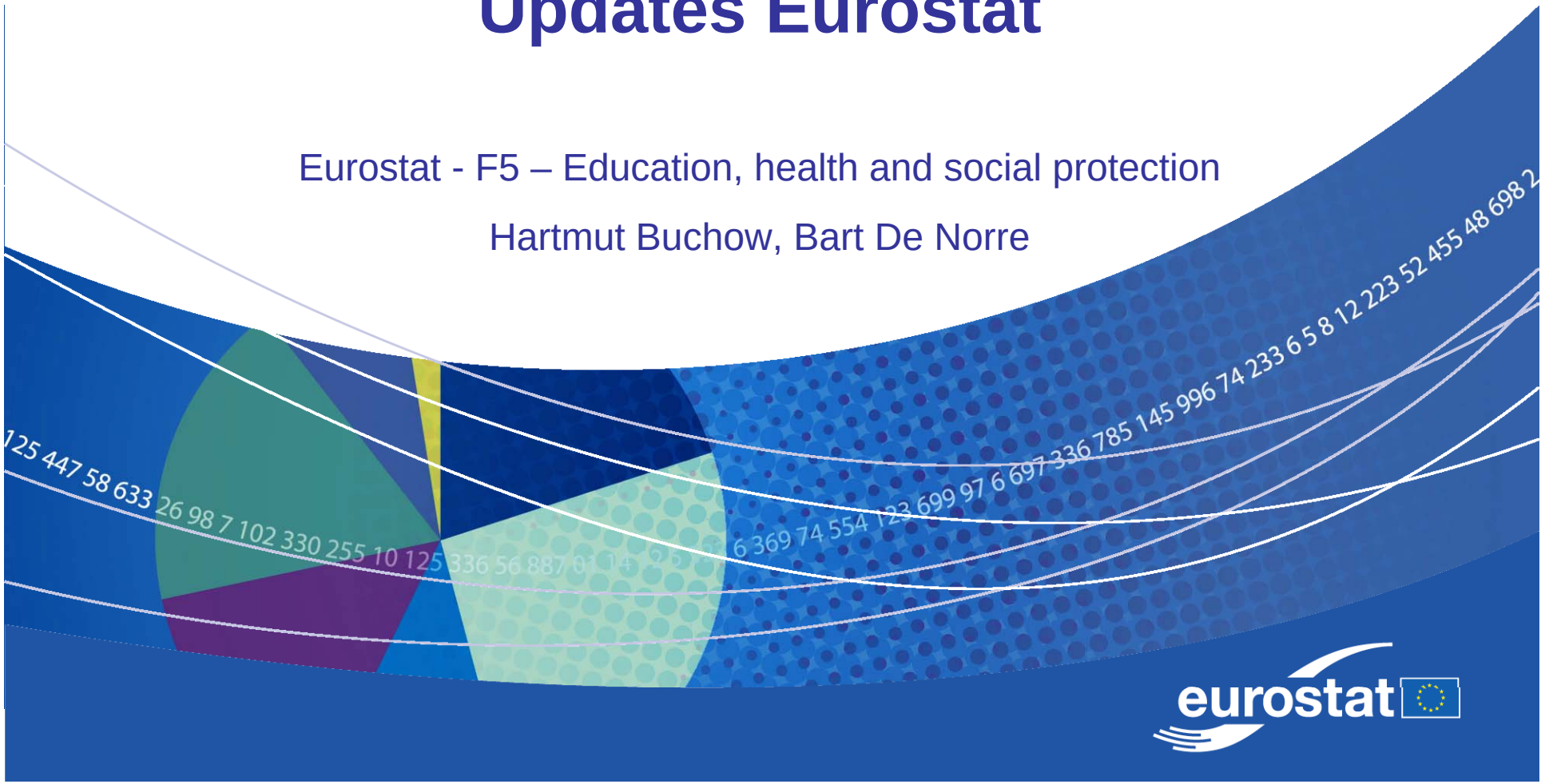

Overview

- Intro
- Causes of death
- Health care non-expenditure
- Health care expenditure
- Morbidity
- SILC-MEHM and HLY
- EHIS wave 1 and 2
- Employment of disabled persons - LFS AHM 2011
- EHSIS (Health and social integration)

introduction

- Reorganisation Eurostat
- Planning of meetings for 2012
  - TG CARE 11-12 June 2012
  - WG Public Health 25-26 September 2012
  - TF on Morbidity November 2012

Causes of Death - COD

- Commission Regulation 238/2011 – 5 April 2011
  - First reference year: 2011 (to be submitted by end of 2013)
- TF recommendations for revision of the shortlist COD plus additional satellite lists
  - TG COD agreed, WGPH agreement expected by mid June
    - Revision of the shortlist will start by end of the year
    - SANCO emphasised needs for satellite lists on specific areas (e.g. tobacco or alcohol related avoidable deaths)
    - Specific TF will be formed after the WGPH meeting
- New standard population
  - TG COD agreed to Eurostat proposal, WGPH agreement expected by mid June
  - Revision of the standardised death rates will start by end of the year
- SIF “Circulatory diseases – Main causes of death for persons aged 65 and more in Europe, 2009”

  http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/publication?p_product_code=KS-SF-12-007

Health Care non-expenditure statistics

- Annual Joint Questionnaire (OECD, ESTAT, WHO) 2012
  - Common module on human and physical resources
    - Improvement of definitions, e.g. revised categories of medical professions
      - General practice (2011) disaggregated to 2 subgroups: General practitioners/family doctors & Other generalists/non-specialist practitioners
      - Definition of former ‘doctors not further defined’ was narrowed down in line with the ISCO-08 and the Eurostat additional module

      Data indicate better allocation of doctors in general practice, and a reduction in number of ’doctors not further defined’
    - Closing the gap on data for practising physicians
      - CG CARE proposed some methodology on how to estimate such data from the ones on licensed or professionally active physicians
      - By now IE provided the respective estimates, FR and IT used new sources for delivering those data; answers by EL, NL, PT and FYROM pending

Health Care non-expenditure statistics

- Improvements for next data collection 2013
  - Agreement with OECD and WHO to extend the common module to health care activities, with respective harmonisation of definitions for ambulatory care, hospital care and procedures
  - Agreement with OECD and WHO to extend the common module to:
    - data on Positron Emission Tomography exams (PET; in addition to CT and MRI exams)
    - Cancer screening for breast and cervical cancer; to be later extended to colon cancer
    - Doctors/dentists consultations (Eurostat: additional breakdown for hospital outpatients)
    - Harmonize the data collections on procedures
  - Ask Member States to nominate one focal point for the 3 organisations on those common module data by September 2012

Health Care expenditure statistics

- Annual Joint Questionnaire (OECD, ESTAT, WHO)
- Eurostat to develop a Commission Regulation on health care expenditure data by end of 2013

  First draft to TG CARE for discussion on 11-12 June 2012

  – Set of mandatory variables from current Joint Questionnaire
  – Three cross-classification tables: Health care functions (HC) x financing agents (HF); HC x health care providers (HP), and HP x HF

- Written consultations of TG CARE beforehand:

  Majority of countries agreed to scope and content as well as cross-classification tables (17/22)

Morbidity Statistics

- Task Force on morbidity statistics since November 2011
  - TF members of 9 Member States: BE, EE, IE, FI, LT, LV, PL, RO, UK (until March also from FR)
- Tasks
  - Analyse results of pilot studies by 16 Member States (2005-2011) in view of best comparable estimates
  - Revise methodology and short list, if needed
  - Provide recommendations on how to proceed
- Key elements
  - Which types of data sources should be used to calculate best estimates?
  - Which are the best methods for estimating incidence and prevalence indicators from existent data sources?
  - Will best estimates be feasible for all 67 diseases of the current shortlist?
- Schedule:
  - Draft in-depth analysis plus recommendations on methodology and revision of the shortlist by September – presentation at the WG PH meeting
  - Final recommendations by 1st quarter of 2013

SILC-MEHM and HLY

- SILC-GALI and HLY
  - Comparability and accuracy; compliance, metadata and understanding
  - Consultation round SILC delegates:
    - Prefilled questionnaire <= previous assessments; EHEMU reports; national SILC questionnaires
    - Replies received from 28 (out of 31) countries
    - Breaks in national series largely explained by changes in question
      - Next steps: Finalise bilateral exchange with some; synthesis report
      - Complete flags in tables
      - Metadata: tabular overviews Country / Year
        (Compliance to the standard; changes over time; references to national SILC questionnaires on CIRCA)
  - Update “real age at interview” (age at reference income period)
- Dissemination HLY
  (split table 2004 - …; added “at age 50”; Statistics Explained, news release)
- JA EHLEIS collaboration

EHIS wave 1

- Dissemination
  - Results:
    - Tables on web site
    - Statistics explained , news release
  - Assessment reports
    (Problems faced, National quality reports, Comparability issues, Wording)
  - Request for more tables on line
- Access to micro data: anonymisation:
  - Rules: TG EHIS January 2011, feedback + review
  - SDC (Statistical Disclosure Control) expert meeting 26 April 2012
    - Characterise (Quasi identifying / outcome (or both); Extremely / very / simply identifying)
    - Modification rules (Remove; Grouping answer categories; Top coding for very high and very low values); Very few country specific rules)
  - Working Group Statistical confidentiality ? => methodological study
  - Delay

EHIS wave 2

Revision process, actors and steps

- Involvement / decision taking MS (ESS process)
  - ESS-net Public Health: Core Group and subcontractors
    - ⇒ Lessons from EHIS wave 1
    - ⇒ synthesis of quality reports, experienced problems, comparability question wording, comparison of indicator calculations
  - Technical Group EHIS, Working Group PH (meetings, written consultation rounds)
- Grants for detailed studies and tests:
  - RKI-DE, IPH-BE, NIHD - EE
  - implication of subject matter experts
  - Workshop
- Definition / priority EC policy services
- Principles in revising the questionnaire

EHIS wave 2 – draft regulation

- Content
  - Variables (115 health variables)
  - Minimum sample sizes
  - Only wave 2: 2014 (2013,2015)
  - Data collection period (min 3 months including 1 autumn month)
  - Metadata
  - Date of provision of micro data
  - Reference to EHIS manual (guidelines + model questionnaire)
- Derogations to be minimized => negotiation round:
  - Reference period
  - 15+, 16+
  - Medicine use: only 2 general questions

EHIS wave 2 – next steps

- Technical Group EHIS (January 2012)
- Written consultation Working Group Public Health Statistics (February 2012)
- Eurostat Directors Meeting (March 2012)
- DSS Meeting (Directors Social Statistics) (March 2012)
- Negotiation round derogations TG EHIS (April-May 2012)
- Written consultation DSS (June 2012)
- Inter Service Consultation Commission (July 2012)
- ESSC (ESS Committee) (September 2012)
- EP and Council (Scrutiny period)
- Regulation to be adopted end of 2012

2011 Labour Force Survey (LFS) ad-hoc module on employment of disabled people

- situation on the labour market of disabled people
- only barriers in the area of employment

  associated with health problems

  difficulties in basic activities

  other personal/environmental reasons

  ⇒ disabled persons (in employment) are those who declare that a health condition or disease or a difficulty in basic activities (such as seeing, hearing, bending, etc.) causes their limitation in work.

2011 LFS AHM – current and next steps

- Transmission to Eurostat: March-June 2012
- April – October 2012: data validation
- 2nd quarter of 2012: call for tender for evaluation and dissemination to be available in 2013/2014
- 2nd quarter of 2013: dissemination of first results on the Eurostat website

European Health and Social Integration Survey - EHSIS 2012

- statistics on disability as defined by the UN Convention and ICF
- Implementation in 2012 in all Member States, Norway and Iceland as an independent survey via a call for tender (30 lots)
- Total EU (plus Norway and Iceland) sample size: 230.000 persons (8.000 persons on average per MS)
- Fieldwork: September 2012 – February 2013
- Results:
  - Micro-data should be sent to Eurostat by Autumn 2013
  - Tables on Eurostat website by first semester of 2014

EHSIS: content of questionnaire

- **Eurostat core social variables** (background variables common to all European social surveys)
- Questions about **general health** and **longstanding health problems** (Minimum European Health Module, impairments, Activities of Daily Living - ADL, Instrumental Activities of Daily Living – IADL)
- Questions on **barriers in 10 life domains**:
  - Mobility
  - Transport
  - Accessibility to buildings
  - Education and training
  - Employment
  - Internet use
  - Social contact and support
  - Leisure pursuits
  - Economic life
  - Attitudes and Behaviour

EHSIS – Indicators

- Overall disability indicator
  - Code 4 or 5 on any of the barriers questions in each life domain ⇒ disabled person
    - code 4: a health condition, illness, or disease
    - code 5: longstanding difficulties with basic activities (such as seeing, hearing, concentrating, moving around)
- Specific disability indicators (barriers to a specific domain)
- Indicators on the (overall or specific) barriers associated with specific health conditions or basic activity difficulties and personal/environmental factors