



Mapping metrics of health promotion and disease prevention for health system performance assessment



Report by *the Expert Group on Health Systems Performance Assessment*

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EXECUTIVE SUMMARY

As noted in the State of Health in the EU Companion Report 2019¹, there is substantial scope for developing health promotion and disease prevention indicators within health system performance assessment (HSPA). HSPA frameworks provide a shared vision for health system strengthening and act as a tool for policy making. As a result, the HSPA Expert group dedicated the 2022 cycle to addressing the gap in information about health promotion and disease prevention indicators used across the EU.

In November–December 2021, the HSPA Secretariat conducted a survey on metrics used by Member States for measuring health promotion and disease prevention with the context of HSPA. The purpose of the survey was to map indicators used by Member States to monitor and measure their health system performance. In the survey, 15 Member States reported more than 800 indicators. The main areas covered by the indicators were health status; lifestyle; healthcare services; environment; income, economy, and labour; education; and other.

Key findings include:

- Indicators on cancer screening and vaccination coverage were the most commonly used to measure prevention activities.
- Most countries also included key lifestyle and risk factor indicators, such as smoking, alcohol consumption, overweight and obesity, diet, as well as physical activity. Socio-economic determinants, such as education, income, economy and labour, although widely collected, were reported inconsistently by countries.
- Vaccination coverage, cancer screening coverage, healthcare quality and activity monitoring metrics were often linked to national targets. However, few countries explicitly included these indicators as part of the HSPA process.
- Not all countries have a formal HSPA framework and therefore having these indicators included as national targets may help to inform policy making.
- In terms of data sources for indicators, national sources predominated. When international sources were mentioned, it was usually in relation to self-reported health, lifestyle and wellbeing indicators, often collected in the framework of internationally standardised population surveys.
- While many indicators allow disaggregation by age, gender and geography, capturing socio-economic inequities is rare, except for population survey data.

Case studies and group discussions were used to further explore the topics of health promotion strategies, mental health metrics and health literacy indicators, indicating potential areas for expanding HSPA frameworks beyond traditional public health indicators.

Investing in measuring health literacy (including digital health, navigational health literacy², and mental health) was felt to be an important first step to informing the development of health literacy policy and practice. Health literacy indicators are increasingly collected, and international initiatives ensure good quality and comparable information. Digital health literacy was seen as key to navigating health information through technology and social media applications.

Mental health is another area increasingly being captured in European health surveys, especially in the aftermath of the COVID-19 pandemic. Age-stratified data on population mental health remain limited in quality and coverage. School surveys remain the key source where the mental health of children and adolescents is captured (an area which was of particular interest across Member States). Further consideration of the continuum of mental health and contributing factors (contextual and behavioural factors) also requires attention to establishing and promoting wellbeing.

In ageing societies, promoting health and preventing disease and disability or mitigating their burden is

- 1 State of Health in the EU: Companion Report. 2019. https://health.ec.europa.eu/system/files/2019-11/2019_companion_en_0.pdf
- 2 Navigational health literacy is a domain of health literacy described as the ability to obtain, comprehend, evaluate and apply knowledge about health systems, health organization and its processes. https://eupha.org/general_page.php?p=269

crucial for sustainability and resilience of health systems. In recent years, a shift towards integrated, equitable and person-centred care models have resulted in initiatives such as social prescribing. It has a potential to contribute to health promotion, disease prevention and person-centred care, but is yet to firmly establish itself in practice.

This report explores which indicators on health promotion and disease prevention are used by Member States in the context of HSPA and identified some potential areas for which additional indicators could be used. While health promotion and disease prevention are recognized as important areas of HSPA, there is no consensus on which metrics should be used to measure them. On a macro level, there is a need to strengthen the health information systems to allow for health promotion and disease prevention indicators to be collected consistently and systematically across Member States to inform policy making.

PREAMBLE

The focus of this report from the Expert group on Health Systems Performance Assessment (HSPA) is to map and assess the scope of health promotion and disease prevention metrics and indicators, in national HSPA practices. To achieve this aim, an HSPA prevention working group was established with Member State representatives participating from Austria, Croatia, France, Hungary, Luxembourg, Malta, Romania, Slovenia as well as the European Observatory on Health Systems and Policies, Organisation for Economic Co-operation and Development (OECD), the World Health Organization (WHO) Regional Office for Europe and the Directorate-General for Health and Food Safety (DG SANTE).

Box 1: Health Systems Performance Assessment Expert group³

In 2014, the European Commission set up an Expert group on Health Systems Performance Assessment to provide EU countries with a forum to exchange experiences in this field and to support national policymakers by identifying tools and methodologies to develop HSPA. International organisations such as the WHO, the European Observatory on Health Systems and Policies and the Organisation for Economic Co-operation and Development proactively contribute to the work of the Expert group. The Expert group defines priority areas it wishes to work on. Since July 2022, the Expert group has an extended mandate going beyond HSPA and providing EU countries with a forum to discuss and promote strategic innovative approaches to strengthening health systems.

The priority topic for 2021/2022 was prevention. For the purposes of this report, and because there was no consensus in the HSPA Expert group on how health promotion and disease prevention should be measured and included within HSPA, when the drafting of the report started, we remain flexible in the use of both concepts and where possible specify the breadth when discussing specific indicators, policies, and illustrating boundaries with case studies.

3 European Commission. Overview. 2021. Health Performance Assessment Expert group: https://health.ec.europa.eu/health-systems-performance-assessment/overview_en

Introduction

Over the past two years, the ongoing COVID-19 pandemic has further emphasised how health systems are vulnerable to sudden changes in population health, particularly affecting people who are at risk^{4,5} and highlighting the need for more systematic and measurable efforts directed at improving health and preventing disease. At the same time, European health systems are simultaneously undergoing a rapid transformation to prepare for future challenges beyond the pandemic, such as climate change⁶, rising anti-microbial resistance (AMR)⁷, non-communicable diseases (NCDs)⁸ and population ageing⁹. This transformation opens a unique window of opportunity to broaden the scope of collaboration with other sectors in this area, leading to greater emphasis on creating health systems and policies which address health promotion and disease prevention in targeted and meaningful ways across sectors.

In December 2021 the European Commission launched Healthier Together¹⁰ – an EU non-communicable diseases (NCD) initiative to support EU countries in identifying and implementing effective policies and actions to reduce the burden of major NCDs and improve citizens' health and well-being. The initiative covers the 2022-2027 period and includes 5 strands:

1. **Health determinants**
2. **Cardiovascular diseases**
3. **Diabetes**
4. **Chronic respiratory diseases**
5. **Mental health and neurological disorders**

All strands include a health equity dimension, thus supporting the reduction of health inequalities. While the strands enable addressing particular challenges of each disease group, the initiative as such promotes a holistic and coordinated approach to prevention and care. The actions identified in the Initiative are developed with the EU support from the EU4Health programme.

Another key EU initiative with a strong prevention emphasis is Europe's Beating Cancer Plan. The Plan, which is also funded by the EU4Health Programme, sets out 10 flagship initiatives and numerous supporting actions, with a focus on improving cancer prevention and care for everybody, everywhere in the European Union. As one of the flagships of the Cancer Plan, the European Cancer Inequality Registry¹¹ addresses the inequalities dimension, by highlighting trends, disparities and inequalities in cancer prevention and care across EU Member States, Norway and Iceland.

In 2021/2022 the Expert Group decided to focus its work on mapping and assessing the scope of health promotion and disease prevention metrics in the national HSPA practices. This decision comes in the context of the impact of COVID-19 pandemic, which highlighted the need for health systems and its responsible agents to be able to look beyond the traditional remit of healthcare services and consider the broader environment and engagement with other sectors. It was also felt that disease prevention and health promotion more generally can be relevant for the overall performance of national health systems.

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- 4 Moreno C, Wykes T, Galderisi S, Nordentoft M, Crossley N, Jones N, Cannon M, Correll CU, Byrne L, Carr S, Chen EY. How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry*. 2020 Sep 1;7(9):813-24.
 - 5 Shrestha N, Shad MY, Ulvi O, Khan MH, Karamelic-Muratovic A, Nguyen US, Baghbanzadeh M, Wardrup R, Aghamohammadi N, Cervantes D, Nahiduzzaman KM. The impact of COVID-19 on globalization. *One Health*. 2020 Dec 20;11:100180.
 - 6 Romanello M, van Daalen K, Anto JM, Dasandi N, Drummond P, Hamilton IG, Jankin S, Kendrovski V, Lowe R, Rocklöv J, Schmoll O. Tracking progress on health and climate change in Europe. *The Lancet Public Health*. 2021 Nov 1;6(11):e858-65.
 - 7 Lindbaek M, Berild D, Straand J, Hjortdahl P. Influence of prescription patterns in general practice on anti-microbial resistance in Norway. *British journal of general practice*. 1999 Jun 1;49(443):436-40.
 - 8 Healthier together – EU non-communicable diseases initiative. https://health.ec.europa.eu/non-communicable-diseases/healthier-together-eu-non-communicable-diseases-initiative_en
 - 9 Pammolli F, Riccaboni M, Magazzini L. The sustainability of European health care systems: beyond income and aging. *The European Journal of Health Economics*. 2012 Oct;13(5):623-34.
 - 10 European Commission. Healthier Together. 2021. https://health.ec.europa.eu/non-communicable-diseases/healthier-together-eu-non-communicable-diseases-initiative_en#:~:text=The%20European%20Commission%20has%20launched,%20health%20and%20well%20being
 - 11 A cancer plan for European Commission. https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/promoting-our-european-way-life/european-health-union/cancer-plan-europe_en#flagship-initiatives

Aims of the report

The primary aim of this report is to explore how health promotion and disease prevention are measured across the Member States, and whether they are collected in the context of established HSPA processes.¹² We look to do this by understanding which key indicators encompass health promotion and disease prevention in Member States, how and if they are linked to and used in HSPA or national health targets and whether they reflect intersectoral collaboration or Health in All Policies¹³. This report reflects on trends and examples of their application to improve existing HSPA processes as well as help Member States establish their formal HSPA processes.

Structure of the report

This report is divided into the following chapters:

1. **Chapter 1** introduces the concepts of health promotion and disease prevention and links the two concepts to HSPA.
2. **Chapter 2** presents the results of a survey on health promotion and disease prevention metrics across 15 Member States conducted by the Expert group.
3. **Chapter 3** presents examples of Health In All Policies in Austria and explores health literacy and mental health as areas of particular interest to policymakers in the field of health promotion. The chapter draws on information from small group discussions with the Member States and other stakeholders.
4. **Chapter 4** provides a discussion and conclusions.

12 WHO publication on Health Systems Performance Assessment: <https://www.who.int/publications/i/item/9789240042476>

13 Health In All Policies: <https://www.euro.who.int/en/health-topics/health-determinants/social-determinants/policy/entry-points-for-addressing-socially-determined-health-inequities/health-in-all-policies-hiap>

Chapter 1: A brief introduction to health promotion and disease prevention

Health systems have enormous potential to develop further their role in health promotion and disease prevention within HSPA. This breadth of opportunities, however, increases the complexity of decision-making. As a result, there is no standard list of health promotion and disease prevention indicators and policies reported in practice to assess health systems.¹⁴

Yet, as seen from the interest expressed in this topic by the HSPA Expert group, there is the ambition to expand beyond the few traditional metrics and recognition that the current approach (primarily focussed on classic public health services such as screening and vaccination), needs to move towards a broader yet still measurable model that can be firmly embedded in the policy-making cycle. Before we link HSPA with health promotion and disease prevention, it is important to clarify those fundamental concepts.

DISEASE PREVENTION

Disease prevention aims to minimize the burden of diseases and associated risk factors or avoid the development of a disease entirely.¹⁵ Primary prevention seeks to minimise the exposure to disease risk factors and proactively prevent illness. Secondary prevention aims to detect diseases or conditions early to improve disease trajectory and health outlook. Tertiary prevention looks to slow down the progression of diseases and aspires to preserve quality of life in conjunction with disease treatment (See Box 2).

Disease prevention may include but is not limited to actions to improve health as wide as improving the impact of social and economic determinants on health; the commercial determinants of health; or the provision of awareness raising and education; or as targeted as nutritional and food supplementation and clinical preventive services such as immunization and vaccination.

It is important to note that primary prevention activities may be implemented independently of other health care services, this is not the case for subsequent levels of prevention (secondary, tertiary) in which they exist within healthcare systems. The area of disease prevention looks to address early detection to improve the chance of positive health outcome.

HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions¹⁶ and acknowledges the significant impact of social and economic health determinants.¹⁷ Health promotion is strengths-based and usually addresses even contextual influenced behaviours that pose as risk factors to disease (both independent to or in the presence of disease). This would include but is not limited to tobacco and alcohol use, diet, and physical activity, healthy ageing, mental health, violence and injury prevention, drug abuse control, health behaviour related to sexually transmitted diseases, and sexual health. An important enabler for health promotion is health literacy (see Box 6).

14 Arah OA, Klazinga NS, Delnoij DM, Asbroek AT, Custers T. Conceptual frameworks for health systems performance: a quest for effectiveness, quality, and improvement. *International journal for quality in health care*. 2003 Oct 1;15(5):377-98.

15 Breslow L. From disease prevention to health promotion. *Jama*. 1999 Mar 17;281(11):1030-3.

16 World Health Organization. Health Promotion: <https://www.who.int/westernpacific/about/how-we-work/programmes/health-promotion>.

17 19. Essential public health operations <https://www.euro.who.int/en/health-topics/Health-systems/public-health-services/policy/the-10-essential-public-health-operations>

Box 2: Definitions of Health Promotion and Disease Prevention

Health Promotion

- Health promotion is the process of enabling people to increase control over, and to improve their health.
- Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental, and economic determinants of health to optimize their positive impact on public and personal health. Health promotion is the process of enabling people, individually and collectively, to increase control over the determinants of health and thereby improve their health.
- The Ottawa Charter¹⁸ identifies three basic strategies for health promotion. These are advocacy for health to create the essential conditions for health indicated above; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health.
- The Ottawa Charter identified five priority action areas: to build healthy public policy; create supportive environments for health; strengthen community action for health; develop personal skills; and re-orient health services.

Disease Prevention

- Disease prevention, usually understood as specific interventions for primary, secondary (early detection) and tertiary (including rehabilitation) prevention, aims to minimize the burden of diseases and associated risk factors.
- Primary Prevention: measures aimed at vulnerable populations or individuals with the main aim to prevent a disease from ever occurring. Thus, its target population is people before the onset of biologically tangible damage. It commonly institutes activities that limit risk exposure or increase the immunity of individuals at risk to prevent a disease from progressing in a susceptible individual to subclinical disease. For example, immunizations are a form of primary prevention.
- Secondary Prevention: emphasizes early disease detection, with a target of healthy-appearing individuals with subclinical forms of the disease. The subclinical disease consists of pathologic changes, but no overt symptoms that are diagnosable under routine health examination. Secondary prevention often occurs in the form of screenings. For example, a Papanicolaou (Pap) smear is a form of secondary prevention aimed to diagnose cervical cancer in its subclinical state before progression.
- Tertiary Prevention: targets both the clinical and outcome stages of a disease. It is implemented in symptomatic patients and aims to reduce the severity of the disease as well as of any associated sequelae. While secondary prevention seeks to prevent the onset of illness, tertiary prevention aims to reduce the effects of the disease once established in an individual. Forms of tertiary prevention are commonly rehabilitation efforts.
- Quaternary Prevention: action taken to identify patients at risk of over-medicalization, to protect them from new medical invasion, with aims to suggest interventions, which are ethically acceptable. Put simply, an action taken to protect individuals (persons/patients) from medical interventions that are likely to cause more harm than good.¹⁹

Source: WHO Health Promotion Glossary²⁰

18 The Ottawa Charter. https://www.euro.who.int/_data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf

19 Martins C, Godycki-Cwirko M, Heleno B, Brodersen J. Quaternary prevention: reviewing the concept: Quaternary prevention aims to protect patients from medical harm. *European Journal of General Practice*. 2018 Jan 1;24(1):106-11.

20 WHO Health Promotion Glossary (2021). <https://www.who.int/publications/i/item/9789240038349>

Linking health promotion and disease prevention to HSPA

The primary purpose of this report is to assist the Member States by showcasing how health promotion and disease prevention activities and outcomes are measured within different HSPA frameworks. This task, however, is complicated by the nature of HSPA, where at times, the default lens of HSPA calls for a complex and narrow focus. It is further complicated by the varying range of formal HSPA processes across the Member States. Hence, it is interesting to see if and how health promotion and disease prevention indicators are linked to HSPA in practice.

Linking measurement and monitoring to policy

Linking health promotion and disease prevention to policy enables countries to identify, measure, assess, prioritise, and fund appropriate actions in a more informed way. Currently, health promotion and disease prevention indicators reflect intersectoral and health policies but are often not directly embedded into HSPA²¹. For example, efforts to improve population health and well-being, consideration of social determinants of health, and attention to broader inter-connected factors (e.g., air pollution, urban design and transport, social exclusion, etc.) are demonstrated at an international level through such initiatives as Health in All Policies initiative²¹ and health outcomes linked to the Sustainable Development Goals³¹. In this report, we attempt to look at such metrics as well, as they may be better suited to illustrate the potential scope of collaboration, enhance the role and importance of health systems, and empower the Member States to create policies (and appropriate metrics) that reflect better the interdependencies between health, health systems and the broader environment in the context of health promotion and disease prevention.

21 Of note: Not all Member States have an active HSPA framework. This may, in fact, be influential behind the reasons for not embedding health promotion and disease prevention in HSPA.

Chapter 2: Survey on health promotion and disease prevention indicators

In November-December 2021, the HSPA Secretariat, on behalf of the Expert group, conducted a survey among the HSPA experts focusing on the Member State's approach to measuring health promotion and disease prevention, whether they are included in HSPA and, how those indicators are used to support policy on health promotion and disease prevention. This chapter provides a cross-country analysis of (i) the scope and focus of their health promotion and prevention indicators, and (ii) how they are developed and used to assess health system performance.

The purpose of the survey was mainly to create a mapping of indicators on health promotion and disease prevention used by the Member States to monitor and measure their health system performance. The survey aimed to distinguish indicators into health promotion, primary, secondary, and tertiary prevention. The prevention working group discussed and agreed on the survey before it was distributed to all members of the HSPA Expert group.

Constructing the survey

The Questionnaire (included in Annex 1) was developed by the HSPA Secretariat following consultation with the expert group's working group on prevention. The final questionnaire was sent to all Member States as well as Norway with a deadline of 10 working days. Fifteen countries replied in total. All indicators are included in a separate Annex.

Box 3: Limitations of the survey

It is important to note that participation in the survey was voluntary. The survey instructions did not specify the nature of indicators beyond “health promotion and disease prevention” (although it did ask to distinguish primary, secondary, tertiary prevention or other), and responders were primarily free to interpret the scope. This was deliberate to have an accurate picture of what the respective Member States perceived as prevention. The key issues affecting the interpretation of the survey were:

- Non-response (information for only 15 countries was submitted from a possible 27 Member States plus Norway)
- Non-uniform response: Varying level of detail for individual indicators and likely overlaps despite differences in the labelling of indicators – further grouping was done to bring the level of detail to a common denominator.
- Missing details, particularly for sections identifying linkage to HSPA or national targets.
- The survey results need to be interpreted with caution, considering these limitations. They are aimed to illustrate the breadth of concepts and potential metrics, as well as prompt interest in how countries address health promotion and disease prevention monitoring.
- One reason for not correctly capturing the outcomes of health promotion and disease prevention is that too many health systems still provide only limited preventive services. All this leads to the conclusion that, for the time being, it has to be kept in mind that missing data, comparability problems, and lack of appropriate indicators to assess health system performance across the targeted dimensions fully constrain the explanatory power of the framework. As a result, the analytical results must be interpreted with caution.
- It should also be kept in mind that in the several EU Member States, the responsibilities and governance structures for health systems lay at the regional level, and regions may display significant differences in health, economic development, and health system performance.²² Caution is required as initiatives that rely on poorly validated measures, and biased policy interpretations may lead to adverse policy and political impact.²³

Survey results

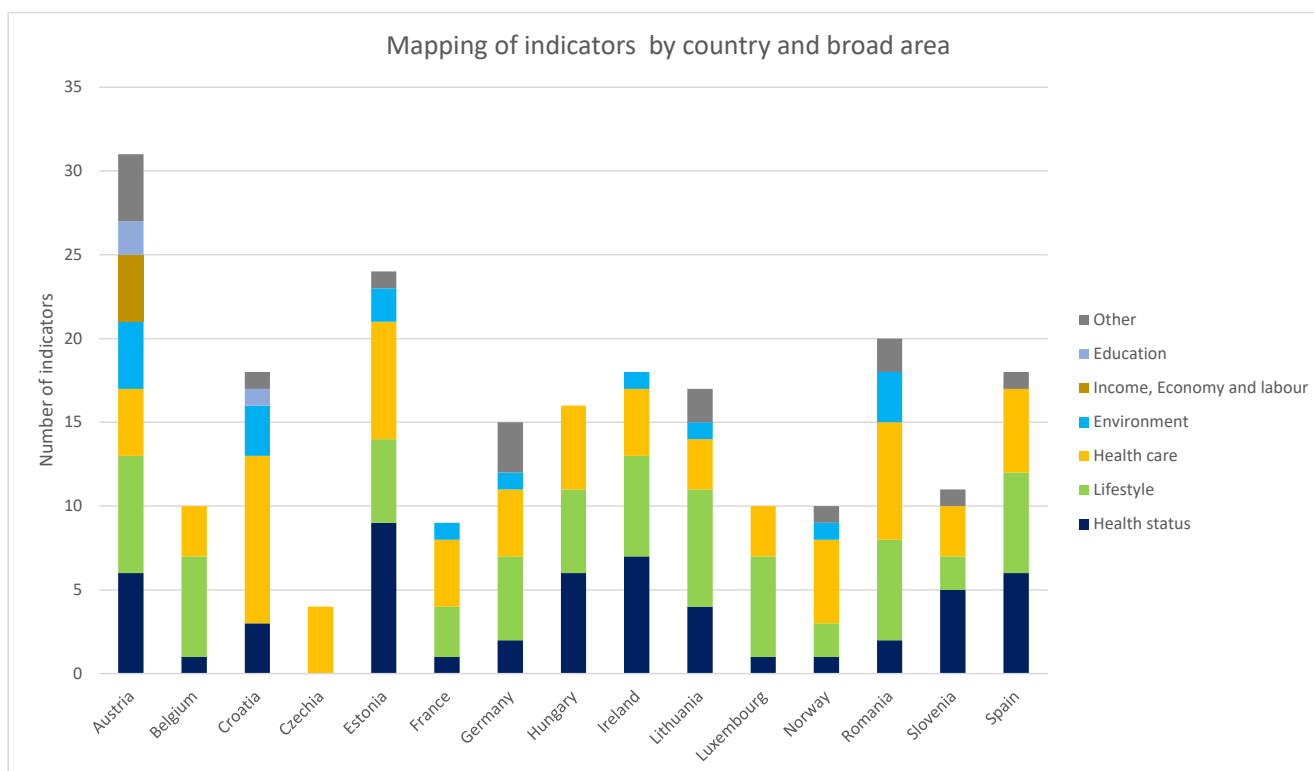
Responses from 15 countries were received by the end of December 2021. Collectively 861 indicators were listed (with a range of 16 to 190 per country). However, as indicators were detailed to a different level (e.g., some reported overall theme, such as “cancer screening”, while others provided further breakdown (e.g., by type of cancer, or age group), we harmonised the list of indicators for each country to bring them to the smallest common denominator. The final grouping resulted in a total of 230 indicators, ranging from 3 to 31 per country. For summary purposes, we also grouped indicators into 7 areas: health status; lifestyle; health care; environment; income, economy, and labour; education; and other.

Figure 1 shows the breakdown of indicators by country and broad area. Notably, health care is the area with the largest number of indicators (n=71), and the only one included in all countries. Lifestyle (n=66) and health status (n=54) are also among the top areas, present in most countries’ responses. Furthermore, 9 countries included environmental indicators (n=17). Socio-economic determinants, such as education or income, economy and labour indicators were not routinely reported by countries within the context of health promotion and disease prevention. The group “other” consisted of broad indicators that are more challenging to attribute to existing groups, such as broad policy or activity in health promotion or disease prevention, wellbeing, and demographic indicators.

22 Towards a Joint Assessment Framework in the Area of Health. 2016 Update.

23 Papanicolas I, Smith P. Health system performance comparison: an agenda for policy, information and research: an agenda for policy, information and research. McGraw-Hill Education (UK); 2013 Jun 1.

Figure 1: Mapping of indicators by country and broad area (n=230)



Note: Some countries appear on the chart without indicators within a certain group, however this does not mean that such country cannot provide the indicators, it only indicates that they were not included in the response to the questionnaire.

Figure 2 (below) provides more specific breakdown of indicators. As expected, it shows that cancer screening and vaccination coverage were the indicators most commonly attributed to health promotion and disease prevention (reported in at least 13 countries). To various extent, countries also reported indicators that relate to health service activity volume (e.g., number of visits, clinics, consultations, or hospitalisations), quality of care (e.g., in-hospital mortality, avoidable hospitalisations), targeted prevention activities (e.g., CVD and diabetes screening, addiction services, pregnancy/maternity care, preventive checks for specific populations).

Most countries (n= 12) also included key lifestyle and risk factor indicators – alcohol and tobacco consumption, and body mass index, to lesser extent physical activity, diet, and consumption of illicit drugs. Health literacy indicator (used in at least 2 countries and planned to be used in at least one) generated a substantial interest in the HSPA group for potential to be considered in more countries. Therefore, this indicator will be discussed separately in this report (see Chapter 3).

At least seven countries reported measuring some sort of health promotion activity at the population level. The examples of specific indicators in this group include several health-promoting interventions, schools, or enterprises for various population groups, as well as the development of materials for health promotion.

A wide variety of indicators relating to health status were reported across countries. This could be explained by health status as part of a broader contextual assessment. However, among those reported indicators, the most frequent was the prevalence of infectious diseases (e.g., TB, HIV), maternal and child health indicators, self-assessed health, mental health, avoidable mortality and prevalence of disability and chronic disease.

Environmental areas, notably pollution, water and sanitation indicators, were reported in at least nine countries. Finally, at least five countries included indicators of social well-being. Specific metrics varied widely

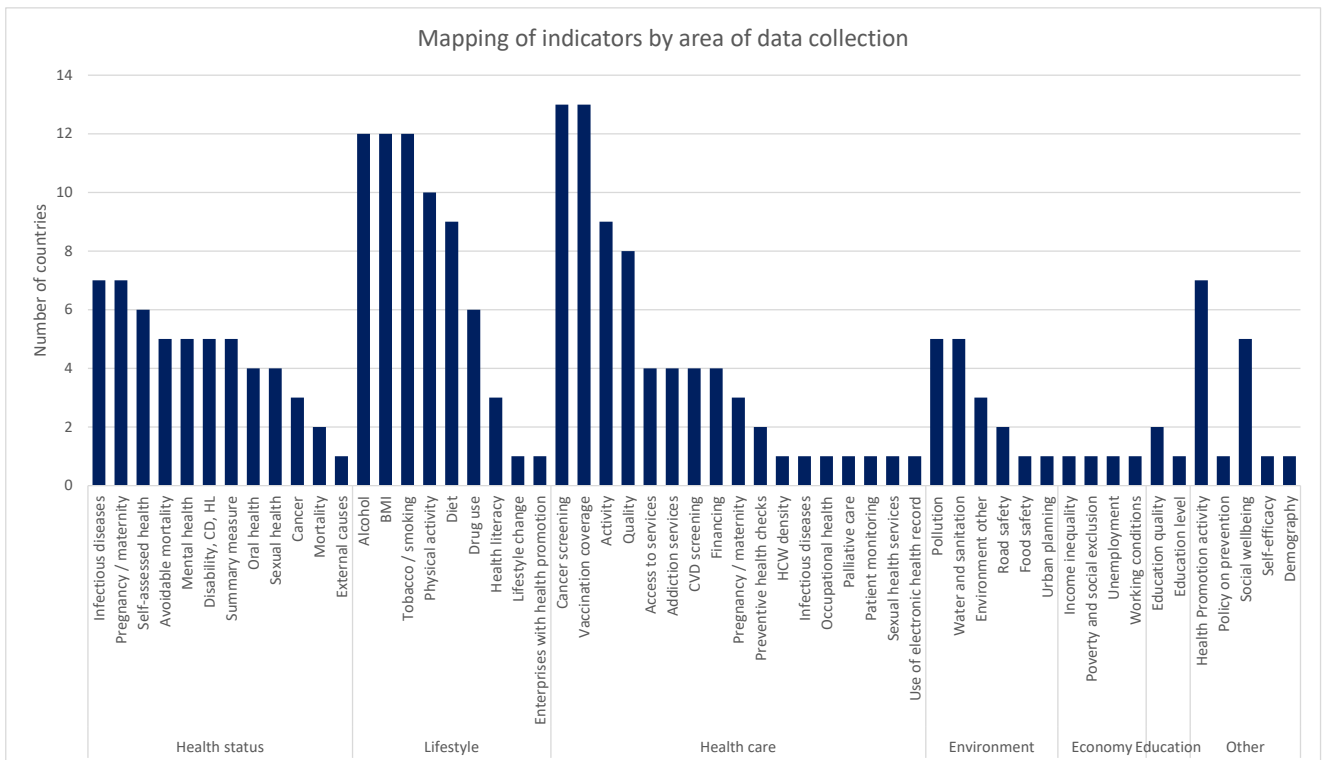
and were challenging to harmonise. Examples include social support, social trust, supportive relationships, quality of life, measures of bullying, etc.

While **Figure 1** and **Figure 2** represent a somewhat broad list of what HSPA experts perceive as metrics linked to health promotion and disease prevention, **Figure 3** gives a better idea of the indicators used in policymaking. However, the broad view is like that of figure 2, with vaccination coverage, cancer screening coverage, risk factors (smoking, alcohol, BMI), health care quality and activity monitoring metrics are most frequently linked to HSPA. Often, they are also linked to national targets.²⁴ Health promotion activities seem to be more frequently linked to targets than HSPA. It must be noted, however, that not all countries have a formal HSPA setup and therefore having these indicators included as targets may be the only way to enhance accountability for those specific issues.

Box 4 details the list of selected most common indicators that are linked to either HSPA or national targets and illustrates various ways that these metrics were represented in the survey. The level of detail provided in the survey varied, and it is not possible to say with certainty whether countries tend to select few indicators to represent an area (e.g., coverage of 2nd dose of MMR for eligible children as a proxy for childhood vaccination coverage) or use all available indicators.

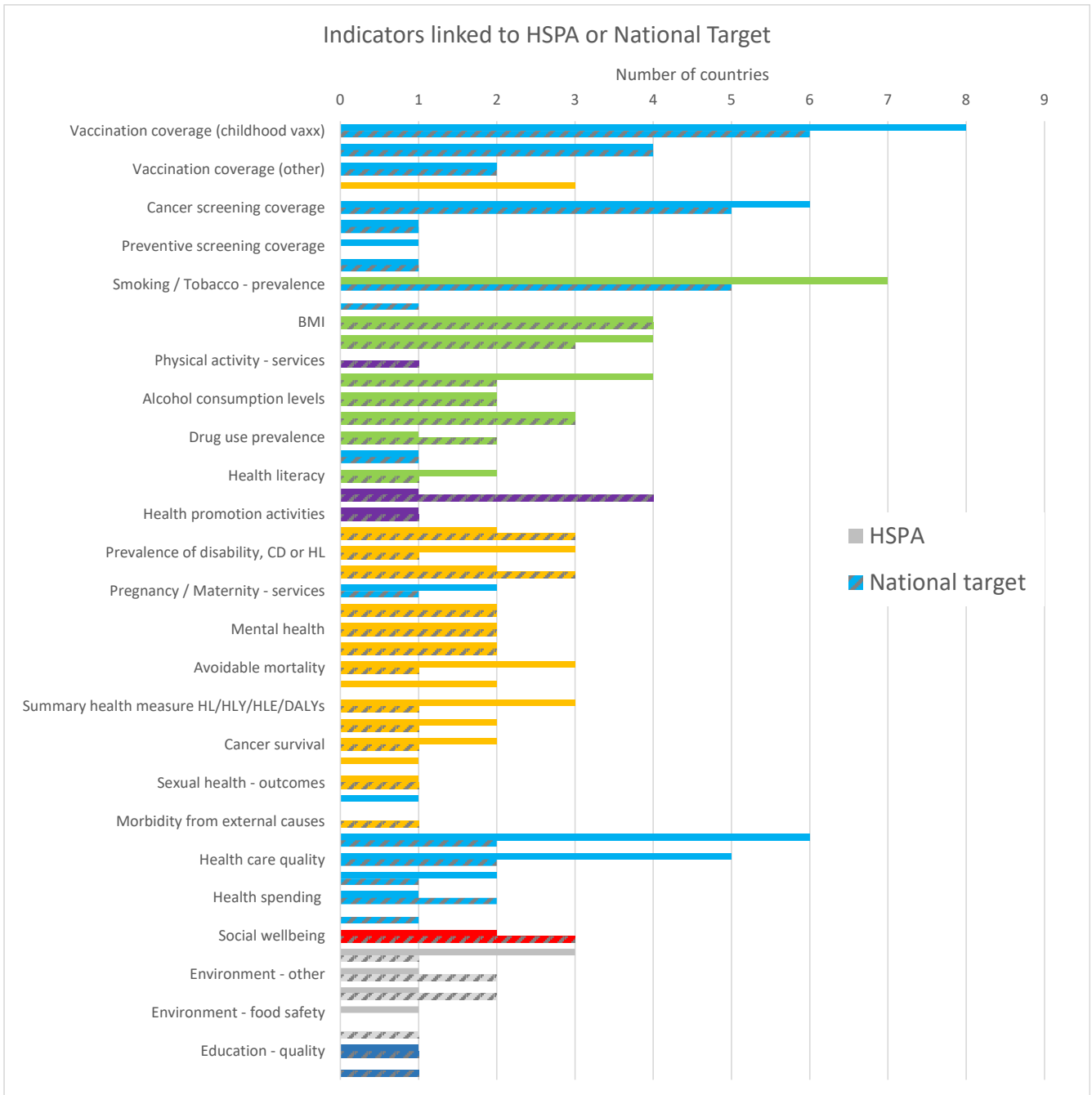
All countries that reported vaccination coverage were monitoring childhood vaccinations, and fewer reported tracking HPV, influenza, as well as incidence of vaccine-preventable diseases. Childhood vaccinations were often linked to HSPA, as well as national targets. Apart from specific disease, target age and dosage, few further breakdowns were available. Therefore, it seems that vaccination coverage is a proxy indicator showing general level, while identifying gaps in vaccination coverage is not routinely part of the assessment process. It also seems that expansion of coverage for influenza, HPV and COVID-19 is an area much less well monitored.

Figure 2. Mapping of indicators by broad area (n=230)



24 Of note: **EU indicators** are commonly agreed EU indicators which can be compared across Member States. **National indicators** are based on commonly agreed definitions and assumptions that provide key information to assess the progress of MS in relation to certain objectives. May not be suitable for direct cross-country comparison. <http://ec.europa.eu/social/main.jsp?catId=756>

Figure 3. Indicators linked to HSPA or national targets (n=230)



Many countries reported screening for non-communicable diseases, more systematically for cancers (n=13), but also for cardiovascular disease (n=4). Breast, cervical and colorectal cancer screening indicators were ones most often included however the indicators vary by country, which may present a challenge for comparability of data, particularly international comparability. For example, for breast, cervical and cancer screening target populations may vary (from 45-50 to 69 for breast cancer; 20-25 to 59-65 for cervical cancer; and all people aged 50-74 for colorectal cancer). The frequency of coverage may also vary (e.g., whether people attended the screening in the past 1-5 years), and so did the source of information – programme coverage/administrative data vs population surveys, and, finally, the denominator (people eligible vs entire population). Screening for other types of cancers was reported much less frequently, but prostate, pancreas, lung, uterus cancer screening indicators were also mentioned. Few countries reported indicators that monitor CVD and diabetes screening coverage, with geographic and demographic breakdown often available, but socio-economic one less so.

Lifestyle and risk factor indicators was another large and regularly reported group, with smoking prevalence being the most frequently reported indicator there. As Box 4 illustrates, there is a large variety of available indicators on risk factors, often derived from using standardised tools, such as Health Interview Surveys (EHIS), health behaviours in school-aged children survey (HBSC), etc. However, international comparability is limited due to the varied and often inconsistent ways (definitions, categorization, etc.) these indicators are recorded. For example, smoking rates was an indicator measured in most countries, but there was variance in questions asking about frequency, onset of smoking, duration, etc. at the time of recording. A lack of shared definitions in measurement serves as a barrier for comparable measures. Of note, only 7 countries reported that lifestyle indicators are included in HSPA, most of which were focused on adults.

Box 4: Examples of most frequently reported indicators for vaccination coverage, NCD screening and risk factors from the survey

Vaccination coverage

Childhood vaccinations

Percentage of infants vaccinated against diphtheria (and other vaccine-preventable disease)*

Proportion of children presenting their vaccination card at school entry health examinations with vaccination against hepatitis B (and other vaccine-preventable disease)

% of 2 years old having received all mandatory vaccines

Measles vaccination in adolescents (% 1st and 2nd dose)

BCG vaccination of newborns

HPV

Increase in coverage of HPV (human papillomavirus) vaccination among 13-year-old girls.

HPV - the percentage of women vaccinated for HPV among the female population.

Influenza

Proportion of people aged 65+ reporting a vaccination against flu in the past 12 months (survey data)

Proportion of people aged 65+ who have been immunised against influenza in the past 12 months (administrative data)*

Increase in coverage of seasonal influenza vaccination among the population.

Increase in vaccination coverage of seasonal influenza among 65+ year old.

Other

COVID-19 vaccination coverage

Incidence rate for vaccine-preventable diseases

NCD screening

Cancer screening

Proportion of women (aged 45-69) who have received a bilateral mammography in the past 2 years (% , administrative data)

Proportion of women (aged 50-69) reporting a mammography in the past 2 years (survey data)*

Percentages of those turning up for breast cancer screening among those invited over a 2-year cycle.

Proportion of women (aged 25-59) who have been screened for cervical cancer in the past year (% , administrative data)

Cervical cancer screening: proportion of women aged 25-59 years in the last 3 years.

Proportion of women aged 25-65 years with a cervical cancer screening in the last 3 or 5 years (%)

Colon cancer screening - organized programme (% men and women aged 50-74)

Proportion of people (aged 50 and over) who have undergone colorectal cancer screening in the past 2 years (% , administrative data)

Prostate cancer screening of men aged 50-69 years and men over the age of 45 if their parents and brothers had prostate cancer in the last 2 years.

CVD and diabetes

Early detection of diabetes in pregnancy

Early detection of diabetes in the general population older than 50 years and overweight/ obese people under 50 years with additional risk factors

Proportion of people aged 15 years and over according to the last measurement of blood cholesterol, blood pressure, blood sugar.

Cardiovascular diseases high risk group screening of men aged 40-54 years and women aged 50-64 years in the last year.

Lifestyle / risk factors

Alcohol

Alcohol consumption per capita*

Adults who consumed alcohol at least once a week in the last 12 months, %

Adults who consumed alcohol at least once a week in the last 30 days, %

Adults who consumed alcohol daily in the last 30 days, %

School-aged children who consumed alcohol at least once in the last 12 months, %

School-aged children who consumed alcohol at least once in the last 30 days, %

High BMI

Proportion of obese residents (aged 19-75) (%)*

Physical activity

Adults who report are physical active at least 30 min 5 and more days a week , %

Proportion of residents (aged 19-75) who are insufficiently physically active (%)

School-aged children who report at least 60 min are physical active 5 or more times per week (counting with school hours), %

School-aged children who report at least 60 min are physical active daily (counting without school hours), %

School-aged children who spend about 4 and more hours on screens per day (TV, computer, tablet, smart phone), %

Smoking

Adults who smoked electronic cigarettes daily in the last 30 days, %*

Adults who smoked electronic cigarettes daily in the last 12 months, %*

Adults who used tobacco daily in the last 12 months, %

Adults who used tobacco daily in the last 30 days, %

School-aged children who smoked at least once in the last 12 months, %

School-aged children who smoked at least once in the last 30 days, %*

School-aged children who smoked electronic cigarettes or used other electronic devices for smoking at least once in the last 30 days, %

School-aged children who smoked electronic cigarettes or used other electronic devices for smoking at least once in the last 12 months, %

Tobacco consumption per capita

Percentage of successful tobacco quitters

*denotes indicators OECD reports international comparisons²⁵

In terms of assessing inequalities within countries, many indicators can be broken down by age and sex, whilst substantially fewer by location, education, or socioeconomic status in general. Moreover, it is not possible to assess from information provided in the survey to what extent inequalities in health promotion and disease prevention are being monitored.

In terms of data sources for indicators, national sources predominated, as usually data are supplied by national agencies, statistical offices, or, especially in the case of lifestyle and wellbeing indicators, draws on national surveys. For the latter, however it was often unclear whether national surveys are also part of the international collaborative networks especially Eurostat. When international sources were mentioned, it was usually in relation to self-reported health, lifestyle and wellbeing indicators, with Health Behaviour in School-aged Children (HBSC) and European Health Interview Survey (EHIS) dominating. Other international sources of data mentioned were Eurostat/European Union Statistics on Income and Living Conditions (EU-SILC) for data on self-assessed health, prevalence of disability and chronic disease, poverty and social exclusion, avoidable mortality, OECD Health at a Glance and selected indicators reported in OECD statistics, EURO CARE for cancer-related indicators, the Survey of Health, Ageing and Retirement in Europe (SHARE) for working conditions, Health Literacy Survey (HLS19) for health literacy, European School Survey Project on Alcohol and other Drugs (EPAD) for illicit drug use, Eurobarometer for physical activity, Global Burden of Disease study for behavioural risk factors, cancer incidence and mortality, WHO for HIV incidence and WHO European Childhood Obesity Surveillance Initiative (WHO COSI) survey for childhood obesity.

Chapter 3: Case studies based on the mapping survey and additional best practices

OVERVIEW

Overall, HSPA frameworks have been built to provide a shared vision for health system strengthening and act as a tool for governance as policy makers and government work towards better and more equitable health outcomes. HSPA objectives are tailored to the policy context of each country and its particular tradition of health system governance, capacity, and needs²⁶ all of which are routinely reviewed and revised. In the EU, there are varying levels of development of HSPA frameworks and their use of health promotion and disease prevention indicators. While HSPA is a country-specific process, there are many similarities in Member States HSPA frameworks and choice of health indicators more broadly. Interestingly the findings from the indicator survey across Member States respondents demonstrated that the choice and measurement of specific health promotion and disease prevention indicators indeed varies greatly (Chapter 2). For this report, three case studies were chosen to illustrate the diversity of indicators and showcase interesting examples which we felt deserved increasing attention.

In addition, this chapter presents best practices (not linked to the survey) based on presentations and expertise of further experts.

METHODS REGARDING CASE STUDIES

This chapter represents the findings of three case studies: Health in All Policies in Austria, health literacy and mental health. The selection of the case studies was based on the survey results and, discussion with the HSPA Expert group. The participating countries were selected based on their engagement with the survey, expressed interest and also to represent a variety of experiences with HSPA in different contexts across the region. Small discussion groups were organised and facilitated by the European Observatory on Health Systems and Policy and convened on the topics of mental health and health literacy. The countries represented were Austria, Belgium, Germany, Hungary, Ireland, Lithuania, Malta, Netherlands, Portugal, and Romania. National health promotion and policy experts from WHO and OECD also participated. The selection of informants followed a snowball approach, where one key informant was identified (usually the HSPA group expert) for each country, and then followed by recommendations for colleagues specialising in either health literacy or mental health respectively. The case study small group discussions were conducted in May and June 2022 remotely (set up over two two-hour meetings with up to three informants per country). The group discussions followed a semi-structured interview approach, starting with a presentation from each country informing on their HSPA framework and the specific health topic (health literacy indicator or mental health metrics) which was followed by a small group discussion of three structured questions which are described below. The information gathered from the discussions were the basis for this chapter and helped inform the discussion in the later chapter. The Austrian case study was documented by representatives from the Austrian Ministry of Health at the request of the European Observatory on Health Systems and Policies, in order to illustrate how a national HIAP strategy can incorporate health promotion and disease prevention with much broader determinants of health and link it to HSPA.

Programme case study: Austrian Health Promotion Strategy

OVERVIEW

The new Austrian National government Health Promotion Strategy (HPS)²⁷ was established in 2014 as part of Health In All Policies²¹ which uses a cross-sector action approach to wider health determinants and/or intersectoral health considerations. It is based on the Framework Health Goals (2012-2031)²⁸, which act as the national health targets developed with the aim to prolong the healthy life years of all people living in Austria within 20 years, irrespective education or income level or personal living condition) and the Health Promotion Strategy (HPS) 2013-2022³⁸ and will be considered for use as a framework to shape decisions for the next

26 World Health Organization. https://www.euro.who.int/_data/assets/pdf_file/0008/168875/Case-Studies-for-HSPA-ENG.pdf

27 Further information about the Austrian Health Promotion Strategy can be found here: <https://eurohealthobservatory.who.int/publications/m/austria-country-health-profile-2021>

28 Framework Health Goals. <https://gesundheitsziele-oesterreich.at/english-summary/>

decades. An update of the HPS was planned for 2022 but has been postponed for a year in line with the extension of the target-based health governance system (Zielsteuerung Gesundheit). More, this allows better coordination with a recently started initiative of the Ministry of Health (MoH) Agenda Health Promotion.

The central goal of the HPS is to contribute to a longer, self-determined life in good health for all people in Austria. The strategy aims for a more targeted and coordinated health promotion and primary prevention approach in Austria. Various stakeholders (national and regional governments, health insurance, communities) have responsibility for health promotion and primary prevention and the HPS is one instrument to improve coordination and collaboration between sectors.

The HPS goals are outlined below:

- Supporting the implementation of the framework health goals, the provincial health goals and the health promotion topics in the management of health.
- Strengthening and further development of cross-policy cooperation in the sense of Health in All Policies
- Promotion of a broadly coordinated approach in the field of health promotion.
- Contribution to quality development in the field of health promotion
- Contribution to capacity building in the field of health promotion
- Dissemination of well-developed examples of practice

The HPS has been agreed upon and delivered between National Government (MoH), Regional governments and Health Insurance organizations. Funding is provided from regional governments and health Insurance procurement. Investment decisions are made on a regional level and these decisions are monitored in a data base, reports on the process have been outlined in 2016 and 2020 for the periods 2013-2015 und 2016-2019 by the Austrian National Public Health Institute. MoH is partner with the federal states and the social insurance in the framework of the health reform. Within this framework MoH coordinates and oversees the process to strengthen health promotion and commissions monitoring.

Health targets and HSPA

Health targets play a pivotal role in the Austrian HPS (see box 5) where some of the indicators are further used in the national HSPA programmes relating to health promotion and prevention.

Box 5: Austrian Health Promotion Targets

- Target 1: to provide health-promoting living and working conditions for all population groups through cooperation of all societal and political areas.
- Target 2: to promote fair and equal opportunities in health, irrespective of gender, socio-economic group, ethnic origin, and age.
- Target 3: to enhance health literacy in the population.
- Target 4: to secure sustainable natural resources such as air, water and soil and health environments for future generations.
- Target 5: to strengthen social cohesion as a health enhancer.
- Target 6: to ensure conditions under which children and young people can grow up as healthy as possible.
- Target 7: to provide access to healthy diet for all.
- Target 8: to promote healthy, safe exercise and activity in everyday life through appropriate environments.
- Target 9: to promote psychosocial health in all population groups.
- Target 10: to secure sustainable and efficient health care services of high quality for all.

The first HSPA process is in the context of the federal target-based health governance system (i.e., the national health reform ongoing since 2013, called “Zielsteuerung Gesundheit”). It encompasses both financial targets and jointly defined (public) health targets for health outcomes, and for processes and structures of services provision. The financial targets and the health outcomes are not tied together, i.e., no sanctions apply if public health targets are not met. The reform has as one of its core principles and values the Austrian health targets “Gesundheitsziele” (see above,) and these are mentioned in the agreement that is the basis of the reform between the main financing partners in the Austrian health care system (states, MoH, social insurance). Indicators in the HSPA process in the national target-based governance reform (“Zielsteuerung Gesundheit” - Monitoring) include:

- measles, mumps, rubella vaccination rates (% of children aged 4-year-old with two shots)
- % of diabetes mellitus patients participating in the disease management programme Therapie Aktiv
- % of respondents with excellent or sufficient health literacy
- % of daily smokers

The second HSPA process was also developed as part of the ongoing health reform. It comprises an outcome measurement framework developed by an expert panel in 2015 to systematically monitor the health system’s performance, which provides a regular update on outcome indicators. It comprises 54 indicators, of which 18 cannot be calculated due to a lack of data availability. The following indicators in outcome measurement (HSPA process) refer to the areas of health promotion and prevention.

Health promotion:

- Working conditions of older people: index value (average) between 0 and 100
- School climate: average index value between 0 and 100
- Social capital: % with a high level of social support
- Fruit and vegetable consumption
- Health-promoting physical activity
- Prevention:
- Pertrochanteric femur fracture
- The dental health of six-year-olds (DMFT)
- Tobacco consumption
- Alcohol consumption
- Obesity
- Vaccination prevalence in children

Financing: measures financed within HP-strategy

Austria has committed to spending EUR 15 million annually for health promotion measures (resources allocated according to the number of inhabitants of the nine regions). 87% of this money comes from health insurance and 13% from regional governments. What is demonstrated is that much of the financing for health promotion is money generated directly from the consumer through health insurance rather than a share from healthcare budgeting for health services.

As the concept of health promotion and measuring it is vast and heterogeneous, the Austrian strategy comprises a “catalogue” of topics for which funding needs to be allocated. This catalogue considers target groups according to age and categorisation according to health promotion settings. Six of these topics are prioritised, and at least 66% of the health promotion funds must be used for the prioritised topics.

Additionally, to the framework of topics which should be addressed, conformity to quality criteria²⁹ is mandatory as consideration of evidence and good practice, Health in all Policies, and contribution to health equity. The Federal Ministry of Social Affairs, Health, Care and Consumer Protection is also providing EUR 24 million for health promotion for 2022–2024. Three competence centres are established under “Agenda Health Promotion: Competence Centre Health Promotion and Health System, Competence Centre Climate and Health and Competence Centre Future Health Promotion”³⁰.

29 Of note: Quality criteria of health promotion originate from the Fonds Gesundes Österreich (Austrian Health Promotion Foundation): https://fgoe.org/qualitaetskriterien_grundprinzipien (German only)

30 <https://agenda-gesundheitsfoerderung.at/>

Evaluation: Measures and metrics

In Austria, some indicators of the HPS are also part of HSPA monitoring processes in the context of the national health reform. Part of success of implementing the health promotion strategy is monitoring. Results are published in German.³¹

Monitoring is demonstrated as follows:

- Compliance with the principles of use of funds (e.g., scientific knowledge and good practice, health in all policies, health equity)
- Defined quality criteria (resource orientation and empowerment, setting(s)/field(s) of intervention, geographical scope/location, determinants of health, target group interests and target groups, inclusion of actors in the setting, sustainability of the measure, evaluation).
- Intended effects. Here, the monitoring of the health promotion strategy looks at the extent to which the basic principles of health promotion and health promotion are adhered to. Among other things, the sustainability of the measures is examined. Indicators are for example: the continuation of the measure to the current extent is aimed for or an expansion of the measure is planned.

It was reported that the overlaps were coincidental, and the development of the monitoring was based on setting-oriented health promotion and corresponding criteria.

Measures of sustainability

Sustainability is measured by means of three indicators throughout the health promotion strategy:

1. While measurement is taking place, if sustainable structural changes are made (*establishment of new structures, e.g., committees; financing models, definition of responsibilities*).
2. If the measure is continued for the extent, it was originally aimed for (*piloting becomes routine*).
3. And if an expansion of the measure is planned (*roll-out of previously restricted/regionally limited measures*).

All these indicators are self-reported assessments from the health promotion funds which are established at regional level. For the last period (2016-2019) for about one third of measures impact on structural changes have been reported, for 53% a continuation of measures is reported and for 15% an extension of the measure is reported.

Indicator case study: Health literacy

Health literacy was identified through the survey of indicators on health promotion and disease prevention as one of the indicators of interest for the HSPA group. Health literacy is an increasingly relevant indicator of population health as it is estimated on average 47% of European citizens (of participating countries in the first European Health Literacy Survey (2009-2011) have inadequate or problematic self-reported health literacy skills.³² In simple terms, nearly half of Europeans are not properly armed with the knowledge or tools to make informed health decisions. This is particularly problematic as the burden of NCDs continues to rise, and the complexity for citizens to manage health outcomes increases. A review³³ completed in 2020 suggests health literacy is one (if not the most) promising and cost-effective concept to overcome the NCD challenges. As a result, many countries have included improving health literacy as a key priority for their health planning agenda.

The HSPA survey (Chapter 2) showed that health literacy indicators are not used routinely across all member states. For example, Ireland has explicitly included health literacy when recently building their HSPA framework with a few countries stating within the Expert group they are thinking of and how to include health literacy in their HSPA framework. The prevention working group suggested to conduct a discussion group on health literacy in order to include it as a case study. This was carried out with representatives from Belgium, Portugal, Malta, Austria, Germany, Hungary, Ireland and WHO taking part in the discussion. Representatives included both health literacy experts and HSPA experts, though none felt that they were an expert in both domains.

31 Austria Health Promotion Strategy. https://jasmin.goeg.at/1547/1/2_Bundesmonitoringbericht_GF-Strategie%202020_bf.pdf

32 Kickbusch, Ilona, Pelikan, Jürgen M, Apfel, Franklin & Tsouros, Agis D. (2013). Health literacy: the solid facts. World Health Organization. Regional Office for Europe. <https://apps.who.int/iris/handle/10665/326432>

33 Liu C, Wang D, Liu C, Jiang J, Wang X, Chen H, Ju X, Zhang X. What is the meaning of health literacy? A systematic review and qualitative synthesis. *Family medicine and community health*. 2020;8(2).

Box 6: Health literacy defined

Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.³⁴

Inadequate health literacy is associated with difficulties in comprehension of health information, limited knowledge of diseases and lower medication adherence, which contribute to poor health, high risk of mortality, insufficient and ineffective use of healthcare, increased costs, and health disparities.³⁵

The first part of the meeting consisted of country representatives providing a brief presentation on health literacy work in their respective countries in the context of HSPA. This was followed by a semi-structured discussion around the three questions:

1. Do you think health literacy would be a useful indicator to include in HSPA?
2. If you are familiar with instruments that measure health literacy, which one do you think is most suitable for EU-wide use?
3. How health literacy metrics should be used to improve health systems?

Health literacy metrics for HSPA

There was general consensus in the discussion group that health literacy is a useful metric for HSPA. Moreover, some countries – e.g., Austria and Ireland, already include health literacy into their existing HSPA frameworks, however in Ireland the indicator is not yet used routinely. The discussion on the inclusion of the health literacy metrics into HSPA is underway in Germany, Belgium, and Malta. HSPA experts from Germany reported that in the process of preparing the first HSPA (published in 2021), indicators were selected on the basis of a feasibility study conducted in 2018.³⁶ At the time, health literacy metrics were looked at, but did not pass feasibility thresholds (well-established and validated indicator, data availability, ability to analyse trends and conduct country comparisons). However, this pre-dated the Health Literacy Survey 2019 (HLS19). For the next round of HSPA, health literacy metrics will be assessed for inclusion in Germany however results have not been determined to date. It is also important to note that health literacy is sometimes represented within its own domain in HSPA, though it has clear connections to prevention and health promotion.

Box 7: Health Literacy Survey (HLS19)³⁷

This survey created by Measurement of Population and Organizational Health Literacy in Europe (M-POHL) aimed to measure population health literacy in as many member states of the WHO European Region as possible. This survey generated high-quality data on the comprehensive health literacy of general populations that enables comparisons both within and between countries and has made major inequities visible. The European Health Literacy Survey tools can serve as a basis for strengthening capacity to measure how the many promising interventions described here may affect population health.

34 Kickbusch I., Pelikan, J. M., Apfel, F., and Tsouros, A. D. (2013) Health literacy. The solid facts. Copenhagen: WHO Regional Office for Europe.

35 Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A, Brasure M, Lohr KN, Harden E, Tant E. Health literacy interventions and outcomes: an updated systematic review. Evidence report/technology assessment. 2011 Mar 1(199):1-941.

36 The feasibility study encompassed a) the development of a conceptual framework (including dimensions and categories) for a German HSPA, b) the development of a set of indicators (including an indicator assessment regarding the suitability for a German HSPA along a standardized template), c) identification of missing or suboptimal indicators in each dimension – especially for efficiency – and d) a suggestion to operationalize HSPA with the current available national and international databases. Feasibility study: Perić N, Hofmarcher MM, Simon J. Headline indicators for monitoring the performance of health systems: findings from the European Health Systems Indicator (euHS_I) survey. Archives of Public Health. 2018 Dec;76(1):1-7.

37 Health Literacy Survey (HLS19). https://m-pohl.net/HLS19_Project

Measuring health literacy in Europe

Based off the small group discussion, there was consensus around the importance of indicators covered in the HLS19 survey, which currently is viewed as the most promising and broadly validated tool (validated for use in 17 countries in Europe). It also has a shortened (HLQ12) questionnaire that is easier to implement. National surveys are coordinated by the MPOHL³⁸ network which supports countries in implementation and use of the surveys, as well as from a technical and policy perspective (See box 7).

Among the more interesting aspects of health literacy, digital health literacy and mental health literacy were singled out as indicators that are particularly important in the current environment.

Box 8: M-POHL: Measuring population and organization health literacy of European Health Information Initiative (EHII) WHO-Europe

M-POHL was created to enhance health literacy in the WHO European Region by ensuring the availability of high-quality and internationally comparative data to support evidence-informed political decisions and targeted practice interventions. The aims of M-POHL are:

- support health literacy by strengthening the collaboration between research and policy,
- address the personal health literacy among general population and patients,
- institutionalize regular, high-quality internationally comparative population health literacy surveys,
- address health literacy-friendliness of systems and organizations,
- support collection and analysis of data on organizational health literacy (health literacy-friendly structures and processes), and
- foster evidence-informed policy and practice.

Austria is a pioneer in health literacy metrics with multiple surveys and further pilots dedicated to it. Among more novel areas of health literacy, Austria has been exploring health literacy in children, nutritional health literacy, as well as organisational health literacy in hospitals. Areas that are currently measured are navigational health literacy, communicative health literacy, digital health literacy and vaccination health literacy.

Health literacy metrics to improve health systems

Interpretation of health literacy levels in the context of HSPA is not always immediately clear and there is lack of clarity in how much this indicator can be used to inform policy and actions across Member States. However, the Austrian experience showed that information on low health literacy levels in the population identified through an initial survey served as a starting point for defining policy action, and subsequently became part of an established process linked to decision-making. In another example, from Portugal, where health literacy around vaccinations was very high, a positive outcome of pre-existing high levels of health literacy among the population was noted during the COVID-19 vaccination campaign, with Portugal achieving one with the highest vaccination coverage rates in the EU.

From a practical perspective, to analyse health literacy rates further, this data can be disaggregated, which would give a better indication for areas that are more problematic (for example, digital health and mental health literacy). However, use of the high-level indicator or breakdowns would depend on the specific country context with some experts feeling that starting from reporting overall health literacy levels is already a step forward.

38 MPOHL Action Network. https://m-pohl.net/mpohl_action_network

Future outlook

In reflecting upon initial issues raised by Germany's feasibility study on validity, data availability and comparisons, experts expect that information collected more recently through the HLS19 (specifically health literacy information) could present a reliable source of information. This can be used for HSPA as a reflection on health system responsiveness and as a prerequisite for improved health care effectiveness and leading to better health outcomes. An open invitation was made for any member states interested to join M-POHL where the condition for network membership is to have a dual representation per country – with both research and policy roles being represented. This ensures a closer link from reporting the findings of health literacy surveys to formulating policy and action, as well as to dissemination of results among policy makers. We will discuss digital health literacy and mental health literacy further in the discussion section in Chapter 4.

Indicator case study: Mental health metrics

The identification of mental health metrics as a further area of interest to explore in more detail for the HSPA prevention report was less obvious and straightforward than health literacy. A well-constructed indicators must define boundaries of capturing population well-being or population mental ill health. For this reason, measuring mental health has always been a difficult task. Measurement tools are routinely relied upon to aid assessment and to monitor and evaluate treatment and service effectiveness³⁹ however the number of tools available is large. A recent systematic review of the literature found 127 studies which used upwards of 65 mental health measurement tools.⁴⁰

The HSPA members survey demonstrated that, while mental health indicators are included in at least several countries, there is no consistency in metrics identified and linked to health promotion and disease prevention. The HSPA working group generally felt that mental health was an area that deserves timely consideration in HSPA. There were concerns, however, that mental health is generally a broad area, and people involved who are best placed to discuss metrics and the country situation may often be placed outside of the HSPA Expert group. Despite mental health being a heterogeneous area, interest in these metrics as a potential area for HSPA was further confirmed by the good participation in the discussion group, with representatives from 9 countries taking part in the discussion.

The first part of the meeting consisted of representatives from Lithuania, Romania, Hungary, Germany, Austria, Malta, Belgium, Netherlands, and Ireland presenting mental health metrics and data collection tools used in their respective countries. These presentations were followed by a semi-structured discussion facilitated by the European Observatory on Health Systems and Policies which looked at answering the following questions:

1. Do you think mental health would be a helpful indicator to include in HSPA?
2. If you are familiar with instruments that measure mental health, which one do you think is most suitable for EU-wide use?
3. How should mental health metrics be used to improve health systems?
4. Is mental health integrated into the HSPA framework in your country, and if not, what are the main barriers?

Mental health and links to HSPA

Participants generally felt that mental health metrics are not always included in HSPA, and mental health remains siloed from other health areas/domains. Although countries recognise the importance of mental health, very different approaches to measuring population mental health and access and quality of mental health services have been taken to date. For example, Ireland and Lithuania explicitly include mental health indicators in HSPA. Germany noted that there is an overlap between mental health assessment and HSPA. Yet, indicators that were commonly mentioned in the survey are mostly those reflecting wider determinants of health, such as unemployment, deprivation, etc. In the discussion, mental health was acknowledged as a very

39 Bentley N, Hartley S, Bucci S. Systematic review of self-report measures of general mental health and wellbeing in adolescent mental health. *Clinical Child and Family Psychology Review*. 2019 Jun;22(2):225-52.

40 Breedvelt JJ, Zamperoni V, South E, Uphoff EP, Gilbody S, Bockting CL, Churchill R, Kousoulis AA. A systematic review of mental health measurement scales for evaluating the effects of mental health prevention interventions. *European Journal of Public Health*. 2020 Jun 1.

broad topic. Hence, mental health promotion and prevention is only one angle to address mental health and overall mental health needs to be discussed within HSPA processes. Most importantly, it was felt that tailoring health services (paying attention to contextual and behavioural considerations) to mental health needs of the population would have a big impact on overall health system performance.

In a number of countries mental health metrics are linked with health strategies or legislation. Examples include Malta which established the Mental Health Act (2012), or Lithuania which seeks to achieve certain goals by 2030.

Box 9: Potential risk of mental health exclusion from HSPA

Where mental health is absent from HSPA, the following risks can be identified:

- Lack of coherent implementation of mental health policies.
- Difficulty in sound planning of human and physical resources needed to address mental health needs.
- Challenges in monitoring, if metrics are not reported as part of the HSPA and are left to a different, less regular process or one that is not routinely integrated into policy making.

Tools and metrics

As mentioned earlier, there are multiple tools that measure mental health. Netherlands is an example of a country which uses multiple tools of measurement simultaneously, collecting the data with various frequency.⁴¹ Often when measuring different aspects of mental health, multiple metrics (in the forms of surveys) are used at the same time. Netherlands uses multiple tools in their population health surveys, for example rolling out a psychiatric epidemiological population study⁴², as a single survey/metric may exclude or overlook vulnerable and at-risk groups, and it can be difficult to capture their mental health status using standard instruments alone. In addition to the various tools implemented through different institutions, there are several institutions, among others the agency Trimbos⁴³ and the RIVM, that is responsible for having a broader overview for mental health recommendations to policy makers.

Germany conducted a scoping review⁴⁴ of mental health indicators to inform the framework for assessing mental health and mental health services in efforts to build a strong mental health surveillance program. The review provides an extensive indicator set to give guidance to establishing public mental health monitoring.

It was noted that while EU-wide standardised surveys contain some information on mental health, experts believed that mental health data could be problematic for comparisons even for the same indicator within a country (e.g., due to different definitions or measurements of diagnoses over time). Therefore, cross-country comparisons need to be treated with even more caution. Still, it was felt that standardised surveys like the European Health Interview Survey could potentially serve as a baseline for country comparisons. In relation to that, it was also noted that there is a standardised WHO survey on mental health.⁴⁵

Areas that were suggested to be monitored are quite broad and include determinants of mental health (including chronic stress, social connectedness) and general wellbeing, as well as mental health status (including prevalence of mental disorders, suicidality, as well as mortality from suicides), and mental health service metrics. As with many other indicators, it was stressed that data on mental health needs to be collected across different cultural contexts, population groups and geographies. Data that would allow linkage between mental health status and administrative data on service use could potentially help to identify gaps in service provision. Another area of interest was mortality metrics – excess deaths and years of life lost due to mental ill-health (including premature deaths from other conditions that could not be adequately managed due to failure to meet patients' mental health needs). It remains unclear; however, how mental health can be considered when looking at total mortality, excess deaths and years of life lost (YLL).

41 Monitoring Mental Health. <https://www.trimbos.nl/wp-content/uploads/2022/05/AF2003-Monitoren-mentale-gezondheid.pdf>

42 The Netherlands Mental Health Survey. De Graaf RO, Ten Have M, van Dorsselaer S. The Netherlands mental health survey and incidence study-2 (NEMESIS-2): Design and methods. *International journal of methods in psychiatric research*. 2010 Sep;19(3):125-41.

43 Trimbos Institute for Mental Health. <https://www.trimbos.nl/english/>

44 Indicators for Public Mental Health. <https://pubmed.ncbi.nlm.nih.gov/34646802/>

45 World Mental Health Survey Initiative. <https://www.hcp.med.harvard.edu/wmh/>

Box 10: Challenges and barriers for links with HSPA

As one of the participants who strongly recommended inclusion of mental health and mental health care aspects in HSPA put it, “one of the key barriers may be that the area is too daunting”, hampered by stigma among professionals as well as professional silos, plus lacking clarity on what mental health metrics could be key to include in HSPA. Despite mental health identified as a priority in many countries, particularly in light of additional levels of mental distress caused by the pandemic, the area remains poorly integrated in the overall HSPA processes.

Future outlook

Mental health performance measurement also has lagged behind current trends in quality monitoring due to a lack of sufficient or available evidence.⁴⁶ It was reflected that more frequently used mental health indicators largely focus on prevalent conditions, and there was lack of indicators or data linkage to capture whether health services are performing well for people with emerging or complex mental health needs. In light of this, it was suggested that indicators that would account for co-morbidity are needed to have a more realistic view of health system performance.

Some countries raised an issue of cost and capacity that is needed to carry out proper mental health surveys in order to have reliable information that could inform HSPA. The discussed also touched upon the issue that mental health tends to be viewed as a single area, yet it needs further disaggregation, looking at measures of well-being and determinants, health promotion, disease prevention, service access and quality, as well as mental health status for various population groups. It was noted that it was particularly challenging to collect information for children and.

ADDITIONAL BEST PRACTICES

Social Prescribing

In recent years, a shift towards integrated, equitable and person-centred care models have resulted in initiatives such as social prescribing.⁴⁷ The definition from The Kings Fund⁴⁸ (2020) describes social prescribing as a practice of “community referral” which enables health professionals to seek out treatment options (of both medical and non-medical causes of ill health) outside the traditional health sector and within a range of local, non-clinical services of care. EuroHealthNet Country Exchange Visit on Social Prescribing⁴⁹ included countries such as Austria, Finland, Portugal, Slovenia, Hungary, Italy, Slovakia, Slovenia, Wales and the Netherlands explored in this study have been using non-medical interventions that are to address wider determinants of health and to help health system users improve health behaviours and better manage their conditions. For example, in Italy, as part of the Regional Prevention Plan 2020–2025⁵⁰, local health authorities adopted a prevention plan to target vital problematic areas of health as part of managing chronic conditions. As part of the Health Gyms Project in Veneto, Italy, social prescribing was found to address non-medical but health-related needs whereby a family doctor refers patients experiencing social problems to appropriate community resources through a link worker (for example, a social worker or nurse) for a social prescription plan to address physical, social, emotional, lifestyle or practical needs. These community general health promotion activities include (but are not limited to) psycho-social support groups, physical activity, arts/culture, and nature-based solutions.⁷⁶ Another example of a cross country EU initiative is the European Physical Activity on Prescription model, where 10 Member States are taking part in a three year project which utilizes the Swedish best practice model for physical activity on prescription (FaR), have overall objectives to promote good health and to prevent of non-communicable disease through implementing country-based physical activity on prescription (PAP) programs in health services.⁵¹

46 Kilbourne AM, Keyser D, Pincus HA. Challenges and opportunities in measuring the quality of mental health care. *The Canadian journal of psychiatry*. 2010 Sep;55(9):549-57.

47 Scarpetti, G, Shadowen H, Williams G et al (in review) A comparison of social prescribing approaches in twelve countries.

48 The King's Fund Strategy. 2020-2024. Towards better, fairer health and care. Retrieved from <https://www.kingsfund.org.uk/sites/default/files/2020-01/kings-fund-strategy-2020-24.pdf>

49 EuroHealthNet Country Exchange Visit on Social Prescribing. 2022. Retrieved from https://eurohealthnet.eu/wp-content/uploads/220630_cev_finalreportcountryexchangevisitsocialprescribing.pdf

50

51 Consumers, Health Agriculture and Food Programme Database. 3rd EU Health Programme. A European Physical Activity on Prescription model. https://webgate.ec.europa.eu/chafea_pdb/health/projects/847174/summary

Early evidence from the 12-country comparative report on the implementation of social prescribing suggests social determinants programmes are often considered alongside other macro level agendas and meso level capacity, whereas social prescribing planning occurs at the micro level with patients, which considers the individual need and availability of resources. Easier integration into pre-existing health systems can be a potential benefit of this individualized process approach.

A clear conclusion from the 12-country comparative report is there is growing support and global recognition of the role of social prescribing in addressing wider social determinants within health promotion, disease prevention and person-centred care. Social prescribing can be a useful tool for policymakers when considering a cross-sectoral measurement approach to health promotion and disease prevention within the context of health systems performance assessment. Best practices for social prescribing are described in Box 15.

Box 11: Global Social Prescribing Alliance: International Playbook⁵²

This resource showcases best practices for Social Prescribing and highlights shared learning that can support health systems worldwide to navigate and deliver Good Health and Wellbeing. The focus is to create a health system emphasising prevention, early intervention and using different types of resources. This approach will enable people and communities to thrive and improve their health and wellbeing, support existing health services, and create new and meaningful jobs, all while supporting the UN's 17 sustainable development goals.

International examples of best practices within health promotion and disease prevention

In July 2018, the European Commission established a new European Commission Expert group, the Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases.. This Expert group has since been replaced by a new Commission Expert group on Public Health in December 2022.⁵³

The Expert group on public health is supported through a comprehensive process of collecting and implementing best practices in the area of health promotion and disease prevention, based on national and EU priorities.⁵⁴ As a support tool on best practices, the European Commission also set up an EU Public Health Best Practice Portal to facilitate the exchange of best practices and facilitate their implementation in other EU countries.⁵⁵ Furthermore, a series of Council Conclusions⁵⁶ relating to health promotion and disease prevention, have highlighted the importance of health promotion and disease prevention in improving population health and wellbeing as evidenced in the EU4Health programme⁵⁷ where a minimum of 20% of the total budget of the programme is reserved for disease prevention and health promotion actions.

The Steering Group on Promotion and Prevention has proven useful in targeting the budget on impactful actions. In 2019, the European Commission's Expert Panel on Effective Ways of Investing in Health⁵⁸ marked health promotion as an essential component of modern health systems, recommending implementing a range of policy measures and financial mechanisms that would support and transform health promotion and disease prevention practices across the European Union, moving to concrete actions within and beyond health systems.

52 Global Social Prescribing Alliance International Playbook: <https://www.gspalliance.com/playbook>

53 Commission Expert group on Public Health (europa.eu)

54 European public health best practice portal - process and criteria for best practice assessment - PubMed (nih.gov)

55 EU Public Health Best Practice Portal. <https://webgate.ec.europa.eu/dyna/bp-portal/>

56 A series of Council Conclusions of relevance to (the interface of health systems and) health promotion: 2006 Council Conclusions on values and principles of health systems; 2010 Council conclusions on Equity and Health in All Policies; 2011 Council conclusions on 'promoting healthy lifestyle behaviors'; the 2011 Council conclusions on modern, responsive and sustainable health systems (recognizes that health promotion and disease prevention are key factors for the long-term sustainability of health systems); 2013 Council conclusions on the «Reflection process on modern, responsive and sustainable health systems» stating that 'health promotion and disease prevention are key factors for the long-term sustainability of health systems as well as for increasing healthy life years.'

57 EU4 Health programme: https://ec.europa.eu/health/system/files/2020-04/2019_healthpromotion_factsheet_en_0.pdf

58 European Commission. *Expert Panel on Effective Ways of Investing in Health*: https://ec.europa.eu/health/system/files/2020-04/2019_healthpromotion_factsheet_en_0.pdf

Assessing and recommending best practices were not within the scope of the report. For readers interested in developing best practice standards, further resources available through the Organization for Economic Co-operation and Development Best Practices in Public Health⁵⁹ and the Directorate-General for Health and Food Safety Best Practice Portal.⁶⁰ These portals help countries overcome challenges and strengthen public health systems by identifying and transferring best practices to prevent and control non-communicable diseases. This public health Best Practice Portal has been created and designed to help countries find reliable and practical information on best practices in health promotion, disease prevention, and the management of non-communicable diseases. It also showcases evidence-based information on healthier lifestyles, integrated care, healthy environments, and digital approaches.

59 OECD. Best practices in public health. <https://www.oecd.org/health/best-practice-in-public-health.htm>

60 Public Health: Best Practice Portal. European Commission. <https://webgate.ec.europa.eu/dyna/bp-portal/>

Chapter 4: Discussion and conclusions

CHALLENGES OF MEASURING AND INTERPRETING METRICS OF HEALTH PROMOTION AND DISEASE PREVENTION

Based on HSPA Expert group discussion, there was a recognised need to include health promotion and disease prevention indicators in HSPA, but what the Expert group discussions and case studies have showcased is that it is less clear which indicators should be used. Indicators that are more straightforward to interpret, are widely available and comparable are often derived from EU-wide initiatives.⁶¹ Few countries make direct links to HSPA or use indicators to inform health policy-making that incorporate information on wider determinants of health to interpret health systems performance. In countries that do (such as Chapter 3 showcase of Austria's Health Promotion Strategy), these indicators can provide important information on the effects of broader policies on population health and well-being.

One initiative developed to aid in comparable data collection, under the Second Programme of Community Action in the Field of Health 2008-2013, the EU funded Joint Action (JA) on European Community Health Indicators Monitoring (ECHIM), has defined core health indicators and consolidated data collection tool which aims to move toward a sustainable health monitoring system in Europe supporting the EU Health Strategy. In June 2012, a shortlist of 88 health indicators was completed and a tool created which has assisted in processes such as structuring of National Health Information systems, stabilization of new indicators and foster cross-country benchmarking.⁶² While indicators were not categorized specifically as health promotion and disease prevention, indicators were categorized into chapters (see Box 11) as well as by policy area. As one example, prevention is captured in the policy area of health determinants as preventable health risks and lifestyle health behavior (which included population below poverty line and income inequality, drug, smoking or alcohol related deaths) or within the chapter health interventions: health promotion which captures data on policies on environmental tobacco smoke (ETS) exposure, policies on healthy nutrition, policies and practices on healthy lifestyle and integrated programmes in setting, including workplace, schools, hospital. Despite the existence of many indicators related to health promotion and disease prevention, their use in the context of HSPA remains limited and insufficient or incomplete data, as well as gaps in comparability, remain a concern across the EU.⁶³

There are also limitations in the extent to which indicators capture health inequities. The 2019 European Union Companion Report⁶⁴ highlights that standard health promotion and disease prevention data routinely used across the EU tend not to capture the multi-dimensional features of health promotion and disease prevention. Even where good data availability exists, for example regarding vaccination coverage, inequities (beyond geographic ones) are rarely captured.

61 State of Health in the EU. The Companion Report 2019. https://health.ec.europa.eu/system/files/2019-11/2019_companion_en_0.pdf

62 Public Health Evaluation and Impact Assessment Consortium. 2013. Evaluation of the use and impact of the European Community Health Indicators ECHI by Member States. https://health.ec.europa.eu/system/files/2016-11/echi_report_executive_summary_v20131031_0.pdf

63 Towards a Joint Assessment Framework in the Area of Health. 2016 Update.

64 European Union Companion Report (2019): https://health.ec.europa.eu/system/files/2019-11/2019_companion_en_0.pdf

Box 12: European Core Health Indicators (ECHI) data tool⁶⁵

The ECHI is an interactive application using a graphics tool to present relevant and comparable information on health at EU level. The tool presents a list of indicators, grouped in five chapters:

- demographic and socio-economic factors (9)*,
- health status (32),
- determinants of health (14),
- health interventions: health services (29),
- health interventions: health promotion (4)

Following on from a shortlist of 88 indicators, definitions and data collection mechanisms are now in place for more than 60 indicators and these are available on the ECHI platform. The aim of the ECHI indicators is to provide the shortest meaningful list of indicators that gives a reliable overview of health and health systems across Europe. In addition, other health indicators are also presented in the graphics tool to provide additional information on various health topics. Where considered useful or appropriate, stratification by gender and age is applied. In the tool, breakdowns by socio-economic or regional level are provided when available.

Most of the data is provided by Eurostat, but many indicators are drawn from other sources, such as WHO, OECD, specific programmes and specialised databases.

*denotes number of indicators within each chapter

Note: The ECHI data tool will have a new interface and updated information at the end of 2023.

While we pre-identified key areas and held semi-structured group discussions discussed in Chapter 3, further indicators which measure health promotion and disease prevention which go beyond HSPA we also discussed. International expert (EuroHealthNet, OECD) reports on social prescribing and international examples of best practices within health promotion and disease prevention monitoring are presented in Chapter 3 as well.

CONCLUSIONS

This report aimed to map existing indicators of health promotion and disease prevention in the context of HSPA. In addition, it identified some potential areas for which additional indicators could be considered.

While health promotion and disease prevention are recognized as important areas of HSPA, there is no consensus on which metrics should be used to measure them. There are many indicators that measure health promotion and disease prevention, and Member States can consider which of those work best for them in the context of HSPA.

The potential benefits of including appropriate indicators in HSPA are not yet fully realised. On a macro level, there is also a need to strengthen the health information systems that allow for these health promotion and disease prevention indicators to be collected consistently, systematically and accurately across Member States.

65 European Core Health Indicators Tool: https://health.ec.europa.eu/indicators-and-data/european-core-health-indicators-echi/echi-european-core-health-indicators_en

Expert Group on Health Systems Performance Assessment (HSPA) Guidance document to assist in filling in the Health promotion and disease prevention survey

Introduction

As part of the HSPA work on priority topic “health promotion and disease prevention”, the purpose of this survey is to create a comprehensive mapping of indicators on health promotion and disease prevention used by Member States to monitor and measure their health system performance.

Health promotion is the process of enabling people to increase control over their health and its determinants, and to improve their health. Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to halt its progress and reduce its consequences once established. Both may relate only to activities within health systems or extend beyond the health sector including actions by other sectors, such as the social sector, education or urban planning. Both are considered key tasks of health systems, as defined by the World Health Organisation⁶⁶.

In the survey, we suggest categorising the indicators into primary, secondary, tertiary prevention and other. These are defined as: (1) primary prevention and health promotion, including health promotion via a whole-of-society approach (e.g. urban planning or health literacy) and minimization of exposure to risk factors; (2) secondary prevention aims to detect diseases or conditions at an early stage in order to improve outlook; and (3) tertiary prevention slows the progress of diseases and enables patients to live with as much functionality and quality of life as possible, which is accompanied by treatment. “Other” might include share of financing dedicated to health promotion / disease prevention, workforce engaged in health promotion / disease prevention activities, etc.

The questionnaire is composed of an Excel file with two spreadsheets (“Part one” and “Part two”) You are requested to fill out both spreadsheets by Friday, 3 December 2021 and send back to SANTE-HSPA@ec.europa.eu, cc'ing Joao-Vasco.NUNES-DOS-SANTOS@ec.europa.eu and Filip-Michal.DOMANSKI@ec.europa.eu. Please see below some guidance to help you with filling in the excel spreadsheets with a short explanation of what is expected for each cell.

Survey instructions

Part 1 comprises your contact information and providing the list of indicators on health promotion and disease prevention collected in your country. Please fill in the survey in English.

Firstly, you are asked to fill your “Country”, “Name of respondent”, “Organisation”, “Function” (function/role within your organisation) and “E-mail”.

In the same sheet, we request you to mention all the indicators on health promotion and disease prevention collected in your country (within or outside your HSPA framework, if you have one). We ask you to be as exhaustive as possible.

You are asked to fill the following columns:

- Indicator category: **here you should first indicate which category the indicator falls into and add the heading “primary prevention and health promotion”, “secondary prevention”, “tertiary prevention” or “other”. For example, use secondary prevention for cervical cancer screening indicator.**

66 <https://www.euro.who.int/en/health-topics/Health-systems/pages/health-systems>

- “Indicator (and unit) on health promotion and/or disease prevention”: **here you should provide the detailed description of the indicator, alongside the unit used to measure. Please put one indicator per row. Please note that the indicator should explain what is measured. – e.g., “Proportion of women aged 20–69 years with a cervical cancer screening in the last 3 years (%)”;**
- “National level”: **here you should state if the indicator is calculated at a national level. You have the following response options “Yes”, “No”, “DNK” (Do not know);**
- “Regional level”: **here you should state if the indicator is calculated at a regional level. You have the following response options “Yes”, “No”, “DNK” (Do not know);**
- “Local level”: **here you should state if the indicator is calculated at a local level. Local level may be interpreted differently by each MS. You have the following response options “Yes”, “No”, “DNK” (Do not know);**
- “Breakdown of indicator by variables”: **Here you should state if the indicator is broken down by additional variables (for example by age, sex or socioeconomic status) State the variables in the row for example ‘age’ or ‘income level’. “None” if it is not broken down; or write DNK if you do not know.**
- “Data source - organisation”: **here you should include the organisation that collects and publishes the indicator (e.g., statistical office, public health institute)**
- “Data source – survey”: **here you should include the survey (or administrative data) used for collecting the information used for this indicator (e.g., “European Health Interview Survey - EHIS”)**
- “Publicly available”: **here you should indicate if the results of the indicator are publicly available. You have the following response options “Yes”, “No”, “DNK” (Do not know);**
- “Weblink to health information product – link”: **here you should include the website link where the indicators are presented, if publicly available (e.g., <https://his.wiv-isp.be/SitePages/Home.aspx>)**
- “How often is it reported”: **here you should provide the frequency at which the indicator is reported. You have the following response options “Daily”, “Weekly”, “Monthly”, “Quarterly”, “Annually”, “Every 2 years”, “Every 3 years”, “Every 4 years”, “Every 5 years”, “Other”;**
- “Last year with available data”: **here you should indicate the last year for which the indicator was collected. You can write directly the year. E.g., “2019” or leave it in blank if you do not know.**
- “Included in HSPA framework”: **here you should indicate if this indicator is included in your country’s HSPA framework if you have one. You have the following response options “Yes”, “No”, “DNK” (Do not know).**
- “Linked to national target”: **here you should state if the indicator is linked to a national target. You have the following response options “Yes”, “No”, “DNK” (Do not know);**
- “National target” – here, **if you replied “Yes” to the previous question, you should describe what the target is. e.g., “50% reduction by 2030”**

Finally, we would ask you to respond to two open question in the second spreadsheet (“Part two” of the Excel file, if relevant (please do not exceed 500 words). The questions aim to gather information about how you chose the prevention indicators and any challenges and lessons learnt that you would like to share on the use and choice of these indicators. Do you plan any changes? Has COVID-19 changed the health promotion and disease prevention planning or collection?

If you encounter any problems completing the survey, please contact SANTE-HSPA@ec.europa.eu, cc’ing Joao-Vasco.NUNES-DOS-SANTOS@ec.europa.eu and Filip-Michal.DOMANSKI@ec.europa.eu.

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