The modern world has, at its heart, a strange paradox. In surveys, individuals invariably place good health at the top of their list of priorities; however, as societies we expend remarkably little effort in assessing whether we are achieving this goal or not. Instead, as is apparent from even a superficial glance at the financial pages of any leading newspaper, we devote enormous efforts to tracking economic progress (or at least some elements of it). When it comes to measuring the progress of nations, wealth wins out over health nearly every time.1 This deficit is especially important in Europe. The European idea is much more than an economic concept.2 Unlike other regional trading blocs such as the North American Free Trade Association, the development of a social Europe is just as important. Furthermore, the diversity that exists within Europe, a diversity that will increase dramatically as fifteen become twenty-five, provides a uniquely rich setting in which to understand the determinants of health and disease and to learn what policies enhance health, and in what circumstances. Examples abound.3 The observation that deaths from heart disease are so much higher in northern than in southern Europe led to identification of the benefits of what is now described as the “Mediterranean diet”. Those working in the fields of HIV/AIDS, tobacco control, and injury prevention have developed effective networks to exchange experience and promote mutual learning. The benefits of such mutual learning are recognised in the endorsement of the Open Method of Co-ordination, a structure that encourages Member States to share experiences and learn from best practice in Europe in policy areas where legal harmonisation is either precluded or undesirable.4 This approach is currently used in the areas of social exclusion, pensions and health care. So can we chart the social progress of Europe in the same way that we follow its economic progress? At the most superficial level, clearly we can. Life expectancy at birth, for both sexes combined, improved from 74.2 years in 1980 to 78.3 years in 1999.5 The countries of Europe have long had effective systems of vital registrations allowing them to monitor births and deaths, and so to track changes in population (although we should not overlook the fact that the imperative for monitoring these data is as much about providing economic information as about monitoring health). There is also high quality information about causes of death, although there are large gaps in our understanding of how those deaths are distributed within populations, and in particular how a person’s risk of dying prematurely is influenced by their position in society, their education or employment, or their ethnicity. When one goes beyond basic measures, coverage is rather more patchy. In particular, there is still very little information on morbidity or on health status. Yet health is much more than a function of births and deaths, increasingly so as ageing populations confront a rising tide of chronic diseases that lead to long-term disability but not death. At present, the health needs of millions of European citizens are effectively invisible. It was to remedy this situation that the Community Action Programme on Health Monitoring was established in 1997. It has three strands: improving health information; development of a community-wide network for sharing health data; and strengthening analyses and reporting. In its short existence it has achieved a great deal and this supplement seeks to bring a small selection of its many outputs to a wider audience. The papers brought together here range from methodological development to cataloguing of existing data sources. Some look at particular health challenges, others at particular populations, and yet others at the many settings in which it is possible to capture information on health. They encompass information on health determinants, on health status, and on health care utilisation. One of the major obstacles to better understanding of patterns and determinants of health status has been the absence of standardised survey instruments. The EUROREVES project team describe how, even for a widely used concept such as self-perceived health, existing surveys vary widely in whether the respondent is asked about health in general, or in comparison to others of the same age, whether there is a reference to the time over which health is assessed, or the number of response categories.6 This project has proposed a set of instruments covering functional limitations, activity restriction, global activity

INTRODUCTION

Monitoring health in Europe: opportunities, challenges, and progress

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The deficit is especially important in Europe. The European idea is much more than an economic concept. Unlike other regional trading blocs such as the North American Free Trade Association, the development of a social Europe is just as important. Furthermore, the diversity that exists within Europe, a diversity that will increase dramatically as fifteen become twenty-five, provides a uniquely rich setting in which to understand the determinants of health and disease and to learn what policies enhance health, and in what circumstances. Examples abound. The observation that deaths from heart disease are so much higher in northern than in southern Europe led to identification of the benefits of what is now described as the “Mediterranean diet”. Those working in the fields of HIV/AIDS, tobacco control, and injury prevention have developed effective networks to exchange experience and promote mutual learning. The benefits of such mutual learning are recognised in the endorsement of the Open Method of Co-ordination, a structure that encourages Member States to share experiences and learn from best practice in Europe in policy areas where legal harmonisation is either precluded or undesirable. This approach is currently used in the areas of social exclusion, pensions and health care. So can we chart the social progress of Europe in the same way that we follow its economic progress? At the most superficial level, clearly we can. Life expectancy at birth, for both sexes combined, improved from 74.2 years in 1980 to 78.3 years in 1999. The countries of Europe have long had effective systems of vital registrations allowing them to monitor births and deaths, and so to track changes in population (although we should not overlook the fact that the imperative for monitoring these data is as much about providing economic information as about monitoring health). There is also high quality information about causes of death, although there are large gaps in our understanding of how those deaths are distributed within populations, and in particular how a person’s risk of dying prematurely is influenced by their position in society, their education or employment, or their ethnicity. When one goes beyond basic measures, coverage is rather more patchy. In particular, there is still very little information on morbidity or on health status. Yet health is much more than a function of births and deaths, increasingly so as ageing populations confront a rising tide of chronic diseases that lead to long-term disability but not death. At present, the health needs of millions of European citizens are effectively invisible. It was to remedy this situation that the Community Action Programme on Health Monitoring was established in 1997. It has three strands: improving health information; development of a community-wide network for sharing health data; and strengthening analyses and reporting. In its short existence it has achieved a great deal and this supplement seeks to bring a small selection of its many outputs to a wider audience. The papers brought together here range from methodological development to cataloguing of existing data sources. Some look at particular health challenges, others at particular populations, and yet others at the many settings in which it is possible to capture information on health. They encompass information on health determinants, on health status, and on health care utilisation. One of the major obstacles to better understanding of patterns and determinants of health status has been the absence of standardised survey instruments. The EUROREVES project team describe how, even for a widely used concept such as self-perceived health, existing surveys vary widely in whether the respondent is asked about health in general, or in comparison to others of the same age, whether there is a reference to the time over which health is assessed, or the number of response categories. This project has proposed a set of instruments covering functional limitations, activity restriction, global activity
limitations, perceived health, and mental health. This is a major contribution that should ultimately provide the basis for meaningful comparisons of the health of Europeans. Another paper, by van Buuren et al., looks at the problem of comparing data from surveys that, while each looking at the same issue, use slightly different versions of the same question. They show how, if there is some overlap between the surveys, it is possible to achieve some degree of comparability, applying a new method, response conversion, to a widely used question of functional ability. While some projects, such as EURO-REVES, are well advanced, others are still at an early stage. Bruusgard describes the search for consensus in relation to methods of monitoring musculoskeletal complaints. Although these are very common health problems, there is surprisingly little comparable data at a European level. This paper sets out the first steps to remedying this situation. Methodological development is not, however, limited to health status. There is an urgent need to obtain much better information on exposure to risk factors. As noted above, one of the most obvious ways in which the people of Europe differ is in what they eat. Yet while it is easy to describe a "typical" Italian, Spanish or Swedish diet, it is much more difficult to assess what people actually do eat, and in particular how this varies with one's position in society. Dietary assessment is extremely difficult and not well suited to routine monitoring. The DAFNE group have been working on an alternative, the use of household budgetary surveys, to see how they might be used to assess what people eat. Once again, they highlight how the data currently used have not kept pace with the needs of a changing society, in this case failing, in most countries, to take account of the increasingly important role of food eaten outside the household. They also illustrate the need to go beyond national averages to look at the distribution of variables within a population, thereby showing how, in the United Kingdom, consumption of fresh vegetables has, reassuringly, increased in non-manual households but, alarmingly, has fallen in those households where the head is in manual employment. Remaining with the theme of variation within countries, yet another aspect of methodology is explored in a contribution by Ochoa et al. They examine what is meant by a region, in the context of health monitoring. As they show, this is far from clear, since statistical divisions are driven by administrative factors, which in turn reflect each country's political choice about how to balance national and local decision making.

A second set of papers look at existing information and future needs in relation to particular groups in society. The PERISTAT group, for example, have critically assessed reporting of perinatal statistics. As in other papers in this collection, they reveal how widely-used statistics on which the performance of countries are compared, are not strictly comparable. For example, although there is a very clear and simple WHO definition of the perinatal period, in reality several European countries use different ones, in particular incorporating different definitions of a stillbirth. This group has gone on to identify a set of indicators, providing a good example of why it is important to take account of the views of practitioners and not only academics and policy makers. A paper from the CHILD group reports a similar exercise, this time looking at the information needs in relation to children. It places the child at the centre of a diverse range of influences on health and development and seeks to identify ways of monitoring progress in each of these areas. Although, as the team note, there is a large gap between the present-day reality and the ultimate goal of having comprehensive and appropriate information, this is an important step on the way. A third paper looks at a group of people who are often invisible to the policy community, those with intellectual disabilities. This study is at an earlier stage than the others but again it is placing an important item on the agenda. Other papers describe efforts to take full advantage of information that already exists. Several seek to establish inventories of the various registers and sources of routine data that can be used to monitor the changing burden of disease due to some of the leading causes of ill health. In this collection such efforts are reported for diabetes, cardiovascular and cerebrovascular disease, and cancer. The example of cardiovascular disease is instructive. Even though it is one of the leading causes of premature death in Europe, and is the subject of programmes of research that have consumed many millions of euros, there is not even a common definition of what it is. In some countries registers are based on the diagnostic criteria established in the MONICA study while others use the more recent test for troponin levels, even though, as a recent study in Scotland showed, the use of criteria based on troponin levels yields almost two-thirds more cases and the additional ones are older, more likely to be female, and less likely to survive. Consequently, as in so many other areas, superficial comparisons are unlikely to be comparing like with like. A fourth paper in this group looks not at specific illnesses but at the increasing number of health interview and examination surveys across Europe, creating a database that provides easy access to others seeking information on survey methods and instruments. Once again, this study demonstrates the inconsistency of many of the sources of routine data that are so often used in superficial comparisons, in this case showing the great diversity in both questions used and survey methods. A further group of papers explores the opportunities for gathering data in different settings, either within the health care system, in primary care, hospitals, through emergency services, or at work. The challenges differ in these various settings. Thus, in hospitals, it is easy to be drowned in the vast amount of data that are often collected. The challenge is to turn those data into information that can actually be used and interpreted for the purpose of monitoring health and disease. In primary care, in many countries the amount of data collected is
much more limited, but as Fleming et al. show, the development of well-designed sentinel networks can provide invaluable information on the pattern of ill-health presenting to what is, for most people, the first point of contact with the health care system. A third paper in this group, on the scope for collecting information from emergency services, is still at an early stage but it does show, quite graphically, the challenges faced in achieving European harmonisation as it describes the failure so far to implement a common, Europe-wide telephone number for emergency services. A fourth paper in this group, from the WORKHEALTH team, looks at the scope for gathering information on work-related health.

Many of these papers demonstrate that there is a considerable degree of inconsistency in the way that data are collected. One of the best examples is contained in a paper that describes expenditure and utilisation of pharmaceuticals in Europe. At first sight this might be surprising: this is the area most closely linked to the financial statistics that, as was noted earlier, governments and industry expend so many resources to monitor. Yet, as the authors note, differences in packaging, formulation and marketing mean that the products involved are rarely comparable. Of even more concern, the data from many countries cover only some parts of the population, typically those covered by statutory insurance. Furthermore, as is often the case, the United Kingdom is considered synonymous with England, ignoring the people of Scotland, Wales and Northern Ireland.

Finally, two papers take a broader perspective, seeking to identify Europe-wide indicators of health or health promotion activities. The former has already made considerable progress; the latter is still at an early stage but has already generated a conceptual framework of indicators, based on the elements of the Ottawa Charter, that go well beyond information currently collected.

In this supplement it has only been possible to bring together a small amount of what has been achieved by the Health Monitoring Programme. Furthermore, although much has already been achieved, in many cases the full benefits will not be until validated, comparable survey instruments have been incorporated into national systems of data collection and the resulting information is publicly available. Our ability to monitor and explain the health of all Europeans remains imperfect but the work undertaken within this programme has done much to facilitate this process. We hope that, by bringing this information together into a single volume, we will help to accelerate the process of mutual learning and uptake of innovations in health monitoring.

In closing, we would like to thank all those individuals and teams who have contributed so much to the work of this programme, and specifically, to their rapid responses that have enabled us to bring this supplement to fruition. Above all, we would like to thank the individual who did more than anyone else to make this programme a reality, Dr Henriette Chamouillet, who not only ensured he smooth running of the overall programme but also contributed so much the intellectual development of many of the projects.

REFERENCES