Monitoring the health of the population has always been an important role for public health, at national, regional and local levels although, inevitably, the ways by which this task has been carried out have varied considerably. In several European countries, there has been increasing interest in the regular production of such reports in recent years.

When the latest national public health report for Sweden was being produced, I was asked to review how public health reports were being produced in different countries, especially in Europe. I decided to use the European Public Health Association (EUPHA) network plus other personal contacts to collect public health reports from as many countries as possible and to inquire about what types of report were being produced, how often and by whom.

Not surprisingly, the methods of public health reporting varied considerably. Nevertheless, when confronted by a pile of books from ten European countries, we were struck by the fact that so many of them had more or less the same types of figures and diagrams on mortality, cancer incidence, use of alcohol and tobacco and use of health services. On the one hand, this may seem reasonable, since the health conditions in the industrialised countries are, to a large extent, converging. On the other hand, public health must be based on local culture and needs, and one would think that countries such as Sweden, The Netherlands and Spain might want to look at different aspects of the population's health.

Our definition of a public health report was a report in which the health situation of the country's population is described and analysed in a systematic way, for strategic or policy purposes. We identified ten European countries that had produced such a report during the 1990s. All were in western Europe. Despite attempts we could not identify any public health report, according to our definition, from the former socialist countries. Although this survey may not have been exhaustive, some interesting conclusions could be drawn regarding the status of public health reporting in Europe. I will summarise some of our conclusions and propose suggestions for consideration concerning future public health reporting.

WHO COMMISSIONS AND WHO READS THE REPORT?

All reports were commissioned by the ministry of health or a similar ministry. They were produced by a governmental office or an independent research institute. One would imagine that the target group, the readers, would be decision makers in the governmental offices or persons in other central or regional policy making bodies. However, the way most reports are written makes this difficult. They are generally written by persons with a medical or epidemiological background and in a rather technical style. Like scientific reports, few general conclusions are drawn and policy implications arising from the data are rarely identified.

HOW ARE THE REPORTS STRUCTURED?

Most reports have a classical epidemiological structure, with sections classified either according to types of data: on mortality, morbidity, risk factors, use of health services, etc, or according to types of health problems: cardiovascular disorders, musculoskeletal disorders, substance abuse problems, etc. The Dutch report has an interesting system oriented approach, in which determinants of health are related to policy areas. The British report has the longest tradition and is more policy oriented than the others. Possible measures are suggested to address the various problems identified. Indicators are described in relation to targets set and comparisons are made over time in a systematic way. Some other countries have attempted to address specific problem areas, such as inequalities in health. To a large extent, however, we are provided with epidemiological reports in a textbook-like structure.

WHICH DETERMINANTS OF HEALTH ARE IDENTIFIED?

Most reports note that the main determinants of the population's health lie outside the health care system. A range of social and economic indicators and their changes over time are given, but coverage is largely descriptive. The relationship between socio-economic conditions and health is indeed a complex issue and some reports attempt to discuss this, but others simply provide descriptive data. All reports describe classical risk factors such as alcohol, tobacco, diet and other lifestyle indicators, but with little attempt to link these to socio-economic conditions. Occupational hazards, including those related to the psychosocial and work environment, are discussed in some reports but the role of unemployment is discussed only rarely, and even data on unemployment is rarely given.
TO WHAT EXTENT ARE TARGETS AND THEIR ACHIEVEMENT REPORTED?

Several reports cite national targets, but in some countries these have been set only recently, and it is too early to make any assessment of their achievement. As mentioned above, the British report regularly monitors previously identified strategic goals, and each year’s report focuses on developments in specific areas. In the French report from 1994, a number of targets for the year 2000 are described, as well as their present status. These targets are based on the WHO Health-for-all targets, to which reference is also made in some other reports. Priority setting in public health is still in its infancy, as was recently discussed in this journal. Thus, public health reports in general are vague about targets, but in some countries promising initiatives are underway, and future reports may be more explicit about national targets and their achievement fulfilment.

MEETING THE NEED?

Although impressive efforts are made in many European countries to produce a public health report on a regular basis, the philosophy behind them is not always clear. National public health reports are typically commissioned by the government for guidance in policy and decision making, as well as monitoring measures taken. With few exceptions, the public health reports do not have the appropriate format to respond to these needs. They all contain valuable information on health indicators, well presented and with correct standardisation of variables and cautious handling of ‘soft’ data. But where is the link to public policy and decision making?

A possible way forward is to examine what is now typically found in public health reports and think about whether they should be trying to meet different needs and whether there are better ways of meeting these needs, perhaps using new information technology. Several ideas come to mind.

- Basic epidemiological data, including indicators of social and economic conditions, could be made available on the internet, such as is done with the WHO Health-for-all database. Data could be made available on national, regional and local level and be updated regularly. Tables, figures and graphs can be easily retrieved for use in reviews and summary reports, teaching, public health planning and many other purposes.
- Policy oriented reports should reflect the priorities and targets set out in government policy. This task could well be carried out by a research institute or an independent body. But whatever type of data are generated, they should provide feedback and guidance to policy and decision makers, and help focus on appropriate public health policy.
- In-depth reports or reviews can be produced according to specific needs or as background material for the public debate. Topics like BSE, drug policy, and migrants’ health are discussed in some public health reports, but the complexity of the issues makes it appropriate to highlight them in forms other than in a standard public health report.

Although our survey concerned national public health reports, I have made similar observations for a number of regional and local public health reports. Given the number of such reports produced in Europe and elsewhere, a general debate on public health reporting: its aims, orientation, structure and content, now seems appropriate.

REFERENCES