

USING STANDARDIZED HEALTH CONSUMER INDICATORS AS A POLICY DEVELOPMENT TOOL

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Abstract

This study describes the relations between the European Union standardized health indicators and the community-based health policy. One of the goals of the European Commission is to provide standardized information on health in order to make it comparable at a trans-national level. Hence, numerous projects aimed at developing health indicators, and improving databases relating to these were supported by the Program of Community Action in the Field of Public Health. In this paper the authors argue that standardized health indicators can provide more than a prototype for a future health monitoring system. Bearing in mind that the production of comparable information on health is based upon four different tasks (the analysis of data needs in a specific area, definition of indicators and quality assurance, reporting and analysis, and promotion of the results) the authors assert that all of these tasks are important steps towards the development of community-based health policy. Thus, the main objective of this study is to analyze their utility as premises for policy development.

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Throughout this paper the concept of 'Health Indicators' is used as it was conceptualized by the World Health Organization: "Health indicators summarize data that have been collected in order to answer questions relevant to the planning and management of health programs. Health indicators can be used to assess the health status of a group, a population, or the differences between groups, at a certain moment. Health indicators can also be used to monitor changes over time, the effect of a program, i.e. implementation and outcome, etc. Care providers may use health indicators to provide the necessary care and to control the quality of the care provided".

Public health officers may use health indicators to monitor the health status of groups or to assess the outcome of care provision for specific groups. Researchers may want to evaluate programs, search for a knowledge base, or highlight issues that need more attention from policy makers and/or care providers"¹.

Given the necessity for a standardized measure of these health indicators throughout the European Union, The European Parliament and the Council of Europe adopted the European Commission Health Monitoring Program (1997-2002)² on 30 June 1997. The European Union Health Monitoring Program endeavored to create a health monitoring system focused on proving comparable information regarding the measurement, and the methodology of monitoring and comparing the health status of various groups.

Different sets of health indicators have been formulated at the level of the European Union; some examples include:

1. European Community Health Indicators (ECHI);
2. Sub-national indicators - ISARE (Indicateurs de Santé dans les Régions de l'Europe);
3. Urban and rural indicators - Projects submitted for the first time on Work Plan 2005;
4. Structural indicators - Healthy Life Years (HLY), etc.;
5. Others - Indicators on Social Protection, Sustainable Development Indicators.

The European Community Health Indicators (ECHI) project was devised in order to create a list of European Community Health Indicators and is intended to grant a basis for the European health information and knowledge system. At the moment, it is considered that ECHI project has developed an exhaustive list of indicators and it is able to prioritize the work for harmonization of data collection by EU Member States³.

In order to understand how we can use the standardized indicators as a policy development tool is important to comprehend both the differences and the similarities

¹ Definition available at: www.who.int/reproductivehealth Oct 6, 2004.

² *Interim Report from the Commission to the Council*, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the implementation of the program of Community action on health monitoring within the framework for action in the field of Public Health (1997-2001) (Decision No 1400/97/CE of the European Parliament and of the Council).

³ Information related to this project is available on: http://ec.europa.eu/health/ph_information/indicators/indic_data_en.htm

among the European health systems. It is known that the European Public Health System is divided among various public policy programs, but it is also acknowledged that the European health systems are facing similar problems such as the aging of population or in the field of financing health systems.

One of the criteria on which the ECHI indicators are collected, stems from their policy relevance. Consequently, standardized indicators could be efficient tools in policy making, bearing a significant importance with regard to the problem assessment phase, and are the first step in the identification of the *status quo* of a community. Using a system of comparable information about health represents a practical tool for the development of region-based health policy, one must not neglect however the relationship between the health system and tradition, national culture, the characteristics of the political system, and the typologies of the state's citizens. Thus, when comparing the indicators of health and health-related behavior listed in the ECHI project the policy-makers also have to use some other types of instruments.

Over the years, assessment tools of the population's health status have been built in order to give specific indicators that could be compared at a trans-national level. One conclusive example could be the use of infant mortality rates, used as indicators of the populations' health status⁴. However, summary measures of populations' health cannot be the sole element at the base of effective policies.

In the final report called "Evaluating the uptake of the healthy life years indicators"⁵ it is depicted the situation of one of the European Community standardized Health Indicators and the information presented provides enough factual data to support our previous assumptions. The authors of the report explain why the use of the Healthy Life Years (HLY) indicator is not that widespread in the European Commission and Member States and their findings include the following as reasons for the restricted use of the HLY indicator: limited awareness regarding the concept, stage of development of the HLY indicator, use of a similar health indicators prior to the adoption of the HLY indicator (e.g. healthy life expectancy), and the fact that differences between health expectancy indicators and the HLY indicator are not well understood. To summarize, these information suggest that HLY indicator provide comparable data to a trans-national level, but they also render HLY as a measure dependent upon tradition, national culture and economic development. Therefore, the authors of the "Evaluating the uptake of the healthy life years indicators" report bring evidence for our claim that professionals should complement regional assessment with other evaluation instruments in order to fully comprehend what is really measured.

A specific attention must be given to countries from the former soviet block, part of the European Union now. Namely, we are referring to the 10 post-communist countries which have acceded to the EU, starting with the year 2004: Estonia, Latvia,

⁴ D.D. Reidpath, P. Allotey. "Infant Mortality rate as an indicator of population health", in *Journal of Epidemiology and Community Health* 2003, 57: 344-346.

⁵ "Evaluating the uptake of the healthy life years indicators", Prepared for European Commission (DG SANCO), Rand Europe, 15 December 2006. Available at:
http://ec.europa.eu/health/ph_information/indicators/docs/RAND_HLY_en.pdf

Lithuania, Poland, Hungary, the Czech Republic, Slovakia, and Slovenia, and two more which have become members in 2007: Bulgaria and Romania. Even though these countries have gone through serious improvement during the transition period, their context differs in a significant manner from the other European countries. For example, between the years 1989 and 2001, Romania has undergone a transition period, which implied repeated reforms at all levels, national, regional and local, and in all fields.

Consequently, the healthcare system has gone through a series of reforms which had an impact on all its outcomes. The effect of these reforms has been studied by the specialized literature, and the findings indicated a rather difficult situation, characterized by low financial and human resources. Moreover, it has been emphasized that the pitfalls of the reforms enhanced inequity, and moreover healthcare accessibility has decreased (Bara et. al; 2002). Consequently, standardized indicators, build to be relevant at the European level, may not be sufficient to underline the needs or the problems of these countries' communities. As a response, the European Union has developed sets of sub-national indicators - ISARE (Indicateurs de Santé dans les Régions de l'Europe)⁶, which were devised to gather information about the knowledge and use of health indicators in the regions (sub-national level) of the European Union. The only difference between ISARE and The European Community Health Indicators is that the former seeks to identify the "health regions" in order to describe the data availability at these levels and only after that step to test the feasibility of gathering data in the "health regions". The results of ISARE include: regional health database creation, identification of the institutes able to provide regional data, calculation of health indicators, examples of the use of regional health data, internet website creation, and elaboration of recommendations. However, until now, ISARE can provide data for only 14 EU countries, but the database is continuously growing.

In order to advance the profiles depicted by these indicators (national and sub-national), series of structural indicators are developed. These focus on certain aspects of the population's health like perinatal health (PERISTAT), child health, mental health, injury prevention combined with systems of health indicators for rural and urban areas. In this way, more in depth analyses can be conducted for well targeted policies, meant to improve the population's health status.

The Euro Health Consumer Index applied a standard evaluation matrix on the European Union member states, regardless of their specific structure of the health system. The broad categories may appear random, but they target critical junctures of the health systems – patient's rights and access to information, waiting time, outcomes, "generosity" of the public healthcare systems and, finally, pharmaceuticals. The Romania ranks 25, the major problem being the "informal payments" aspect. This issue has been raised in national surveys before as a plague of the health system related to ethical aspects. However, in this new context, the Euro Health Consumer

⁶ Information related to this project is available on:

http://ec.europa.eu/health/ph_information/implement/wp/indicators/docs/ev_20051020_a08_en.pdf

Index identifies this concern as one of the main barriers in the way of an efficient and equitable health system.

There is a great need for the development of new tools and instruments for assessing the state and progress of the health systems. The main problems met are the complexity of the subjects involved, the intricacy with the social, economical, political and administrative apparatus, the variety of the involved stakeholders and the moral and ethical aspects. The European Union is nowhere yet on the road towards an integrated unitary health system in the European space, due to the great variety of approaches and structural backgrounds. Although there are some ideas which are central to all health systems (cost-containment, equity, equality and access), the differences in financing and priorities are still overwhelming.

The health consumer standardized indicators have a significant role in planning a reform, taking into account the so needed feed-back from the users of the health system. On one hand, performance indicators offer the consumer of health care the information needed for an evidence-based choice of the desired service. On the other hand, the consumer indicators can easily ground the health policy development process.

It is the policy development process that has to be taken into account. In order to be able to isolate the problem approached later on in the policy implementation stage, one must be able to gather evidence-based data and integrate them in the specific environment⁷. But the question that has to be asked is why do we need health customer's indicators assessments? And is it more useful to have a standardized tool for the entire European Union rather than a custom made one for each member country?

The countries that are part of the European Union structure are facing now a new paradigm from the point of view of patients' rights and access. As European citizens who are covered, one way or another, by health insurance, they should be entitled to have equal access to fast quality health services regardless of their country of location. The community development plans are already being developed on a trans-national basis, the main criteria being homogeneity in organizational patterns and need assessment results. The formal territory lines fade away as merchandise and people move freely as a result. However, one might argue that although industry or community characteristics might prove to have similarities which make them compatible across frontiers, the health systems are a completely different issue, which require a different approach.

⁷ Weil, O., McKee, M., Brodin, M., Oberlé, D. (eds.), *Priorities for public health action in the European Union*, European Commission, 1999

⁸ Cristina Hernandez-Quevedo, Andrew M. Jones, Angel Lopez-Nicolas and Nigel Rice, Socioeconomic inequalities in health: A comparative longitudinal analysis using the European Community Household Panel, *Social Science & Medicine* Volume 63, Issue 5, , September 2006, Pages 1246-1261.

(<http://www.sciencedirect.com/science/article/B6VBF-4JVT1VF-1/2/ed2ad5504dede3ba1b172afd7bcd02fa>)

At the European Summit in Lisbon in March 2000, social policy was given for the first time a special focus in the European framework⁸. Poverty and social exclusion were the main topics on the list. It may sound as a social development plan, but the fact remains that just by being members of the European Union, there is a tremendous economical pressure and new reference standards. The level of inequalities has, in fact, increased overall due to the merge of all these different structures in a confederate approach.

Funding health policy development has to be connected nowadays not only to the status and context at the national level, but rather at the European level. Policymakers need to be aware of the problems that arise from a European compared assessment and take them into consideration as policy targets. The objective is no longer to make the national health system more accessible and cost-efficient, but to optimize them from the standpoint of the European standards.

Most of the European countries have their own health system assessment⁹ - the "Bundes Gesundheitssurvey" from Germany that started in 1997; the Microcensus conducted in Austria by the National Institute for Health from 1995; the survey conducted in Denmark from 1987 by the Danish Institute for Clinical Epidemiology; the national health survey conducted in Spain by the Ministry of Health; the survey conducted in Finland from 1964 by the Social insurance Institution – later on developed in a series of surveys by the Statistics Finland, the Social Insurance Institution (abbreviated KELA in Finnish), the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (STAKES); the national care survey conducted in France by the Institut National de la Statistique et des Etudes Economiques (INSEE) and the Centre de Recherche, d'Etude et de Documentation en Economie de la Sante´ (CREDES) since 1960; the multi-purpose household survey conducted in Italy by the National Institutes of Statistics; the survey conducted in Netherlands from 1974 by the National Statistical Institute; the national health survey developed in Portugal from 1987 by the Portuguese Ministry of health; the survey conducted in Sweden from 1975 by Statistics Sweden; the "Schweizerische Gesundheitsbefragung" conducted in Switzerland by the Federal Office of Statistics; the surveys conducted in United Kingdom by the University of Cambridge School of Clinical Medicine, Department of Health, the Joint Health Surveys Unit of Social and Community Planning Research (SCPR) and the Department of Epidemiology and Public Health of the University College London (UCL) and the Office for National Statistics. These are just a few of the assessments conducted at national level, but they do not provide comparable information needed for policy development within the European Union as opposed to transnational survey.

Besides structural characteristics of different national health systems, there are, of course, geographical, social, political, economical discrepancies in health determinants. Identifying them requires a huge effort, as well, as it requires the

⁹ Christianne L.H. Hupkens a,*, Jaap van den Berg b, Jouke van der Zee, National health interview surveys in Europe: an Overview, *Health Policy* 47 (1999) 145–168

development of the comparison structure¹⁰, which enable us to map on a system matrix the direction and needs.

More and more international organizations and institutions are realizing the need for comparative surveys¹¹ - World Health Organization (Health for All Program), the European Union (The Eurostat Statistical Office and the European Standardization Committee), the Organization for Economical Co-Operation and Development, UNICEF, etc. They need to be supported by all national policy makers, given their own interest in the acquisition of reliable international standardized statistical information regarding health consumer indicators. Having this kind of data at hand will enable them to develop problem-based policy even through a rational model process, securing the best projected outcome and increased efficiency.

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¹⁰ Eurostat, *Facts through figures.*, Office for Official Publications of the European Communities, Luxembourg (1992).

¹¹ K. Schaapveld, A. Chorus, R. Perenboom, *The European health potential: what can we learn from each other?* *Health Policy*, Volume 33, Issue 3, Pages 205-217.

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