

**Can we build on existing information systems to monitor health inequities and the social determinants of health in the EU?**



## Acknowledgements

*EuroHealthNet is an active network of national and regional public health and health promotion institutes in all EU Member States established in 1998. It is an experienced leader of pan-European projects (Health and Social Inclusion, Closing the Gap, DETERMINE, Gradient) particularly in the field of tackling health inequalities. It has a well developed knowledge base on EU Policies and instruments in relation to public health and health equity across the European Commission, and has a professional and multi-disciplinary European team located at the heart of Europe.*

*This report is a product of EuroHealthNet and has been made possible by the Department of Health in England and developed following the priorities established by the Spanish Presidency of the European Council for 2010.*

*This document was developed by Cristina Chiotan(EuroHealthNet) in collaboration with Caroline Costongs (EuroHealthNet). We would like to thank Ingrid Stegeman(EuroHealthNet) and Clive Needle (EuroHealthNet) for their support and input. A big thank you also to Pieter Kramers (National Institute for Public Health and Environment, RIVM Netherlands) and Michael de Looper (Organisation for Economic Co-operation and Development, OECD) for their added value and contribution to this work.*

EuroHealthNet  
Brussels, Rue de La Loi, 67,  
January 2010

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## Foreword and purpose of this paper

*“Action on the social determinants of health to improve overall health outcomes and reduce health inequities will be much more effective if basic data systems are in place, nationally and internationally, and there are mechanisms to ensure that the data can be understood and applied to develop more effective interventions.”*

(MEKN, 2007b)

One of the main three overarching recommendations of the WHO Commission on Social Determinants of Health, “ensuring that routine monitoring systems for health equity and social determinants of health are in place, locally, nationally and internationally”<sup>1</sup>, is used in this paper as a starting point for presenting what is available at EU and national level in terms of resources, data and indicators.

The objective of this paper is to provide a brief overview of the data collected and indicators that are available at national and EU level, to monitor health inequalities and socio-economic determinants of health. It will specifically look at data and indicators with relevance to health inequities and their determinants.

This paper has been written to inform public health and health promotion professionals and decision makers who are not directly involved in collecting of data, but who are users of data. The information presented has been collected from various sources and articles. Rather than providing an exhaustive analysis, the aim is to present an overall picture that can lead to a better understanding of the existing situation in Europe, to highlight the need for a more coordinated approach in this area.

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<sup>1</sup> Closing the Gap in a Generation. Final Report of the World Health Organisation’s Commission on Social Determinants of Health, 2008

## Chapter 1 Introduction and definitions

Over the past few decades there has been an improvement in overall health in Europe due to the improved living and working conditions, food supply, and access to essential goods and services, such as education, health promotion and health care. However, despite the overall improvements in health indicators, health inequalities within and between countries have continued to exist and in some cases have widened.

Between EU Member States, there is a 5-fold difference in death of babies under one year of age, a 14 year gap in life expectancy at birth for men and an 8 year gap for women<sup>2</sup>. Throughout the EU, a social gradient in health status exists where people with lower education, a lower occupational class or lower income tend to die at a younger age and to have a higher prevalence of most types of health problems<sup>3</sup>. Differences in life expectancy at birth between lowest and highest socio-economic groups reach 10 years for men and 6 years for women<sup>4</sup>.

### 1.1 Analysing data on socio-economic determinants of health and health inequalities

**Health Inequalities** reflect the differences in health between various groups, populations or individuals due to the determinants of health. Health inequalities can reflect the differences in health between countries, regions, by age or gender and also between socio-economic groups.

The **determinants of health** are the factors that influence health. They include the socio-economic determinants of health – living and working conditions (housing, health care services, water and sanitation, unemployment work environment, education, agriculture and food production) social and community networks and life-style related determinants of health. Other determinants of health are also age, sex and genetic factors.

**Health inequities** are associated with differences in the social and economic conditions that people operate in. In recent times it has been proven that the exposure to almost all risk factors (material, psychosocial and behavioural) is inversely related to social position – that is, the lower the social position, the greater the exposure to different health hazards – producing what is known as the “gradient” in health<sup>5</sup>. Therefore, knowledge of the socio-economic determinants of health for the general population is ‘necessary, but not sufficient, for identifying and analysing the **determinants of social inequities in health**. The analysis of causal factors needs to be developed further, as ‘the determinants of inequities in health may be different from the social determinants of health for the whole population – that is, the most important determinants of health may differ for different socio-economic groups’<sup>6</sup>.

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<sup>2</sup> European Commission Communication “Solidarity in Health: Reducing Health Inequalities in the EU”, 20 October 2009

<sup>3</sup> Health Inequalities: Europe in Profile. Mackenbach J., 2006

<sup>4</sup> European Commission Communication “Solidarity in Health: Reducing Health Inequalities in the EU”, 20 October 2009

<sup>5</sup> Levelling up (part 2): a discussion paper on European Strategies for tackling social inequities in health’, Goran Dahlgren, Margaret Whitehead

<sup>6</sup> *ibid*

The **health inequities** refer to those inequalities that are avoidable and unfair – more specific this paper is looking at the **social inequity in health**, as to differences in health status between socio-economic groups; measuring those requires stratification of health data by income, education and/or occupation. All systematic social inequities within a country are socially produced, modifiable and unfair. It becomes then, ‘of critical importance to distinguish between social determinants of health for the overall population and the social determinants of inequities in health’<sup>7</sup>.

*“For example, unhealthy physical work environments are a major risk factor for unskilled workers in Sweden, while this is not the case for senior civil servants or for the population as a whole”* Lundberg (1991)

Measuring **health inequities** requires also the analysis of the exposure to different risk factors and determinants of health for each socioeconomic group. It will then be possible to identify ‘which risk factors are important for which group and whether these differ from the important risk factors for the overall population’<sup>8</sup>. Clear data on the socioeconomic determinants of health inequities would facilitate the development of more targeted policies and specialized methods and approaches, to address the health hazards for those at greatest risk.

## 1.2 How is data being collected?

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The following three types of data sources form the core of a monitoring system for health inequities:

- nationally representative data from routine health records;
- nationally representative, individual level data on mortality stratified by socio-economic status;
- nationally representative data from health interviews or multi-purpose surveys<sup>9</sup>.

At national level, the information flow starts with the data registered on an individual fiche that comprises medical information and some general information about the person – like gender, age, health insurance number, personal identification number, or residence, etc.. The information is collected by various medical facilities, such as: hospitals, general practitioners offices, therapeutic ambulatories, pathology laboratories, etc.. The data collected is reported to a central state or regional level; exactly how the system is organised differs from one country to another. Data on individuals is aggregated at different levels in the system which leads to the development of indicators corresponding to the local, regional or national level. It should be noted that the regular information collected on the medical fiche rarely includes information related to socio-economic status, such as: educational level, ethnicity, occupational status, income, wealth, etc.

The information flow is usually the same for the mortality registries, when personal data on the deceased is collected on personal fiches and reported at a regional and then national level for

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<sup>7</sup> Levelling up (part 2): a discussion paper on European Strategies for tackling social inequities in health’, Goran Dahlgren, Margaret Whitehead

<sup>8</sup> ibid

<sup>9</sup> ‘The social determinants of health: developing an evidence base for political action’, Michael P. Kelly, Josiane Bonnefoy, Antony Morgan, Jennifer Butt, Vivian Bergman

processing and analysis. Special regulations in force at national and EU level make mandatory the security encryption of medical records and personal files, ensuring the confidentiality and protection of personal data within the system.

Depending on the level of development of the information systems there is the possibility to link data from the health databases with other general databases/sources on population, which comprises information on education, ethnicity, occupational level, etc. The linkages could make available **health data stratified by socio-economic status** that can be used to measure inequalities in health by socio-economic status.

Specific data on health and determinants of health stratified by socio-economic status can be provided by **health interview surveys** - where information on health related issues is regularly collected by means of interviews in a representative sample of the population. If the socio-economic stratifiers are introduced in the population surveys (i.e. health interview surveys) then data on health and determinants of health can be stratified by socio-economic status (SES).

## Chapter 2 What should a comprehensive health equity surveillance system look like?

*“A health equity surveillance system routinely collects, collates and disseminates information on health, health inequities and health determinants in a coherent fashion”* WHO, CSDH Report (2008)

Routine monitoring of health inequity and the social determinants of health are critical to improve overall health outcomes and to reduce health inequalities within and between countries. ‘Monitoring and evaluation mechanisms needs to be in place at national and international level to ensure the evidence base and information needed to support identification of entry points for intervention and for evaluating the impact of policies and interventions undertaken<sup>10</sup>.

By signing the World Health Assembly Resolution on Social Determinants of Health, international organisations and member states globally have shown commitment to ensuring better monitoring in the area of health inequities. This Resolution calls on the need to “develop, make use of, and if necessary improve health information systems and research capacity in order to monitor and measure the health of national populations, with disaggregated data such as age, gender, ethnicity, race, caste, occupation, education, income and employment ...so that health inequities can be detected and the impact of policies on health equity measured”, (WHA62.14, 22 May 2009).

The most recent Communication from the Commission of the European Communities “Solidarity in Health: Reducing Health Inequalities in the EU” stresses the importance of ‘improving the data and knowledge base and mechanisms for measuring, monitoring and evaluation and reporting’. The EU level actions established through the Communication include support for ‘the further development and collection of data and health inequalities indicators by sex, age, socio-economic status and geographic dimension’. At the same time, in close collaboration with the Commission, Member States should aim to establish a common set of indicators to monitor health inequalities and also to be able to identify and prioritize areas of improvement and best practices.

Many countries and international organisations already collect and analyse data on the social determinants of health and health inequalities. However, the possibilities for regular analysis of social inequities in health are available only in some countries. The process of identification and analysis of health inequalities and the socio-economic determinants is mainly based on various sources and dispersed within different information systems. The indicators that can be used to measure and describe social inequities in health are not routinely provided in a comparable manner across the EU, although harmonised data on population health already exists, i.e. ECHI. Sometimes existing data is underutilised. The availability of data for analysing health inequities at national and EU level varies widely by Member State and depends mainly on the level of development of the health data collection systems and on the availability of national health surveys and studies.

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<sup>10</sup> Closing the Gap in a Generation. Final Report of the World Health Organisation’s Commission on Social Determinants of Health, 2008



A health equity surveillance system could build on the existing health information systems, by adding two important things:

1. While most existing data systems provide country and sometimes regional averages, usually stratified by age and gender, a health equity surveillance system would present the same health indicators stratified by social groups;
2. While data on different social determinants of health is dispersed across a multitude of information systems, a health equity surveillance system would bring together in one place data on a broad range of social determinants of health in a routinely and coherent fashion.<sup>11</sup>

A **basic national health equity surveillance system** should provide mortality and morbidity data stratified by socioeconomic group and by regions within countries.

A more **comprehensive health equity surveillance system** should provide data on a range of social determinants of health along the causal pathway, ranging from daily living conditions to more structural drivers of health inequities.

Applying the framework provided by the WHO Commission on Social Determinants of Health Report would involve looking at health data on health inequities and their determinants and the consequences of ill health. Specifically, this action would be based on information on:

- Health inequities – on: health outcomes (mortality, self-assessed physical and mental health, etc.) stratified by sex, at least two socio-economic stratifiers (education, income/wealth, occupational class), ethnic group, place of residence;
- Determinants, where applicable including stratified data – such as:
  - Daily living conditions: health behaviours (smoking, alcohol, physical activity, diet and nutrition, housing conditions, transport, etc.), working conditions, health care (coverage, health system infrastructure), social protection (coverage, generosity);
  - Structural drivers of health inequity: gender, social inequities (social exclusion, income and wealth distribution, education), socio-political context (civil rights, employment conditions, macroeconomic conditions);
- Consequences of ill-health – such as: economic consequences, social consequences<sup>12</sup>.

The framework includes only broad categories of health outcomes and determinants, therefore further indicators for each area need to be developed. Compatibility and comparability of data between countries could be achieved if, for a defined number of indicators, common definitions and methodologies for collecting and analysing the data are agreed at national and international level.

The health equity surveillance system should be coordinated at national level so that it can be useful for national and local policy makers. Local communities should be involved as an integrated part of the overall equity surveillance process, since community-based monitoring can expose various conditions at grass roots level; it can be empowering for local people and can enable ‘communities to make choices and decisions on issues affecting their lives’<sup>13</sup>.

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<sup>11</sup> Closing the Gap in a Generation. Final Report of the World Health Organisation’s Commission on Social Determinants of Health, 2008

<sup>12</sup> ibid

<sup>13</sup> ibid

## Chapter 3 What data and information is currently gathered at EU level?

[EUROSTAT](#) is the Statistical Office of the European Communities with the ‘task to provide the European Union with statistics at European level that enable comparisons between countries and regions. As national statistics are still important for national purposes in Member States, EU statistics are essential for decisions and evaluation at European level. The indicators provided by EUROSTAT rely on national statistics and the agreements reached with Member States. The aim is to ensure indicators which enable comparisons between countries and regions on various health, economic, environment or demographic areas. EUROSTAT aims to ensure coherency and comparability of data between EU Member States through the use of common standardised tools and methodologies for data collection and processing.

Health indicators gathered at EU level can be found in Eurostat under “Health” area, divided in two subthemes: “Public Health” and “Health and safety at work”. The indicators included in the “Public Health” subtheme includes: causes of death (data are available at national and regional level, broken down by age groups and sex), health care expenditure, health care non-expenditure, health care indicators from surveys (such as: **unmet needs for medical or dental care**), health status indicators from surveys (such as: **self-perceived health**). The tables with indicators are the product of data provided mainly by the national statistical institutes and the ministries of health or other national competent institutes. Disaggregation by age, sex and other variables are provided where available. Some tables contain also regional data.

In the EUROSTAT framework, specific indicators related to health inequities are included under the “Employment and Social Policy Indicators” area - part of the “Open Method of Coordination on Social Inclusion and Social Protection”, where the access to health care and inequalities in health outcomes are listed as main objectives. Within this area, the following indicators are listed as ‘under development’:

- the Healthy Life Years by socio-economic status;
- the Life expectancy by socio-economic status;
- the Infant mortality by socio-economic status.

These three indicators are among the most frequently used for monitoring population health and social progress, being directly linked with health status, and being also influenced by socioeconomic conditions and public health practices. Their inclusion in the regular reporting system from Member States will enable the identification of inequalities in health by socio-economic groups.

### 3.1 Indicators on the wider determinants of health

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Indicators for the analysis of determinants of population health can be found under various different categories, such as: Structural Indicators, Sustainable Development Indicators, and Employment & Social Policy Indicators.

For example, determinants of health related to physical and social environment, such as: infrastructure, transport and urban design, air quality, are listed under the EU “Structural Indicators”, respectively under “Environment” area, while determinants related to social protection are listed under the “Social

Cohesion or Economic Reform” area. Other indicators related to the socio-political context (employment conditions, governance and public spending and some macroeconomic conditions) are partially included under the “Employment and Social Policy Indicators” area.

Some indicators related to structural drivers of health inequities, respectively social exclusion, income and education are presented under “Sustainable Development Indicators” (such as: monetary poverty and living conditions, access to labour market, education- early school leavers). Health status indicators, such as: Healthy Life Years and life expectancy at birth are included in the subheading “Public Health” and “Health and Health Inequalities”.

The indicators included in Eurostat categories and areas provide knowledge of the general determinants of population health, showing inequalities between countries and regions.

This data however is not sufficient for identifying and analysing the determinants of social inequities in health.

The following example can better reflect the need for more in depth analysis to identify the causes of health inequities: ‘for a high-income country the role played by poverty in determining the overall health of the population may only be a minor one. The size of its role will depend on how many individuals live in poverty in that country. In a country where the prevalence of poverty is low, poverty may only account for 2% of the total burden of disease on the population. At the same time, it could account for 10% of the difference in the burden of disease between affluent and low-income groups within that country.’<sup>14</sup>

### **3.2 Sources of data: the European Cross-national Surveys related to health**

The main source for identification and measurement of health inequities at EU level is provided by data collected through the European level surveys.

Data on inequalities and health status (especially morbidity and disability) and in access and use of health care as well as on health related behaviours (such as: smoking, physical activity, intake of vegetables and fruits) are collected at national level through the health interview surveys (HIS). The HIS data is collected on different years depending on the country, starting from 1996 to 2003; the countries were asked to harmonise the data according to the guidelines (HIS\_guidelines 2004). There is no fixed periodicity and very few countries have a yearly survey on these topics. The national level surveys incorporate EU health modules which enable comparability of data at EU level, resulting in the EU level health surveys.

The EU cross-national health surveys are based on interviews or both interviews and examination. The inclusion of data on education and income enables stratification of data by socio-economic status. By using a common set of questions and methodologies to analyse the information collected, the EU level surveys aim to provide data that is compatible and comparable between countries.

From the organisational point of view, the European Health Survey System (EHSS) was developed under the EUROSTAT (ESTAT) and Directorate General Health and Consumer (SANCO). The aim of EHSS is to bring together under a single framework the different health and health related surveys taking place at

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<sup>14</sup> Levelling up (part 2): a discussion paper on European Strategies for tackling social inequities in health. Goran Dahlgren, Margaret Whitehead, 2006

the EU level for different purposes and by a variety of actors. The EHSS activities are coordinated by a Steering Committee (SANCO, ESTAT, member experts, when relevant other DG's or EU bodies) with the main task of making recommendations concerning the development and implementation of the EHSS instruments and tools.

From the perspective of analysing the socio-economic inequalities in health, four EU level surveys provide more relevant data and indicators:

- The **European Union Statistics on Income and Living Conditions (EU-SILC)** is one of the cross-national surveys that have been developed by EUROSTAT. The starting date for the EU-SILC instrument under a framework Regulation was 2004 for the EU-15 (with the exception of Germany, the Netherlands and the United Kingdom, which had derogations until 2005), as well as for Estonia, Norway and Iceland. The 10 new Member States with the exception of Estonia started in 2005. The instrument has also been implemented in Bulgaria, Romania as of 2007. EU-SILC covers the representative sample of the adult population aged 15 years and over and contains questions that can be used to analyse inequalities in areas like: self-rated general health, chronic illness and conditions, activity limitations and unmet need for medical care. Because information on education and income is also collected the data can be stratified by socio-economic status.
- The **European Health Interview Survey (EHIS)** is a cross national survey that was developed by EUROSTAT with the main objective of monitoring the health status and health care use in EU Member States. One of its objectives is also “analysis of social (in) equality in health and access to health services”. It comprises of a set of modules that aim to ensure a harmonised measure of a wide variety of indicators in health status, health care use and socio-economic status. The whole questionnaire is finished and submitted in most Member States. The results are expected by end 2010.
- The **Survey of Health, Ageing and Retirement in Europe (SHARE)** is a multidisciplinary and cross-national panel database which contains questions on physical health, behavioural risks, cognitive function, mental health and health care as well as on socio-economic status and social support variables for individuals aged 50 or over. Eleven countries contributed to the 2004 baseline study and 15 participated in a second wave of data collection in 2006-07 with 16 due to participate in 2008-09. The survey is based on a pre established methodology and a rigorous procedure harmonized across- countries. It provides health data for a specific age group stratified by socio-economic status and allows comparisons of socio economic determinants of health and health inequalities between and within countries.
- The **EUROBAROMETER** is devised to explore opinions and has limited use from the epidemiological perspective and for a limited number of topics each year. It is collecting information on life-style and living and working conditions through questionnaires developed by DG Health and Consumer's Protection and face-to-face interviews in participants' homes.

### **3.3 Examples of health indicators provided by the surveys**

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Indicators like “**self perceived general health**” or “**self perceived limitations in activities people usually do as a result of health problems and lasting for at least the last 6 months (severely hampered in activities)**”, stratified by income quintile, are calculated on the basis of data provided by EU-SILC.

EU-SILC also provides data to analyse inequalities in health access and health care, producing indicators like **“self reported unmet need for medical care in the last year, by income quintile”**, **“distance to the hospital, by income quintile”** or **“distance to the general practitioner/family doctor, by income quintile”**.

Some health inequalities indicators like **“self perceived general health, activity limitations and long-term problems plus specific activity limitations by education and income level”** or **“Odds ratios of having a chronic disease between 2004 and 2006 comparing low and middle with high wealth”** are calculated from the SHARE survey. At the same time, the EHIS can ensure routine collection of these data.

Indicators related to healthy behaviours, like smoking or alcohol consumption, are calculated from data obtained in the health surveys and the Eurobarometer interviews (such as: **“regular daily smokers in the population, %, age +15”** or **“pure alcohol consumption, litres per capita”**).

The survey based measures of health status and of health care access and use can be subject to potential limitations due to cultural biases, recall biases, different coverage of the population and issues related to the representatives of the survey sample<sup>15</sup>. For example, lower amount of financial compensation for treatment or care can be perceived as an ‘unmet need for medical care’, or answers to the ‘self rated general health’ can vary from one culture to another.

More in depth analysis needs to be performed to ensure accurate data and identify entry points for political action, taking into consideration the political, cultural and contextual factors.

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<sup>15</sup> OECD/de Looper, Michael and Gaetan Lafortune (2009) “Measuring disparities in Health Status and in Access and Use of Health Care in OECD countries” OECD Health Working Papers no.43, [www.oecd.org/els/health/workingpapers](http://www.oecd.org/els/health/workingpapers);

## Chapter 4 Development of a more comprehensive set of European Community Health Indicators

*Action to reduce health inequalities is an overall aim and objective of the current EC Health Programme: "Together for Health: Health Programme 2008-2013". The programme supports the development of strategies and measures on socio-economic health determinants and identifying health inequalities using data from the Community health information system.*

[http://ec.europa.eu/health/ph\\_information/indicators/indic\\_data\\_en.htm](http://ec.europa.eu/health/ph_information/indicators/indic_data_en.htm)

The first set of common European Community Health Indicators (ECHIs) was produced in early 2001 by the ECHI-1 project, and comprised a first list of over 400 indicators. From this expanding 'long list' the second ECHI project (2002-2005) produced the so-called ECHI short list of about 90 indicators (half of them are currently implemented), with indicators on population health status and health outcomes, general determinants of health, and health care systems. The ECHI shortlist has been developed and assessed in close cooperation with SANCO, with its working parties and committees, under the information strand. Eurostat was also involved by making a preliminary assessment of the availability of data for the shortlist indicators.

The ECHI shortlist was 'adopted by DG SANCO as a cornerstone of the envisaged Health Information and Knowledge System'; starting with 2005, the data connected to the shortlist mostly derived from Eurostat, has been presented on the SANCO website. The list is also a 'guiding element in the Eurostat directive on data delivery by the Member States that is currently being developed. Moreover, several Member States started using the ECHI shortlist as a basis for their monitoring and information system.'<sup>16</sup>

The ECHI shortlist is made up of four main categories:

- (1) demographic and socio-economic factors,
- (2) health status,
- (3) determinants of health,
- (4) health interventions (health services).

Area (1) "Demographic and socio-economic factors" include indicators related to the structural drivers of inequality, such as: **employment and poverty (population below poverty line)**.

Area (2) "Health status" includes indicators related to health outcomes, such as: **infant mortality, perinatal mortality, cancer incidence, and self reported chronic morbidity**.

Other indicators providing information on health behaviours such as: **rates of regular smokers, total alcohol consumption, consumption/availability of fruit/ vegetables**, is provided under area no. (3)

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<sup>16</sup> 12<sup>th</sup> European Health Forum Gastein 2009 – 'Health Indicators in the EU', Pieter Kramers on behalf of the ECHIM Joint Action partners

“Determinants of health”. Data on tobacco use is provided on a comparable basis by Eurostat and comes from non-harmonised national health information surveys, collected in different years depending on the country (1996-2003). Data on alcohol consumption is provided by WHO and a different methodology is used by countries. Data on consumption/availability of fruits/vegetables is gathered through surveys only in some Member States.

Indicators related to health services coverage (such as: **vaccination coverage in children, cervical cancer screening coverage**), and to health care system infrastructure (such as: **hospital beds, physicians employed, MRI units, CT scans**) are included under area no. (4) “Health interventions -health services”.

One important indicator for monitoring health as a productivity/economic factor, comprised within area (2) “Health Status”, is the **Healthy Life Years (HLY)**. Adopted as a Lisbon Structural Indicator in 2005, the HLY indicator (disability-free life expectancy) measures the number of remaining years that a person of a certain age is expected to live without disability. This indicator reflects loss in health that has important secondary effects, such as an altered pattern of resource use within the health care system and effects on consumption and production throughout the economy - therefore it can be used to increase policy makers awareness of doing too little to prevent ill-health.

The indicators listed in the SANCO website mainly provide the health data stratification by gender and age, where it is considered useful and appropriate. Their regular reporting provides population based country averages and measures of health inequalities between countries. Further analysis and stratification of data by socio-economic groups need to be ensured to provide information to measure health inequities and to identify the determinants of social inequities in health.

One of the important recommendations in the final report by the ECHI project is that, where this is appropriate and possible, indicators should be presented by age group and gender, and also by socio-economic status and subnational region. The recommendations call for mortality data to be stratified by education and occupation and data coming out of interview surveys to be stratified by education and income.

([www.ec.europa.eu/health/ph\\_projects/2001/monitoring/fp\\_monitoring\\_2001\\_frep\\_08\\_en.pdf](http://www.ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_frep_08_en.pdf)).

In the period 2005-2008, the ECHIM (‘M’ is for monitoring) project ‘continued and expanded on this work and acted as the secretariat of the Working Party Indicators, in which all Member States participated’<sup>17</sup>. The main accomplishment of ECHIM was the development of ‘documentation sheets’, which include ‘for each shortlist indicator, its precise definition, the indication of the preferred data source and other meta-information, based on a fixed format’<sup>18</sup>. Stratification by socio-economic status was included, where identified as appropriate, and based on recommendations resulting from EU projects – e.g. the Eurothine report.

This work has been done in close contact with the Social Protection Committee on indicators of health and long term care, of Eurostat Structural Indicators, of OECD on Health Care Quality Indicators, etc. By trying to harmonise the definitions and to follow the best expertise, the work was focused on ensuring the compatibility and comparability between countries. A first inventory has also been done regarding

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<sup>17</sup> 12<sup>th</sup> European Health Forum Gastein 2009 – ‘Health Indicators in the EU’, Pieter Kramers on behalf of the ECHIM Joint Action partners

<sup>18</sup> *ibid*

'the ability of the Member States to meet the data requirements connected with the implementation of the short list.'<sup>19</sup>

Recently, as a follow-up of the ECHIM project, DG SANCO initiated the ECHIM Joint Action, with their explicit request to Member States to become involved. 14 countries plus WHO Euro and Eurostat are participating in the Core Group, and there are contact persons in 26 Member States and 7 in candidate countries. Specific funds have been assigned up to 2011, based on a project structure, under Finnish coordination. The actual work includes 'cooperation with EUROSTAT, especially on the EHIS (European Health Interview Survey) and on cause-specific morbidity, and with other networks, such as Eurochip on cancer and Peristat on perinatal health.'<sup>20</sup>

A second important issue under the ECHIM Joint Action is the implementation of the indicators in the Member States – after several countries assessment of shortlist data availability, they are now preparing their 'national' implementation plans on how to improve the situation. The third point is to describe the actual flow of data and to perform a pilot for the collection of data and reporting using data available in international data bases and also with data directly derived from the Member States.

([http://ec.europa.eu/health/ph\\_information/indicators/indic\\_data\\_en.htm](http://ec.europa.eu/health/ph_information/indicators/indic_data_en.htm), ECHIM final report)

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<sup>19</sup> 12<sup>th</sup> European Health Forum Gastein 2009 – 'Health Indicators in the EU', Pieter Kramers on behalf of the ECHIM Joint Action partners

<sup>20</sup> ibid



## Chapter 5 Overview of European projects and initiatives for identifying and analysing health inequalities

The following projects presented are only punctual, time bound initiatives co-funded by the EU, which looked at, or are presently looking at, identifying and analysing health inequalities and the inequity in health across Europe. Some of these initiatives build upon one another and apply the information previously generated, while others have been implemented separately.

### 5.1 EUROTHINE project (2004-2007)

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The **EUROTHINE project** funded by EC aimed 'to improve the description of health inequalities in Europe and to enhance the evidence base for policies to reduce inequalities in health'. Its main objective focused on: preparing overviews that provide benchmarking data on inequalities in mortality, morbidity and health determinants to participating countries.

The project used national health interview surveys or similar surveys and, when available, mortality registries with information on socio-economic characteristics of the deceased. Data sets obtained from participating countries have been harmonised in order to maximise the international comparability of data.

A comprehensive list of the indicators developed, the data and analysis performed are available at <http://survey.erasmusmc.nl/eurothine/>.

### Health inequalities: Europe in profile (2005)

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This report provides the most extensive and comprehensive analysis on health inequalities in the EU by reviewing the evidence on the existence of socio-economic inequalities in health in the EU and its immediate neighbours. It presents data on socio-economic inequalities in mortality in 21 countries, on socio-economic inequalities of self-assessed health in 18 countries and on inequalities in smoking in 23 countries.

The report reviews 'the evidence on some behavioural risk factors, for which comparable data on social patterning are available from many European countries'. Where possible, the report is 'drawing upon a number of comparative studies which were recently completed which have looked at inequalities in mortality, self-reported morbidity and selected life style factors during the 1990's in a number of EU member countries' and taken care to make the data as comparable as possible.

For example, the report includes an analysis of the **mortality risk indicator** which is one of the most commonly applied indicators to analysing population health. This indicator is analysed from the perspective of health inequalities and socio-economic determinants of health, in the lowest to the highest socio-economic group in 21 EU countries. The socio-economic measure includes **education, occupation or housing tenure as stratifiers**. The data is obtained through national census- data linked with mortality data, follow-up or through national cross-sectional or longitudinal studies. Because of the differences in data collection and classification, direct comparisons between countries could not be ensured.

Another health indicator that is included is **infant mortality rates**, available between countries and within countries, stratified **by occupational class or educational level**. However, stratified data has been available for only six countries and the definitions used for the occupational class or educational level are different from one country to another due to the differences in available information and systems. Direct comparisons between countries and follow-up time trends are not available.

Using mainly the indicators provided by EUROTHINE project, the report is looking at a large amount of data and indicators from many countries for measuring health inequities and their socio economic determinants. However, the report mentions that 'there are also important gaps in data on socio-economic inequalities in health for many other Member States'. The year of data collection, age-group, socio-economic classification do not correspond across Member States. It is also mentioned that 'many countries do not have valid, nationally representative data on socio-economic inequalities in mortality by cause of data' and 'not all countries have good survey data on inequalities in self-reported morbidity, health-related behaviours and other determinants of health problems'. The conclusion is that, above all, there is 'a serious lack of internationally comparable data'. The report recommends that 'national and international authorities should therefore aim to strengthen data collection systems in order to fill these data gaps.'

## 5.2 EUPHIX (2008)

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**EUPHIX** is a web-based knowledge system for health professionals, policy makers and others. It presents structured European public health information, including data measuring socio-economic determinants of health. It provides insight into similarities and differences between EU Member States. EUPHIX has been developed with funding from the European Commission and several Member States as a prototype for a web based European public health reporting and monitoring system. The project phase for the system's development ended in 2008 but the website has been kept on-line, to serve as an example for other web based reporting tools.

The information presented is structured into several areas, like: Health Status, Determinants of health, Health interventions & systems, Health policies, Demography and broader public health themes projects, in the same structure provided by the ECHI shortlist.

The website includes indicators and analysis developed at EU level to measure health inequalities, by using all sources provided by projects, studies and surveys (such as Eurothine). Structured explanatory information is provided for each measurement and indicator chosen.

The information on health inequalities includes is structured on areas/domains, such as: Inequalities in mortality and morbidity (using indicators like : 'Relative inequalities in total mortality by level of education' or 'Relative inequalities in self assessed health by level of education' Source Eurothine, 2007); Inequalities in lifestyle (using indicators like: 'Percentage age-adjusted prevalence of a sedentary lifestyle by educational level in men and women in selected countries, Source Eurothine, 2007); Inequalities in health care service access or the inequalities within the EU's Social Protection and Social Inclusion Process, the 'Unmet need for medical care' and 'Number of deaths under 1 year, per 1000 live births, for selected ISARE health regions, 1999'.

### **5.3 ISARE (1999-2007) and I2SARE (2008-2010)**

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The **ISARE project** was built on the initiative of Fnors (French observatories) and for the past 10 years has demonstrated the importance of health indicators at the regional level. It comprises three phases: Isare I (1999-2001) which identified the most appropriate sub-national level – the "health region"; Isare II (2002-2004) which tested the feasibility of collecting regional data in each country; Isare III (2005-2007) which extended the two previous phases to the new countries of EU and developed the database.

**I2SARE** project is an ongoing European project (September 2008- August 2010) that was established to produce a health profile for each region of the EU, to create a typology of those regions and a typology of subregional territories in a selection of countries and regions. I2SARE's main objective is 'to assist European, national, regional and local decision makers in developing their health policies through a better understanding of the health status of the population and of health inequalities at regional and sub regional level'. One objective is 'to assemble and validate data collected at sub-national level from EU Member States and candidate countries for a set of agreed indicators covering the following areas: health care delivery and structure, population demographics and socio-economic status, biological factors and health related lifestyle'. Based on the initial project reports, the indicators applied cover the areas mentioned for a specific sub national level/region. The project aims to make available figures at subnational/regional level that can then be compared with general population figures.

Further information on the project at:

<http://www.pratiquesensante.info/media/pdf/newsletter1i2sare.pdf>

### **5.4 EHLEIS - European Health and Life Expectancy Information System (2007-2010)**

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The EHLEIS project is an initiative funded by the European Commission that is 'monitoring and exploring gender gaps and inequalities in health expectancies between Member States, identifying explanatory factors for convergent or divergent trends'.

Life expectancy is 'no longer sufficient as the sole indicator of population ageing. Politicians and individuals are more concerned about the quality of life. From a planning perspective it is needed to identify whether healthy life expectancy (HLE) is increasing more or less rapidly than life expectancy'. EHLEIS works on the definition of indicators of healthy life expectancy stratified by socio-economic status.

By providing a continuing updated of an online information system of health and life expectancy and delivery of a training workshop and a conference for policy makers to demonstrate good practice, the EHLEIS is aiming to maximise the use by the EU and its Member States of the EU SILC and of the forthcoming EHIS, alongside with the national data to compute Healthy Life Years indicator and monitor population health with harmonised data and methods.

The overall strategy of EHLEIS is 'to disseminate high quality information on HLE through a wide range of means including a dedicated website, ad-hoc technical reports, regular country reports, a training workshop, the European conference and its proceedings and scientific papers. This will be implemented by an established and well-respected group of experts in HLE with a strong network of public health collaborators covering the 25 MS'.

More information on EHLIS at: <http://www.ehemu.eu/index.php?option=ehleisproject>.

## **5.5 Equity in Health: Inequalities in Health System Performance and their Social Determinants in Europe – Tools for Assessment and Information Sharing (2007-2010)**

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This is an ongoing action led by WHO Europe and the European Commission (April 2007 – April 2010). The project consists of two major parts: (1) developing an interactive atlas at the sub-national level of structural determinants, intermediary determinants, and health outcomes and (2) provide statistical associations between the above and developing a range of sources to enable countries to take action to address health inequalities determined by socio-economic factors. The focus is on providing information on geographically defined inequalities in health in the EU and selected neighbouring countries and to associate indicators of socio-economic factors with health indicators at level of population groups. It aims to improve the use of readily available statistical data and information relevant to equity in health by producing an interactive atlas as a tool for information sharing.

It is using Eurostat as the major data source and other potential sources of aggregated data, such as the European Social Survey, Health Behaviour in School-Aged Children (WHO/HBSC) and Eur Life databases of European foundation for Improvement of Living & Working conditions.

The indicators used on socio-economic status are income, educational attainment, employment and unemployment rates and infant mortality (as a general deprivation measure). The indicators used on health systems are grouped by inputs (density of doctors, nurses, hospital beds by type), outputs (hospitalizations) and outcomes (mortality and hospital admissions, selected diagnostic groups).

Composite indicators will provide measures of association between socio-economic status/factors and health indicators, including comparisons of data on socio-economic determinants of health (such as: employment, educational attainment) and data on health indicators, showing absolute and relative inequities among regions. For example, it will provide simultaneously the value of mortality rate and employment ratio for a specific region, using measures of association. Moreover, different atlases for each socio-economic variable and topic are being developed and ensure comparability of a limited number of key indicators between 2-3 regions. The tool will provide a real time comprehensive analysis using available data, mainly from EUROSTAT.

## **5.6 European Observatory on the Social Situation – Health States and Living Conditions Network “Health Status and Living Conditions in an Enlarged Europe”**

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The latest **Monitoring Report** prepared by the **European Observatory on the Social Situation – Health Status and Living Conditions Network “Health Status and Living Conditions in an Enlarged Europe”(2007)** –investigates differences in health status between European Countries, analysing the relationship between living conditions, socioeconomic factors and health. The report has two parts. Part One provides a descriptive analysis of trends and living conditions across EU and candidate countries and an overview of country mortality indicators, disease patterns and behaviours. Part two is concerned with the policies pursued by governments to address the health issues described in the first section. (*“Health Status and Living Conditions in an Enlarged Europe 2007”, Monitoring Report prepared by the European Observatory on the Social Situation – Health status and Living Conditions Network; [http://ec.europa.eu/employment\\_social/spsi/reports\\_and\\_papers\\_en.htm](http://ec.europa.eu/employment_social/spsi/reports_and_papers_en.htm)* )

## 5.7 Eurofound, the European Foundation for the Improvement of Living and Working Conditions – EurLife data base - “Living conditions, social exclusion and mental well-being” report on the Second European Quality of Life Survey

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**Eurofound**, the European Foundation for the Improvement of Living and Working conditions, is a European Union body that has the role to provide information, advice and expertise on living and working conditions, industrial relations and managing change in Europe for key actors in the field of EU social policy.

Eurofound also provides an active data base of quality of life indicators (**EurLife**), offering data drawn from the **European Quality of Life Survey (EQLS)** and from other published sources. The database comprises the EU 27 Member States and Turkey and Croatia and deals with objective living conditions and subjective well-being of European citizens.

The database includes extensive data on living conditions and well-being, grouped in the following areas: health, employment, income deprivation, education, family, social participation, housing, environment, transport, safety, leisure, life satisfaction.

The health area includes country average indicators on objective health conditions, like “life expectancy at birth”, “infant mortality” and also “overweight”, “smoking”, or “distance from a general practitioner” and “health care expenditure as a part of GDP”. Subjective well-being is reflected by indicators like “satisfaction with the health care system”.

In the employment area, the objective conditions of living are reflected by indicators like “employment rate” or “long-term unemployment”, while information on the subjective well-being is provided by indicators like “job satisfaction” or “job prevents giving time to the family”.

In a similar way, the other areas provide comprehensive indicators, including both objective data on living and working conditions and data on the subjective well-being conditions within a country.

The latest report published by Eurofound, “**Living conditions, social exclusion and mental well-being**” looks at the relationship between living conditions, social exclusion and mental well-being. It uses the data from the **second EQLS** to examine the factors that influence perceived social exclusion and the impact that this has on mental well-being. Such factors include labour market access, income and lifestyle standards, and availability of social support.

For example, the report looks at the impact of social conditions on perceived social exclusion, providing stratified data by social groups, such as ‘average perceived social exclusion, by country and unemployment rate’ or ‘index of average perceived social exclusion, by principal economic status of respondent’. It also focuses on the impact of living conditions and perceived social exclusion on mental well-being, analysing the average WHO measure of mental well-being stratified by gender, by employment status or by occupational category.

More information at [www.eurofound.europa.eu/](http://www.eurofound.europa.eu/).

## Chapter 6 Other international initiatives for measuring health inequalities

*“Data sources used to monitor socioeconomic inequalities in health should be nationally representative, and must contain individual level information which can be combined to form groups of similar socioeconomic status. Data should contain measures of age, sex, SES and health status of health care access and use. To ensure cross-national comparisons, each of these measures must be collected in a standard fashion across all countries.”* Measuring Disparities in Health Status and in Access and Use of Health Care in OECD countries OECD Health Working Papers no. 43.

### 6.1 OECD

The Organisation for Economic Co-operation and Development (OECD) recently developed a report to ‘assess the availability and comparability of selected indicators of inequality in health status and in health care access and use across OECD countries, focusing on disparities among socioeconomic groups. The report provides a selection of leading indicators that might be used to measure different socioeconomic inequalities in health status, and also in health care access and use.

The document comprises a review of indicators and data that can be used and provided in OECD countries, and an outline of the steps required to improve the availability and comparability of these indicators. It also classifies social groups, provides measures of socio-economic inequalities in health and data sources and challenges to improve comparability. Existing national or cross-national data sources are used to stratify populations by income, education or occupation level.

The selected indicators for measuring inequalities of health status have been grouped into three categories:

- indicators related to life expectancy and mortality, such as: life expectancy by socio-economic status (SES), total mortality rate by SES, infant mortality rate by SES;
- indicators related to morbidity and disability, such as: self-rated disability by SES;
- composite indicators which include both mortality and morbidity information, such as: disability free life expectancy by SES, health adjusted life expectancy by SES, etc.

Indicators for measuring inequalities in health care access and use include: health insurance coverage, health care utilisation in relation to different services, measures of unmet care needs and out-of-pocket expenditure as a share of household income.

The stratification on socioeconomic status (SES) is provided by using already available information on income level, education level or occupational group. SES information has been sourced from health surveys and censuses.

The report analyses the possibilities of ensuring regular monitoring of socio determinants of health inequalities. Based on the data and information systems existing at country level, some of the indicators are presented as best suited for routine collection (annual or biennial, such as: self-rated health, self-

rated disability and measures of unmet care needs) and others for periodic collection (every 3-5 years, such as: life expectancy, total mortality rate, infant mortality rate, health care coverage, health care use).

The feasibility of international data collection is included in the description of the indicators selected, reflecting the availability of data, whether data collection instruments are harmonised across countries and whether linkages between different data collections is required. From this perspective, the indicators related to healthy life expectancy (disability free life expectancy, health adjusted life expectancy and disability adjusted years) stratified by SES, are “less feasible”.

The data sources presented are the national mortality registries, national health sector information, health surveys and cross-national health interview surveys (with a focus on European ones).

It is mentioned that national mortality registries provide information by sex, age and cause, while little or no information is collected in most countries registries that can be used to determine socioeconomic status. The main challenge for countries is to link data from mortality registries to a measure of SES, provided for example by censuses (or other comprehensive information sources on the population) so that indicators of mortality or life expectancy can be classified by income or educational level. For the purpose of international comparisons the same measures of SES should be used in all countries.

In a similar way, national health sector information (such as: hospital admissions records or primary health care records), rarely include information on income, education or other SES measure. Therefore, linkages between these data and other information sources on population need to be made.

Regarding the morbidity based indicators the main challenge is to further harmonise a key set of questions in national health survey modules on health status and health care use and to be able to link this information with a standard measure of SES, as it is done through the European Health Interview survey. ‘At international level, comparability of data is limited by variations on questions to measure health status or socio-economic status or by the differences in the methodologies used or in the way the survey is conducted and data is analysed’.

One of the report’s conclusions is that: ‘Even if the survey based measures of health status and of health care access and use can be subject of potential limitations such as cultural biases, recall biases, different coverage of the population and issues related to the representativeness of the survey sample, they remain a unique source of data in most countries to measure SDH and health inequalities in health and health care access and use’.

For many of the indicators suggested, broad comparisons across OECD countries can be made only if improvements in data availability and comparability are made. One of the conclusions is that standard classifications and survey questions need to be established to enable meaningful cross countries comparisons. This requires data collection instruments harmonised between countries and also linkages between different data collections and systems.

Future OECD work may focus on developing a small set of indicators to measure health inequalities and their inclusion in OECD Health Data database.

## 6.2 HBSC

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The **Health Behaviour in School -aged Children study (HBSC)** is a WHO collaborative cross-national survey, involving a multi-disciplinary network of researchers from 43 countries & regions in Europe and North America. [www.education.ed.ac.uk/cahru/research/hbsc.php](http://www.education.ed.ac.uk/cahru/research/hbsc.php)

The HBSC study has collected data on health and health behaviour of young people over the last twenty-five years, across a multitude of countries, generating data useful for researchers, policy makers and health practitioners. Through standardised and regular data collection every four years, HBSC is able to monitor the health status of young people and to analyse important child and adolescent health trends, aiming to gain new insight into, and increase understanding of adolescent health behaviours, health and lifestyles in their social context. The survey instrument used is a standard questionnaire developed by the international network of researchers and used by all participating countries. The target age groups are 11, 13 and 15 year olds with a sample of approximately 1500 from each age group in all participating countries.

Each survey questionnaire contains a core set of questions looking at: background factors (demographics, social background including socio-economic status, maturation), individual and social resources (body image, family support, peers, school environment), health behaviours (physical activity, eating and dieting, smoking, alcohol use, cannabis use, sexual behaviour, violence and bullying, injuries) and health outcomes (symptoms, life satisfaction, self-reported health, Body Mass Index).

The data collected allows cross-national comparisons to be made and, with successive surveys, trend data is gathered and may be examined at both the national and cross-national level. As well as being a research and monitoring study, HBSC also aims to inform and have impact on health promotion and health education policy, programmes and practice aimed at young people at both national and international levels.

The international report from the 2005/2006 survey presents the key findings on patterns of health among young people aged 11, 13 and 15 years in 41 countries and regions across the WHO European Region and North America in 2005/2006. The theme of the report is health inequalities and it quantifies the gender, age, geographic and socioeconomic dimensions of health differentials. Its aim is to highlight where these inequalities exist, to inform and influence policy and practice and to help improve health for all young people.

([www.euro.who.int/InformationSources/Publications/Catalogue/20080616\\_1](http://www.euro.who.int/InformationSources/Publications/Catalogue/20080616_1) ).



## Chapter 7 Conclusions

### 7.1 The need for monitoring health inequities

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This paper provides a brief overview of the current health information and monitoring structures that are available to measure health and provide information on health inequalities between and within countries in Europe. It is aimed at public health and health promotion professionals and decision makers that are using data and evidence to develop policies and interventions on health equity.

Indeed, well developed monitoring and evaluation structures have supported the identification and implementation of appropriate policy actions and have therefore contributed to substantial improvements in overall population health in the past decades. Differences and inequalities in health, however, continue to grow among populations despite overall gains in the last 50 years. A more comprehensive and sensitive monitoring system is therefore needed to detect progress and policy impacts on different socio-economic groups across the EU. The WHO Commission on Social Determinants of Health stressed that *“evidence-based policy-making requires good data on the extent of the problem, and up-to-date evidence on the determinants and on what works to reduce health inequities. It also requires an understanding of evidence, among policy-makers and practitioners, such that social determinants of health are acted on”*.

### 7.2 The challenge of linking health information with socio-economic data and using comparable methodologies

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The data analysed and indicators established in the past years show that health inequalities exist in the EU, between and within countries, and are influenced by socio-economic factors. Although a lot of progress has been made in the last 10 years on measuring health inequities and on the identification of the socio-economic determinants of health, the data and information remains difficult to access. The available data is not analysed on a regular basis nor in a comparable way across the EU. Most of the health data that is regularly collected at national and EU level doesn't include a socio-economic marker. Where analysis of health inequities and their socio economic determinants is available, there are differences between countries in the methodologies and definitions used in collecting the data and performing the analysis. Therefore, direct comparisons between countries and regions are not available, while the main challenge for many countries remains the stratification of health data by socio-economic status. Moreover, measuring the effectiveness of interventions and policies and gathering evidence on social determinants of health inequities requires in-depth analysis using both quantitative and qualitative data that also includes political, contextual and cultural aspects.

There are only a few countries in the EU that are already collecting and analysing data on health inequities on a regular basis. In general, those countries with comprehensive policies and programmes to address socio-economic inequalities in health are those identifying, collecting, processing and analysing data in a regular way.

The countries that are less advanced in addressing socio-economic inequalities in health, also in most cases have more limited information on this topic. This can be due to the fact that their information systems are less developed, or to the irregularity of national surveys or censuses, or due to insufficient

capacity and resources to conduct specific research studies and in depth analysis of existing data. These differences between EU countries are one of the factors preventing a regular monitoring of socio-economic inequalities in health at EU level. Additional support is therefore needed to close this monitoring gap.

### **7.3 Health data collection systems should be adapted to include SES information**

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As mentioned before in this paper, there are two important sources that can provide stratified data: (1) the nationally representative data from routine health records (or data on mortality) linked with other relevant sources of information on the country's population, and (2) EU cross national surveys related to health and social issues.

The regular data collection systems from the national level can provide data on health and determinants of health stratified by socio economic status (SES), if at least one of the two different mechanisms is put in place:

1. Information regarding socio economic factors to be included in the **initial health data collection** process. This approach could be undertaken by countries which are in the process of revising their data collection systems, involving changes in the reporting forms within mortality and morbidity registries. *For example, information on educational level or occupation could be included on death certificates (within the mortality registries) and/or hospital medical fiches. This information could then be used to stratify health data by socioeconomic status.*
2. Health data stratified by socio-economic status to be obtained by ensuring **linkages** between the national health information system and other comprehensive information sources on the population (like censuses). This approach could be undertaken by countries with well developed health data collection systems that are gathering good quality data on mortality and morbidity; within the data bases, the data should exist in disaggregated form, so it can be brought to individual level; these data linked with other general information data base/source on the population could be combined to form socio-economic groups. *For example, the mortality registry should be linked with a census or other information source on the population to provide mortality ratios by SES.*

This second approach however, requires existing good quality registries on health status and outcomes and also well developed capacity in the area of research/data analysis. Moreover, 'in the case of the linkage with a census, regular monitoring cannot be ensured, since censuses are infrequent'<sup>21</sup>.

### **7.4 Leadership and coordination at EU level is crucial**

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This paper outlined existing EU initiatives, projects and expert experiences that contribute to monitoring health inequalities in Europe. Following these findings, the regular monitoring and analysing of health inequities and their determinants requires stronger EU leadership and technical collaboration with WHO, in order to ensure the development of comprehensive and appropriate systems and indicators at national and regional level.

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<sup>21</sup> OECD/de Looper, Michael and Gaetan Lafortune (2009) "Measuring disparities in Health Status and in Access and Use of Health Care in OECD countries" OECD Health Working Papers no.43, [www.oecd.org/els/health/workingpapers](http://www.oecd.org/els/health/workingpapers);

Within the Commission Communication, a framework for policy development, implementation, monitoring and evaluation, and for ‘establishing comparisons, deriving best-practices and reallocating resources where they are most needed’<sup>22</sup> has been initiated. However, specific coordination and action should be in place at EU and Member States level.

In the process of improving overall monitoring of health inequities, the WHO could play a crucial role in supporting health equity surveillance systems at the Member States level; this should include providing technical support for systems improvement, improving quality and comparability of data (across countries and over time) and building capacity at the country level to use the data for policy-making, public health programme development, and analysis<sup>23</sup>. The EU level leadership in this process could help close the monitoring gap between countries.

Further support and work should be coordinated by the EU, to encourage agreement by all EU Member States on a core set of indicators and on standard definitions and methodologies to collect, process and analyse data.

The EU Member States efforts should be:

- To further develop an organisational or institutional body to be responsible for the collection, processing and analysis of data, including full implementation of the EU cross-national surveys and further analysis of existing data;
- To establish the regulatory framework and allocate resources for appropriate systems development;
- To ensure that data and indicators are made available for regional and local level for local policies and interventions development;
- To support building the evidence base for further development of targeted policies and interventions; to identify specific entry points for policy action and adequately monitor and evaluate programmes addressing health inequities.

## **7.5 The need for special action on health inequities monitoring**

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The main purpose of this paper has been to provide an overview of the existing data collection and analysis systems in Europe to describe and monitor health inequities and identify the socio-economic determinants. The overview shows that there are structures in place, but, as discussed above, there is much room for improvement.

Such improvements can be achieved through the establishment of an action group at EU level to look at what has already been done in the EU with respect to the collection, reporting and analysing of data (based on a more detailed analysis than could be done in this paper). The group could also help to arrive at common definitions and methodologies, to help mobilise resources, build capacities and improve data collection structures at national level. This work could build on the experience and knowledge gathered over the last years to measure health inequities and identify the socio-economic determinants. An integrated and coordinated approach could be the next step forward to ensuring the effectiveness and sustainability of our efforts to monitor and address health inequities and reduce the unjust differences in health in the EU.

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<sup>22</sup> Commission Communication “Solidarity in Health: Reducing Health Inequalities in the EU”, 20 October 2009

<sup>23</sup> Closing the Gap in a Generation. Final Report of the World Health Organisation’s Commission on Social Determinants of Health, 2008