

Background

Ethnic specific trends in mortality provide aetiological clues about the influence of environmental exposure and also about the management of individual conditions. Cancers are major causes of death for ethnic minorities, but research and policy has focused more on cardiovascular diseases than cancers. We examine trends in migrant mortality for lung, breast, prostate and colorectal cancers for 1979–83, 1989–93 and 1999–2003.

Methods

Standardized sex specific death rates for the main migrant groups and persons (aged 30–69) born in England and Wales (=1.00 in rate ratios, RR).

Results

For each migrant group the selected cancers featured the seven main causes of cancer death. Declines in rates were not consistent across groups. In decade two, rates rose for lung cancer in Jamaican men (34%), breast in Pakistani (10%) and Italian women (5%), prostate in Jamaican (32%), Other Caribbean (35%) and Northern Irish (8%) men and colorectal cancer in Jamaican men (16%). Compared to England and Wales, many groups had slower declines: with less than half the decline for lung cancer in Pakistani, Italian and Hungarian men; and breast in Caribbean, East African, Pakistani, Irish and Hungarian women. Differential declines resulted in either convergence to England and Wales rates for low mortality groups (lung cancer in Italian 1979–83: RR=0.62, 95%CI=0.50–0.78; 1999–2003: 0.95, 0.79–1.15 and Pakistani men 1979–83: 0.35, 0.26–0.47; 1999–2003: 0.55, 0.46–0.66 or breast in Pakistani women 1979–83: 0.36, 0.22–0.58; 1999–2003: 0.68, 0.56–0.83); increasing divergence (lung cancer in Irishmen from the Republic 1979–83: 1.28, 1.22–1.34; 1999–2003: 1.77, 1.66–1.88); or cross-over (Jamaican men 1979–83: 0.59, 0.45–0.77; 1999–2003: 1.30, 1.13–1.50). Percentages of excess deaths in groups with consistent higher mortality (lung and colorectal for Scots, prostate cancer for Caribbeans) remained unchanged.

Conclusions

Over the last two decades in the UK, ethnic inequalities in cancer mortality have either remained static or worsened for many groups. There is an urgent need for prevention and treatment programmes to maximize coverage across all minority groups.

Mortality patterns of Former Soviet Union immigrants in Israel, 1990–2003

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Background

Health of migrants is assessed extensively in terms of both their

risk factor profile and their health care behaviour. However, longitudinal data on the mortality of migrants, which is of sufficient quality, to permit the use of proper analytical methods is sparse. Moreover, not much is known about the mortality patterns of migrants who are admitted on the basis of ethnicity such as Diaspora migrants. The present study analyses population-based mortality data of all immigrants from the Former Soviet Union (FSU) who arrived in Israel between 1990 and 2003.

Methods

Data for this study were provided by the Central Bureau of Statistics in Israel. All deaths were professionally coded according to ICD-9 and ICD-10, depending on date of occurrence. Age-adjusted mortality rates were calculated for different groups of causes of death and for each sex separately. Indirect standardization was applied to standardize cause-specific mortality of migrants to both, the mortality rates of the Russian population and to the rates of other Israelis.

Results

Between 1990 and 2003, about 927 thousand individuals from the FSU migrated to Israel. Age-standardized mortality rates for FSU-immigrants are similar to those of other Israelis and much lower than those in Russia, particularly in the case of circulatory disease mortality. Indirect standardization to Russian mortality shows a lower overall mortality risk in male and female migrants with an SMR of 0.406 (95%CI=0.401–0.411) and 0.568 (95%CI=0.562–0.574), respectively. When comparing immigrants with their country of origin, the highest SMR of 1.71 (95%CI=1.50–1.94) in males and 1.77 (95%CI=1.56–2.02) in females were found for malignant neoplasm of the brain. Leukemia was also found to be higher in the immigrant group than in Russia with an SMR of 1.51 (95%CI=1.36–1.68) among males and 1.70 (95%CI=1.52–1.90) among females. The opposite relationship is observed for death from stomach cancer. Immigrants of both sexes show a lower mortality than that of their country of origin, with, however, almost twice the risk of dying from stomach cancer than Israelis. Higher mortality of male immigrants compared to other Israelis is observed for external causes of death, with an SMR of 1.41 (95%CI=1.35–1.47). The complete mortality patterns will be presented.

Conclusions

Findings from this unique migrant cohort suggest a lower mortality of FSU-immigrants when compared to their country of origin. However, they have considerable disadvantages for particular causes of death when compared to Israelis. The study contributes to the understanding of health changes in populations and identifies areas to mitigate premature mortality. The variety of causes of death analysed provides a potential for designing culturally sensitive and targeted health promotion activities.

3.9. Workshop: The Working Party on Health Systems of DG SANCO: The current state of health system indicators development in Europe

Chairs: Helmut Brand, Tit Albrecht*

Organiser: NIVEL- Netherlands Institute for Health Services Research, EUPHA section on Health Services Research, Health Systems Working Party of DG SANCO

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International health systems research depends greatly on the development and availability of comparable information on health systems and/or services across countries. The aim of this workshop is to shed light on the current state of health system

indicators development in Europe. The Health Systems Working Party, which is one of the implementing structures of the European Commission's main health information instrument for implementing the EU's health strategy, has invited some of the major suppliers of health system indicators in Europe (OECD, WHO and Eurostat) to present their *raison d'être*; the way they approach health systems, touching upon the facts, reasons, frameworks and assumptions

forming the basis of their indicator development. The purpose of the indicators and related data collections will be explained. The specific key characteristics of the different indicator collections that separate them from other major suppliers of health indicators will be outlined. The current state of the indicators and related data collections will be described by providing an outline of the availability of indicators (and data used for their construction), their implementation and comparability, benefits, limitations and risks that users should be aware of and the sustainability of indicators and their data collection. This should facilitate further development and subsequent use of the correct indicators for the appropriate purposes, thereby contributing to the quality of comparative health system research in Europe.

The contribution of DG SANCO's Health System Working Party to the European health information system

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Achieving a high-level of health status for European citizens means helping the people and governments to understand how to behave appropriately in today's environment with regards to health and to assure the provision of best possible health care services. Both goals can be reached with the help of data, information and knowledge management. The Public Health Programme is the European Commission's main instrument for implementing the EU's health strategy. The programme aims, via a number of projects it funds to improve the level of physical and mental health and well-being of EU citizens and reduce health inequalities throughout the Community. The Health Systems Working Party (HSWP) was set out in 2003 to decide, define and render operational series of information items required to monitor Europe wide, national and sub-national developments in the field of health systems. This will enable benchmarking and performance assessment and the exchange of information on best practices while recognizing the Member States' own primary responsibilities for their health systems. The WP has currently over 25 projects running that can roughly be structured according to two high level topics: health systems performance and health system organization and structure. The input of the HSWP should be seen as providing comparable, valid, timely and understandable information for health and health care decision making. All activities of the HSWP in synergy are aimed at gradually building the information system for health care in the EU in collaboration with other international organizations such as Eurostat, OECD and WHO (European Observatory). The workshop will provide a comprehensive overview and starting point for discussion on the HSWP's achievements so far and its goals for the future for improving the contribution of the European Commission to the health information and knowledge system on health systems in Europe.

Towards more comparable data for assessing the performance of health systems across countries: Past, present and future work at the OECD

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Comparison of health system performance has long been of interest to developed countries in Europe and outside Europe, because of the interest in benchmarking against

peers. Health systems are striking in their differences and the variations across countries in the range of available indicators on health expenditures, resource use, outputs and outcomes. The objective of this presentation will be to provide an update on progress in expanding and strengthening the capacity to make meaningful comparisons of health systems and health-system performance across developed countries. The presentation will focus particularly on two developmental projects for OECD Health Data, an annually updated database presenting descriptive statistics and health-system indicators for 30 countries. The first is the further elaboration and refinement of the OECD System of Health Accounts, a major project aiming to define global health accounting standards undertaken in collaboration with Eurostat and WHO. A second priority is the work underway to produce internationally comparable data on the quality of health care under the Health Care Quality Indicators Project. These two projects are linked directly to the debate about the extent to which the growing expenditure on health services is justified by the health value it helps to create. The presentation will illustrate progress made in evaluating these and other dimensions of health system performance by showing, for example, how a country like Finland compares with other OECD countries on key indicators of health status, health spending, health care activity and the quality of health care.

EUROSTAT's activities in the area of health system comparisons

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EUROSTAT is the statistical office of the European Communities and works together with the official statistical authorities in the Member States, MS (as well as the EFTA countries) to create truly comparable statistics at the EU level.

In the framework of public health member states, EUROSTAT and Community services (like SANCO) are closely working together. In the framework of the Statistical Programme of EUROSTAT, decisions on the programme to be executed by the health unit of EUROSTAT are presented and evaluated by the Working Group on Public Health (WGPH). SANCO is one of the Directorates that drives the demand for health statistics by defining the basic indicators necessary for health policy at the EU level.

In emphasizing the involvement of the MS in the work EUROSTAT created the Partnership Health. In the framework of the Partnership Health (PH), four groups dealing with methodology and guiding implementation are active (Causes of Death, COD, Health care, CARE, health Interview Surveys, HIS, Morbidity, MORB).

Within the Care statistics the System of Health Accounts (SHA) plays a dominant role. SHA is a system in which providers of care, financing of care and the functions performed are integrated. Since 2005 a Joint OECD-EUROSTAT-WHO questionnaire (JQ) is used to collect information on expenditure in health care.

In the area of the non-expenditure health care data EUROSTAT collects information on beds, discharges and personnel. EUROSTAT together with the partners succeeded in creating an International Short list of Hospital Morbidity Tabulation (ISHMT), which is part of the Family of International Classifications of WHO.

The COD statistics is the oldest data collection. Data on variety of causes are produced and disseminated on a regular basis on the EUROSTAT website.

Since this year the European HIS (EHIS) is put forward as the central instrument in the survey data collection on health provided by a sample of EU citizens.

The perspectives of WHO on country indicators

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Health information is a pre-requisite for the analysis, interpretation, development and comparison of health systems. Depending on the users, the information must be analysed and presented in a valid, usable and understandable way. It is a longstanding policy of the WHO Regional Office for Europe to provide indicator-based information for all 53 European member states. This is in part achieved by the maintenance of databases which also comprise health system indicators. One of the main focuses of the WHO European Office with respect to health information is to strengthen the data quality of all databases and the further sophistication of databases to enable more in-depth analysis. This applies to the standardization of data collection, the evaluation of reporting biases and finally the validation of submitted data. In addition to the European Health for All database (HFA-DB), the product range has been broadened recently. To give users access to more detailed

mortality data by cause of death, age and sex, two separate versions of the mortality database have been developed, each offering data at a different level of aggregation. A new source of information is also the European hospital morbidity database (HMBD) containing hospital discharge data, all accessible via www.who.euro.int.

In line with WHO's normative function, initiatives and continuous efforts are being made towards development of international definitions, standards and data collection instruments, which are essential pre-requisites for improving international comparability of health and health systems indicators. WHO has worked closely with EUROSTAT and OECD on the harmonization of health system parameters and will continue to support any efforts to produce valid inter-country comparisons. One of the future priorities will be to foster the harmonized development of health and health system indicators in close cooperation with EUROSTAT and OECD. The challenge, however, is to cover and include in this process also other WHO European Member States, which are not members of the EU or OECD.

3.10. Workshop: The implementation of the 'International Classification of Functioning, Disability and Health' (ICF) in disability assessment

*Chair: Peter Donceel (Professor and PhD)**

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Organiser: EUPHA Section on Social Security and Health; Prof. Peter Donceel (PhD), Department of Public Health, Katholieke Universiteit Leuven, Belgium; Dr. Soren Brage (PhD), Department of General Practice and Community Medicine, University of Oslo, Norway

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Sickness absence and disability pension run high in many countries and health care/physicians have a key role in assessing level of work incapacity that can legitimate benefits. However, criteria and procedures for the evaluation of the level of disability and work incapacity substantially differ among European countries. This poses a major difficulty for comparative analyses and data exchange. In 2001, the WHO adopted the International Classification of Functioning, Disability, and Health (ICF). The ICF introduces both a universal conceptual framework and a detailed classification system. This means that the ICF also holds the possibility of becoming an interesting and useful tool in the field of social security and disability evaluation.

First, the fundamental concepts of the ICF will be discussed with their implications for disability assessment. Secondly, since the detailed classification system of the ICF is too inconvenient for use in daily practice, core sets are proposed as a practical alternative. An adjusted method to develop core sets will be presented. Thirdly, the results of a European core for the assessment of long-term disability are presented. The final contribution discusses the need and the methodology for the validation of core sets in practice.

The framework and the concepts of the ICF and their implications for disability assessment

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Issue

The International Classification of Functioning, Disability and Health (ICF) is a new WHO classification. It proposes a uniform language to describe health impairments and their repercussion on the functioning of a person in his environment.

ICF is organised in two parts: functioning and participation (with its social dimensions) and the contextual factors including personal and environmental factors. The categories (description units) are organized on four levels. Each category describes the level of disability by means of ordinal qualifiers (five levels).

Description of the problem

ICF proposes four levels of complexity. The first level contains 30 categories, the second level 362 categories and the third and fourth levels 1424 categories. Each level contains the lower levels like Russian dolls. The first level is too simple to describe a social functioning with enough details and the third and fourth levels are too complex. However, if the second level seems to be a good compromise, it still remains quite complex to use.

Lessons learned

ICF introduces new concepts that differ from the traditional biomedical framework. Training is necessary to understand the concepts and to use the classification. Environmental factors should be used to assess the impact of the environment on the personal functioning.

ICF is theoretically useful in medical assessment of social repercussions of impairments. However, ICF is too complex to be used in routine and a solution is to build core sets suitable to describe each different problem to be assessed e.g. incapacity to work or need of assistance from a third person.

Conclusion

ICF can help to improve the quality of communication between the different professionals involved in medico- social assessment and can be useful to allow communication between professionals of different countries. Core sets must be built to make the classification more convivial and suitable for a routine use.