

**Policy Impact Assessment of
Public Health Reporting
(PIA PHR)**

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Key messages

Public Health Reporting (PHR) activities are a discipline to organise and disseminate findings from health statistics and other information and knowledge sources, not only but to a great extent for (policy) informing and also lobbying. They are also commissioned to give account about own activities or to create political support and legitimation.

PHR practitioners can influence necessary but not all sufficient preconditions to realise an impact on policy making. The needs of audiences, the utilization of PHR activities and the satisfaction with PHR activities are influenced by specific national circumstances (e.g. the political system, the health system, political culture, but also specific economic, social and health conditions). The geopolitical levels of PHR activities are also of relevance. The opportunities and challenges to realize a policy impact are further influenced by functions of PHR activities (to deliver information, ideas, arguments, enlightenment, monitoring, and support for managerial or political purposes) and the involvement in the stages of policy making (assessment, policy formulation, assurance, evaluation). In cause of different decision making structures, responsibilities and actor constellations it makes a difference if PHR activities handle issues e.g. in the fields of health promotion, prevention or curative health services.

The political, policy and polity contexts, target groups and aims differ for PHR activities. These differences have influence on the success of dissemination strategies. It has also to be taken into account that the assessment of needs of audiences, of the utilization of information and knowledge from PHR activities and of the satisfaction with the supply is influenced by different managerial and political contexts and different expectations or concepts of activities concerning target groups, functions, opportunities and challenges. The expectations of potential audiences influence the utilisation and satisfaction.

The findings of the project “Policy Impact Assessment of Public Health Reporting” (PIA PHR) about opportunities and challenges to realise a policy impact by PHR activities – drawn from the literature and by analysis of in depth and group interviews with target audiences for PHR activities and those being active in PHR activities – encompass:

- Information and knowledge from PHR activities must be accessible, intelligible, reliable, delivered in time and attract interest.
- It is necessary to identify and close gaps of the health statistics enterprise and to work on a conceptual frame to describe and analyse the health of populations and its determinants.
- Adequate resources (budget, manpower, qualification, information) are a precondition for effective PHR activities.

- The access to relevant information for those being active in PHR activities and potential user groups has to be optimised.
- It is important to deliver guidance to cope with an information overload (e.g. by the media, scientific publications etc), to inform about the validity of provided information and to support the selection of information and knowledge from different and competing sources.
- To provide information in a timely manner („policy windows“) and on demand increases the chances to realise a policy impact. Material should be delivered or be available when a debate is ready to happen. A knowledge stock to deliver information and knowledge in a short period should be generated.
- A newsletter, an attractive design (inclusive “eye-catcher”) and short presentations of main findings (with links to further information) offer opportunities to attract interest.
- For public health professionals the findings from PHR activities are not surprising. But they might be new for other audiences and comparative approaches, local information or more detailed information as well as describing the magnitude of a problem and how people are effected offer opportunities to create “new” knowledge and attract attention.
- Comparative approaches are of high value to promote the development of understanding, motivate for action and realise a policy impact. Missing information or other problems to compare entities are often a problem. Sometimes there is political resistance because undesired consequences (discrimination, segregation) or negative political consequences (political pressure, responsibilities) are expected. As far as resistance is motivated by political reasons only, political pressure could be build up by comparative approaches from above.
- As far as European policies and member states are concerned, it seems to be necessary to support multilevel comparative approaches. Resources are redistributed at the European level and in line with the differences across Europe. But there are also relevant differences between regions in and between Member States to be taken into account.
- PHR activities can be a valuable tool to stimulate change / support innovations and the diffusion of innovations. The spread of „innovation“ is influenced by the perceived benefit, the visibility and measurability of results, the compatibility with norms, experiences, interests, dominant believes and strategies for problem solving as well as the complexity / extent of required change for implementation.
- Lessons learned from the analysis of legislative policy making lead to the recommendations to focus the providence of information and knowledge on narrowing uncertainties in the policy debate, to deliver findings timely, to keep in mind that the work should make a difference and to watch the line between research and propaganda.

- Horizontal and vertical cooperation (division of labour, mutual learning, comparability of reports) can promote effective and efficient PHR activities. Higher levels of PHR activities should support conceptual developments, the availability of data, comparative indicators and approaches and the development of supportive tools for PHR activities on lower levels. For a policy impact decision making at the local / organizational level is also very important. The cooperation between levels and at one level can be supportive for an effective and efficient use of scarce resources.
- It is a promising approach to organise communication between target groups to prepare the commissioning of a report (to specify why a report is being commissioned and which questions should be answered) and to organise a second round where the findings of the preliminary report are presented, interpreted and discussed (to develop a common understanding, draw conclusions, develop recommendations for action) from different perspectives, professional backgrounds, different kinds of scientific knowledge and expertises. This strategy links the analysis of problems and the development of a common understanding with the presentation and discussion of possible solutions and it also delivers the foundation for an evaluation of the implementation of interventions.
- PHR activities should be framed by a definition of questions and aims and a cooperative interpretation of findings as well as deduction of conclusions for policy making.
- Those working on reports should interact with “policy entrepreneurs” (those who want to shape policies) but should not become policy makers by themselves to prevent political conflicts and defend the scientific character of PHR reports.
- It needs policy entrepreneurs to enlarge the chance to realise a policy impact by PHR activities. Policy entrepreneurs / policy makers should specify questions and aims to be reconsidered by those writing reports, interpret the findings and draw conclusions for policy making.
- Questions to be answered by the report and conclusions for policy making should be documented, e.g. as parts of the published version of a health report. But the parts linked with policy entrepreneurship and the providence of scientific, neutral and confidential knowledge should be separated.
- It is very important to disseminate findings from PHR activities to target groups and meet their needs, but it is also important to support people looking for information and knowledge by providing a knowledge stock which can be used for own purposes (directory for information sources, flexible utilization of indicators, texts, charts, graphs).
- There is need for a professionalized public relations strategy to disseminate findings from PHR activities and to take care about an accurate communication of the findings as well as an accurate deduction of arguments.

- Personal communication is a promising way for effective dissemination. Alliances with stakeholders are also promising. Especially when they comment findings of PHR reports from their point of view, this might enlarge the interest of the media.
- The media are helpful for the dissemination of results from PHR activities, but they follow their own concept of „news value“, jump from headline to headline and not follow always public health professionals' perceptions and perspectives. Professionalized public relations work and a respective qualification of journalists can be assessed to be supportive.

These findings have been used to develop a concept for an application to support the policy impact of PHR activities. Geo-demographic software applications deliver the opportunity to meet a lot of the topics listed above. They allow multiple comparative approaches, not at least on a regional level, can attract interest for issues which have to be explored more closely and support PHR activities as well as the dissemination of findings from PHR activities. They can be used to identify differences as well as similarities between regions. Information over the health status of populations can be linked with programmes and projects and thereby support cooperation, coordination and mutual learning.

Geo-demographic applications can offer the possibility of a flexible utilization. They can be used to create short reports and to export created maps, charts, graphs to own documents or more encompassing reports. Target groups can become involved in PHR activities by themselves. It is possible to deliver some guidance integrated in the application (recommendations about relevant topics, the relevance of certain indicators for this topic and the interpretation of results) or to integrate the application in online reports: While the texts of a report can describe the situation more in general, e.g. for the European level, audiences would get the possibility to take a closer, more detailed look at the Member States or regions of interest and analyse their status in the European or national context.

Such an application can build to a large extent on work already done (e.g. by Eurostat, DG SANCO and DG Regio) and maybe linked with ongoing projects (e.g. EUPHIX, EUREGIO II, EUREGIO III). It should be conceptualised as work in progress and stimulate discussions and debates about the further development of concepts, health statistics and empirical studies to close knowledge gaps.

Following the arguments that wealth influences health, that health is wealth and investments in health can have positive effects on economic growth and employment, within such an application information about health and health services can be linked with information about demographic, social and economic conditions to support investments in health by EU structural funds.

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1. Introduction

1.1 Background of the project

The interest in information and knowledge about public health and related issues has been growing for the last three decades. There is also a high general public as a political interest in health and related issues. A number of driving forces may explain the growing interest:

- New challenges are emerging, e.g. population ageing (European Commission 2007a; The Swedish Institute of Public Health 2006), new threats to health and new technologies (COM 2007a).
- Besides questions addressing population's health, health systems are reorganised and medical as well as other public health services are evaluated to link cost containment, effectiveness and efficiency.
- Partially influenced by those developments the interest on issues like prevention and health promotion has been growing.
- There is a debate about the social dimension of health and health inequalities (e.g. Mackenbach/Bakker 2003; CSDH 2008), for ethical and social reasons, but also for its economic consequences. With the integration of new EU Member States the differences in health have widened. It is seen as a major issue to close health gaps between populations and regions within Member States as well as between Member States.
- The World Health Organisation, the EU Health Strategy 2008-2013 and EU Structural Funds (EU SF) policies bring the interrelations of health and wealth, economic growth and employment into focus (COM 2007a,b; Figueras et al. 2007; McDaid et al. 2008; WHO 2008a,b). Spending for health and health services is not only seen as costs and a burden for the economy, but as an investment for wealth, e.g. economic growth and employment (Mackenbach/Meerding/Kunst 2007; Suhrke et al. 2005, 2007, 2008).

“Information”, “knowledge” and “understanding” (Friedman/Parrish II/Gibson et al. 2005) are needed to identify needs for action and to set priorities, to develop ideas and strategies to solve problems, to monitor and evaluate the consequences of major health reforms and programmes – at the European, national, regional and local level as well as at the organisational level. Use of the best available knowledge is very important for effective policy making. Qualified information and knowledge can support decision making, the development of a common understanding and the achievement of a better cooperation and coordination between the many actors involved in managing health systems, prevention and health promotion. It assures transparency and contributes to legitimation (Maasen/Weingart 2005; Weingart 2006). A strategic approach like the “open method of coordination”, if applied to

health policies, needs an encompassing foundation of information and knowledge to define targets, develop strategies and monitor and evaluate developments.

Public health reporting (PHR) activities are an important source to deliver information and knowledge. A lot of resources have been mobilised to develop and supply health indicators (e.g. by projects funded by the EU Commission), a lot of reports have been written (see for example the collection of public health reports at www.pia-phr.nrw.de), there are more and more experiences with the effects of different kinds of presenting and disseminating information.

The enhanced availability of health statistics and new technologies offer opportunities to disseminate high quality information as a prerequisite for informed decision making and “good governance”. While the opportunities have become better, there are also many challenges linked with health monitoring and reporting activities. It is well understood that for the purposes mentioned above as well as the opportunity to learn from each other the comparability of data and indicators has to be enhanced, e.g. in the European context, between Member States and their regions, but also within Member States. Still there is the question of how monitoring and reporting on population’s health can and should be configured. It has to be clarified how PHR activities are placed between different kinds of activities, e.g. health statistics, monitoring and policy counselling. It has to be analysed how to meet the needs and expectations of different audiences (Lögd 2003) and to disseminate information and knowledge effectively. Opportunities and challenges to realise an impact on policy making (Kuhn/Busch 2005; Robert Koch Institut 2002) must be better understood.

While the growing interest in information and knowledge about the population’s health and its determinants are an opportunity for health monitoring, PHR activities, health intelligence and other kinds of public health related information resources for policy counselling, it is very important to prove that reporting on population’s health is a valuable tool for policy makers and that respective investments are justified. Not at least those who decide about investments in PHR activities must be convinced.

For those being active in PHR it is necessary to learn from past and current experiences and to think about strategies to promote the effectiveness and efficiency of public health reporting activities by exploring new technologies, empowering mutual learning and making the best use out of existing, sometimes restricted and scarce resources, e.g. by working on horizontal and vertical integration of PHR activities, not at least to promote the own sustainability. It must be acknowledged that PHR is not “only” linked with collecting, organizing and analysing data and information and the production of health reports, but also mainly with the challenges to disseminate information and knowledge to target groups, to attract interest and/or to satisfy information needs especially but not exclusive among policy makers and others who can influence the health of a population (Rosén 1998; Rosén 2002), to motivate for activities or even to build up to political pressure. The challenges to realise a policy impact have been addressed at various conferences and meetings in

the past, e.g. in Bilthoven ten years ago (RIVM 1998), in Berlin in 2001 (Robert Koch-Institut 2002) and in a conference in Bielefeld 2003, beyond others being followed by the project “Policy Impact Assessment of Public Health Reporting” (PIA PHR).

1.2 Short description of the project

The EU funded project “Policy Impact Assessment of Public Health Reporting” (PIA PHR; Grant Agreement N° 2004109) was geared towards developing a methodology for PHR activities and a health information tool box which supports those being active in PHR to realize a policy impact. Major topics of the project were to understand decision-making processes, needs, expectations of different user groups in different European countries at the national, regional and local level, to learn about appropriate and effective ways of disseminating information and knowledge, to enhance the policy impact of PHR activities and to develop a respective tool box for those being active in reporting on population’s health. From the beginning it was assumed that differences in health systems, health policies and decision making between states and between the local, regional, national and European levels influence the strategies and kinds of institutionalisation of PHR activities and the opportunities and challenges to realise a policy impact.

The main questions for the project were:

- Do information and knowledge from PHR activities reach target audiences?
- How do they reach them?
- Do PHR activities meet the requirements of decision-making processes and needs, expectations of different user groups in different European countries on the national, regional and local level?
- Do PHR activities have an impact on (target) audiences? Do they “make a difference” in policy making?
- Which factors influence the policy impact of PHR activities?
- Are there differences between different contexts (e.g. purposes of PHR activities, countries, levels)?
- What can be done to realize a high policy impact of PHR activities?
- How to support those being active in PHR in terms of realising a high policy impact?
- Which consequences should be drawn for activities at the European level?

The project started with a desktop research about the impact of scientific knowledge on decision making, not only but also in the field of policy counselling (s. figure 1). The findings from desktop research were used to prepare and conduct a Delphi survey and group and in-depth interviews with representatives from different target

groups and those being active in PHR. The empirical material was analysed with qualitative methods to learn about the factors influencing the policy impact of PHR activities and to develop a respective methodology for PHR activities. The findings deliver the basis for a concept for an application which has been developed to maximise the chances to realise a policy impact by PHR activities. To test the concept of the application, an issue of major political interest was chosen: The “Health is Wealth”-debate and the opportunities to link public health issues with strategies for regional development and investments in health by EU Structural Funds.

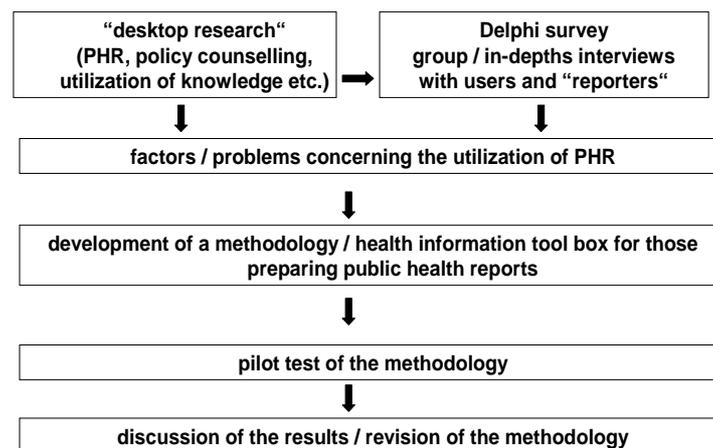


Figure 1: Project Design

1.3 Structure of the final report

Chapter 2 gives a technical overview about the activities of the project in the period from September 2005 to October 2008: It includes activity and output indicators (in line with the respective information in the Grant Agreement), the major trends and steps of the project (inclusive the impact of project meetings) and the dissemination of information about and findings from the project.

The methods and findings concerning the analysis of opportunities and challenges to realise a policy impact by PHR activities were used to conceptualise a methodology for PHR activities. The results are presented in chapter 3. Starting with the outline of a concept which places PHR activities between health statistics and policy counselling, a couple of critical topics are discussed and some recommendations to realise a policy impact and to support those being active in PHR activities are given.

These findings delivered the basis for the development of an application for PHR activities which aims to stress the links between health and wealth and to support the tackling of health issues within strategies of regional development, especially within EU Structural Funds policies. Chapter 4 describes the political relevance of the issue as well as the concept and design of the application which is based on geo-

demographic software and has the character of a tool box for those being active in PHR. The main part of the final report ends with some conclusions and an outlook on ongoing and further activities in chapter 5.

The report is accomplished by enclosures. Annex 1 presents the project members and is followed by the presentation of the project flyer in Annex 2. The results of a Delphi survey which prepared in-depth and group interviews are delivered in Annex 3. They are followed by reports about PHR activities concerning the opportunities and challenges to realise a policy impact in the six countries of the project members (France, Germany, Hungary, Ireland, Malta, United Kingdom/England) in Annex 4. The materials which were produced for the final conference of the project (conference flyer and abstracts) are entailed in Annex 5. Annex 6 is a tool box to support those being active in PHR in realising a policy impact by their activities.

2. Activities

2.1. Activity and output indicators

Chart 1: Work packages

Work package (WP)	First results / next steps
<p>WP 1: Development of an instrument to conduct group- and in-depth interviews months 1 – 8 (11/2005 – 6/2006)</p>	<p>The development of the instrument (guidelines) was accomplished 12/2006 by the following activities:</p> <p>desktop research about PHR, policy research, policy counselling, utilization of knowledge, impact of different products of the health information and knowledge system, e.g. reports, HNA, HTA, HIA etc. (desktop research was continued through the whole period of the project)</p> <p>several interviews/talks with PHR experts about PHR activities and its policy impact (11/2005 – 2/2006)</p> <p>a Delphi survey about features of PHR in six European countries: the first round (8/2006 – 10/2006) was about the “as is” state, the “importance in principle” and thereby also about deficits of 86 features of PHR, due to the low participation in the second round the survey was cancelled</p>
<p>WP 2: Conduct of focus group interviews (and additional in-depth interviews) months 7 – 17 (5/2006 – 3/2007)</p>	<p>appr. 150 persons (users and producers of PHR information) were interviewed in France, Germany, Hungary, Ireland, Malta and the United Kingdom mainly in the period 1/2007 – 4/2007 (some additional interviews until 11/2007)</p>
<p>WP 3: Analysis of group interviews months 14 – 23 (12/2006 – 9/2007)</p>	<p>The group and in-depth interviews were analysed during the period 3/2007-11/2007, country reports have been written (s. annex) and the material has been used as an empirical base to develop the concepts of an evidence-based methodology and an application for PHR activities which can serve as a tool box for those being active in PHR</p>
<p>WP 4: Pilot to test application of methodology months 18 – 28 (4/2007 – 2/2008)</p>	<p>Ideas for the pilot test were developed in the period 4/2007 – 11/2007</p> <p>A pilot for an interactive geo-demographic application was developed in the period 12/2007 – 10/2008.</p>

<p>WP 5: Project meetings / European conference months 3 – 31 (1/2006 – 5/2008)</p>	<p>first project meeting: 2/2006 (Bielefeld, Germany) second meeting: 11/2006 (Montreux, Switzerland) third meeting: 10/2007 (Helsinki, Finland) final conference: 9/2008 (Düsseldorf, Germany)</p>
<p>WP 6: Final Report / Dissemination of results</p>	<p>articles, abstracts and oral presentations of the project, e.g. at the EUPHA-conference 11/2006 (Montreux, Switzerland), a workshop at the EUPHA-conference 10/2007 (Helsinki) and a presentation at the EUPHA-conference in Lisbon 11/2008</p> <p>the final report has been sent to DG SANCO at the end of January 2009 and will be published together with the pilot application after its confirmation by DG SANCO</p> <p>the project webpage www.pia-phr.nrw.de has been established in the beginning of the project</p>
<p>WP 7: Coordination of Project months 1 – 36 (11/2005 – 10/2008)</p>	<p>finished</p>

Chart 2: Output indicators

Output indicator title	Target value to achieve	Status
Bibliography of health reports	approx. 120 entries	131 health reports have been collected and uploaded
Project Information Flyer	2,000 copies	1600 copies distributed electronic versions of the flyers were distributed by mail to invite for the participation in interviews and the final conference of the project
Internet page www.pia-phr.de	100 visits a day expected	webpage is online
Pilot application published as a paper	200 copies	The description of the concept of the pilot application is part of the final report. The application will be provided online as an electronic version after it has been confirmed by DG SANCO.
Papers and presentations delivered at international conferences	5	1 (EUPHA conference Montreux 11/2006) 1 (ISARE conference, Prague, 4/2007) 1 (Meeting of the Working Party on Health Systems, 6/2007, Luxembourg) 4 (EUPHA conference Helsinki 10/2007) 11 (PIA PHR final conference) 1 (EUPHA conference Lisbon 11/2008) in addition: presentations at national conferences / events
International conference	100 participants expected	Final conference 9/2008 in Düsseldorf, Germany, with approx. 40 participants
Distribution of final reports	500 copies	to be accomplished after confirmed by DG SANCO

Chart 3: Activity indicators

Indicator title	Target value to achieve	Status
Project meetings	3	3 (2/2006, 11/2006, 10/2007)
Group interviews: conduct and analysis	2/partner	Accomplished with a dominance of in-depth interviews instead of group interviews
Interim report	2	2
Presentation of results at conferences and in journals	5	e.g. 7 abstracts 2 articles 25 presentations it is planned to publish an article about the main findings after the confirmation of the final report by DG SANCO
Collection of health reports	120	131 national and regional reports have been collected
Maintenance of webpage	monthly update	reports have been uploaded; it is possible to search for reports by country and keywords interim reports have been uploaded presentations have been uploaded
Final report	1	Has been send to DG SANCO in January 2009

2.2 Major trends of the project and project meetings

The project started with desktop research about the impact of research and scientific knowledge on different kinds of decision making, interface problems and the utilization of knowledge, not at least in policy counselling. This was continued through the whole period of the project. For the first meeting of the project a couple of questions emerged, e.g.

- can PHR activities by themselves be seen as policy consultancy or do they deliver an information basis for policy consultancy? How are and how should PHR activities be linked with activities within the policy cycle?
- are there different contexts of the utilization of PHR activities which should be addressed by different kinds of supply of information and knowledge?
 - Are there differences between political systems, political culture, health systems?
 - Are there differences between the levels of policy-making (national, regional, local)?
 - Are there differences in needs and expectations between user groups, e.g. politicians, public officials, members of associations (health insurances, health professionals, charity organisations etc.), scientists, the media, the interested public?

At the first project meeting on February 16th/17th 2006 in Bielefeld (Germany), the aims, objectives and methodological implications of the project were discussed together with these questions.

To identify differences in PHR activities, different needs and expectations of target audiences as well as opportunities and challenges to realise a policy impact it was originally planned to conduct two group interviews and additional in-depth interviews with representatives from major audiences from the relevant political levels (local, regional national) in six European countries (France, Germany, Ireland, Hungary, Malta, United Kingdom). After the discussion about the in-depth and group interviews it was decided not only to interview representatives of different target audiences of PHR activities, but also those being active in PHR to learn from their experiences.

Further it was decided to prepare and complement the group and in-depth interviews by a online Delphi survey. It was assumed that two group interviews per country and some additional in-depth interviews would not allow the integration of all the different target groups of PHR activities, especially not of their representatives from the national, regional and local level of PHR activities. It was assumed to reach more potential interviewees by a Delphi survey.

An online questionnaire with characteristic items of PHR activities which had been drawn from literature and which addressed products, contents, structuring and

methods, functions, addressees of PHR activities, the utilisation and process of PHR activities as well as the roles of those preparing Public Health reports and the satisfaction with the respective activities on the different levels was developed and translated into English, French and German.

It was planned to ask the interviewees in the first round of the Delphi survey (see Annex 3) to assess the “as-is state” of characteristic features of PHR activities and their “importance in principle”. In a second and third round, the interviewees should have been asked about their preferences for the further development of PHR activities in the lights of the findings of the first round. Therefore the onlined questionnaire was programmed to present the findings of the antecedent rounds of the survey.

Starting with 192 participants (France: 22; Germany: 62; Hungary: 29; Ireland: 17; Malta: 32; United Kingdom: 32; other: 1), the Delphi survey unfortunately had to be cancelled due to the low participation rate in the second round. Even for the first round, the results have to be interpreted carefully. The sample is not representative for the utilization of knowledge from PHR activities. The compilation of the sample reflects the intention to integrate a certain number of representatives of different target audiences (country, level, professional activity) and of those being involved in PHR activities in the survey. The number of participants differed between countries, levels and professions. Politicians were especially reluctant to participate. But despite these difficulties, the assessments of experts raised some questions which were used in the construction of hypotheses for the following in-depth and group interviews.

After the first round of the Delphi survey was finished, first findings were presented at the EUPHA conference in Montreux (Switzerland), where the second project meeting took place on November 18th 2006. Topics included the discussion of the first round of the Delphi survey, the preparation of the second round, the preparation of the group- and in-depth interviews and the discussion about first ideas for the concept of a methodology for PHR activities and a health information tool box for those being active in PHR.

After it became clear that the second round of the Delphi survey would not be successful, the group and in-depth interviews started. From 1/2007 till 11/2007 154 persons were interviewed in France (10), Germany (42), Hungary (31), Ireland (12), Malta (48) and the United Kingdom (11). As in the online survey, the interviewees were representatives of the most important user groups at the relevant levels of PHR activities, people active in PHR activities and experts for PHR activities. Due to differences in the political and health systems, the compilation of interviewees differed somewhat between the countries in which the interviews were conducted.

Originally it was planned and outlined in the Grant Agreement to conduct two focus group interviews and additional in-depth interviews per country. For four reasons this

was changed for the majority of the countries and most interviews were conducted as expert interviews:

1. The number of interviewees would have been too restricted with two focus group interviews and only additional in-depth interviews. Also, there was the problem how to include representatives from a couple of different groups at the national, regional and local level in two focus groups only.
2. When asked about their willingness to participate in a focus group interview, most of the people were reluctant due to other time and effort commitments. But the willingness to participate in an individual in depth interview was high.
3. Some interviewees said that the anonymity of the in-depth interviews would be positive and there was the impression by the interviewer that interviewees were more open and free to give their opinions about the policy impact of PHR.
4. Focus groups have the advantage to stimulate a group dynamic and discussion. They allow analysing the interaction between people. But the timeframe is restrictive and it is not possible to discuss issues in detail with the experts involved. In-depth interviews offered the opportunity to get more detailed information about the experiences and impressions of the interviewees.

The interviews were conducted by telephone or face by face. They were based on a guideline. The questions of the guideline were about

1. the satisfaction with the supply of PHR activities (different levels)
2. the utilization of PHR resources (which? how?);
3. examples for a high / low policy impact;
4. PHR and the policy cycle (professional assessment, agenda setting, assessment stimulated by political interest to act, policy formulation, policy implementation, evaluation);
5. priorities for the further development of PHR and
6. possibilities to support people active in PHR.

The findings have been used to compare PHR activities, the utilization of information from PHR activities and the needs and expectations of interviewees in

1. England and Ireland;
2. France and Germany;
3. Hungary and Malta.

The comparisons have been discussed and presented at the third project meeting on October 10th 2007 and in a workshop at the EUPHA conference in Helsinki (Finland). The discussion identified similarities and differences between countries, raised questions and facilitated the development of hypotheses as well as producing some

new insights which influenced the (re)interpretation of national findings. Further topics of the discussion were the role of the media in the dissemination of information from PHR, possible positive effects to link PHR activities with economic issues, the dependency and independency of PHR activities in relation to political interest, the relevance of cooperation between commissioners of PHR activities, target audiences and those being active in PHR and the links between research and PHR activities.

A further topic was the conceptual framework of the methodology and the health information tool box. It was suggested to take into account that opportunities and challenges for PHR activities differ for different levels (local, regional, national, international), for different stages of the PHR processes (e.g. preparation to produce a product, production of the product, dissemination of the product/entailed information, evaluation of the process and the impact of this PHR activity) and for different functions or contexts of PHR activities, more or less linked with policy and decision making and the delivery of information, ideas and arguments.

It was specified in the Grant Agreement that findings about factors influencing the policy impact of PHR activities should be used for the development of a concept for an application concerning a public health issue of major importance. At the 8th Meeting of the Working Party of Health Systems in Luxembourg at June 11th/12th 2007 the development of an application which would use health-relevant indicators and social and economic indicators to support people active in PHR in developing and supporting "Health is Wealth"-strategies for regional development – not at least by the utilization of the EU Structural Funds was chosen. This topic was discussed and confirmed at the third project meeting. The target audiences were not only specified as people being active in PHR, but also as people who are involved in the development of strategies for regional development, who want to set health issues on the agenda within strategies for regional development, who want to realize projects and utilize funding from the EU Structural Funds or who decide about utilization of the budgets of the EU-Structural Funds. The information about regions should be useful for audiences at the local, regional, national and European level. It was mentioned that it is necessary to talk to economists about their information needs and expectations concerning information from PHR activities.

Reports for each country and the respective PHR system were written (see Annex 4). The empirical material has been summarised and arranged along main topics to develop the concepts for a methodology of PHR activities and a pilot application which can serve as a tool box for those being active in PHR activities (s. Chapters 3 and 4).

The reports about PHR activities in the six countries of the project members, the findings concerning factors influencing the policy impact of PHR activities and the concept for the pilot application have been presented and discussed at the final conference of the project at September 4th 2008 in Düsseldorf (Germany). The

concept for the pilot application was also presented at the EUPHA conference in Lisbon (Portugal).

During the project PIA PHR a collection of national and regional public health reports established by the predecessor project EVA PHR was expanded (<http://www.pia-phr.nrw.de/reports.html>). Websites of relevant public health institutions were searched for recent reports. Furthermore, institutions which are active in public health reporting (http://ec.europa.eu/health/ph_information/reporting/systems_en.htm (accessed March 2008) were asked in spring 2008 via e-mail to forward information on recent public health reports, or information on other bodies in their country that are active in public health reporting. Both activities resulted in the identification of 131 publications of all European member states and applicant countries as well as reports from the European Union (see chart 4).

Chart 4: Overview of countries for which new public health reports were entered in the database (collection period 2006 to 2008)

Country	Number of reports	Country	Number of reports
Austria	13	Lithuania	2
Belgium*	3	Luxembourg	1
Bulgaria	1	Malta	6
Cyprus	1	Netherlands	5
Czech Republic	18	Norway	3
Denmark	4	Poland	2
Estonia	1	Portugal	1
Europe	13	Romania	1
Finland	5	Slovakia	1
France	7	Slovenia	1
Germany	10	Spain	1
Hungary	7	Sweden	1
Ireland	8	Turkey	3
Italy	1	UK	10
Latvia	1		
TOTAL	131		

* additional two older reports updated

Reports can be searched by country or by topic (keywords). National online databases or information systems were also added. However, it should be mentioned that the collection contains not all available public health reports. The integrated ones

are a sample of online available reports, predominately with at least English written summaries.

2.3 Dissemination of information and findings

A project flyer with information on the aims, objectives, work packages, partners and contact persons of the project was produced in the beginning of the project. A further flyer was produced 2008 to announce the final conference. Electronic flyers were distributed by email, as attachments for the invitation to participate in the Delphi survey, the interviews and the final conference. Users and those preparing public health reports in the countries represented in the project were informed about the project and its aims when they were asked to participate in the Delphi survey as well as in the group- and in-depth interviews conducted as part of the project.

The website (www.pia-phr.nrw.de) informing about the project was developed at the beginning of the project and has been extended during the course of the project with a collection of public health reports and those presentations which have been delivered in the course of the project. It is possible to search for reports by choosing countries and keywords.

The aims, objectives and findings of the project were presented at a couple of national and international events – directly (the project as the main topic) or indirectly (main topics: policy consultancy, the use of research or scientific knowledge, the interface between those preparing public health reports and users of public health reporting, public health reporting activities in countries of the project members, findings from the project and the application which has been developed to support investments in health by EU SF; see chart 4).

Some of the findings of the project were discussed in the institutions of the project members and at events in their own countries. Some of the project members and their institutions participated and participate in other EU-funded projects, e.g. ISARE, I2SARE, EUPHIX, EUGLOREH. Thereby, the exchange of information between projects was supported.

The EUPHA conferences offered the opportunity to present the project at several occasions. In 2006 the aims of the project and preliminary findings were presented. In 2007, PHR activities and respective policy impacts in the countries of project members were presented in a workshop organised by the PIA PHR group. In 2008 the concept of the application which has been developed in the course of the project was introduced.

A final project conference with approximately 40 participants was organised in 9/2008 in Düsseldorf. As a result of the restricted budget it was not possible to pay the travel expenses of participants. Therefore, most of the participants were from Germany despite the fact that the invitation for the conference was disseminated broadly through European and national networks. Many people were therefore at least

informed about the existence of the project and the topics of the final conference. The presentations and abstracts are available to download from the project's webpage.

A printed version of the final report (500 copies) will be produced after the final report has been accepted by DG SANCO. It will be available to download the report from the project's webpage. Information about the project and its findings have already been disseminated by a couple of publications (articles and abstracts; s. chart 4). It is envisaged that there will be dissemination of information from the final report through further publications after the report has been confirmed by DG SANCO.

The concept for the application which has been developed in the course of the project will also be placed at the webpage of the project if the final report has been confirmed by DG SANCO.

Chart 5: Events at which the project was presented

Events		
Date	Venue	Presenter / Topic
(period of the first interim report)		
03.05.06	Public "lög training seminars", Institute of Public Health NRW, Bielefeld (Germany)	Kai Michelsen: "PIA PHR"
14.08.06	Sommerakademie Magdeburg- Stendal, Magdeburg (Germany)	Kai Michelsen: "How Can Political Parties Support Health Promotion"
(period of the second interim report)		
2.11.06	EPHZ-Meeting, Düsseldorf (Germany)	Kai Michelsen / "PIA PHR"
18.11.06	Annual EUPHA Conference, Montreux (Switzerland)	Kai Michelsen: "PIA PHR – First Results of A Delphi Survey"
21.11.06	EU Funds, Community Initiatives and Programmes 2004-2006, Ministry of Health, Valletta (Malta)	Amanda Salib: "PIA PHR"
24.11.06	Studentische Fachtagung Pflegewissenschaft, Fulda (Germany)	Kai Michelsen: "Policy Counselling and Health Policy"
26.-27. 4.2007	ISARE, Final Conference, Prague (Czech Republic)	Kai Michelsen: "PIA PHR"
26.-28.4.07	57th Scientific Congress of Physicians and Dentists of Public Health Services; Bad Lausick (Germany)	Helmut Brand/Kai Michelsen: „Gesundheitsberichterstattung als Politikberatung?“ ("PHR activities as policy counselling?")

23-24.5.07	6 th National Health Information Forum (HCSO, TARKI; Budapest)	Csilla Kaposvári: "PIA-PHR First findings of the Delphi Survey"
08.06.07	Training "Monitoring and Reporting System Public Health (Mrs. PH)"; Jurmala (Lettland)	Wolfgang Hellmeier: "Understanding the reasons for "Mrs. PH" from a customer's point of view"
11.- 12.6.2007	8 th Meeting of the Working Party of Health Systems, Luxembourg	Kai Michelsen: PIA PHR / Discussion of the pilot test
15.06.2007	PHR working group of the "Arbeitsgemeinschaften der obersten Landesgesundheitsbehörden"; Hamburg (Germany)	Wolfgang Hellmeier: "PIA PHR"
10.09.07	Conference for branch managers of local health conferences in North-Rhine Westphalia; Beckum (Germany)	Kai Michelsen: "Local PHR activities: As-is state, deficits and need for support. First results from expert interviews within the project (PIA PHR)"
10.- 13.10.07	Annual EUPHA Conference, Helsinki (Finland)	Workshop: Public health reporting – The challenge to realize a policy impact (Chairperson: John Wilkinson): Claire Bradford, Rachel Barrett, Anthony Staines: "Public health reporting systems, utilisation and impact in England and Ireland" Csilla Kaposvári, Amanda Salib: "Public health reporting systems, their utilization and impact in Hungary and Malta" Bernard Ledésert, Kai Michelsen: "Public health reporting systems, their utilization and impact in France and Germany" Helmut Brand, Alfons Hollederer, Kai Michelsen, Nicole Rosenkötter: "Scientific knowledge, its utilization and impact – some hypotheses for public health reporting"

22-24.11.07	Congress 2007 of the French Public Health Society; Montpellier (France)	Bernard Ledésert, Kai Michelsen, Helmut Brand, John Wilkinson: Rapports de santé: comment améliorer leur impact auprès des décideurs (Health reports : how to improve their impact on decision makers)
30.11.07	13th Congress Poverty and Health; Berlin (Germany)	Alfons Holleederer: PHR and Policy Counselling. First Findings of the EU-Project "Policy Impact Assessment of Public Health Reporting"
4.9.2008	Expert Meeting / Final Conference of the project: "The 'Policy Impact' of Health Reporting: Opportunities and Challenges; Düsseldorf (Germany)	<p>Helmut Brand: Between monitoring, policy advising and innovation management: Factors influencing the "policy impact" of public health reporting (</p> <p>Wolfgang Hellmeier: North Rhine-Westphalia: Indicators based health reporting with interactive tools</p> <p>Claire Bradford England: Regional intelligence for health improvement</p> <p>Bernard Ledésert: France: Do changes in the public health system imply changes in PHR activities and their policy impact?</p> <p>Amanda Salib: Malta: realising a high public health policy impact in a small island state</p> <p>Csilla Kaposvari: Hungary: Health reporting an health reforms</p> <p>Anthony Staines: Ireland: On the situation of health reporting</p> <p>John Wilkinson: The importance of regional public health reporting activities in Europe in the light of regionalisation and devolution in the UK</p> <p>Kai Michelsen: Information, ideas and arguments for investments into health and regional developments: Presentation and discussion of an application based on the project "Policy Impact Assessment of Public Health Reporting"</p>

4.9.2008	Expert Meeting / Final Conference of the project: "The 'Policy Impact' of Health Reporting: Opportunities and Challenges; Düsseldorf (Germany)	<p>Helmut Brand: Between monitoring, policy advising and innovation management: Factors influencing the "policy impact" of public health reporting (</p> <p>Wolfgang Hellmeier: North Rhine-Westphalia: Indicators based health reporting with interactive tools</p> <p>Claire Bradford England: Regional intelligence for health improvement</p> <p>Bernard Ledésert: France: Do changes in the public health system imply changes in PHR activities and their policy impact?</p> <p>Amanda Salib: Malta: realising a high public health policy impact in a small island state</p> <p>Csilla Kaposvari: Hungary: Health reporting an health reforms</p> <p>Anthony Staines: Ireland: On the situation of health reporting</p> <p>John Wilkinson: The importance of regional public health reporting activities in Europe in the light of regionalisation and devolution in the UK</p> <p>Kai Michelsen: Information, ideas and arguments for investments into health and regional developments: Presentation and discussion of an application based on the project "Policy Impact Assessment of Public Health Reporting"</p>
November 2008	EUPHA Conference; Lisbon (Portugal)	Helmut Brand: An interactive application to support investments in health by EU Structural Funds
Posters (period of the first interim report)		
16.-19.11.05	Medica, Düsseldorf (Germany)	Poster / "PIA PHR"
16.-18.11.06	Medica, Düsseldorf (Germany)	Poster / "PIA PHR"

Chart 6: Publications

Bradford, Claire / Barrett, Rachel / Staines, Anthony (2007): Public health reporting systems, utilization and impact in England and Ireland. European Journal of Public Health Vol. 17 Supplement 2. 15th EUPHA Conference. Abstract Supplement

Brand, Helmut / Holleder, Alfons / Michelsen, Kai / Rosenkötter, Nicole / Ward, Gudula (2008): An interactive application to support decision making about investments in health by EU structural funds. European Journal of Public Health Vol. 18 Supplement 1. 16th EUPHA Conference. Abstract Supplement

Brand, Helmut / Michelsen, Kai (2007): GBE als Politikberatung. Das Gesundheitswesen Vol. 69 No. 3: 178 (Abstract)

Brand, Helmut / Michelsen, Kai: Politikberatung durch Gesundheitsberichterstattung? Das Gesundheitswesen Vol. 69 No. 10: 527-533

Brand, Helmut / Holleder, Alfons / Michelsen, Kai / Rosenkötter, Nicole (2007): Scientific knowledge, its utilization and impact – some hypotheses for public health reporting. European Journal of Public Health Vol. 17 Supplement 2. 15th EUPHA Conference. Abstract Supplement

Kaposvári, Csilla / Salib, Amanda (2007): Public health reporting systems, their utilization and impact in Hungary and Malta. European Journal of Public Health Vol. 17 Supplement 2. 15th EUPHA Conference. Abstract Supplement

Ledésert, Bernard / Michelsen, Kai (2007): Public health reporting systems, their utilization and impact in France and Germany. European Journal of Public Health Vol. 17 Supplement 2. 15th EUPHA Conference. Abstract Supplement

Michelsen, Kai (2006): Policy Impact Assessment of Public Health Reporting (PIA PHR). European Journal of Public Health Vol. 16 Supplement 1. 14th EUPHA Conference. Abstract Supplement

Michelsen, Kai / Brand, Helmut (2007): Gesundheitsberichterstattung und Politik. In: Reintjes, Ralf / Klein, Silvia (Hrsg.) (2007): Gesundheitsberichterstattung und Surveillance. Messen, Entscheiden, Handeln. Bern: Verlag Hans Huber

3. PHR activities: A conceptual approach

3.1 Different opportunities and challenges to realise a policy impact by PHR activities

It is one of the most striking findings of the project that there are multiple kinds of PHR activities and beside the availability of resources (financial, personnel, health statistics) and experiences with the effectiveness of PHR activities the needs of audiences and the utilization of PHR activities are influenced by different contexts and concepts.

PHR activities inform about the health of population(s) and influences on health of population(s) by tailoring information and events to context. They can link the information with information about organized activities (like the health system, health policies/programmes, health targets etc.). Some reports aim to deliver a general overview (= basic reports), other concentrate on certain population groups, health problems, segments of health services or certain activities (special reports). PHR activities can be conducted continuously or they can be a single event, describing specific circumstances or delivering information and knowledge for a specific situation. They can be commissioned to monitor developments as part of managerial purposes, to support managerial policy making or decisions about major health reforms. Intentions might be to inform, persuade and/or motivate for action. They are expected to deliver information, but also to create knowledge and enable understanding. They are targeted to certain or multiple audiences.

Reporting activities are embedded in a social structure in which someone commissions or organises the dissemination of information and knowledge to target audiences for certain purposes (s. figure 2). PHR activities can be commissioned or organised by a public health authority, other public officials, the government or other institutions (NGO's, agencies, associations etc.). They can be commissioned

- to satisfy own information needs,
- for agenda setting
- to identify priority fields for action,
- to support the formulation of policies for defined priority fields for action,
- to monitor the effects of intervention,
- to support common understanding and cooperation in a pluralistic health system,
- to build up political support,
- to build up political pressure,

- to control activities of “agents” who might be responsible to give account over their activities,
- to fulfil the responsibility to create transparency and legitimation.

So, the purposes of PHR activities may be more or less defined. PHR activities can be practised for monitoring purposes, only leading to action if need is indicated (e.g. regulations for the planning of hospital beds versus emergence of new health problems). They might be linked with internal management, inter-organisational or intra-organisational policy making (health programmes; decisions within the regulative frame) or decision making about major health reforms (regulative decisions). PHR activities are a tool for the dissemination of information which can be used for policy management or governance, e.g. in a pluralistic and fragmented health system with a lot of actors, competing interests and need for coordination and cooperation. A report can stimulate a discussion, deliver the foundation for a debate or rationalize political controversies. It is also possible that reports are written to support individual decision making or that there are no explicit links with actual decision making at all.

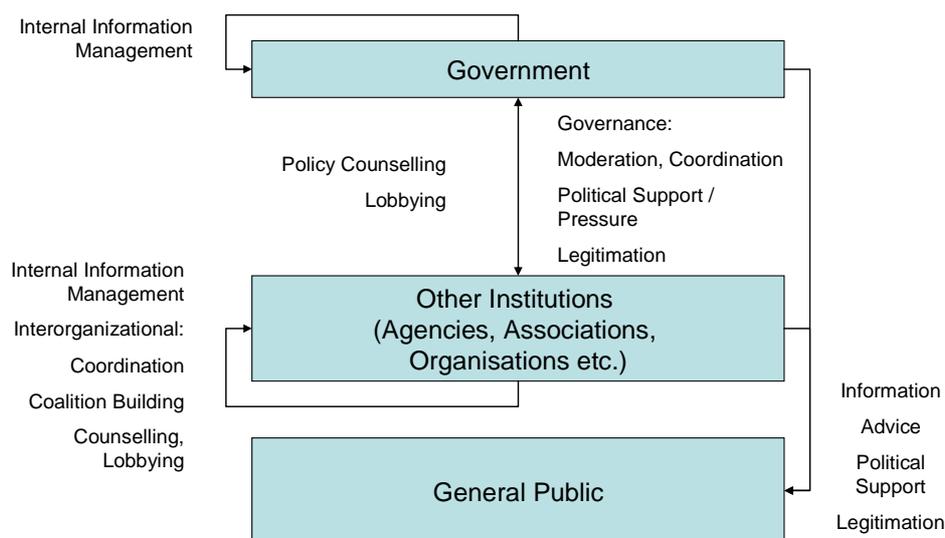


Figure 2: PHR, policy counselling, governance

There are differences between countries, the local, regional, national and European level and the linkages between PHR activities and policy making. The differences are influenced by specific national circumstances (e.g. the political system, the health system, political culture, as well as specific economic, social and health conditions), the distribution of competencies between the local, regional, national level, as well as differences in the placement of PHR activities between information, management, policies and politics. For example, the contexts for PHR activities seem to differ between national health services and social insurance based health systems, between centralised and federal states, between states with a more centralised and a

more pluralistic health system, between states with more or less emphasis on health targets as well as between larger and smaller states. As a result of different decision making structures, responsibilities and actor constellations, the content of PHR activities also seems to make a difference: PHR activities in the fields of prevention and health promotion can be placed in another political, policy and polity context than PHR activities addressing health services.

Further, people seem to have different concepts of PHR activities, their functions and the opportunities and challenges to realise a policy impact. These different concepts influence not only the assessment of needs, but also the utilization of information and knowledge and the satisfaction with PHR activities.

All these differences influence the effect of dissemination strategies. The opportunities and challenges to realize a policy impact seem to be quite different. The country reports describe the differences more in detail (s. Annex 4). In this chapter, the findings of the project are presented in an abstract, generalised way to deliver a conceptual approach for a methodology for PHR activities.

PHR activities have been defined as „a system for collecting, organizing, analysing, reporting, and disseminating data and information on health, diseases and their determinants in a defined population“ which can include “annual statistical reports, statistics made available on the internet, summaries and reports on the health status of population, conferences on public health issues, formulation of targets, health impact assessments, etc.“ (Rosén 2002: 94). This definition had strong influence on the project. As a consequence of literature research and the analysis of interviews being conducted in the course of the project it is further suggested to place reporting on population health between health statistics and (scientific) policy counselling as well as policy management.

Of course, the suggested distinction between health statistics, PHR activities and policy counselling is analytical only. While knowledge creation is not the main focus of reporting activities, reporting activities participate de facto in the knowledge creation process by compiling and structuring knowledge from different sources which may shape thereby the „health statistics enterprise“ (cf. Hunter et al. 2005). And while policy counselling is also not the main focus of reporting activities, in case of compiling and structuring knowledge from different sources for more or less targeted audiences and purposes reporting activities cannot strictly be distinguished from policy counselling: There are overlaps.

But the outlined conceptual approach stresses that questions about the policy impact of PHR activities and challenges and opportunities to realise a policy impact by PHR activities must address at least three stages (s. figures 3, 4):

1. The creation of knowledge, its dissemination and utilization.

2. Factors of influence concern PHR products (design, content), the process of producing products, the dissemination of information and knowledge and the integration of PHR activities and policy counselling.
3. The institutionalisation and different environments of PHR activities (e.g. distribution of responsibilities, political system, relevance and content of health policies, political culture) have consequences for the policy impact of PHR activities.

PHR and ...

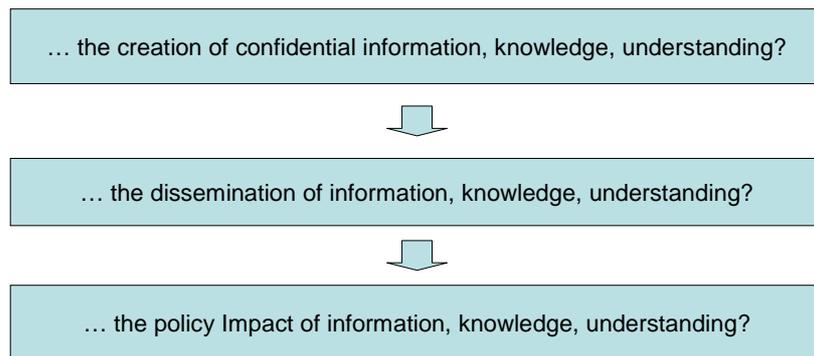


Figure 3: Stages of realising a policy impact

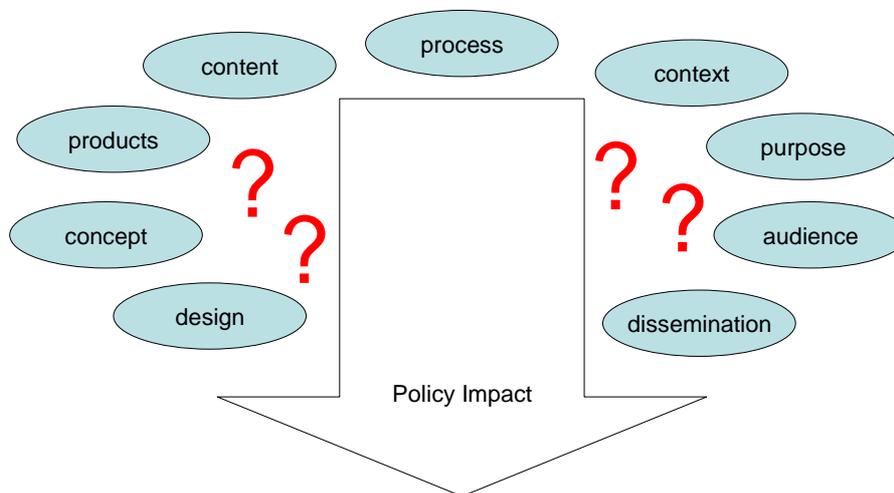


Figure 4: Factors influencing the policy impact of PHR

For reflections and recommendations concerning the policy impact of PHR activities, the findings from the interview and the desktop research underline the relevance of the relationship between health statistics and PHR activities and health statistics as a precondition of PHR activities, the issue of knowledge creation, PHR activities and policy making as well as policy counselling. After these topics have been addressed

as background information, some recommendations to realise a policy impact by PHR activities are given.

3.2 Background information: Topics of special interest

3.2.1 PHR activities and health statistics

“Health statistics” have been defined as “numerical data that characterize the health of a population and the influence that affect its health” (Parish II/Friedman/Hunter 2005: 3). They focus on “(1) quantification; (2) aggregation of data from observation on individuals, their communities, and the context of their communities; and (3) population health and the influence on it.” (ibid.: 5) They have to be distinguished from

- health data (which beside an aggregation of observations can entail single factual or individual observations and aggregation of observations),
- health information (which can include health statistics but also multiple other forms of information and knowledge resources) and
- health surveillance (which can refer to individuals, groups and populations and does not need to rely on quantitative methods) (ibid: 4).

Activities of the health statistics enterprise are the collection of data from different sources, the aggregation and compilation of data into health statistics, the analysis and translation of health statistics in order to make them comprehensible to varied users; and the evaluation of health statistics and the health statistics enterprise (Hunter/Friedman/Parrish II/Gibson 2005: 54). In this respect, elements of the “health statistics cycle” are defining data needs, specifying necessary data attributes, collecting, aggregating, and compiling data, analyzing statistics, translating statistics for use, evaluating the extent to which needs are met and hub-integrating¹ the health statistics enterprise (s. figure 5).

¹ “An effective hub, which may involve multiple organizations, approaches, and influences, can serve as a centre of gravity for diverse elements, holding the health statistics enterprise together and ensuring that the cycle of development and improvement continues to move in constructive ways.” (Hunter/Friedman/Parrish II/Gibson 62)

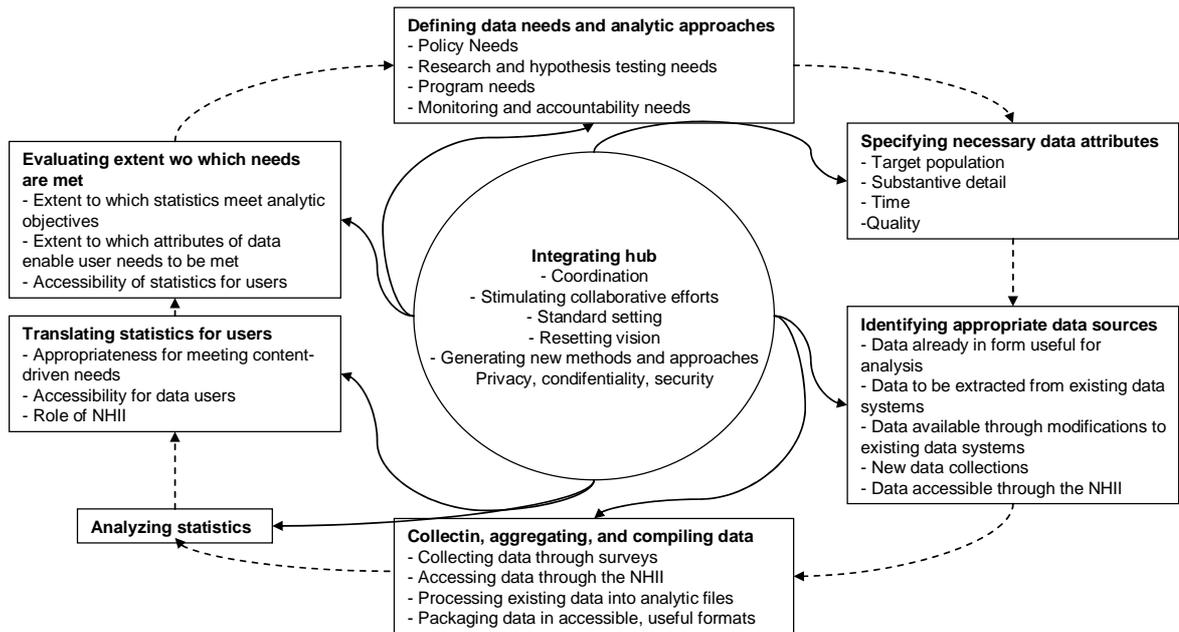


Figure 5: The Health Statistics Cycle / National Health Information Infrastructure
(Hunter et al. 2005: 57)

Health statistics contribute to the creation of fundamental knowledge about health related issues. They deliver health indicators (standardised measures to indicate “something”) and statistical analysis, describe the status of population health and factors of influence and allow comparing a status between populations in one region, between regions, between points in time and between an “as is”-state and a “should be”-state. They allow an interpretation / judgement about something which is not directly observable.

They can support policy making (assessment, definition of goals, planning, formulation of programmes and reforms, evaluation, and refinement of health programs and other interventions). They can also guide personal health decisions (ibid: 16). They can “enable citizens, policymakers, public health workers, and health care providers to assess local or national health, mobilize to improve it, and evaluate the success of their efforts” – but only *if they are “properly organized and communicated”* (ibid.: 4).

The transfer of information and knowledge is a major challenge and issues hindering a community’s ability to make effective use of existing community health information have been encountered (e.g. Buckeridge et al. 2002: 1200). In line with the capabilities of addressees it might be necessary to combine health statistics with information from other sources, e.g. to link epidemiological information with information about certain diseases or health risks, to add advices how to stay healthy or how to prevent risks, where to ask for help or how to intervene.

From this perspective, PHR activities are part of the "Health Statistics Enterprise", which "includes the many organizations that collect, analyze, and disseminate data on the health of populations and on the factors that influence health [...]." (Hunter et al. 2005). PHR activities are based on health statistics, are influenced by and might influence the conceptual framework of the "Health Statistics Enterprise". PHR activities aim to support the purposes of health statistics described by Parish II/Friedman/Hunter (2005: 6 ff.):

- to enable understanding of where we stand in terms of health;
- to allow individuals to place themselves;
- to allow comparisons of groups;
- to allow a better understanding of society;
- to contribute to a collective understanding of health, experiences with health systems, public health problems and challenges and
- to provide information for public decisions.

But while the "Health Statistics Enterprise" is primarily scientific and linked with research, PHR activities are based on scientific standards, but not primarily linked with the production of new scientific knowledge and quantitative statistics. The major issue is to link information, knowledge and understanding, to bridge the gap between scientific knowledge, "expertise" and decision making or policy making, to support the step from information from health statistics and other resources to intelligible, comprehensible and usable knowledge, to satisfy certain information needs. Therefore it is suggested to conceptualize PHR activities mainly as a tool

- to disseminate the findings from health statistics and other information and knowledge sources and
- to support a properly organisation and communication of information and knowledge.

The difference between health statistics and PHR activities is not necessarily based on the form. If the capabilities of the addressees allow them to understand information delivered in the form of indicators, charts and graphics, the report can look like "pure" health statistics. The main difference is the social context and the concept behind the report: to present and disseminate information in a way that it "fits" to the purposes of the commissioners and the needs and capabilities of audiences.

3.2.2 Health statistics as a precondition for PHR activities

While PHR activities analyse, interpret, translate, transform and amalgamate information and knowledge from different sources for specific purposes and target

audiences, health statistics are an important precondition to realise a policy impact by PHR activities. Health statistics are a crucial fundament of PHR activities.

During the last decades, new opportunities for health statistics and PHR activities developed. Data from different sources has been brought together, additional data resources have been provided, surveys are important supplements to routine data, the comparability of data has been strengthened and new technologies are available.

But there are still gaps of the health statistics enterprise, shrinking the quality and effectiveness of the "PHR enterprise". The gaps identified by the analysis of interviews which have been conducted within the PIA PHR project are quite similar to the gaps which are mentioned by Hunter/Friedman/Parrish II/Gibson (2005: 68 ff.) for the US health statistic enterprise.

The "measure of success" for the health statistics enterprise "is the extent to which [...] individual components work in concert to meet the broader mission of understanding the population's health and influences on it." (Parish II/Friedman/Hunter 2005: 3 ff.; 53) That means "to provide [easy accessible; K.M.] timely, accurate, and relevant information that can be used to improve the population's health, including information about the status of the population's health, information that can be used to formulate and evaluate the effects of health policy, and information that can be used to manage health interventions and programs." (Friedman/Hunter/ Parrish II 2005: 506)

On the one hand, the current situation is sometimes characterised by a lack of data since it is not always possible to display recommended geographic details or other specifics and it is a challenge to deliver topical information. On the other hand, there is a great amount of data being collected. But this data might deliver either sometimes poor information or is difficult to locate, access or use. The connections between data sources, organisations which deliver data and data users are not always sufficient. Resource constraints have negative impacts on coordination, enterprise-wide planning, innovations, flexibility and adaptability. An optimal allocation of resources and training in health statistics and reporting activities as well for people being active on those fields as for the audiences of their work is necessary.

Topics for further development of the health statistics enterprise (s. Hunter/Friedman/Parrish II/Gibson 2005: 68 ff.) are also of relevance for the further development of the PHR enterprise:

- development of consensus approaches;
- investments in methods, technologies, approaches;
- training in health statistics;
- influence on decision makers who influence the availability of data;

- development of conceptual frameworks;
- support and training for users;
- optimal allocation of resources;
- flexibility and adaptability;
- enterprise-wide planning.

A population health framework to monitor the population health and the health system performance should include a focus on positive health and wellbeing beside ill-health and disease and consider the full range of influences rather than just the most proximate influences (Friedman/Hunter/Parrish II 2005: 501 f.). The work on more rational, cohesive, and comprehensive national health statistics enterprises should be continued (ibid: 503 ff.) Challenges and opportunities consider methodological and process issues. It is necessary to work on population-level summary measures. Sufficient detail at different levels of aggregation is needed. Possibilities for simulation, causal modelling and forecasting should be enhanced. Integrated, streamlined data collection for multiple purposes is important. To facilitate linkage and sharing of data sets, barriers for standards and reluctance of data providers to share information for health statistics must be overcome. The development of data standards and standard indicators is very useful. The “enterprise” should also be flexible to identify and address emergent health issues and needs. Timely production of valid and reliable health statistics is important. It is necessary that the public achieves an appropriate understanding of the value accruing from health statistics. Appropriate access to and ease of use of health statistics has to be promoted. Continuous evaluation of the scientific integrity, relevance, accuracy, and timeliness of health statistics and of the ability of the health statistics enterprise should guarantee the successful development of the enterprise. It is necessary to maximise the scientific integrity of all aspects of health statistics while acknowledging the specific ways in which the political, cultural, and business contexts may affect data collection, analysis and interpretation. Enterprise-wide planning, coordination and collaboration among data users, producers and suppliers at local, state and national levels should optimize the enterprise’s accountability to its users. This will ensure efficiency, the fulfilment of expected functions and will increase the relevance to local, state and national policy and program decision making, which may lead to an overall conceptual framework of the influence on the health of populations.

3.2.3 Knowledge creation

The terms “data”, “information”, “knowledge” and “understanding” can be placed in a hierarchical framework to describe the process of health statistics and PHR activities which starts “with basic data, facts, and other observations, moves through the compilation of data within a context; continues with the analysis of observations for

possible associations; and concludes with the development and testing of hypotheses, ultimately resulting in theories and laws about how things work.” (Friedman/Parrish II/Moiduddin/Ketchel 2005: 246).

“Data” can be defined as numerical and nonnumerical elemental facts representing objects, events and properties. Following Ackhoff (1996, 28-29), “[i]nformation is contained in descriptions, in answers to questions that begin with such words as who, what, where, when, and how many. Information is usable in deciding what to do, not how to do it. ... Answers to how-to questions constitute knowledge. ... Knowledge is contained in instructions. Knowledge consists of know-how, for example, knowing how a system works or how to make it work in a desired way. It makes maintenance and control of objects, systems, and events possible. ... Understanding is contained in explanations, answers to why questions.” (cit. by Friedman/Parrish II/Moiduddin/Ketchel 2005: 244 ff.)

While “knowledge creation” is sometimes viewed “as a process of transforming tacit knowledge [...] into explicit knowledge [...]”, Friedman/Parrish II/Moiduddin/Ketchel (2005: 246 ff.) define knowledge creation as “the process by which knowledge is developed, disseminated, and used”. For them, knowledge development and research are synonymous, while knowledge creation includes also the dissemination and use of knowledge. Health statistics and PHR activities can support to the creation of knowledge and help to develop understanding by comparisons, analysing possible associations and causal relationships. They can be used to test the validity of a hypothesis and are also related to knowledge development (= research) (ibid: 251). They can also support understanding of potential solutions to health problems, especially if points in time, regions, populations are compared (ibid: 243).

The critical question for health statistics and PHR activities is how to contribute to “knowledge creation”. In a first step, the challenges of the transfer of knowledge and knowledge management can be described by looking at the blueprint of an information system. An information system can be described as a “ladder of knowledge creation” (North 1998; s. figure 6). A couple of steps have to be taken successfully for an effective operative management. Signs have to be “ordered” (syntax) to get data. Data has to be combined with meaning to get information. Indicators are an example for this. Information has to be integrated to and combined with “scientific knowledge” as well as “expertise”. The impact on policy or decision making is influenced by the ability and the willingness to do something as a precondition for action, and there is an interest in doing something “right”. Beside information about the extent of a problem and factors of influence policy makers need knowledge about what works to tackle a problem or an idea what could work.

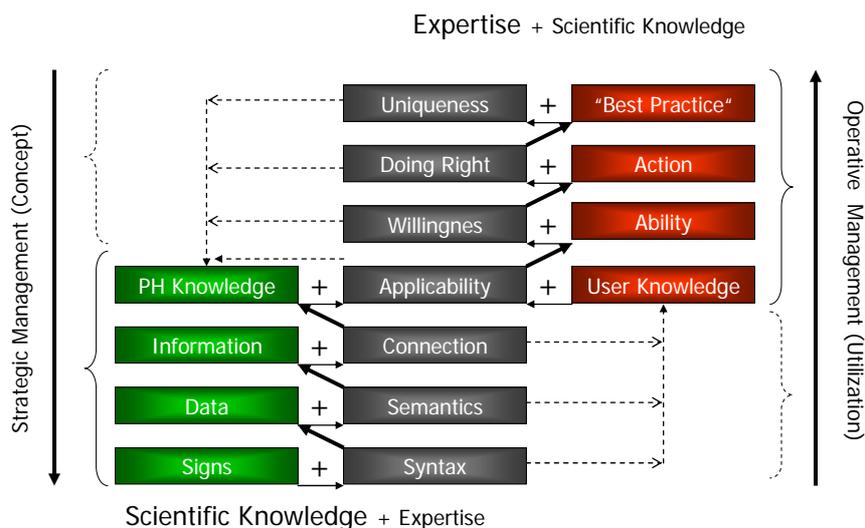


Figure 6: Management information system: The ladder of knowledge creation

People being involved in the strategic management of information flow have to know at least something about the information needs as well as the understanding and knowledge of target audiences. PHR activities must meet the status quo of audiences. Audiences need a lot of knowledge and understanding to interpret and understand the information delivered. Therefore, it would be necessary for them to know what an indicator measures, how the results of a measurement can be interpreted and how findings can be integrated in the existing knowledge and understanding. It is one of the major aims of PHR activities to translate information to minimise the preconditions of understanding. It would be very supportive for the chances to realise a policy impact by PHR activities that experts working on the strategic management of information systems and people being active in PHR understand the needs of decision makers, that commissioners of PHR activities specify their needs, that audiences understand PH professionals perspectives and are able to translate the findings and amalgamate them with practical knowledge. But this is not always the case. The capabilities of target audiences differ. And while such a management information system is effective in a well defined surrounding, PHR activities are often confronted with multiple target audiences, information needs and kinds of utilization which hamper the strategic and operative management as far as the process of decision making is concerned.²

Also, while sometimes pure (scientific) information is needed and directly linked with decision making, situations in which scientific knowledge has indirect effects by stimulating the development of ideas or delivering ammunition in political controversies are of high importance for realising a policy impact. Both, ideas and

² For a critical assessment concerning the utilization of social sciences for social problem solving s. Lindblom/Cohen (1979).

arguments can be more or less close to the original information and knowledge supplied (Weiss 1991).

Further, even if scientific standards are followed, the possibility to realise a policy impact by delivering reliable and widely accepted information and influencing knowledge creation is often restricted in cause of the normative dimension. "Reference to 'knowledge' or 'research' does not signify a single body of thinking, data or literature that is commonly recognized and accepted. To the contrary, it implies a struggle between different 'knowledges' or what are often described as 'discourses', 'worldviews' and 'regimes of truth'. Accordingly for many, the issue is not simply the creation and dissemination of knowledge, but the kind of knowledge that is produced and the kind of knowledge that dominates." (Stone/Maxwell/Keating 2001: 30) Therefore, the creation, concept and utilization of a knowledge base are always political.

3.2.4 PHR activities and policy making

"Policy" can be defined as „an institutionalised ,plan or course for action [...] intended to influence and determine decisions, actions and other matters' [...]" (American Heritage Foundation 2000; cit. by Friedman/Parrish II/Moiduddin/Ketchel 2005: 260). Policies define relationships, allocate resources, and determine the rules for operation (Feder/Levitt 2005: 278). The process of policy making encompasses assessments, agenda setting, specification of alternatives, authoritative choice over alternatives, the assurance of the implementation and evaluation (cf. Buse/Mays/Walt 2005).

Health statistics and PHR activities can provide in particular much of the core information utilized for the assessment, but at least in theory they can also support policy development, assurance and evaluation. They are of relevance for the ten services that constitute public health practice (Oswald/Friedman/Hargreaves 2005: 297):

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships at the state and the local levels to identify and solve health problems.
5. Develop policies and practices that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to health services and ensure the provision of health care when it is otherwise unavailable.

8. Ensure the existence of a public health and personal health care workforce.
9. Evaluate the effectiveness, accessibility and quality of personal and population based health services.
10. Conduct research to develop new insights and innovative solutions to health problems.

It is an ongoing, not only technical challenge for the creation of knowledge to translate health statistics and other kinds of professional and scientific public health knowledge for policy making. To realise a policy impact by PHR activities focussing on the providence of scientific, neutral and confidential information seems to be easier in a “pure” administrative, managerial environment, while the utilization of information and knowledge in a more political environment is influenced by politics. Even public health practise is not a merely technical issue but has at least to a certain degree a political dimension. While “evidence” from research and scientific knowledge is of importance for the legitimation of policy making, the impact and the knowledge utilization “is uncertain and contingent on social and political context.” (Stone/Maxwell/Keating 2001: 2, 21).³

How information and knowledge from research (and PHR activities) feeds into policy is influenced by couple of factors. The utilisation is affected by

- the ambiguity / unambiguity of research findings:
- the interaction between characteristics of the receiver, the source, the message and the channel of information and
- core values and beliefs (which are used to digest and transform information but in the process may be transformed themselves) (Friedman/Parrish II/Moiduddin,/Ketchel 2005: 263 f.).

Ten ways of conceiving the dynamic between scientific knowledge / research and policy-making have been identified by Stone/Maxwell/Keating (2001: 3 f.). Here they have been summarised to nine ways and it should be mentioned that the different perceptions of problems are only exclusive if the discussion is about the main dimension of a problem. But it is also possible to see them as different dimensions of the problem. These nine ways address the existence of relevant knowledge, the supply of relevant knowledge, the access to relevant knowledge and capabilities, the willingness of audiences to use relevant knowledge, the different purposes which are linked with the providence of knowledge as well as the power of relationships:

- At first, there might be a public goods problem: As an inadequate supply of policy relevant research (ivory tower).

³ See also Innvær et al. 2002, Lomas 2000, Reiners 2005.

- Secondly, relevant knowledge might exist, but policy making can be confronted with a lack of access to research, data and analysis. A solution would be to improve the access and the diffusion of knowledge.
- Thirdly, there might be a poor policy comprehension of researchers and those delivering scientific knowledge. Researchers and those providing scientific knowledge should get closer to policy making. It has been suggested to study the policy process, to demonstrate the relevance of research for policy making and evaluate the relevance of research.
- Fourthly, there is the possibility that relevant knowledge is offered, but ineffectively communicated. The answer would be improved communication strategies. The problem might be seen as one of effective dissemination.
- Fifthly, it has been mentioned that problems not only concern the relationship between scientists and policy makers. Sometimes also a societal disconnection of researchers and policy makers on the one hand and those do research is about or intended for on the other. This can undermine an effective implementation. This problem could be solved by a participatory process.
- Sixthly, the utilization of scientific knowledge can be restricted in cause of ignorance of politicians or bureaucrats being dismissive, unresponsive or incapable of using research. The answer could be to improve the capacities to recognise and absorb research. Conference and workshops and the appointment of specialists to government committees have been recommended.
- Seventhly, it might be the purpose not to realise a direct impact on policy making but to realize socio-political, economic and cultural influence. Then it seems to be necessary to define the domains of scientific knowledge and to develop a long term perspective.
- Eighthly, power relations influence the definition of “valid knowledge”, the influence of ideology, the struggle over the control of knowledge and censorship.
- Ninthly, there is an epistemological discussion over the validity of research and the possibility to base action on scientific knowledge.

While decision makers are interested in scientific based and expert knowledge to legitimate their policies, for a couple of reasons, scientific knowledge is also challenge for policy makers (Weingart 2006) and there might be conflicts between policy makers and those being active in PHR. From a Public Health perspective, usefulness is defined by a positive change in populations health or by a more effective and efficient use of resources which in the end also could be used to “produce” more health. But political needs and interests might differ from public health professional’s perspectives. For policy makers, the effects on health might be important, but usefulness has also a political dimension. Often there are conflicts concerning the allocation of available resources and it is necessary to organize

political majorities to defend the own political power or for the successful implementation of policies and programmes. Policy makers must be able to identify and prioritize problems. The motivation to act is linked with the assumption that change is possible and with an idea which kind of action could be successful. It is a problem when research findings and reports address problems which are not prioritised by policy makers, create political pressure while policy makers do not want to act on the problem at least not immediately or do not see the possibility to act successfully, or when envisaged policies are challenged by competing scientific analysis and advice. It is also a problem for policy makers, when policies which might have been carefully based on scientific knowledge yesterday can be challenged by new insights from new research findings tomorrow. Also, it has to be noted that scientific knowledge – the scientific assessment of a problem and scientific advice of doing right “in theory” – might as well fail to deliver a useful construction of reality as to meet political realities.

People with political responsibilities can try to prevent the emergence of political pressure by using their political power or their role as commissioners of research or reporting activities to control the production and dissemination of knowledge. There might be a struggle over the control of knowledge with scientists and those being active in PHR activities who want to publish their findings (Weingart 2006) or argue for the need of action.

3.2.5 Policy counselling

There are different visions and models of policy counselling (e.g. Cassel 2002, 2003; Dagger et al. 2004; Habermas 1969; Lompe 2006). It is a popular assumption that scientists or other experts counsel politicians or representatives of the government along the steps of the policy cycle or the „Public Health Action Cycle“ in context with problem identification, agenda-setting, policy formulation, implementation, assurance and evaluation (Falk et al. 2006, Rosenbrock/Gerlinger 2006). But policy counselling has many different forms which can be structured historically as well as in typologically (Rudloff 2004).

Following the “decisionistic model” (Habermas 1969, Lompe 2006; Saretzki 2007), decisions have to be made by political decision makers. Policy counselling takes place to realise defined values and interests, or finally decisions are made on the foundation of own values and norms.

The “technocratic model” assumes the possibility that scientists are able to identify the best possible solution for a problem. This assumption is critical for democratic norms and the experiences with policy counselling and competing expertises demonstrates the limits of policy counselling. Also, there is the question about the impact of scientific policy counselling on policy making. In modern societies, the legitimation of policies depends as well on a democratic representation of interests as on the quality of the knowledge behind decisions and there might be tensions

between these to foundations of legitimation (Weingart 2006; Weber-Hassemer 2008). Beside evidence-based knowledge the public opinion, financial conditions, political priorities, assumptions about the opportunities of implementation, ideologies and subjective concepts are influential (Kurth 2006).

The „pragmatistic model“ transcends a critical interdependence between experts and policy makers. It is argued that the communication between experts and policy makers must consider societal interests and the given social circumstances because the direction of technical progress is rooted in tradition-bound self concepts of practical demands and the self concepts are measured and criticised on the basis of the opportunities and challenges to satisfy the demands (Habermas 1969). The model follows the assumption that the intermediation of scientific knowledge and policies is dependent from the public and communication between citizens for reasons of legitimacy. Policy counselling is placed in the area of conflict between sciences, the public and politics (Saretzki 2007). For PHR activities this could e.g. mean not only to report about the health of populations and the respective health determinants, but also about needs, interests and values as well as possibilities to meet the needs of the population and about the need for research.

Changes in the area of conflict raise the question how to conceptualize policy counselling in future (Saretzki 2007). It has been recommended to counsel the society beside policy makers. On the one hand it has been argued that politicians are interested in power in the first line and less in scientific-based decisions. Therefore policy makers would not be the right target groups for the purposes of scientific policy counselling (Cassel 2002, 2003). Another argument says that sometimes politicians are not the right target group, e.g. when relevant decisions are not made by politicians or when decision making is not easy to regulate by political regulations (Mayntz 1994). In these cases policy counselling should not be oriented in supporting decision making but support orientation (Saretzki 2007). Instead of following the models of social engineering or problem solving policy counselling should follow the „enlightenment model“ (Weiss 1977). Especially as far as prevention and health promotion are addressed, PHR activities should be addressed to policy makers as well as the civil society.

The impact of scientific knowledge on policy making has been analysed and discussed in studies and essays concerning the utilization of knowledge, policy making and policy counselling. From experiences with PHR activities, studies about the utilization of knowledge in decision-making and about policy counselling it is known that there are interface problems between the “two worlds” of science and policy-making and different ways of using scientific knowledge (e.g. Heinrichs 2002). But the situation is even more complex. Different types of policies have been distinguished (e.g. Lomas 1990: clinical, administrative and legislative policy making). Together with different contexts of policy making they influence the utilization of information and knowledge from research, sciences and therefore also PHR activities

and the effects of strategies to realise an impact with research findings or PHR activities (Almeida/Bascolo 2006; Friedman et al. 2005; Hanney et al. 2003; Weiss 1991). The differences might explain the existence of a couple of different models to describe the utilization and impact of scientific knowledge (e.g. Cohen/March/Olsen 1972: garbage can process; Lindblom 1959: science of mudding through; the policy cycle as a model for rational policy making, new institutionalism, advocacy coalitions, constructivist approaches, post modern approaches, s. Stone/Maxwell/Keating 2001: 5 ff.).

Therefore, also the possibilities to realise a policy impact by PHR activities differ. They are influenced by the kind of the counsellor, by the institutionalisation of counselling, the respective policies and the conduits of advice. The abilities to access policy making differ for contract researchers, “in-house” researchers, political advisors, civil society researchers and “desinterested” researchers (Stone/Maxwell/Keating 2001: 13 ff.). It makes a difference if advice is given within legislative procedures, for bureaucratic decision making, more general educational purposes or to influence opinions. It makes a difference to give advice to policy makers, to people being involved in participatory processes or within “own” networks. On the other side, the political culture, bureaucratic traditions, responsibilities, role expectations, available resources, education and capabilities of decision makers in the political executive, legislatures, civil servants and appointed officials, street level bureaucrats, research editors and evaluators influence utilization of scientific knowledge. Furthermore, the reception of research communication, the strategies to look for scientific knowledge and preferences for different possibilities to get advice are influenced (ibid. 2001: 21 ff.).

3.3 Opportunities and challenges for the policy impact of PHR activities

3.3.1 How it should be

As the strength of experiences, studies about the utilization of findings from research and scientific knowledge as well the findings from the interviews conducted within the project PIA PHR indicate, reporting activities should have a sound information base of best possible quality. The analysis and presentation of information should follow scientific standards, including the use of a conceptual approach. The conceptual approach allows the integration of information and provides a frame to support the step from information to knowledge. Because any kind of providing information reduces the complexity of reality, an explicit conceptual approach allows a discussion of the perspective and underlying hypotheses and models – a prerequisite of scientific standards.

PHR activities should produce and disseminate reliable information / knowledge and support understanding. They should give orientation in a world of competing statistics

and positions, help to detect issues of major importance, raise attention or deliver requested information timely to target audiences. The supply of information should be easy to assess for all people being interested and looking for information and knowledge. It should be organised to support different and individual usages.

Reporting activities should support answering questions of audiences, e.g. are there reasons to become active, what is the problem, what are the reasons for a problem, what could be done, what has proven to be effective, who could do it, which effects can be expected etc. Therefore it seems to be useful to look for possibilities to narrow or even bridge the gap between a public health perspective and political responsibilities and decision making structures by the development of an adequate conceptual frame.

PHR activities should support people to get an impression of the magnitude of a problem and help them to set priorities. Comparative approaches are of high value. If possible, it should also be clarified how people are affected by health problems. To deliver information for the local level seems strongly motivate for action when possibilities for intervention exist. At all levels the concepts for PHR activities / reports should reflect existing decision making structures to bridge the gap between professional public health perspectives and policy making.

3.3.2 Handling limited resources

Preconditions for effective PHR activities are adequate resources (financial, personnel, informational). Those being active in PHR have to be qualified in health statistics and the utilisation of the informational infrastructure. It might be a problem to convince potential commissioners or investors in PHR activities to provide enough resources in the starting phase, because a lack of resources makes it difficult to prove the opportunities of PHR activities. But it is decisive to convince them that investments are satisfied.

People being active in PHR can be supported by the delivery of “models of good practise” (process, design of products, concepts, methods, utilization of new technologies) and activities to support the development of good practise, e.g. by horizontal (between activities at the same level) and vertical (between activities at different levels) cooperation or integration. Cooperation between institutions at the same (e.g. local) level is helpful. It is possible to foster a process of specialisation and division of labour: The development of conceptual approaches, “example reports” and more ambitious statistical methods could be delegated to certain specialised institutions at the same level of PHR activities. “Higher” levels of PHR activities (regional, national, European) could also take care about the conceptual work and further about the availability and comparability of data to support comparative approaches. Flexibility and pluralism of PHR activities should be combined with coordination and cooperation to handle limited resources effectively, to facilitate comparative approaches and to support mutual learning.

All in all, it is recommended that higher levels of PHR activities should conduct PHR activities for their own policy making, but also support conceptual developments, comparative approaches and the development of supportive tools for PHR activities on lower levels, while PHR activities at lower levels could reproduce well known epidemiological knowledge to attract interest at the local level but should especially focus on bridging the gap between scientific knowledge and local action, taking local circumstances concerning health and other relevant services and actor constellations into account (s. Figure 7).

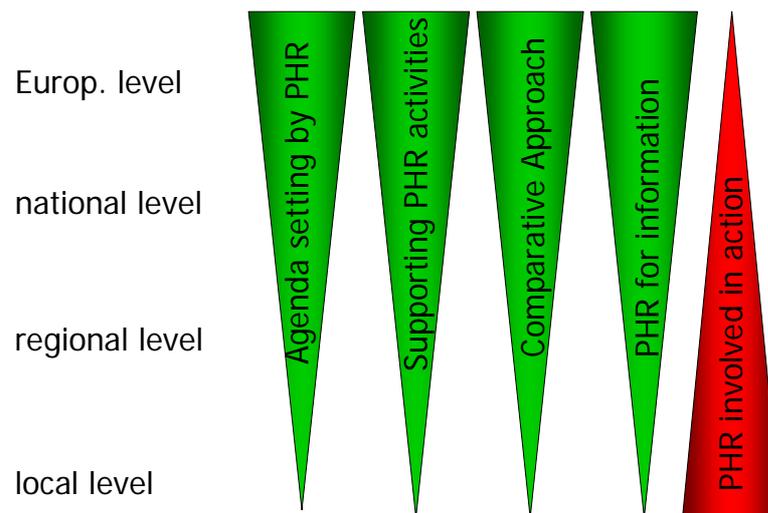


Figure 7: Vertical cooperation

To compare points in time, populations and regions is of fundamental importance to support the development of understanding and enlarge the opportunities to realise a policy impact. Comparative approaches allow an assessment about the status quo, illustrate gaps, illustrate that something could be better, motivate for action and build up political pressure. It would be helpful to enhance the complementary and comparability of information delivered by different reports (e.g. at the same, especially local level).

3.3.3 Dissemination and integrating PHR activities in the process of policy making

To realise a policy impact findings from PHR activities have to be disseminated and “marketed”. Attracting interest is a major issue, and it has positive effects if already existing questions are answered. Defining questions to be answered and the aims of a report can contribute to an environment which is comfortable for the chance to realise a policy impact. But even if the expectations should be well defined, it has to be reconsidered that PHR activities are not always routine. They are sometimes of a project character, linked with a certain degree of uncertainty and ambiguity which is typical for a cooperation between practitioners / policy makers and scientists. It has

been said that “[...] successful community/university research collaboration demands from all partners a patience with and tolerance for the uncertainty and ambiguity of a necessarily emergent research project.” (Buckeridge et al. 2002: 1202) The same holds for PHR activities until they have established themselves as a regular routine monitoring and information management system.

Following Stone/Maxwell/Keating (2001: 13) “[...] for researchers interested in policy impact, ‘do nothing’ is not an option. ‘Better dissemination’ is better but still only a partial answer. ‘Policy entrepreneurship’ seems to be the way forward.” But it is questionable if scientists and those writing reports should become “policy entrepreneurs” and thereby policy makers by themselves. There might be conflicts with the delivery of reliable information and conflicts with those commissioning reports. For political reasons, decision makers are maybe more interested in a neutral scientific information tool which supports their own “policy entrepreneurship”.

The gap between the providence of scientific, reliable and neutral information and policy entrepreneurship can be closed if policy counselling is seen as an intermediary step. Public health professionals, heads of public health services and other stakeholders like associations of health providers, health insurances, charity organisations, self help groups etc., scientific staff of parliamentarians or political parties can play a decisive role in picking up findings from PHR activities and interpreting as well translating them for policy making. In this process, PHR professionals could take care that findings are not communicated incorrect, e.g. for political reasons. They can deliver and defend a reliable and neutral information base which can serve as the fundament for a rationalised but in the end always political process of priority setting and policy formulation and thereby support cooperation and coordination.

Therefore to bridge the gap between scientific knowledge and practise and policy making it is a promising approach to organise communication between target groups to prepare the commissioning of a report (to specify why a report is being commissioned and which questions should be answered) and to organise a second round where the findings of the preliminary report are presented, interpreted and discussed (to develop a common understanding, draw conclusions, develop recommendations for action) from different perspectives, professional backgrounds, different kinds of scientific knowledge and expertises. This strategy links the analysis of problems and the development of a common understanding with the presentation and discussion of possible solutions and it also delivers the foundation for an evaluation of the implementation of interventions. In principle, the recommended interaction can be practised in quiet different environments and under the rules of quiet different health systems and structures of policy making (s. figure 8).

But even if the questions about structures and institutions are very important, the relevance of key people and key events for maintaining the life and momentum of collaborative projects (leadership style, seed funding, willingness to learn from

failures) should be acknowledged not only for the period in which PHR activities have a project character. To a certain degree these factors influence the chances to realise a policy impact by PHR activities also after they have been established in a more institutionalized form.

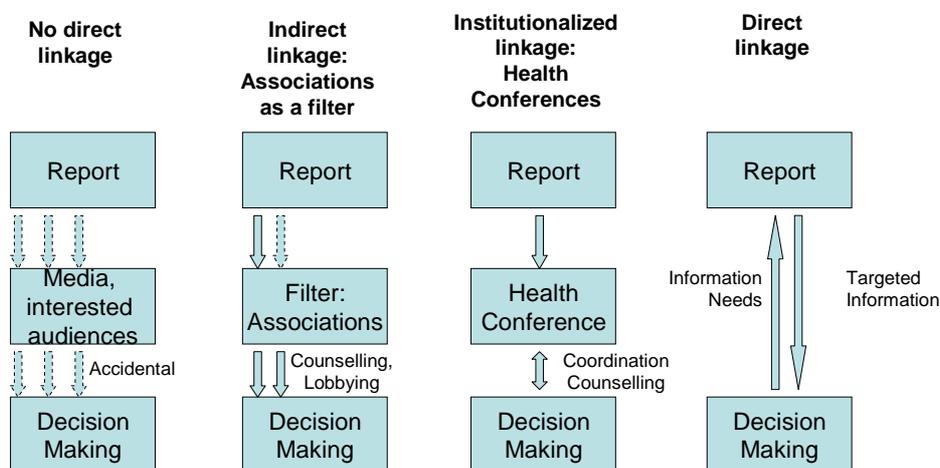


Figure 8: Different channels of dissemination

The aims of a report and the major questions as well as the interpretation of the findings, the conclusions for policy making and decisions about policies should be documented and the documentation can be published as a part of a public health report. But the parts linked with political entrepreneurship and policy making should be strictly separated from parts which deliver scientific based information and knowledge.

As a consequence of these recommendations, it seems to be useful to incorporate those being involved in commissioning reports and being interested in picking up its findings as part of political entrepreneurship as multipliers in the dissemination strategy.

Linking information from public health reports with statements by policy makers would also offer additional chances to attract the interest by the media. But nevertheless it can be considered and should not be neglected that health statistics can deliver attractive material which can support knowledge dissemination by themselves. The public is highly interested in health issues and therefore the media try to meet the demand. They report about new research findings or even controversies and use statistical data as points of interest and contexts for stories (health issues, health policy). Health statistics are also used for public education campaigns to promote certain health behaviour or policy choices. But it should also be considered that widespread reporting can contribute to information overload as there are more and more sophisticated efforts by individual researchers, agencies

and institutions to gain media attention for their products and findings (Friedman/Parrish II/Moiduddin/Ketchel 2005: 256 ff.)

Furthermore, the supply of information by the media is selective so that public perceptions of health and health risks can be skewed by the nature of the news and other information that reaches them (Friedman/Parrish II/Moiduddin/Ketchel 2005: 259). Therefore professional public relations strategies to prevent misunderstandings and to secure an adequate presentation of findings as well by the media as by the stakeholders of a report are needed for all parties being involved in the dissemination of findings from PHR.

The relevance of providing a knowledge stock should not be underestimated. Beside “active” dissemination “passive” dissemination is very important: It is supportive to address information to target groups and disseminate them effectively, but it is also of relevance to provide information and knowledge in a way that people looking for answers on certain questions have a good chance to use the knowledge stock effectively. People looking for specific information should be supported to satisfy their needs. It should be easy to use provided information and knowledge (indicators, statistics, charts and graphs) for own purposes (e.g. further reporting activities or policy entrepreneurship). Maybe it would be useful to think about strategies to empower people potentially interested in using the information and knowledge stock.

3.4 Summary of main topics

- Information and knowledge from PHR activities must be accessible, intelligible, reliable, timely and attract interest.
- It is necessary to identify gaps of the health statistics enterprise, to continue the work on a conceptual frame to describe and analyse the health of populations and its determinants.
- Adequate resources (budget, manpower, qualification, information) are a precondition for effective PHR activities, and effective PHR activities are relevant to convince those commissioning them that investments and spending are justified. Scarce resources should be used strategically to prove the value of PHR activities for policy making.
- Access to relevant information (e.g. health statistics), information about data sources and methods for those being active in PHR activities and potential user groups have to be optimised.
- It is not only important to ensure access to information, but to deliver guidance to cope with an information flood, to inform about the validity of provided information and to support the selection of information and knowledge from different and competing sources.

- To provide timely information and information on demand increases the chances of realising a policy impact. Open „policy windows“ are needed and material for a debate should be available when needed. Because it takes time to write a report on a new issue, a knowledge stock to deliver information and knowledge in a short period should be generated.
- A newsletter, an attractive design (inclusive “eyecatcher”) and a short presentation of main findings with key messages (policy briefs, summaries, short reports) linked with further information offer opportunities to attract interest.
- Often PHR activities provide information and knowledge which are not surprising for public health professionals. But on the one hand information and knowledge might be at least „new“ for some audiences. And on the other hand possibilities to provide „new“ information should not be underestimated: Comparative approaches, local information or more detailed information as well as describing the magnitude of a problem and how people are effected offer a lot of opportunities to create “new” knowledge and attract attention.
- Comparative approaches (populations, population groups, time) are of high value to promote the development of understanding, motivate for action and realise a policy impact. Decision makers need to decide if any action should be taken. Therefore it is very helpful to compare the as-is state with a theoretical state, another point in time or tendencies over time, other regions, of populations, diseases, health threats etc. By doing so, comparative approaches can deliver valuable insights, attract interest and motivate action. Missing information or missing comparable entities are often a problem for comparative approaches. Sometimes there is political resistance because undesired consequences (discrimination, segregation) or negative political consequences (political pressure, responsibilities) are expected. As far as resistance is motivated by political reasons, political pressure could be build up by comparative approaches from above.
- PHR activities can be a valuable tool to stimulate change / support innovations and the diffusion of innovations. The spread of „innovation“ is influenced by the perceived benefit, the visibility and measurability of results, the compatibility with norms, experiences, interests, dominant believes and strategies for problem solving as well as the complexity / extent of required change for implementation. To motivate action and build up political pressure the description of population health could somehow be linked with examples of what could be done.
- Lessons from the analysis of legislative policy making lead to the recommendations to focus the providence of information and knowledge on narrowing uncertainties in the policy debate, to deliver timely findings to keep in mind that the work should make a difference and to watch the line between research and propaganda.

- Following scientific standards can mean to mention limits of certainty and knowledge: Reliable information does not necessarily mean certainty but is often based on probabilities and can lead to uncertainty. Uncertainty has negative effects on the political will to do something and the possibilities to develop and implement policies. Below the line, uncertainties seem to be of advantage for those being in opposition of policies, arguing that it is not sure that a policy is necessary or will have positive effects. Therefore, the proportion between reliability and uncertainty seems to be of relevance for the policy impact.
- Horizontal and vertical cooperation (division of labour, mutual learning, comparability of reports) can promote effective and efficient PHR activities. PHR activities can support health policy making at the European and national level. But for the policy impact decision making at the local / organizational level is also very important. Especially at the local level resources for PHR activities are scarce. The cooperation between levels and at one level can be supportive for an effective and efficient use of scarce resources and supportive for mutual learning.
- The world is full of different and competing statistics and messages. PHR activities can deliver reliable and authoritative information accepted by policy makers, contribute to a common understanding and rationalize political controversies.
- PHR activities should be framed by a definition of questions and aims for PHR activities and a cooperative interpretation of findings as well as deduction of conclusions for policy making.
- Those working on reports should interact with policy entrepreneurs but should not become policy makers by themselves to prevent political conflicts and defend the scientific character of PHR reports.
- It needs policy entrepreneurs to enlarge the chance to realise a policy impact by PHR activities. Policy entrepreneurs / policy makers should specify questions and aims to be reconsidered by those writing reports, interpret the findings and draw conclusions for policy making.
- Questions to be answered by the report and conclusions for policy making should be documented, e.g. as parts of the published version of a health report. But the parts linked with policy entrepreneurship and the providence of scientific, neutral and confidential knowledge should be separated.
- It is very important to disseminate findings from PHR activities to target groups and meet their needs, but it is also important to support people looking for information and knowledge by providing a knowledge stock which can be used for own purposes (directory for information sources, flexible utilization of indicators, texts, charts, graphs).

- It needs a professionalized public relations strategy to disseminate findings from PHR activities and to take care about an accurate communication of the findings as well as an accurate deduction of arguments.
- Personal communication is a promising way for effective dissemination. Alliances with stakeholders are also promising. Especially when they comment findings of PHR reports from their point of view, this might enlarge the interest of the media.
- The media are helpful for the dissemination of results from PHR activities, but they follow their own concept of „news value“, jump from headline to headline and follow not always public health professionals perceptions and perspectives. Professionalized public relations work and a respective qualification of journalists can be assessed to be supportive.

4. An application to support the policy impact of PHR activities

4.1 “Health is wealth” and EU Structural Funds policies: An important issue for PHR activities

It is well known that “wealth” influences health. The complementary thesis that the health of populations influences the wealth of nations has received a new stimulus by the report of the WHO Commission on Macroeconomics and Health (2001), “which demonstrated that health improvement can be seen as a key strategy for income growth and poverty reduction in low- and middle-income countries”. A further publication (Suhrcke et al., 2005) gave an overview of evidence for high-income countries and the European Union. It was concluded “that investing in health should not only be seen as a cost to society, but also as a potential driver of economic growth” (Mackenbach/Meerding/Kunst 2007).

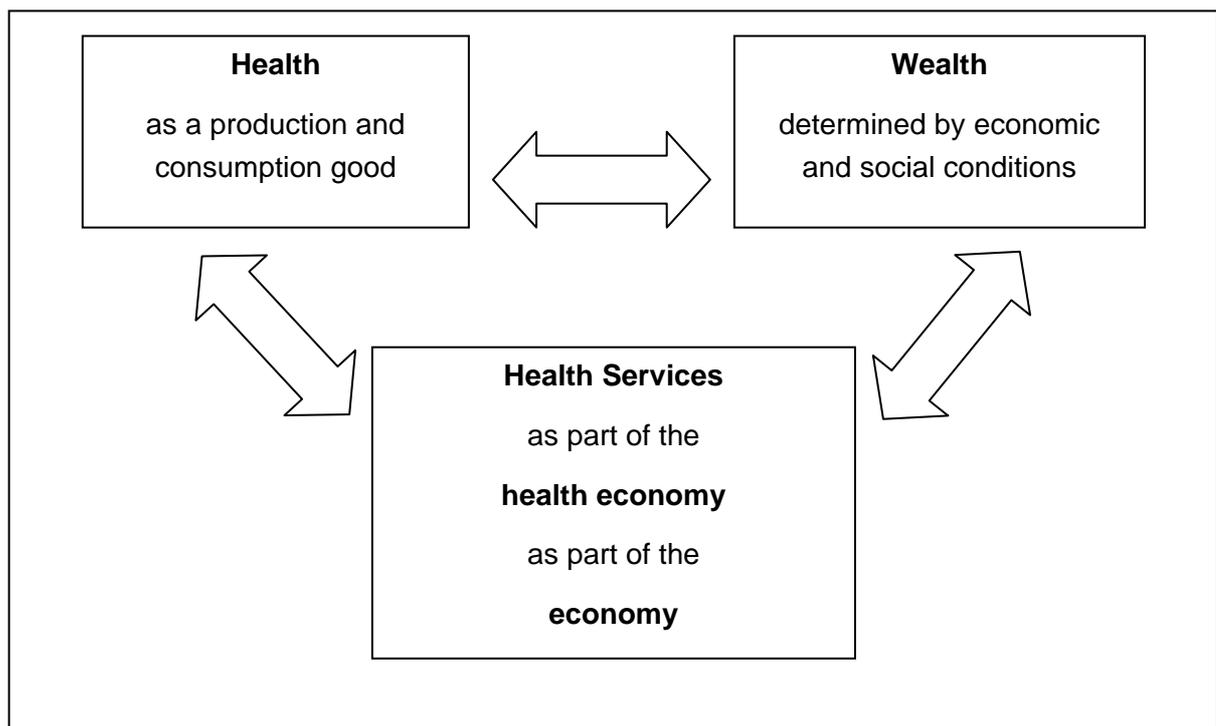


Figure 9: Health, Wealth, Health Services

It was suggested by the project group and decided at the 8th Meeting of the Working Party on Health Systems to link the project PIA PHR with the “Health is Wealth”-campaign and EU Structural Funds (EU SF) policies with their new opportunities for investments in health (s. figure 9). This public health related issue of major interest was chosen for the development of a concept for an application which is based on the findings about factors influencing PHR activities and their policy impact.

The issue has been chosen for a couple of reasons. At first, the EU SF policies already influence population's health and offer now some new opportunities for explicit investments in health, health services and health technologies. The budget of the EU SF and the amount of money which is earmarked for investments in health is much higher than the budget for the EU health programme.

Secondly, the paradigm shift to look at spending for health and health services not only as a burden but an investment for economic prosperity, employment and wealth is not only an opportunity but also a challenge. Until now, respective strategies of regional development can neither build upon a broad evidence base nor is this approach familiar for policy makers in this field. Policy makers at the European, national and regional level must be informed and convinced to follow this approach. They need information and knowledge about the new opportunities for investments and criteria for decisions about investments – while public health professionals need arguments to set public health issues on the agenda.

In the following, an overview about the political background for investments in health as part of strategies for regional development is given. It is argued that even when “health is wealth” has become a political statement there is a need to bring the public health perspective in. Thereafter, the concept of the application is presented.

4.2 The political background: An overview

4.2.1 WHO policies

From the “health is wealth”-perspective, better health has positive effects at the micro-level and macro-level of the economy and health has to be considered as a ‘consumption good’ (contribution to an individual's “happiness” or “satisfaction”) and a “capital good” (health as an important component of the value of human beings as means of production; Mackenbach/Meerding/Kunst 2007).⁴

Under the slogan “Regions invest in health – and it pays off for both people and the economy!” ten theses in regional health and wealth (WHO 2008b) have been

⁴ “While the estimates of inequalities-related losses to health as a ‘capital good’ (leading to less labour productivity) seem to be modest in relative terms (1.4% of GDP), they are large in absolute terms (€141 billion). It is valuing health as a ‘consumption good’ which makes clear that the economic impact of socioeconomic inequalities in health is really huge: in the order of about €1,000 billion, or 9.5% of GDP. The separately calculated impacts on costs of social security and health care systems and health care support these conclusions. Inequalities-related losses to health account for 15% of the costs of social security systems, and for 20% of the costs of health care systems in the European Union as a whole. It is important to emphasize that all these estimates represent yearly values, and that as long as health inequalities persist, these losses will continue to accumulate over the years.” (Mackenbach/Meerding/Kunst 2007: 41)

published. The central messages of the theses are that “good health is an attractive product that meets widespread demand [...], benefits regions that serve this demand and attracts considerable public and private investment”, that “investing public resources in health generates a respectable return” and that “the question to future research in health economics is not ‘How much health expenditure can we afford?’ but rather ‘How much do we need to invest in health to become or stay competitive?’” (ibid.)

All in all, the thesis mainly argue that investments in health services and health industries can have positive effects on regional development and that economic prosperity and employment have positive effects on health. That “policies in other sectors can significantly influence health, and that health, in turn, has important effects on realising such goals as economic development” is also mentioned, but that investments in population health have positive consequences on wealth is not the main argument. The theses are:

- Regions are active promoters for better health
- Good health is a responsibility of the regions
- Healthy people are the key to a productive economy
- Health industry is in a paradigm shift – yesterday a burden, tomorrow an opportunity for the economy
- Health industry is an incubator of employment, technological progress and innovation
- Health industry generates income – to the benefit of the local economy cycle
- Procurement stands between local markets, modern management and (inter-) national champion
- Quality and innovation in health services need the regional base
- International mobility of health care providers and consumers carries both risks and benefits
- Health and wealth must be thought anew

4.2.2 The EU Lisbon Agenda and the EU Health Strategy

The EU policies are framed by the Lisbon Agenda. The Lisbon Agenda is based on three pillars (economic, social, environmental pillar). While “health” is only mentioned in one sentence in chapter 3.3.: “Creating more and better jobs” (“In order to attract and keep more people in employment, the Commission will assist Member States in developing active ageing strategies, including measures to increase healthy life years.”), the EU Health Strategy (COM 2007a) stresses the necessity “to reinforce the importance of health within key EC policies such as the Lisbon Strategy for

Growth and Jobs, in terms of the links between health and economic prosperity” (COM 2007b: 2).⁵ Challenges like pandemics, major physical and biological incidents, bioterrorism, the consequences of population ageing and the challenge to foster a dynamic health system and the utilization of new technologies are stated to be of relevance for health policies but also for economic prosperity and wealth (COM 2007a: 3). The fourth principle of the health strategy⁶ is “health is the greatest wealth”. It is stated that “[h]ealth is important for wellbeing of individuals and society, but a healthy population is also a prerequisite for economic productivity and prosperity.” (ibid.: 5). It is mentioned that spending in health is not just cost, but investment, that the health sector is a provider for employment and training, a source and user of innovative technologies and a supporter for regional policy and social and economic cohesion (ibid; s. also COM 2007b: 7 ff.).

In the “Commission Staff Working Document” accompanying the “White Paper: Together for health” the links between health and economic prosperity are being described more in detail. The impact of health expenditures for growth rates is mentioned. It is argued that health contributes to wealth and that wealth contributes to health, that investments in health can lead to more efficient health systems and social security schemes (more people avoiding illness in cause of medical treatment and prevention), that the health sector contributes to economic growth through innovations and multiplier effects, employment and education. It is also mentioned that links of health and wealth are not only prevalent at the macro level but also at the micro or individual level and that the values specified in the EU Health Strategy (universality, access to good quality care, equity and solidarity, gender dimension, fundamental rights, citizens’ empowerment, incl. participation in decision making and health literacy, reducing inequities in health, scientific evidence of health policy) should be taken into account.

The effects of lifestyles (nutrition, physical activity, alcohol, drugs, tobacco, sexual behaviour), health and health risks (e.g. diabetes, obesity, mental health), health at the workplace, the impact of social conditions on health (inequality, poverty, social exclusion, participation, social capital), environmental conditions, the relevance of preventive measures and health services (use of medication and associated problems) are discussed. It is recommended to take differences between population groups (young people, working age population⁷, older people, migrants) into account (COM 2007b: 13). The relevance of health for labour productivity, a dynamic health

⁵ Further references mentioned are the Citizens’ Agenda (people’s right to be empowered in their health and healthcare) and the “Health in All Policies” approach.

⁶ Further principles are “shared health values”, “strengthening the EU’s voice in global health” and “Health in all Policies” are further principles (ibid.: 6).

⁷ S. also Safety and Health at Work Strategy 2007-2012

system for health and economic prosperity (health professional workforce, education, training, capacity building, life long learning, new technologies like life sciences and biotechnology, eHealth), issues with cross boarder impact (pharmaceuticals, medical devices to organ donation and transplantation; mobility of patients and health professionals, emergency phone) are listed (COM 2007b: 19 f.).

4.2.3 EU territorial policies

The cohesion policy is based on title XVII “Economic and social cohesion” of the Treaty on European Union and of the Treaty Establishing the European Community. Economic and social cohesion is not explicitly linked with health issues or health inequalities. The key challenge of territorial policies “is to ensure a balanced and sustainable territorial development of the EU as whole, strengthening its economic competitiveness and capacity for growth while respecting the need to preserve its natural assets and ensuring social cohesion” (COM 2008: 6). Territorial cohesion is seen as a “prerequisite for achieving sustainable economic growth and implementing social and economic cohesion – a European social model”. Therefore in all regions “preconditions to enable equal opportunities for its citizens and development perspectives for entrepreneurship” should be developed (Territorial Agenda ... 2007: 3). A more even and sustainable use of assets is expected to go ahead with “economic gains from less congestion and reduced pressure on costs, with benefits for both the environment and the quality of life.” (COM 2008: 5) Overcoming differences in density (concentration), distance (connection) and division (cooperation) are mentioned as key challenges (COM 2008: 6 f.) – besides the handling of certain types of regions with particular challenges (mountain regions, island regions and sparsely populated regions).

The “Green Paper on Territorial Cohesion” (COM 2008) and the “Territorial Agenda” (Territorial Agenda ... 2007) stress the relevance of the regional level and regional policies. Territorial diversity offers the opportunity and challenge to transform “diversity into an asset” and “to make the most of inherent features of these territories” (ibid.: 3). To strengthen “the capacity of the people and business located there to make the best use of all territorial assets” (ibid.) does not only mean to strengthen capacities within a region, but also to strengthen “cooperation, dialogue and partnership between different levels of government and between these and organisations and people on the ground directly involved in the development process” (ibid.: 4). The importance of national and regional competencies is recognised (ibid.: 10). In the sense of governance by cooperation the competencies of actors at the different levels should be brought together in the form of an “intensive and continuous dialogue between all stakeholders of territorial developments” (Territorial Agenda ... 2007: 2). EU policy-making “should have more regard to local, regional and national potentials and the motives of stakeholders”, while “individual city and regional development strategies should explicitly take more account of their national and European contexts” (Territorial Agenda ... 2007: 4). Vertical and

horizontal cooperation as well as mutual learning are stated to be of high relevance for territorial development (Territorial Agenda 2007: 4 ff.). Key topics are:

1. Strengthening of polycentric developments and innovation through networking.
2. New forms of partnership and territorial governance between rural and urban areas.
3. Promotion of regional clusters of competition and innovation in Europe.
4. Strengthening and extension of trans-European networks.
5. Promotion of trans-European risk management including the impacts of climate change.
6. Strengthening ecological structures and cultural resources as the added value for development.

4.2.4 EU Structural Funds policies

The EU Structural Funds (EU SF) are the most important European tools to support territorial policies and regional development.⁸ Under the cohesion policy 2007-2013, the EU SF aim to realise different objectives. The main objectives of EU Structural Funds policies are

1. Convergence (for regions with gross domestic product per capita less than 75 % of the average GDP of the EU-25, Member States with gross national income (GNI) per capita less than 90 % of the average GNI of the EU-25);
2. Regional competitiveness and employment (all regions);
3. European territorial cooperation.

Priorities of the “Strategic Guidelines on Cohesion” (Council Decision of 6 October 2006) are a) to focus on knowledge, research, innovation, human capital, b) to pursue the synergies between economic, social and environmental dimensions; c) to pursue the objective of equality between men and women and d) to prevent any discrimination. Guidelines are

1. Making Europe and its regions more attractive places in which to invest and work (transport infrastructures, synergies between environmental protection and growth, energy sources);
2. Improving knowledge and innovation for growth (investment in research and technological development, innovation, entrepreneurship, information society, e.g. e-health, improve access to finance);

⁸ See Council Decision of October 2006; Council Regulations 1080/2006, 1081/2006, 1084/2006, 1260/2006; Europäische Union Regionalpolitik 2007.

3. More and better jobs (more people in employment, social protection systems, employment policies, quality and productivity at work, social and territorial cohesion, life-cycle approach to work, inclusive labour markets also with regard to disadvantaged people, matching of labour market needs);
4. Raising the administrative capacity (productivity and quality at work in the public sector, support good policy and programme designs);
5. Help maintain a healthy labour force especially in regions lagging behind economically to raise productivity levels (demographic development with an ageing population, reduce health inequalities by health promotion, disease prevention, filling the gaps in health infrastructure, promoting efficient provision of services by adequate technologies, greater participation in the labour market, longer working life, higher productivity, lower healthcare and social costs, information campaigns, transfer of knowledge and technology).

4.2.5 Opportunities and challenges for PHR activities

While links between health and wealth are stressed within EU health policies, these links are not being mentioned strongly within EU regional policies until now. But EU SF policies have an impact on determinants of health and can be used for investments in a couple of areas being relevant for population health (s. Figure 10):

- Healthy workforce: Health promotion and disease prevention, safety at work etc.
- Healthy aging: health promotion and screening, rehabilitation etc.
- Human capacity (especially health professionals)
- Health infrastructure
- Health information and research: investments and capacities
- Cross-border cooperation
- Knowledge and information society.

In a speech Robert Madelin (Director General for Health and Consumer Protection at the European Commission) mentioned the importance of the funds, especially to tackle health gaps and health inequalities (Madelin 2007). He said that the EU Structural Funds may play a key role in reducing health gaps and health inequalities across Europe, that they are an effective tool to achieve the Lisbon objectives (more growth and jobs). Furthermore, one of the priority areas for investment within the new regulations for the use of Structural Funds in 2007-13 are health infrastructure, cooperation and joint infrastructure across regions, investment in human resources, training and capacity building.

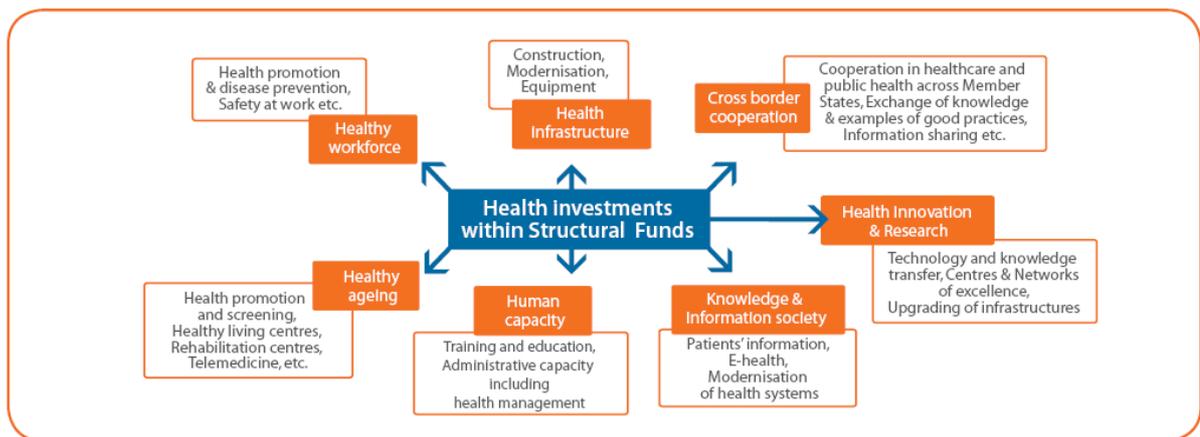


Figure 10: Areas of health investment within EU Structural Funds (European Commission/Health & Consumer Protection 2007)

To set public health issues on the agenda and to support sound decision making (including assessment, policy formulation and evaluation) regional information about economic and social conditions, health and the health system as well as ideas and knowledge about policy options are needed. In his speech, Madelin also mentioned: “[...] to be effective these investments need to be targeted and based on a thorough analysis of the health needs. Sufficient clarity as to the long-term and strategic nature of the investments in health is therefore essential. [...]. Member States need to prioritise health in their national plans as a long-term investment both for population health and for growth and competitiveness.” The challenge to create and provide knowledge is also accentuated by the definition of action for the EU Health Strategy principle “health is the greatest wealth”: “Development of a programme of analytical studies of economic relationships between health status, health investment and economic growth and development” (COM 2007a: 5).

From the perspective of EU health policies it must be taken care that health is not only seen as a “health market” and that investments in health services and health industry is not only evaluated for its economic effects (e.g. Heinze et al. 2006; Potratz 2007), but also for its effect on the populations health and health needs. There is a risk that strategies in regional development concentrate on economic growth and employment in the health sector etc., and that the main focus is on competitiveness, employment and convergence. “Investments in health” can mean to promote regional development by investments in health technologies, to support regional development by investments in health services and health industries, to master the consequences of demographic change in relation to the labour market and employment (healthy ageing, healthy workforce). E.g. also in the “Ten Thesis” published by the WHO investments in health technologies and services seem to be of higher interest than the relevance of public health policies and the positive health related effects of health promotion, prevention and health services on economic prosperity. This is similar for

National Strategic Reference Frameworks of the EU member states and their Operational Programmes, where public health issues are also of minor importance.

PHR activities can support decision making for investments in health by providing information for economists and decision makers who are active in regional development and the utilization of the EU SF and deliver information and arguments to those who want to bring public health issues in. The new EU SF policy is also an opportunity to enhance PHR activities for the regional level: to use existing data and reports, but also to develop new links with economic and social issues and to support more comparisons as well as cooperation between regions in the EU.

If regional and national policy makers want to address health issues, they need information and maybe also recommendation from PHR activities and experts. Arguments are needed to set health issues on the agenda when programmes for regional development are set up. Further information needs are linked with the procedure to get and to use budgets from the funds. National Strategic Reference Frameworks and Operational Programmes have to be written. They must entail an analysis of the social and economic situation of regions in a national, European and world context. Reasons for a chosen strategy have to be given, e.g. it has to be argued that there is a special need for action and that certain effects can be realized. The relationships between growth, employment and health have to be addressed. Indicators to evaluate programmes have to be named. Further, PHR activities are relevant for the documentation of the effectiveness of implemented programmes and there will also be evaluation reports of the projects. Information and knowledge from PHR activities are also relevant for those who are involved in the evaluation of programmes at the EU level.

From a public health perspective and for PHR activities it is not only of relevance to use EU SF for investments in health, but to analyse the impacts of EU SF investments on health. Art. 152 of the EC Treaty says that a “high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities” (ibid.). The EU Health Strategy names the intention to strengthen “integration of health concerns into all policies at Community, Member State and regional levels, including use of Impact Assessment and evaluation tools” (COM 2007a: 6). Therefore, PHR activities are of importance to deliver respective information and knowledge for the different stages of policy making (monitoring, assessment/agenda setting, development of policy options, implementation and evaluation) – at first but not only in health policies.

4.3 Concept of an application to support PHR activities

The application is based on a geo-demographic software (InstantAtlas/Geowise). It aims to

- deliver information, arguments and ideas about linkages between health, the health system, social and economic conditions;
- deliver opportunities for multiple comparisons between geographic entities of EU Member States;
- support the creation of knowledge;
- support cooperation and mutual learning;
- be a tool box for PHR activities as well as a medium for information and knowledge from PHR activities for different target groups.

4.3.1 Selection of indicators

In the first step the concept for the application is mainly based on Eurostat regional indicators for pragmatic reasons. As far as indicators about economic and social conditions are concerned, the selection and providence of indicators is structured in line with the topics of the Eurostat regional yearbook 2007 (Eurostat 2007). The Eurostat regional yearbook 2007 has the following chapters:

- population
- gross domestic product
- household accounts
- labour market
- labour productivity
- science, technology and innovation
- structural business statistics
- transport
- tourism
- education
- agriculture.⁹

⁹ The topic “urban statistics” of the regional yearbook is not considered yet because it is not possible to present the indicators with a map which is based on NUTS classifications.

Eurostat indicators for public health issues and health services are added (s. chart 6). Most of the indicators offered by Eurostat regional statistics are mortality statistics. They can be used to calculate the number of avoidable death and lost life years. The concept of avoidable deaths is based on the assumption that for a couple of causes of death dying before the age of 65 can be defined as “avoidable” and that these causes of death can be assigned to primary, secondary and tertiary prevention (Nolte/McKee 2004). The calculation of lost life years can be used to analyse the magnitude of certain health problems by considering the age of deceased persons.

At a first glance, the number of health related indicators seems small compared to the number of indicators delivered. But it has to be acknowledged that many indicators deliver information about determinants of health.

Chart 7: Selected indicators

Geography and Population
Area (km2)
Average annual population in 1.000; both sexes
Population density
Life births (in 1.000)
Life births per 1.000 inhabitants
Deaths (in 1.000)
Deaths per 1.000 inhabitants
Natural population increase (in 1.000)
Natural population increase per 1.000 inhabitants
Net migration (=change in population which cannot be explained by natural population) in 1.000
Net migration (=change in population which cannot be explained by natural population) per 1.000 inhabitants
Youth age dependency ratio
Old age dependency ratio
Population projections 2004-2030, major drivers of population change
Gross Domestic Product (GDP)
GDP at current market prices; PPP
GDP at current market prices; PPP per inhabitant
GDP at current market prices; PPP per inhabitant in percentage of EU average
GDP growth, annual average % change (constant prices)
Change in the regional share of national population, year to year
Change in the regional share of national population 2000-05
Change in the regional share of GDP, year to year
Change in the regional share of GDP 2000-05

Dispersion NUTS level 2
Dispersion NUTS level 3
Household Accounts
Balance of primary income (uses), net, total; Mio. €
Balance of primary income (uses), net, total; Mio. € PPS
Primary income per inhabitant (uses), net, € PPS
Disposable income (uses), net, total, Mio. €
Disposable income per inhabitant (uses), net, € PPS
Disposable income per inhabitant (uses), net, PPS, in % of primary income
Development of disposable income of private households per inhabitant; year to year change in % PPS
Net operating surplus and net operating income (resources), Mio. of €
Net operating surplus and net operating income (resources), in % of all income sources (property income, compensation of employees and net operating surplus and net operating income)
Compensation of employees (resources), in % of all income sources (property income, compensation of employees and net operating surplus and net operating income)
Compensation of employees (resources), in % of all income sources (property income, compensation of employees and net operating surplus and net operating income)
Property income received (resources), Mio. €
Property income received (resources), in % of property income, compensation of employees and net operating surplus and net operating income
Gini index
Employment and Unemployment
Economically active population, 15 and over (1.000)
Economically active population, males, 15 and over (1.000)
Economically active population, females, 15 and over (1.000)
Employment rates by sex and age in %; total; 15 years and over
Employment rates by sex and age in %; males; 15 years and over
Employment rates by sex and age in %; females; 15 years and over
Difference between male and female employment rate, 15 years and over
Employment rates by sex and age in %, between 55 and 64 years
Employment rates by sex and age in %, males between 55 and 64 years
Employment rates by sex and age in %, females between 55 and 64 years
Unemployment, 15 and over (1.000)
Unemployment, males, 15 and over (1.000)
Unemployment, females, 15 and over (1.000)
Unemployment rates, total, 15 and over
Unemployment rates, males, 15 and over

Unemployment rates, females, 15 and over
Unemployment rates by sex and age in %; total; between 15 and 24 years
Difference between male and female unemployment rates for the 15 and over age group
Long-term unemployment
Ratio between long-term unemployment and unemployment
Labour Productivity
GDP per person employed; €
Productivity growth; %
Dominating sector (NACE division A 3); high proportion of sectoral GDP
Productivity in industry; € per person employed in NACE sections C to F
Productivity in services; € per person employed in NACE sections G to P
Average hours actually worked per year, per employee, full time, All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Average hours actually worked per year, per employee, full time, Public administration and defence; compulsory social security
Average hours actually worked per year, per employee, full time, Health and social work
Average hours actually worked per year, per employee, part time, All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Average hours actually worked per year, per employee, part time, Public administration and defence; compulsory social security
Average hours actually worked per year, per employee, part time, Health and social work
Average hours actually worked per year, per apprentice, total, All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Average hours actually worked per year, per apprentice, total, Public administration and defence; compulsory social security
Average hours actually worked per year, per apprentice, total, Health and social work
Labour cost (excluding apprentices); Per employee in full-time units, per hour (€); 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Labour cost (excluding apprentices); Per employee in full-time units, per hour (€); 2004; Public administration and defence; compulsory social security
Labour cost (excluding apprentices); Per employee in full-time units, per hour (€); 2004; Health and social work
Wages and salaries (excluding apprentices); Per employee in full-time units, per hour (€); 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Wages and salaries (excluding apprentices); Per employee in full-time units, per hour (€); 2004; Public administration and defence; compulsory social security
Wages and salaries (excluding apprentices); Per employee in full-time units, per hour (€); 2004; Health and social work
Direct remuneration, bonuses and allowances (excluding apprentices); Per employee in full-time units, per hour (€); 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Direct remuneration, bonuses and allowances (excluding apprentices); Per employee in full-time units, per hour (€); 2004; Public administration and defence; compulsory social security
Direct remuneration, bonuses and allowances (excluding apprentices); Per employee in full-time units, per hour (€); 2004; Health and social work

Labour cost for apprentices; Per employee in full-time units, per hour (€); 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Labour cost for apprentices; Per employee in full-time units, per hour (€); 2004; Public administration and defence; compulsory social security
Labour cost for apprentices; Per employee in full-time units, per hour (€); 2004; Health and social work
Wages and salaries for apprentices; Per employee in full-time units, per hour (€); 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Wages and salaries for apprentices; Per employee in full-time units, per hour (€); 2004; Public administration and defence; compulsory social security
Wages and salaries for apprentices; Per employee in full-time units, per hour (€); 2004; Health and social work
Labour cost (excluding apprentices); total; 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Labour cost (excluding apprentices); total; 2004; Public administration and defence; compulsory social security
Labour cost (excluding apprentices); total; 2004; Health and social work
Wages and salaries (excluding apprentices); total; 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Wages and salaries (excluding apprentices); total; 2004; Public administration and defence; compulsory social security
Wages and salaries (excluding apprentices); total; 2004; Health and social work
Direct remuneration, bonuses and allowances (excluding apprentices); total; 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Direct remuneration, bonuses and allowances (excluding apprentices); total; 2004; Public administration and defence; compulsory social security
Direct remuneration, bonuses and allowances (excluding apprentices); total; 2004; Health and social work
Labour cost for apprentices; total; 2004; All NACE branches except agriculture, fishing, public administration, private households and extra-territorial organizations
Labour cost for apprentices; total; 2004; Public administration and defence; compulsory social security
Labour cost for apprentices; total; 2004; Health and social work
Science, Technology and Innovation
Total R&D expenditure as a percentage of GDP, all sectors
Researchers as a percentage of persons employed, all sectors
Human resources in science and technology by virtue of occupation (HRSTO) as a percentage of the labour force
Total patent applications to the EPO per million inhabitants
Structural Business Statistics
Employment; all NACE branches, 1.000
Employment - Agriculture, hunting, forestry and fishing, 1.000
Employment - Industry, 1.000
Employment – Services (excluding extra-territorial organizations and bodies), 1.000
Health and Social Work, in 1.000

Health and Social Work, in % of Employment
Specialisation in business services (NACE K 72 and K 74); % of total non-financial business economy-employment
Specialisation in computer services (NACE K 72); % of total non-financial business economy-employment
Specialisation in other business services (NACE K 74); % of total non-financial business economy-employment
Employment growth in computer services (NACE K 72); %
Employment growth in other business services (NACE K 74); %
Gross fixed capital formation at NUTS level 2: All NACE Branches - Total
Gross fixed capital formation at NUTS level 2: Agriculture, hunting, forestry and fishing
Gross fixed capital formation at NUTS level 2: Industry
Gross fixed capital formation at NUTS level 2: Services (excluding extra-territorial organizations and bodies)
Compensation of employees at NUTS level 2: All NACE branches - Total
Compensation of employees at NUTS level 2: Agriculture, hunting, forestry and fishing
Compensation of employees at NUTS level 2: Total industry (excluding construction)
Compensation of employees at NUTS level 2: Services (excluding extra-territorial organizations and bodies)
Transport
Density of roads other than motorways (km of road per 100 km ²)
Number of passenger cars per 1.000 inhabitants
Total number of maritime passengers in relation to population
Total number of road journeys per km ²
Total number of freight transport by air, tonnes
Tourism
Number of bed places in hotels and campsites
Number of bed places in hotels and campsites per 1.000 inhabitants
Number of nights spent in hotels and campsites
Number of nights spent in hotels and campsites per 1.000 inhabitants
Share of non-resident nights spent in hotels and campsites
Education
Participation rates of 4-year-olds in education, %
Students at upper secondary and post-secondary non tertiary education as percentage of the population aged 15 to 24
Educational attainment level, percentage of 25- to 64-year olds in the population with tertiary education
Lifelong learning participation, as percentage of 25- to 64-year-olds participating in education or training during the four weeks preceding the survey
Ratio of the proportion of students (ISCED 5-6) over the proportion of the population by NUTS 1 and NUTS 2 regions

Agriculture
Agricultural Landuse, in % total area
Contribution of agriculture to GDP, %
Gross value added to agriculture per annuyl work unit
Share of secondary activities in agricultural output
Ration of chemical input to agricultural output
Crop output per agricultural area (€)
Animal output per livestock unit (€)
Public Health
Life expectancy at birth; males
Life expectancy at birth; females
Life expectancy at 65; males
Life expectancy at 65; females
All causes of death (A00-Y89); both sexes; absolute number
All causes of death (A00-Y89); males; absolute number
All causes of death (A00-Y89); females; absolute number
All causes of death (A00-Y89); both sexes; less than one year; absolute number
Infant mortality rate
All causes of death (A00-Y89); Standardised death rate per 100,000 inhabitants (3 years average); both sexes
All causes of death (A00-Y89); Standardised death rate per 100,000 inhabitants (3 years average); males
All causes of death (A00-Y89); Standardised death rate per 100,000 inhabitants (3 years average); females
All causes of death (A00-Y89); Standardised death rate per 100,000 inhabitants (3 years average); both sexes; less than 65 years
All causes of death (A00-Y89); Standardised death rate per 100,000 inhabitants (3 years average); males; less than 65 years
All causes of death (A00-Y89); Standardised death rate per 100,000 inhabitants (3 years average); females; less than 65 years
Lost life years for all causes of death (A00-Y89); males under 65
Lost life years for all causes of death (A00-Y89); females under 65
Lost life years for all causes of death (A00-Y89) per 100.000 inhabitants; males under 65
Lost life years for all causes of death (A00-Y89) per 100.000 inhabitants; females under 65
Lost life years for all causes of death (A00-Y89) per 100.000 inhabitants; males between 1 and 65
Lost life years for all causes of death (A00-Y89) per 100.000 inhabitants; females between 1 and 65
Lost life years: Malignant neoplasm liver and the intrahepatic bile ducts (C22), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Malignant neoplasm of larynx and trachea/bronchus/lung (C32-C34), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes

Lost life years: Diseases of the circulatory system (I00-I99); standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Ischaemic heart diseases (I20-I25), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Cerebrovascular diseases (I60-I69), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Chronic liver disease (K70, K73-K74), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: External causes of injury and poisoning (V01-Y89), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Accidents (V01-X59), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Transport accidents (V01-V99), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Suicide and intentional self-harm (X60-X84), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Homicide, assault (X85-Y09), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Malignant melanoma of skin (C43), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Malignant neoplasm of breast (C50), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Malignant neoplasm of cervix uteri (C53), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Malignant neoplasm of other parts of uterus (C54-C55), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Infectious and parasitic diseases (A00-B99), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Malignant neoplasm of lymphatic/haematopoietic tissue (C81-C96), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Diabetes mellitus (E10-E14), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Lost life years: Diseases of the respiratory system (J00-J99), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant neoplasm liver and the intrahepatic bile ducts (C22), standardised death rates (per 100.000 inhabitants); both sexes
Malignant neoplasm of larynx and trachea/bronchus/lung (C32-C34), standardised death rates (per 100.000 inhabitants); both sexes
Diseases of the circulatory system (I00-I99); standardised death rates (per 100.000 inhabitants); both sexes
Ischaemic heart diseases (I20-I25), standardised death rates (per 100.000 inhabitants); both sexes
Cerebrovascular diseases (I60-I69), standardised death rates (per 100.000 inhabitants); both sexes
Chronic liver disease (K70, K73-K74), standardised death rates (per 100.000 inhabitants); both sexes
External causes of injury and poisoning (V01-Y89), standardised death rates (per 100.000 inhabitants); both sexes
Accidents (V01-X59), standardised death rates (per 100.000 inhabitants); both sexes

Transport accidents (V01-V99), standardised death rates (per 100.000 inhabitants); both sexes
Suicide and intentional self-harm (X60-X84), standardised death rates (per 100.000 inhabitants); both sexes
Homicide, assault (X85-Y09), standardised death rates (per 100.000 inhabitants); both sexes
Malignant melanoma of skin (C43), standardised death rates (per 100.000 inhabitants); both sexes
Malignant neoplasm of breast (C50), standardised death rates (per 100.000 inhabitants); both sexes
Malignant neoplasm of cervix uteri (C53), standardised death rates (per 100.000 inhabitants); both sexes
Malignant neoplasm of other parts of uterus (C54-C55), standardised death rates (per 100.000 inhabitants); both sexes
Infectious and parasitic diseases (A00-B99), standardised death rates (per 100.000 inhabitants); both sexes
Malignant neoplasm of lymphatic/haematopoietic tissue (C81-C96), standardised death rates (per 100.000 inhabitants); both sexes
Diabetes mellitus (E10-E14), standardised death rates (per 100.000 inhabitants); both sexes
Diseases of the respiratory system (J00-J99), standardised death rates (per 100.000 inhabitants); both sexes
Malignant neoplasm liver and the intrahepatic bile ducts (C22), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant neoplasm of larynx and trachea/bronchus/lung (C32-C34), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Diseases of the circulatory system (I00-I99); standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Ischaemic heart diseases (I20-I25), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Cerebrovascular diseases (I60-I69), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Chronic liver disease (K70, K73-K74), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
External causes of injury and poisoning (V01-Y89), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Accidents (V01-X59), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Transport accidents (V01-V99), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Suicide and intentional self-harm (X60-X84), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Homicide, assault (X85-Y09), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant melanoma of skin (C43), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant neoplasm of breast (C50), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant neoplasm of cervix uteri (C53), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant neoplasm of other parts of uterus (C54-C55), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Infectious and parasitic diseases (A00-B99), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Malignant neoplasm of lymphatic/haematopoietic tissue (C81-C96), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Diabetes mellitus (E10-E14), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes
Diseases of the respiratory system (J00-J99), standardised death rates (per 100.000 inhabitants); less than 65 years; both sexes

Health Services
Physicians or doctors - rate per 100,000 inhabitants
Dentists - rate per 100,000 inhabitants
Pharmacists - rate per 100,000 inhabitants
Available beds in hospitals (HP.1) - rate per 100,000 inhabitants
Curative beds in hospitals (HP.1) - rate per 100,000 inhabitants
Psychiatric beds in hospitals (HP.1) - rate per 100,000 inhabitants

4.3.2 Maps

The indicators are linked with a map of the European Community. It is possible to use filters and “create” maps for

- NUTS 0, NUTS 1, NUTS 2 and NUTS 3 levels (s. figures 11, 12),
- EU 27, EU 15 and „new“ member state maps,
- Maps for single countries (here also for the different NUTS levels: s. figure 13),
- A map for the ISARE-classification which links subnational regions with subnational decision making structures
- Maps for the territories being funded by the cohesion fund and under the convergence as well as under the competitiveness and employment objectives
- Cross-boarder cooperation regions (s. figure 14)
- Certain cluster of regions etc.

It is possible to add further maps as long as they are based und NUTS-regions, e.g. providing clusters of similar regions (e.g. the classification by the Green Paper with urban areas, intermediate regions, rural regions close to a city and remote regions (COM 2008: 6).

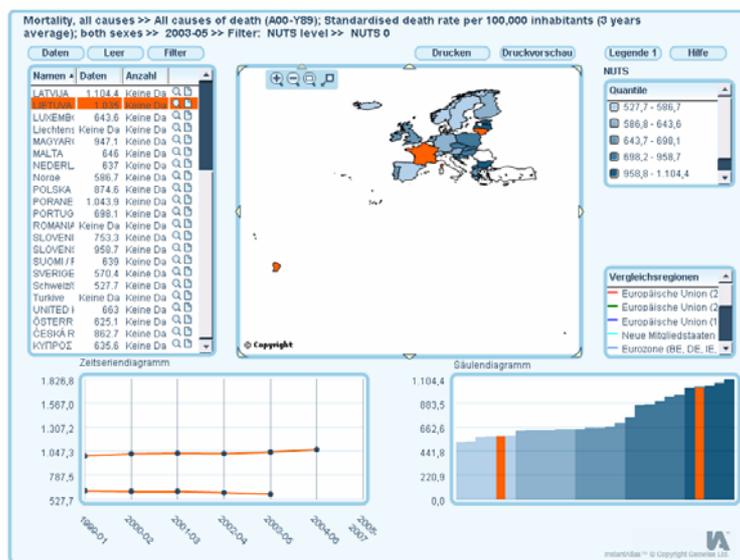


Figure 11: Example: Map EU, NUTS 0

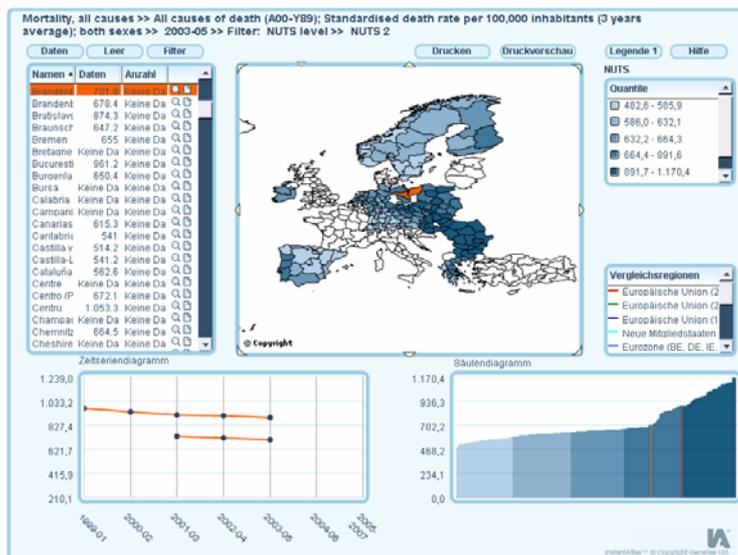


Figure 12: Example: Map EU, NUTS 2

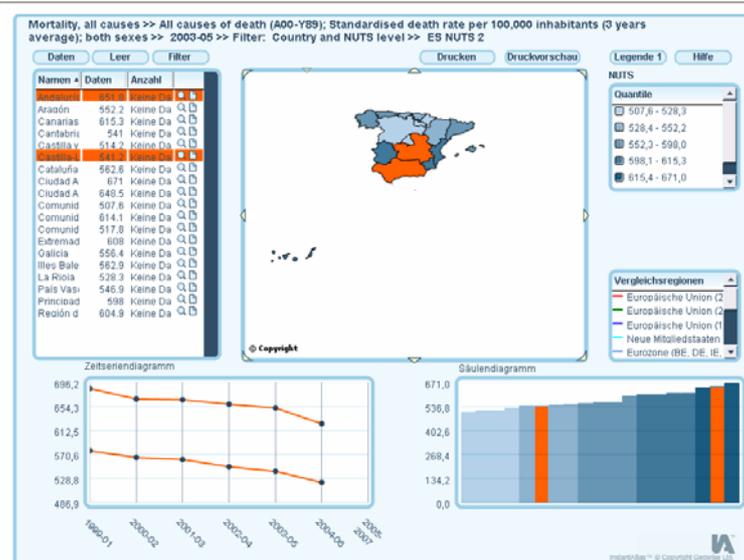


Figure 13: Example: Spain, NUTS 2

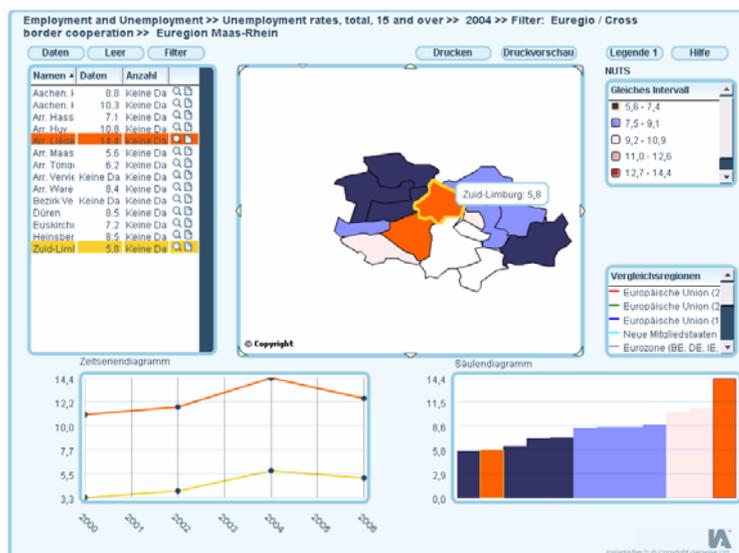


Figure 14: Example: Euregio Maas-Rhein

4.3.3 Comparative approaches

The maps offer the opportunity for multiple comparative approaches. Comparative approaches have been stressed to be of high relevance to realise a policy impact by PHR activities. They not only show differences, but give the idea that a status could be different and sometimes also about opportunities to change something. This can be a strong motivation for action and create political pressure. Also, they contribute to the legitimization for a redistribution of resources, e.g. between countries and regions. As far as European policies and member states are concerned, it seems to be necessary to support multilevel comparative approaches. Resources are redistributed at the European level and in line with the differences across Europe. But there are also relevant differences within Member States or regions of Member

States. For example, differences within Germany should not be overseen in cause of the impressive differences especially between old and new EU Member States.

The maps of the application can give a more general overview over EU Member States, a more detailed picture of the European regions. It is possible to look at the new Member states or old Member States only, or take a look at the differences within a Member State. This is of advantage because looking at differences across the whole European Union is informative while beside large differences between Member States there are also relevant regional differences within Member States. For policy making, looking at different levels and regional entities allows to set priorities for the different levels.

4.3.4 Layers

In theory it is possible to analyse the regions and indicators with different layers:

- With the single map layer one indicator can be chosen to take a look at differences between regions and to identify the relative position of one or more regions. A map and a bar graph visualise the differences for a given year. A further graph informs about time trends.
- With the double map layer two indicators can be chosen and their correlation can be analysed. Two maps (one for each of the indicators) visualise differences between regions. Here it is also possible to choose one or more regions to identify their relative position (s. figure 15)
- The regional profile layer allows choosing one or two regions to get an overview about their relative position to the other regions for a couple of indicators.
- With the funnel plot layer the significance of deviations can be analysed.

Currently the functionalities of the different layers are limited in cause of gaps in the availability of indicators especially for the local and regional level.

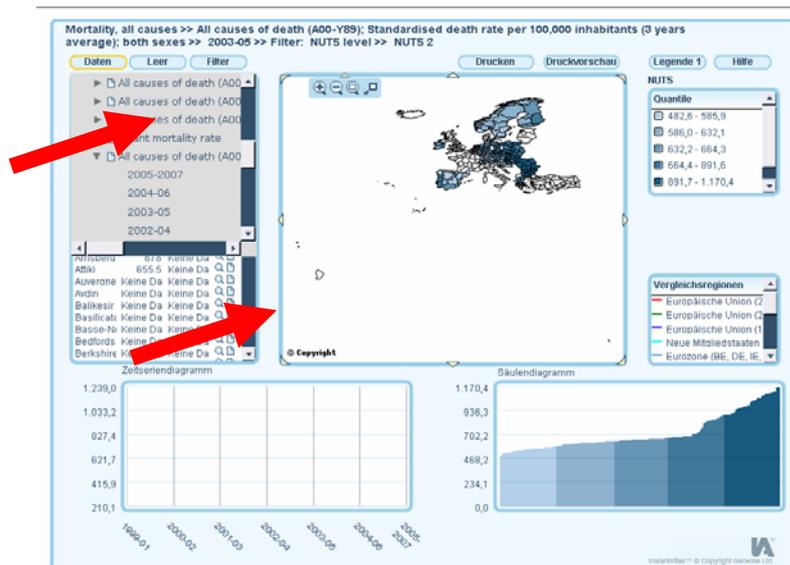


Figure 16: Links to further information

Besides information and guidance concerning the interpretation of indicators it is also possible to provide information or links to further information about regional entities and EU SF policies in documents being linked with the geographic entities. In theory, it is possible to deliver general information about a region, about projects in a region or relevant contacts, e.g. concerning EU SF policies. (Possible) Links for more information about national or regional conditions are:

- EU Health Portal (Statistics, Reports, Programmes) <http://ec.europa.eu/health-eu/>
- DG SANCO (Health Programme, Projects) http://ec.europa.eu/dgs/health_consumer/index_de.htm
- DG REGIO (EU Structural Funds, Projects) http://ec.europa.eu/regional_policy/index_en.htm
- European Observatory (Health Systems, Health Policies) <http://www.euro.who.int/observatory>
- EUPHIX (Health Information and Knowledge System) <http://www.euphix.org>
- PH reports (national, regional, local); www.pia-phr.nrw.de
- Portrait of the Regions (Geography, History, Population, Employment, Economy, Environment, Education, Health, Culture) <http://circa.europa.eu/irc/dsis/regportraits/info/data/en/index.htm>
- ESPON (territorial development) <http://www.espon.eu/>
- Inspire (spatial information Infrastructure) <http://www.ec-gis.org/inspire/whyinspire.cfm>

- WHO <http://www.who.int/en/>
- OECD (Statistics, Economic Outlook) <http://www.oecd.org>
- National Information sources
- Information about the region
- Links to a description of the health system by the European Observatory
- Links to public health reports
- Links to information about the relevant operational programmes
- Contact details for further information about EU Structural Funds policies
- Links to information sources about projects and programmes supported by EU Structural Funds
- Support to use the application
- Information about further sources

4.3.6 Flexible utilization by different target groups

The application offers the opportunity for a flexible utilization. It is possible to create short reports and to export created maps, charts, graphs to own documents or more encompassing reports. People who want to use the application for own purposes get guidance (recommendations about relevant topics, the relevance of certain indicators for this topic and the interpretation of results) to use the application by added reports, documents and links.

Therefore, on the one hand, the application is a tool to support those being active in PHR. But on the other hand, the application can be used directly by all the stakeholders involved in policy making, the media and the interested public. The application is at the same time a tool for PHR activities as a product of PHR activities.

4.3.7 Opportunities and challenges for the further development of the application

The application is directed to deliver information, knowledge and arguments for investments in health in line with strategies for regional development, especially by EU SF. It is based on the main findings about realising a policy impact by PHR activities. To motivate and support action, the application must support an identification of problematic regions and health issues, help to set priorities, give an idea that it is possible to do better and what could be done, deliver arguments for priority setting and provide support to use EU Structural Funds policies. Additionally, it hopefully supports the discussion about linkages between health and wealth or economic growth and employment.

The regional and local levels have been identified as being of importance as well for policy making as to realise a policy impact by PHR activities, while at the same time it has become obvious that PHR activities at this level are (not always) well developed. The application is an opportunity to support PHR activities at the regional and local level, not at least by activities at the European level.

The application can be used to identify regions with similar conditions and problems. It is possible to integrate information over programmes and projects as well as contact details. This offers the opportunity for cooperation, coordination and mutual learning.

It is possible to use the application for different contexts of PHR activities and in line with different philosophies of PHR activities. But it is always a question which information should be delivered, how to depict data, which skills and knowledge of users can be expected and how much further knowledge is necessary to understand the potential and meaning of delivered information. Actors have different “mental” or “conceptual models” (Buckeridge et al. 2002: 1199) and do not always know how to interpret findings in the light of independent and dependent variables: What influences what? Beside the providence of guidance it has to be checked if the data depictions should be constraint to prevent misinterpretation or if different “levels” of depiction should be offered (standard depiction, depictions for professionals) (Buckeridge et al. 2002: 1199 f.).

It is possible to place the application as an information tool in the Internet to be used online. The application could be the entrance or starting point to explore an issue of interest, linked with further relevant information sources, e.g. at the European level.

The application can also be linked with or even integrated in European PHR activities. For example, it is possible to link the Eurostat regional yearbook or other publications with the application. While the texts of the publications can describe the situation in the EU more in general, audiences get the possibility to take a closer look at a region of interest and analyse it in the European or national context.

The application can also be used for own presentations directly if it is distributed by CD's or if there is a download option. This makes it a valuable tool to disseminate information about EU Structural Funds policies and for “territorial governance”. It is possible to explain EU concerns and link the presentation with a discussion about implications for a territorial entity of concern. At the same time, it is possible to use the application for local or regional priority setting and decision making without links to European policies.

Of course it takes more time and effort as well as ongoing work on the application, to actualize and develop it. But only limited resources are needed and a lot of work is already done. It would only be necessary to link it with the maintenance of the application. For example, to use mainly Eurostat regional statistics offers the opportunity to develop a technical solution to integrate new indicator sets easily.

The application must be built around existing evidence and knowledge about links between health and wealth. It should stimulate discussions about the current state of affairs. But it is also necessary to conceptualise the application as “work in progress”. Even if there is some evidence about links between health and wealth, often knowledge is missing. And if there is knowledge about linkages, there are sometimes large deficits in regional statistics and respective indicators are not available yet.

Probably there are enough indicators to stimulate activities and to motivate PH professionals and other scientists to work on closing gaps. Tools for the further development of the application must be added. It should be possible to develop and test hypotheses and the discussion about the interpretation and meaning of available indicators, the need for indicators not available in the moment and the further development of the application has to be promoted. People must be motivated to participate in the discussion about health is wealth strategies and the further development of the application, and the integration of the results of these discussions in the further development of the application.

As for all reporting activities and for all developments of health information systems, a user involvement in the ongoing design process is necessary (Buckeridge et al. 2002: 1202). To inform and involve stakeholders and for the further development of the application

- existing networks should be contacted and asked to comment the application;
- those being responsible for EU Structural Funds policies at the European, national, regional and local level should be motivated to deliver information or links to further information in respect to contact details and national / regional documents about national strategic frameworks and operational programmes,
- those involved in projects should be motivated to deliver information about their projects and a project data bank should be linked with the application to support mutual learning.
- scientists should be motivated to discuss the relevance of provided indicators, the possibilities to use the application for analysis, possibilities to interpret findings information delivered by the application and opportunities for the further development of the application to add “knowledge” and “understanding” to the application (maybe it is a possibility to add a Wikipedia-like application).
- those being active in PHR should be motivated to present their experiences with the application, to articulate their needs and problems and to discuss and develop concepts for PHR activities;

The further development of the application should also be linked with ongoing and new EU projects working on PHR issues and EU Structural Fund policies. In the next years it seems to be possible to continue the work on the application under upcoming EU projects, e.g. I2SARE, EUREGIO II, EUREGIO III etc.

As far as the link between “health” and “wealth” is concerned, the indicators should deliver information about the influences of health on wealth (at the macro and micro level), of wealth on health and of health services and industries on health and wealth. Currently an application can meet these requirements only partially. A lot of indicators are missing and it is only possible to use available indicators for ecological analysis. In the moment, it is not possible to meet the requirements of more or less elaborated and detailed models or concepts, bringing health determinants and health together (s. Figures 17, 18).

It is an issue to close the gaps and add more detailed information, e.g. from European surveys or other studies. Studies might even be restricted on certain countries or regions. To explore the relevance of indicators it is not necessary that data is available for all regions. To deliver certain indicators for a couple of regions only can stimulate a discussion about the relevance and meanings of those indicators. If the relevance is convincing, this might motivate those being responsible for health statistics within EU member states to deliver similar indicators.

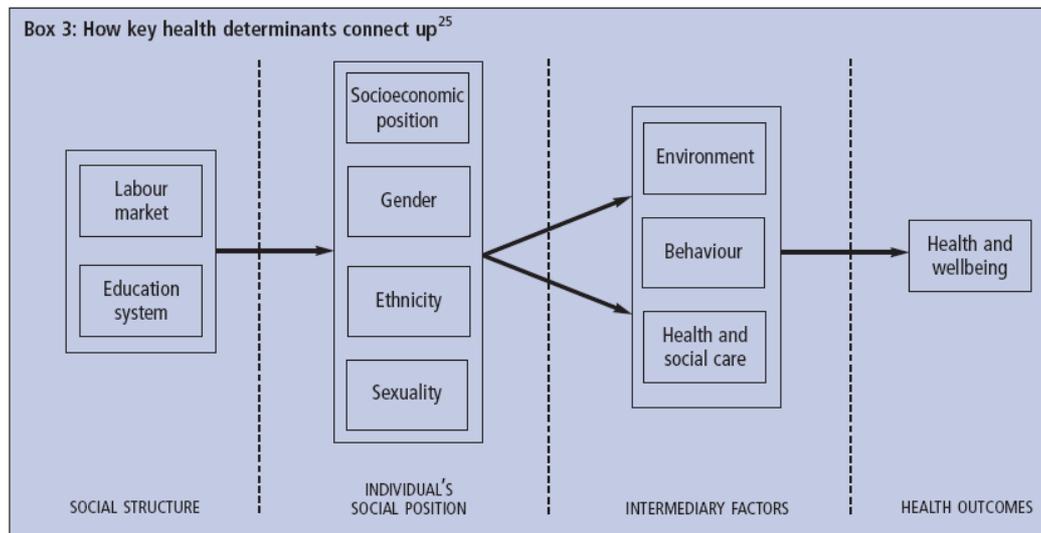


Figure 17: Example for a conceptual frame for PHR (Graham/Kelly 2008: 4)

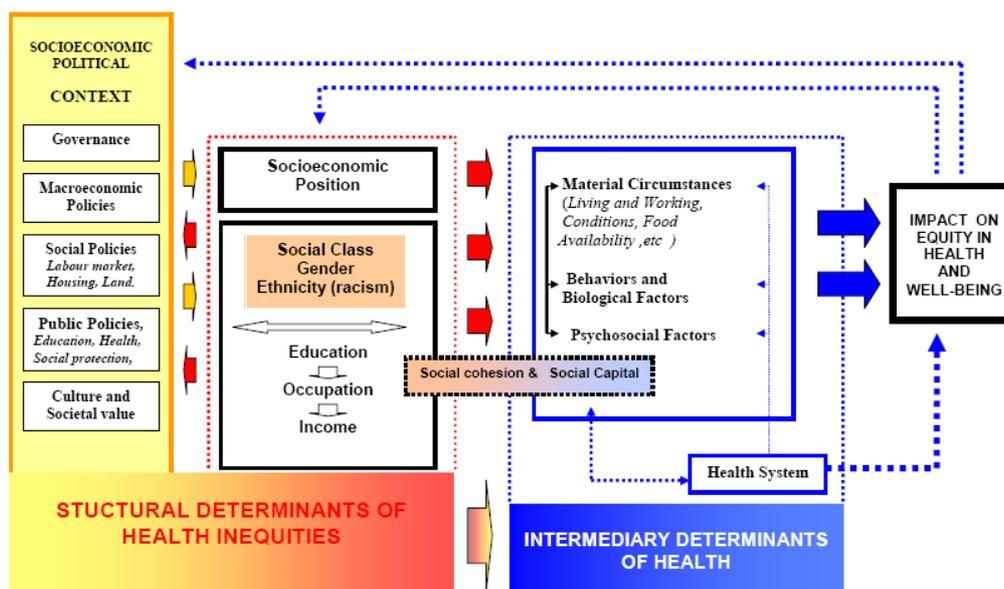


Figure 18: Example for a conceptual frame for PHR (Solar & Irwin 2007)

To explore the effects of socioeconomic and health inequalities is of special importance. There is at least some evidence that eliminating or reducing the health disadvantage of lower socioeconomic group has a great potential for improving average population health and that reducing health inequalities has positive economic effects (Mackenbach/Meerding/Kunst 2007). But while inequities in health – between and within geographic entities – are a topic of major concern, the application currently cannot deliver the information needed for a health equity surveillance system because respective statistics are not available. It has to be checked to which extent available information can be used to explore equities and inequities in health and which further indicators could or should be integrated in the application.

The requirements of a health equity surveillance system have been described by the Committee of Social Determinants on Health (CSDH 2008: 181): “A minimum health equity surveillance system provides basic data on mortality and morbidity by socioeconomic and regional groups within countries. All countries should, as a minimum, have basic health equity data available that are nationally representative and comparable over time. Ideally, mortality is estimated on the basis of complete, good-quality registries of vital events, while morbidity data could be collected using health interview surveys [...]” It is recommended to provide indicators concerning

- health outcomes:
 - mortality: all causes, cause specific, age specific, infant mortality and/or under-5 mortality, maternal mortality, and LEB;

- morbidity: at least three nationally relevant morbidity indicators, which will vary between country contexts and might include prevalence of obesity, diabetes, undernutrition, and HIV;
- disability;
- (self-rated) mental and physical health;
- cause-specific outcomes;
- daily living conditions
 - health behaviours: smoking, alcohol, physical activity, diet and nutrition;
 - physical and social environment: water and sanitation, housing conditions, infrastructure, transport, and urban design, air quality, social capital;
 - working conditions: material working hazards, stress;
 - health care: coverage, health-care system infrastructure;
 - social protection: coverage, generosity.
- consequences of ill health:
 - economic consequences;
 - social consequences;
- structural drivers of health inequity:
 - gender, norms and values, economic participation, sexual and reproductive health;
 - social inequities: social exclusion, income and wealth distribution, education;
 - sociopolitical context: civil rights, employment conditions, governance and public spending priorities, macroeconomic conditions.
- measures of inequity:
 - data on health outcomes should be provided in a stratified manner
 - sex;
 - social markers (e.g. education, income/wealth, occupational class, ethnicity/race);
 - regional markers (e.g. rural/urban, province);
 - the distribution of the population across the sub-groups;
 - summary measures for health inequities

- relative health inequities: rate ratio, relative index of inequality, relative version of the population attributable risk, concentration index;
- absolute health inequity: rate difference, slope index of inequality, population attributable risk.

Taking this into account it becomes clear that the current status of the application is only a starting point for further development. Hopefully it will motivate for respective discussions and developments.

5. Final remarks and outlook

It was the aim of the project to analyse the opportunities and challenges to realise a policy impact by PHR activities. The findings should have been used to develop a methodology and a tool box for those being active in PHR.

While differences in expectations, needs and the utilisation of information and knowledge from PHR activities between target audiences were expected from the beginning, the extent of different contexts, concepts and functions of PHR was surprising.

A reflexion over the context of PHR activities is important, because (not only) the informational infrastructure like health statistics is affected by the political and social contexts. Like those working on health statistics, those being active in PHR “should be aware of their own political and social assumptions, remain aware of the political and social contexts in which they work, and be alert to how assumptions and contexts affect their work.” (Friedman/Hunter/ Parrish II 2005: 501)

But it was a major challenge for the project to take the differences into account and distillate some common features to work on a concept for a methodology of PHR activities and draw some conclusions for recommendations how to maximise the opportunities to realise a policy impact by PHR activities.

Further, asked about the impact of PHR activities, the statements of many interviewees were sceptical. The findings from the analysis of the interviews with representatives of target audiences of PHR activities and those being active in PHR activities show that the experienced problems to realise a policy impact by PHR activities are similar to the challenges to realise a policy impact by research or scientific policy counselling. Therefore the major problems (information base, creation of knowledge, interface problems between the two worlds of sciences and politics) and the recommendations to realise a policy impact seem to be similar, even if the context differs.

Many interviewees shared the impression that scientific knowledge like statistical analysis can “only” provide the raw material for a debate “when it is [...] ready to happen”, being used to shape arguments for or against action and as a “weapon in a political battle” as well as an object of political struggle (Feder/Levitt 2005). But at the same time a lot of examples for realised policy impacts were mentioned. Providing comparative information, to deliver information for smaller, subnational entities at the local or regional level and to contribute to the development of ideas what could and should be done are promising approaches to realise a policy impact. Maybe it would also be useful to strengthen links between PHR activities and HNA, HTA and HIA.

But it also became clear that those being active in PHR have only a limited influence on the policy impact of their activities. They can influence necessary but not all or maybe also the most important sufficient preconditions. Maximising chances for a

policy impact seems to mean to a large degree to shape the context of PHR activities. For knowledge creation it seems to be important to ensure a process of cooperation between target audiences, PH professionals and those being active in PHR activities. The right questions for PHR activities have to be developed, and the findings from PHR activities have to be interpreted. Policy entrepreneurs have to pick up information and knowledge from PHR activities and contribute to their dissemination and policy impact.

Therefore a tool box for those being active in PHR can only have a limited effect on the opportunities to realise a policy impact. On the other hand (and at least to a certain degree different from research activities) offer PHR activities opportunities for horizontal and vertical cooperation and the shaping of a „PHR enterprise“. Activities at the European level or the level of the EU Member States can support PHR activities at the regional and local level by ensuring and providing comparative indicators, information, knowledge and tools. This seems to be of special importance because PHR activities at these levels are often underdeveloped and confronted with limited resources.

The project PIA PHR has delivered a concept for an application based on many of the factors which have been identified to enhance the opportunities to realise a policy impact by PHR activities and which has the capacity to promote horizontal and vertical cooperation. The pilot is linked with a certain issue of currently high relevance for public health, but the concept can be easily transferred. The application transcends to a certain degree the line between audiences of PHR activities and those being active in PHR. It allows a flexible utilisation by both groups. The application needs further engagement and development, beyond the scope of the project. But at least a first step has been made.

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Enclosures

Annex 1:

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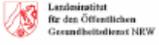
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Annex 2: The PIA PHR project flyer

<p>EU-project PIA PHR</p>	<p>Contact</p>	 <p>PIA PHR Policy Impact Assessment of Public Health Reporting</p>
<p>Funded by the European Union No. 2004109 Duration period: 1st Sept. 2005 – 31st Aug. 2008</p> <p>The PIA PHR project is carried out by a working group under the coordination of the Institute of Public Health North Rhine-Westphalia (Iögd), Bielefeld, Germany with the financial support of the European Commission.</p> <p>Project Partners:</p> <p>European Observatory on Health Systems and Policies, WHO European Centre for Health Policy, Belgium (Mathias Wimmer)</p> <p>Fédération Nationale des Observatoires Régionaux de la Santé (FNORS), France (Bernard Ledezart)</p> <p>University of Applied Sciences Bielefeld, Germany (Angela Brand)</p> <p>Béla János National Center for Epidemiology, Hungary (Csilla Kaposvari)</p> <p>University College Dublin/School of Public Health and Population Sciences, Ireland (Anthony Staines)</p> <p>Ministry of Health, Department of Health Information, Malta (Renzo Pace Azzick)</p> <p>National Institute of Public Health and the Environment (RIVM), the Netherlands (Peter Achterberg)</p> <p>The Association of Public Health Observatories/North East Public Health Observatory, United Kingdom (John Wilkinson)</p> <p>Institute of Public Health North Rhine-Westphalia (Iögd), Germany (Helmut Brand, Alfons Hollfelder, Kai Michelhan, Gudula Wied)</p>	<p>Project Leader and Head of the Institute:</p> <p>Dr Helmut Brand Institute of Public Health NRW (Iögd) Westerfeldstrasse 35/37 33611 Bielefeld, Germany</p> <hr/> <p>For further information please contact</p> <p>Project Coordinator: Dr Kai Michelhan Institute of Public Health NRW (Iögd) Westerfeldstr. 35/37 33611 Bielefeld, Germany</p> <p>Tel.: +49 (0)521 30 07 243 Fax: +49 (0)521 30 07 297</p> <p>http://www.iogd.nrw.de E-Mail: kai.michelhan@iogd.nrw.de</p>	





PIA PHR	PIA PHR	Conceptual Model of PIA PHR
<p>Background</p> <p>In 1997, the European Commission established the Health Monitoring Programme (HMP) to take forward the enhanced responsibilities of the EU in the field of public health. Under this framework, the EU project "Evaluation of National and Regional Public Health Reports" (Eva PHR) aimed to identify "best practice" reports in the sense of useful tools for policy makers at every level of the political system (local, regional and national). It was shown that there was a mismatch between the design of public health reports and the expectations and needs of policy makers.</p> <p>The project "Policy Impact Assessment of Public Health Reporting" (PIA PHR) will seek to build on these results. The central hypothesis is that there are different products of public health reporting whose quality in the sense of policy impact is determined by the respective context.</p> <p>Therefore PIA PHR is concerned with the policy impact of public health reporting as a system with different products for different user groups and objectives at different political levels.</p> <p>Group interviews and in-depth interviews with policy makers in France, Germany, Hungary, Ireland, Malta and the United Kingdom about their actual use of public health reporting, their expectations and needs shall deliver a detailed and differentiated picture of the single groups and differences between them.</p> <p>Since there are good reasons to suppose that the institutional context of public health reporting has a strong influence on the products and their policy impact, the different health reporting systems in the represented European countries will be described, analyzed and compared.</p>	<p>Aims of PIA PHR</p> <ul style="list-style-type: none"> • to analyse the systems of public health reporting, their products and actual policy impact at different levels of the political system in different European countries • to identify the core user groups of different public health reporting products and their respective expectations and needs • to provide a methodology for national and regional public health reporting, which shall enable public health professionals to make information transfer to the needs of the heterogeneous addressees: <ul style="list-style-type: none"> › different policy maker groups (politicians, administrative staff, professionals in the fields of health services and insurance as well as interest groups of the civil society) › at different levels of the political systems (local, regional, national) › in the respective systems of public health reporting in France, Germany, Hungary, Ireland, Malta, United Kingdom • to construct a "health policy tool box" for public health professionals which presents the methodology, the related tools and context-related products of public health reporting with a high policy impact potential in an attractive and pleasant way • to continue a database on health reports including descriptions and bibliographic information • to support the ongoing debate about the quality and future of public health reporting in the process of the European integration 	<p>Phase 1:</p> <ul style="list-style-type: none"> • Analysis of the institutional features of public health reporting systems at the different levels of the political systems in six European countries (France, Germany, Hungary, Ireland, Malta, United Kingdom). • Systematisation of the different products of public health reporting in relation to addressees, function, themes, aims, systems of public health reporting etc. • Identification of core user groups as the main addressees of public health reporting products directed towards the creation of high policy impact. <p>Phase 2:</p> <ul style="list-style-type: none"> • Conduct of group interviews and in-depth interviews with different core groups of policy makers in the corresponding European countries about their <ul style="list-style-type: none"> › use and the policy impact of the different products › meanings, expectations and needs in relation to the usability of existing and the vision of ideal products. <p>Phase 3:</p> <ul style="list-style-type: none"> • Development of a methodology for public health reporting products with a high policy impact potential. • Pilot testing of the methodology by applying it to a main public health issue chosen by the EU Commission. • Construction of a "health information tool box" which provides public health professionals with the methodology, related instruments and examples of context-related public health reporting products with a high policy impact potential.

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1. The design and the process of the Delphi survey

The reasons to conduct a Delphi survey were to prepare group- and in-depth interviews and the opportunity to ask more people about their priorities for the further development of PHR activities than it would have been possible by group- and in-depth interviews alone.

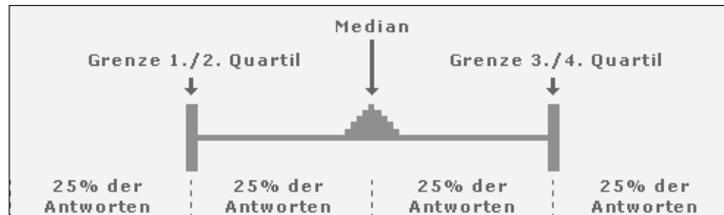
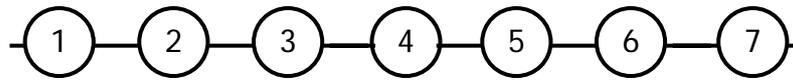
The Delphi survey was planned as a qualitative approach. In a first round from August to October 2006, representatives of different user groups and people active in PHR from the national, regional and local level in France, Germany, Hungary, Ireland, Malta and the United Kingdom were asked to participate in the survey. Participants should come from policy, administration, research, health service organizations and self-help groups and be active at the national, regional and local level, including people who are no regular users of PHR activities at the moment. It was aspired to recruit 2-4 persons for each group of interest. Potential participants were asked by mail, email or personally to take part in the survey. By sending an email they could get a user name and password to access the online questionnaire. After four weeks, a reminder was sent to all people who had been asked to participate.

In the first round the questionnaire entailed mainly 86 statements about attributes of PHR which had been drawn from literature. The item-batteries were about products, contents, structuring and methods, functions, addressees, use, process of PHR and the roles of those preparing public health reports. For each of the statements, two questions were posed:

- “Does this statement apply to your country?” (scale from 1 = not at all to 7 = 100 %)
- “How important is this feature of public health reporting in principle?” (scale from 1 = completely unimportant to 7 = very important)

For each item-battery, the interviewees had the chance to comment on the corresponding aspects of their answers. In a further free text box, they could also add attributes they were missing.

In a second round the results from the first round were presented (see Figure 1). The participants were asked to look at the differences between the “as-is state” and the “importance in principle” for their countries and assess priorities for the further development of PHR. It was possible to take a look at the results for all answers, at the answers for one of the six countries the participants came from, at the answers of people with more experience in PHR activities or at the answers of people with less experience.



-  Does this statement apply to your country? (1 = does not apply at all, 7 = applies fully)
-  How important is this feature for health reporting activities in principle? (1 = not important at all, 7 = very important)

3. Contents		Valid answers	
Public health reporting informs about...	<p>Does this statement apply to your country? (1 = does not apply at all, 7 = applies 100%)</p> <p>How important is this feature for public health reporting in principle? (1 = completely unimportant, 7 = very important)</p>	<p>Please make sure that the column in the middle shows the results of the first survey round for your country.</p> <p>Consider them when answering the following question:</p> <p>When it comes to the improvement of Public Health Reporting in your country. Which priority would you attach to the respective field of action?</p>	<p>extremely low extremely high</p> <p>1-2-3-4-5-6-7 1-2-3-4-5-6-7</p> <p>don't know</p>
3.1 ... demographic conditions.	 <p>N = 162 N = 162</p>	<p>1 2 3 4 5 6 7</p> <p>1 2 3 4 5 6 7</p>	<p>1 2 3 4 5 6 7</p> <p>1 2 3 4 5 6 7</p>
3.2 ... socio-economic conditions.	 <p>N = 159 N = 162</p>	<p>1 2 3 4 5 6 7</p> <p>1 2 3 4 5 6 7</p>	<p>1 2 3 4 5 6 7</p> <p>1 2 3 4 5 6 7</p>
... mortality frequency of	 <p>N = 159</p>	<p>1 2 3 4 5 6 7</p> <p>1 2 3 4 5 6 7</p>	<p>1 2 3 4 5 6 7</p> <p>1 2 3 4 5 6 7</p>

Figure 1: Presentation of the results in the second round of the Delphi survey

The participants from the first round were asked to take part in the second round by email. For each item of the first round the question was: “When it comes to the improvement of Public Health Reporting in your country: Which priority would you attach to the respective field of action?” It was planned to use the answers to create ranking lists and to ask the participants in a third round to comment on these ranking lists from their professional background: Do they assess those areas at the top as most problematic for their work? Do they expect that respective activities on the further development of PHR activities would be supportive for their work, fulfil their

needs and expectations and raise the policy impact of PHR activities? By this design it was expected to get information about the needs and expectations of individuals with different professional backgrounds and thereby different user groups which would be similar to the information derived from in-depth and group interviews.

Unfortunately, the participation rate in the second round was very low even after a reminder had been sent around by email. Of 194 persons of the first round only 57 filled in the questionnaire of the second round at least partially. It was not useful to conduct the third and most important round. Therefore the findings are very restricted. The first round delivers some quantitative information but it can only be used for deducing hypotheses very carefully because the compilation of the sample has not been controlled for bias. Within the design of the Delphi survey this did not seem to be necessary because individual perceptions in the third round should deliver the material for a qualitative analysis and the first two rounds should mainly stimulate the commentaries in the third.

Reasons for the low participation rate in the second round have been that due to workplace changes and in some countries owing to the reorganization of health services and political changes it was not possible to contact participants of the first round by their old email addresses. Also the questionnaire was very long and maybe too monotonous to attract people. There is also the possibility that the questionnaire was too complicated.

In the end, the Delphi survey delivered some empirical material, but the main value for the project was to give some inspirations for the in-depth and group interview, especially concerning opportunities and challenges linked with policy making and the interfaces PHR / policy maker as well as PHR / general public.

2. The first round of the Delphi survey

2.1 The questionnaire

The questionnaire for the first round of the international Delphi Survey had four parts. The first part was about personal information of the interviewees. It was followed by some explanations about the main part of the questionnaire ("Help"). The third and main part asked about features of public health reporting. The questions were arranged in 8 items batteries: Products, contents, structuring and methods, functions, addressees, use, process, roles of those preparing public health reports. The (short) fourth part is about public health reporting on different levels of the political system.

The questionnaire was presented online and has been offered in three different languages (English, German, and French).

The first part of the questionnaire: Personal Information

1.1 In which country do you mainly work?

Germany, France, United Kingdom, Ireland, Malta, Hungary, others namely
(please write out in full)

1.2 In which region of this country (e.g. federal state, province, health region) do you mainly work? (optional, please write out in full)

1.3 In which institution do you mainly work?

- a) Parliament
- b) Political Party
- c) Civil Service (e.g. ministry, local authority, administrative body, board, agency)
- d) Association, interest organisation, (e.g. charity, NGO, campaigning group, union, employers' organization)
- e) Health Insurance Body
- f) Medical Care Facility
- g) Social Care Facility
- h) Media Company
- i) University, research institute
- j) Think tank, private consultancy
- k) Others namely

1.4 Which area mainly covers your professional activity?

- a) Political activities
- b) Management, Administration
- c) Science
- d) Public relations work
- e) Consultancy
- f) Medical and other health care
- g) Social service
- h) Others namely

1.5 At which level are you mainly active?

- a) At the local level (e.g. community, district).
- b) At the regional level (e.g. Bundesland, province)
- c) At the national level.
- d) At the European level.
- e) Others namely:
- f) Cannot be assigned to any level.

1.6 Are you employed in a second job in one of the institutions mentioned under item 1.3?

no

yes (Please give the name of the institution (s.1.3) your field of activity (s. 1.4) and the level (s. 1.5))

1.7 What do you have to do with public health reporting? (from 1 = never to 7= very often)

- 1.7.1 I make use of data from public health reports.
- 1.7.2 I use the most recent health reports.
- 1.7.3 I am involved in producing public health reports.
- 1.7.4 Comment

1.8 How important are the different levels of public health reporting for your work? (1 = does not happen in my country; from 2 = completely unimportant to 8 = very important, 9 = do not know)

- 1.8.1 Local public health reporting (e.g. community, district)
- 1.8.2 Regional public health reporting (e.g. Bundesland, province)
- 1.8.3 National public health reporting
- 1.8.4 European public health reporting (EU)
- 1.8.5 Public health reporting by international organisations (e.g. WHO)
- 1.8.6 Comment

löd Internationale Delphi Expert Survey on
Public Health Reporting
within the project »Policy Impact Assessment of Public Health Reporting«

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[\[1\]](#) [\[help\]](#) [\[2\]](#) [\[3\]](#) [\[4\]](#) [\[5\]](#) [\[6\]](#) [\[7\]](#) [\[8\]](#) [\[9\]](#) [\[10\]](#) [\[English\]](#) [\[Deutsch\]](#) [\[Français\]](#)

Personal information		
1.1	In which country do you mainly work?	
	a) Germany	<input type="radio"/>
	b) France	<input type="radio"/>
	c) United Kingdom	<input type="radio"/>
	d) Ireland	<input type="radio"/>
	e) Malta	<input type="radio"/>
	f) Hungary	<input type="radio"/>
	g) others namely (please write out in full): <input type="text"/>	
1.2	In which region of this country (e.g. federal state, province, health region) do you mainly work? (optional, please write out in full) <input type="text"/>	

Figure 2: The first part of the questionnaire

**The second part of the questionnaire:
“Help” for the main part of the questionnaire**

The main part of the questionnaire contains statements about features of public health reporting. In this section, please give your assessment as to:

- How the statements apply in your country.
- How important they are in principle.

Example

Statement A: You assess that statement A “does not apply at all” in your country. But you believe that the statement is “very important” in principle.

Statement B: You assess that statement B is relatively well suited as a description for your country, but you feel that it is of low importance in principle.

	Does this statement apply to your country?		How important is this feature for public health reporting in principle?	
Public Health Reporting is...	does not apply at all ①—②—③—④—⑤—⑥—⑦ applies 100%	don't know	completely unimportant ①—②—③—④—⑤—⑥—⑦ very important	don't know
...A	<input type="radio"/> ① <input type="radio"/> ② <input type="radio"/> ③ <input type="radio"/> ④ <input type="radio"/> ⑤ <input type="radio"/> ⑥ <input type="radio"/> ⑦	<input type="radio"/>	<input type="radio"/> ① <input type="radio"/> ② <input type="radio"/> ③ <input type="radio"/> ④ <input type="radio"/> ⑤ <input type="radio"/> ⑥ <input type="radio"/> ⑦	<input type="radio"/>
...B	<input type="radio"/> ① <input type="radio"/> ② <input type="radio"/> ③ <input type="radio"/> ④ <input type="radio"/> ⑤ <input type="radio"/> ⑥ <input type="radio"/> ⑦	<input type="radio"/>	<input type="radio"/> ① <input type="radio"/> ② <input type="radio"/> ③ <input type="radio"/> ④ <input type="radio"/> ⑤ <input type="radio"/> ⑥ <input type="radio"/> ⑦	<input type="radio"/>

Important

- There are different forms, levels and products of public health reporting. When asking about the characteristics of public health reporting, we would like to know if with regard to the different public health reporting products these characteristics apply in your country as a general description.
- Even if a statement does not apply in your country - if for example the question refers to public health reporting activities at the local level and if there are no such local public health reporting activities in your country - nevertheless give your opinion as to how important local public health reporting would be for public health reporting in general.
- We are interested in your assessments – there are no “right” or “wrong” answers. Please also give an assessment if you are very uncertain and only opt for “do not know” in exceptional cases. At the end of each block, we will ask you how “safe” you feel in your answers.

The third part of the questionnaire: Main part of the questionnaire

2. Products					
Public health reporting provides ...					
	Does this statement apply to your country?			How important is this feature for public health reporting in principle?	
	<small>does not apply at all</small> ①—②—③—④—⑤—⑥—⑦	<small>applies 100%</small> ①—②—③—④—⑤—⑥—⑦	<small>don't know</small> ①—②—③—④—⑤—⑥—⑦	<small>completely unimportant</small> ①—②—③—④—⑤—⑥—⑦	<small>very important</small> ①—②—③—④—⑤—⑥—⑦
2.1	... publications which concentrate on the presentation of data with little commentary (e.g. in the form of statistical yearbooks for health care systems).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.2	... basic reports (comprehensive reports about the health of the population).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3	... comprehensive special reports (e.g. about the health of certain population groups, certain diseases/health problems).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.4	... short reports.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.5	... regularly newsletters (paper format or online).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.6	... all relevant information over the internet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Figure 3: The main part of the questionnaire

2. Products: Public health reporting provides ...

- 2.1 ... publications which concentrate on the presentation of data with little commentary (e.g. in the form of statistical yearbooks for health care systems).
- 2.2 ... basic reports (comprehensive reports about the health of the population).
- 2.3 ... comprehensive special reports (e.g. about the health of certain population groups, certain diseases/health problems).
- 2.4 ... short reports.
- 2.5 ... regularly newsletters (paper format or online).
- 2.6 ... all relevant information over the internet.
- 2.7 When answering the questions of this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 2.8 In your opinion, are there any important products of public health reporting which are missing? If yes, which ones?
- 2.9 Comment

3. Contents: Public health reporting informs about ...

- 3.1 ... demographic conditions.
- 3.2 ... socio-economic conditions.
- 3.3 ... mortality (number of deaths etc.).
- 3.4 ... morbidity (illness, disease).
- 3.5 ... the subjective health status of populations (e.g. information about how people assess their health status).
- 3.6 ... health-relevant behaviour and lifestyles
- 3.7 ... health-relevant environmental conditions / environmental risks.
- 3.8 ... disease prevention and health promotion.
- 3.9 ... the use of health services.
- 3.10 ... health system resources (personnel, hospital beds etc).
- 3.11 ... demand for medical services and the corresponding supply.
- 3.12 ... costs and financing in the health system.
- 3.13 ... cost-benefit ratios in the provision of services.

- 3.14 ... health-relevant developments in the past.
- 3.15 ... health-relevant developments in the future.
- 3.16 ... age-specific differences in health.
- 3.17 ... sex and gender-specific differences in health.
- 3.18 ... social inequality in health risks (e.g. differences in the health status or risk factors determined by social conditions).
- 3.19 ... the health of migrant groups.
- 3.20 ... context-relevant differences between regional entities (municipalities, regions).
- 3.21 ... international differences.
- 3.22 When answering the questions of this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 3.23 In your opinion, are there any important contents of public health reporting which are missing? If yes, which ones?
- 3.24 Comment

4. Structuring and Methods: Public health reporting ...

- 4.1 ... consists of data and statistics.
- 4.2 ... includes detailed explanations of indicators, statistical methods and technical terms.
- 4.3 ... consists of texts drawn up on the basis of data material.
- 4.4 ... includes summaries of the most important information.
- 4.5 ... attaches special importance to graphical and pictorial display of the most important information.
- 4.6 ... gives links to sources for further information.
- 4.7 ... presents high-quality data.
- 4.8 ... is meant to be as comprehensive as possible.
- 4.9 ... takes account of the different dimensions of health circumstances and problems.
- 4.10 ... is clearly structured.
- 4.11 When answering the questions in this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 4.12 In your opinion, are there any important contents of public health reporting which are missing? If yes, which ones?
- 4.13 Comments

5. Functions: Public health reporting ...

- 5.1 ... provides epidemiological data.
- 5.2 ... provides data which was originally collected for administrative purposes by public administration, health insurances, health services and others (administrative data).
- 5.3 ... provides data which was collected by research (research data).
- 5.4 ... brings together data drawn from different sources.
- 5.5 ... develops indicators for public health reporting.
- 5.6 ... summarises the state-of-the art in research.
- 5.7 ... summarises expert knowledge.
- 5.8 ... provides scientific information in accessible language.
- 5.9 ... provides systematic monitoring and measuring activities to record changes in the health status of populations.
- 5.10 ... supports administrative planning processes.
- 5.11 ... identifies areas in which political action is needed.
- 5.12 ... supports coordination between health policy makers in the field of health care.
- 5.13 ... supports policy making by developing proposals for policies.
- 5.14 ... supports policy making by assessing the impact of policy options.
- 5.15 ... evaluates health programmes
- 5.16 ... serves health counselling for the citizens(e.g. health advisers, health visitors, health trainers).
- 5.17 ... contributes to public transparency in health-relevant concerns.
- 5.18 ... promotes public discussion about health policy.
- 5.19 When answering the questions of this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 5.20 In your opinion, are there any important functions of public health reporting which are missing? If yes, which ones?
- 5.21 Comment

6. Addressees: Public health reporting results reach ...

- 6.1 ... politicians.
- 6.2 ... relevant decision makers in administration and authorities.
- 6.3 ... relevant decision makers in health insurance funds.
- 6.4 ... relevant decision makers in associations of health professions.
- 6.5 ... relevant managers of medical and social care facilities (health centres, hospitals, nursing care facilities and services, helpdesks).
- 6.6 ... health care practitioners.
- 6.7 ... decision makers in organisations representing the interests of patients or handicapped persons.
- 6.8 ... media.
- 6.9 ... the interested general public.
- 6.10 When answering the questions of this section, I was mostly... (uncertain / rather certain / rather certain / certain)
- 6.11 In your opinion, are there any important groups to be addressed by public health reporting activities which are lacking? If yes, which ones?
- 6.12 Comments

7. Use: Public health reporting is ...

- 7.1 ... used for looking up specific information to provide answers to individual questions if the need arises.
- 7.2 ... used to get comprehensive information about a thematic area.
- 7.3 ... used for making sound political and administrative decisions.
- 7.4 ... used to substantiate positions in political conflicts with the help of arguments.
- 7.5 ... interpreted on the basis of different values and interests.
- 7.6 ... aligned with the interests of political decision makers.
- 7.7 ... contributing to change the consciousness of problems among health policy actors in the long run.
- 7.8 ...contributing to change the consciousness of problems in the general public in the long run.
- 7.9 When answering the questions in this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 7.10 In your opinion, are there any important ways of making use of public health reporting activities which are missing? If yes, which ones?
- 7.11 Comments

8. Process

- 8.1 Public health reporting is characterised by continuity and regularity.
- 8.2 Public health reporting is up to date.
- 8.3 The topics to be covered by public health reporting activities are determined by those preparing the reports.
- 8.4 The topics to be covered by public health reporting activities are determined by bodies commissioning these activities.
- 8.5 There are regular contacts between those preparing the reports and the relevant user groups.
- 8.6 Objectives and issues of public health reporting are agreed in close cooperation between those preparing the reports and the bodies commissioning these activities.
- 8.7 Those preparing public health reports and users work together in joint projects.
- 8.8 In their work, those preparing public health reports take account of the requirements and problems of users.
- 8.9 The users know all about the requirements and problems of public health reporting
- 8.10 When answering the questions in this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 8.11 In your opinion, are there any important ways of making use of public health reporting activities which are missing? If yes, which ones?
- 8.12 Comment

9. Roles of those preparing public health reports: Those preparing public health reports are ...

- 9.1 ... "service providers" for the sectors of policy and administration.
- 9.2 ... "service providers" for the general public.
- 9.3 ... independent scientifically qualified experts.
- 9.4 ... policy consultants.
- 9.5 ... "advocates" of the population's interests in health-relevant concerns
- 9.6 When answering the questions in this section, I was mostly ... (uncertain / rather certain / rather certain / certain)
- 9.7 In your opinion, are there any important ways of making use of public health reporting activities which are missing? If yes, which ones?
- 9.8 Comment

The fourth part of the questionnaire: Levels of Public Health Reporting

The screenshot shows a web-based questionnaire interface. At the top, it reads 'Internationale Delphi Expert Survey on Public Health Reporting' and 'within the project »Policy Impact Assessment of Public Health Reporting«'. There are navigation links for 'Logout', 'Impressum', 'Contact', and 'Password'. Below this, there are language options: '[English]', '[Deutsch]', and '[Français]'. The main content area is a table with the following structure:

10	Levels of Public Health Reporting			
10.1	To which extent does public health reporting correspond to the information needs of those involved with health policy at the different levels of the political system?			
		There are no public health reporting activities at that level in my country	not at all completely	do not know
10.1.1	At the local level (e.g. community, district).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.1.2	At the regional level (e.g. federal state, province).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.1.3	At the national level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.1.4	At the EU level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Figure 4: The fourth part of the questionnaire

10.1 To which extent does public health reporting correspond to the information needs of those involved with health policy at the different levels of the political system?

- 10.1.1 At the local level (e.g. community, district).
- 10.1.2 At the regional level (e.g. federal state, province).
- 10.1.3 At the national level.
- 10.1.4 At the EU level.

10.2 Do the actual activities at the following levels correspond to your ideas of high quality public health reporting?

- 10.2.1 Public health reporting on the local level (e.g. community, district)
- 10.2.2 Public health reporting at the regional level (e.g. federal state, province)
- 10.2.3 Public health reporting at the national level
- 10.2.4 Public health reporting at the EU-level

10.3 When answering the questions in this section, I was mostly ... (uncertain / rather certain / rather certain / certain)

10.4 Comment

2.2. Participation and participants

In total, 194 persons started to fill in the questionnaire (see chart). They worked on different levels of the political system, in different institutions and in different areas of professional activity. They differed in their experiences with public health reporting.

Chart 1: Participants of the Delphi survey (first round)

Total	Germany	France	United Kingdom	Ireland	Malta	Hungary	other
194	62	22	32	17	32	29	1

**Chart 2: “In which institution do you mainly work?” Per country
(frequencies; missing: 19)**

	GER	FRA	UK	IRL	MLT	HUN	total
Civil Service	22	4	12	7	17	13	75
Association, Interest Organisation, Health Insurance Body	18	6	2	2	8	3	39
Medical Care Facility	10	3	1		6	1	21
University, Think Tank	5	4	2	7	1	6	25
Other	4	3	8				15
Total / Country	59	20	25	16	32	23	175

Chart 3: “Which area mainly covers your professional activity?”

Per country (frequencies; missing: 33)

	GER	FRA	UK	IRL	MLT	HUN	total
Political Activities	14		9	1			24
Management, Administration	14	5	5	2	11	5	42
Science	8	3	2	1	1	5	20
Public Relations Work	8	2	1		1	2	14
Consultancy	15	6	4	9	13	9	56
Medical and other health care		1	2		2		5
total	59	17	23	13	28	21	161

Chart 4: “At which level are you mainly active?”

Per country (frequencies; missing: 3)

	GER	FRA	UK	IRL	MLT	HUN	total
At the local level (e.g. community, district)	19	2	14	1	3	6	45
At the regional level (e.g. Bundesland, province)	18	14	12	2	1	10	57
At the national level	19	6	3	13	26	9	76
At the European Level	2					3	5
Cannot be assigned to any level	4		2	1	1		8
	62	22	31	17	31	28	191

Chart 5: “I make use of data from public health reports.”

Per country (frequencies; missing: 6)

	GER	FRA	UK	IRL	MLT	HUN	total
1 (never)	3		2		3		8
2	6		2	1	2		11
3	3	2	2		5	4	16
4	7	1	5		4	5	22
5	12	5	7	4	4	6	38
6	19	4	6	6	3	7	45
7 (very often)	11	9	7	6	9	6	48
total / country	61	21	31	17	30	28	188

Chart 6: “I use the most recent public health reports.”

Per country (frequencies; missing: 8)

	GER	FRA	UK	IRL	MLT	HUN	total
1 (never)	2		1		3	1	7
2	4		2	1	1	1	9
3	6		3	2	4	2	17
4	8	3	3	1	5	1	21
5	18	6	7	2	5	5	43
6	11	3	6	5	4	10	39
7 very often	13	9	7	6	7	8	50
total / country	62	21	29	17	29	28	186

Chart 7: “I am involved in producing public health reports.”

Per country (frequencies; missing: 16)

	GER	FRA	UK	IRL	MLT	HUN	total
1 (never)	17		6	3	9	1	36
2	10	4	5	4	3	2	28
3	2	3	2		1	4	12
4	7	1			1	4	13
5	11	4	2	2	5	2	26
6	3	2	2	4	3	6	20
7 (very often)	9	6	9	4	6	9	43
total / country	59	20	26	17	28	28	178

2.3 Findings

Not all of the participants completed the questionnaire, and for each item it was possible to choose “do not know”. Without the missing values and “do not know” answers, the numbers of answers per statement in the main part of the questionnaire were between 127 and 163.

To analyse the results, for each statement of each of the two scales medians were calculated and ranked. The answers give information about the assessment of the as-is state and the visions the participants have about ideal PHR activities.

For the interpretation of the results, the following aspects have to be taken into account:

- The numbers of participants and their compilation differ between countries. Differences between countries and different groups of interviewees have to be assumed.
- The ranking lists which have been produced on the basis of the medians for each country are very similar and it seems to be possible to use the ranking lists for all results to get a rough picture of deficits mentioned by the participants in the survey. But there are some differences in the ranking between countries. They have to be interpreted with caution because of a high probability of bias.
- If the results are analysed to identify areas of PHR activities which should have a high priority for the further development of PHR activities, two variables have to be taken into account: “importance in principle” and the difference between “importance in principle” and the “as-is state”. The most important topics should rank high in their importance and show high deficits.
- It has to be taken into account that the medians for the “importance in principle” are high for most of the items and do not vary strongly. The item with the highest rank has a median of 6,62 and the quartiles are 6,17 (25 percent highest ranks), 5,99 (50 percent) and 5,69 (75 percent). The lowest median is 3,81. Therefore a relatively low rank does not mean that a topic is assessed as unimportant.

For the ranking of the “as is” state the first 25 % of the statements (approximately, ranks in brackets) were:

- PHR informs about mortality (rank 1), morbidity (5), demographic conditions (2) sex and gender-specific differences in health (10), socio-economic conditions (14), age-specific differences in health (15).
- PHR consists of data and statistics (3), provides epidemiological data (4), data which was originally collected for administrative purposes (6), high-quality data (16), data from different sources (18) and consists of texts drawn up on the basis of data material (19).

- PHR provides basic reports (7) and comprehensive special reports (12), includes summaries of the most important information (8), is meant to be as comprehensive as possible (23), attaches special importance to the graphical and pictorial display of the most important information (22).
- Those preparing public health reports are service providers for the sectors of policy and administration (9), the results reach relevant decision makers in administration and authorities (11) and relevant decision makers in associations of health professionals (21).
- PHR is used to get comprehensive information about a thematic area (17) and is interpreted on the basis of different values and interests (13).
- The topics are determined by those preparing the reports (20) or by bodies commissioning those activities (24).

For the ranking of the “importance in principle”, the first 25 % of the statements (approximately, ranks in brackets) were:

- PHR informs about morbidity (1), mortality (8), demographic conditions (10), social inequality in health risks (13), socio-economic conditions (15), health-relevant behaviour and lifestyles (16), sex and gender-specific differences in health (24) and takes account of different dimensions of health circumstances and problems (19).
- PHR provides epidemiological data (9), brings together data from different sources (14) and presents high-quality data (4).
- PHR is up to date (2) and is characterized by continuity and regularity (7).
- PHR is clearly structured (5) and includes summaries of the most important information (6).
- PHR results reach relevant decision makers in administration and authorities (3) as well as politicians (18), provides systematic monitoring and measuring activities to record changes in the health status of populations (11), identifies areas where political action is needed (12), is used to make sound political and administrative decisions (17), supports administrative planning processes (20), supports the coordination between health policy makers (23) and is contributing to a change in the consciousness of problems among health policy actors in the long run (22).
- Those preparing public health reports take account of the requirements and problems of users (21).

A further ranking was constructed by using the individual differences between the assessments about the “as is” state and the “importance in principle”. It informs about deficits seen by the interviewees.

For 83 of the 86 items for the third scale the rating was higher for the “importance in principle” than for the “as-is” state. That means that the participants see deficits for the overwhelming majority of the items. At the top of the list with the largest deficits the first 25 percent of the statements are about:

- Policy making (ranks in brackets): PHR assesses the impact of policy options (2), develops proposals for policies (9), supports sound decisions (10), evaluates health programmes (11), identifies need for political action (13) and provides systematic monitoring and measurement activities of changes in the health status of populations (19).
- Interface PHR – policy maker: Users know all about the requirements and problems of PHR (1), those preparing public health reports know all about the requirements and problems of users (18), there are regular contacts between those preparing public health reports and users (4), they work together in joint projects (21), PHR supports the coordination between policy makers (7) and is contributing to a change in the consciousness of problems among health policy actors in the long run (10).
- Interface PHR – general public: PHR promotes public discussions (5) and contributes to public transparency (6), changes the consciousness of problems in the general public in the long run (8), offers health counselling for citizens (e.g. health advisers, health visitors, health trainers) (15) and PHR results reach the interested general public (17).
- PHR is characterized by continuity and regularity (12) and is up to date (16).
- PHR informs about cost-benefit ratios in the provision of services (3), developments in the future (20), the health of migrant groups (14) and social inequality in health risks (24).

To give an idea about the most important topics for the further development of PHR activities, chart 8 entails the items which belong to the 50 percent of high ranks for “importance in principle” as well as “difference between importance in principle and as-is state”. Because the medians for importance in principle are close together, the items which belong to the 50 percent of the highest ranks for “difference between importance in principle and as-is state” but not for “importance in principle” are listed additionally in chart 9.

Chart 8: Items in the upper half of the ranks of “importance in principle” and “difference between importance in principle and as-is state”

	„Importance in Principal“ (Rank)	Difference between „Importance in Principal“ and „As-Is State“ (Rank)
2.6 PHR provides all relevant information over the internet.	28	29
3.6 PHR informs about health-relevant behaviour and lifestyles	19	40
3.7 PHR informs about health-relevant environmental conditions / environmental risks.	30	30
3.8 PHR informs about disease prevention and health promotion.	26	34
3.18 PHR informs about social inequality in health risks (e.g. differences in the health status or risk factors determined by social conditions).	13	24
4.9 PHR takes account of the different dimensions of health circumstances and problems.	20	33
4.10 PHR is clearly structured	4	36
5.8 PHR provides scientific information in accessible language.	38	27
5.9 PHR provides systematic monitoring and measuring activities to record changes in the health status of populations.	11	21
5.10 PHR supports administrative planning processes.	17	23
5.11 PHR identifies areas in which political action is needed.	12	15
5.12 PHR supports coordination between health policy makers in the field of health care.	21	7
5.13 PHR supports policy making by developing proposals for policies.	23	9
5.14 PHR supports policy making by assessing the impact of policy options.	40	2
5.18 PHR promotes public discussion about health policy.	27	5
6.1 PHR results reach politicians.	18	38
6.2 PHR results reach relevant decision makers in administration and authorities.	2	41
6.5 PHR results reach relevant managers of medical and social care facilities (health centres, hospitals, nursing care facilities and services, helpdesks).	36	32
6.7 PHR results reach decision makers in organisations representing the interests of patients or handicapped persons.	34	28
7.3 PHR is used for making sound political and administrative decisions.	16	6
7.7 PHR is contributing to change the consciousness of problems among health policy actors in the long run.	25	22
8.1 Public health reporting is characterised by continuity and regularity.	6	16
8.2 Public health reporting is up to date.	3	17
8.5 There are regular contacts between those preparing the reports and the relevant user groups.	35	4
8.8 In their work, those preparing public health reports take account of the requirements and problems of users.	33	12
9.3 Those preparing public health reports are independent scientifically qualified experts.	41	42

Chart 9: Items in the upper half of the ranks for “difference between importance in principle and as-is state” but not for “importance in principle”

	„Importance in Principal“ (Rank)	Difference between „Importance in Principal“ and „As-Is State“ (Rank)
3.11 PHR informs about demand for medical services and the corresponding supply.	57	31
3.12 PHR informs about costs and financing in the health system.	52	43
3.13 PHR informs about cost-benefit ratios in the provision of services.	56	3
3.15 PHR informs about health-relevant developments in the future.	61	19
3.19 PHR informs about the health of migrant groups.	67	13
3.20 PHR informs about context-relevant differences between regional entities (municipalities, regions).	64	35
5.6 PHR summarises the state-of-the art in research.	75	37
5.15 PHR evaluates health programmes	45	8
5.16 PHR serves health counselling for the citizens(e.g. health advisers, health visitors, health trainers).	73	18
5.17 PHR contributes to public transparency in health-relevant concerns.	49	9
6.6 PHR results reach health care practitioners.	51	25
6.9 PHR results reach the interested general public.	59	14
7.8 PHR is contributing to change the consciousness of problems in the general public in the long run.	46	11
8.6 Objectives and issues of public health reporting are agreed in close cooperation between those preparing the reports and the bodies commissioning these activities.	70	39
8.7 Those preparing public health reports and users work together in joint projects.	72	20
8.9 The users know all about the requirements and problems of public health reporting	66	1
9.5 Those preparing public health reports are “advocates” of the population’s interests in health-relevant concerns	79	26

A number of audiences are not being reached satisfactorily by PHR activities in the eyes of the interviewees. Decision makers in administration and authorities (6.2) are seen as very important while the deficits do not rank very high. Politicians (6.1), managers of medical and social care facilities (6.5) and decision makers in organisations representing the interests of patients and handicapped persons (6.7) are assessed as important audiences while the differences between “importance in principle” and the “as-is state” is relatively high. Health care practitioners do not rank high on the “importance in principle” scale but the difference between “importance in principle” and the “as-is state” is relatively large.

PHR activities should not only support policy makers and be more successful in changing their consciousness of problems in the long run (7.7). Even if not assessed as very “important in principle”, there seem to be large differences when the general public is concerned. PHR activities should be more effective in reaching the general public (6.9), changing their consciousness in the long run, promoting public discussions about policy making (5.18) and contributing to public transparency in health relevant concerns (5.17).

A couple of items address contents which are important for PHR activities but not addressed satisfactorily. Such contents are health relevant behaviours and lifestyles (3.6), health relevant environmental conditions and environmental risks (3.7), disease prevention and health promotion (3.8), social inequality in health risks (3.18). Some further contents have somewhat lower ranks in the “importance in principle” scale but show high differences between “importance in principle” and the “as-is state”: especially cost-benefit ratios in the provision of health services (3.13), health of migrant groups (3.19), health relevant developments in the future (3.15), but also with somewhat lower ranks demand for medical services and the corresponding supply (3.11), context-relevant differences between regions (3.20) and costs and financing of the health system (3.12). That some of the items which address information about health services and economic questions rank high on the scale “differences between importance in principle and as-is state” have lower ranks on the “importance in principle” scale can perhaps be explained by different concepts of PHR activities which influence the ideas about the content of public health reports and differences between them and public health service reports. Different ideas about the contents of public health reports are perhaps also behind the large differences between “important in principle” and “as-is state” for item 5.16 “PHR serves health counselling for citizens”.

PHR activities should also consider more strongly the different dimensions of health circumstances and problems (4.9) and provide more systematic monitoring and measuring activities to record changes in the health status of populations (5.9). Continuity and regularity (8.1) as well as being up to date (8.2) also seem to be areas with important deficits.

Some items address the form of PHR information. More attention should be paid to a clear structure (4.10) and an accessible language (5.8). Summaries about the state

of art in research (5.6) rank low on the “importance in principle” scale but show even then large differences between the importance in principle and the as-is state.

Only one item addresses products of PHR activities and the dissemination of results: The internet should be used to provide all relevant information (2.6).

The remaining items are about those preparing public health reports. Keywords are independence and / or scientific qualification (9.3). It does not seem to be of high importance in principle that they are “advocates” of the population’s interest in health but they could perhaps do a little bit more in this respect (9.5).

3. Charts

3.1 Numbers (“N”) per country for difference “importance in principal” and “as-is state”

Chart 10: Products

	GER	FR	UK	IRL	MLT	HUN	TOTAL
2.1 PHR provides publications which concentrate on the presentation of data with little commentary (e.g. in the form of statistical yearbooks for health care systems).	55	21	25	13	25	24	163
2.2 PHR provides basic reports (comprehensive reports about the health of the population).	53	21	24	15	26	24	163
2.3 PHR provides comprehensive special reports (e.g. about the health of certain population groups, certain diseases/health problems).	54	21	24	16	26	24	165
2.4 PHR provides short reports.	48	21	21	15	27	24	156
2.5 PHR provides regularly newsletters (paper format or online).	46	21	20	13	26	23	149
2.6 PHR provides all relevant information over the internet.	51	20	23	14	26	23	157

Chart 11: Contents

	GER	FR	UK	IRL	MLT	HUN	TOTAL
3.1 PHR informs about demographic conditions.	51	20	25	15	26	23	160
3.2 PHR informs about socio-economic conditions.	50	19	25	15	26	23	158
3.3 PHR informs about mortality (number of deaths etc.).	49	20	25	14	26	23	157
3.4 PHR informs about morbidity (illness, disease).	48	20	25	14	26	23	156
3.5 PHR informs about the subjective health status of populations (e.g. information about how people assess their health status).	46	21	24	13	25	23	152
3.6 PHR informs about health-relevant behaviour and lifestyles	49	21	25	15	25	22	157
3.7 PHR informs about health-relevant environmental conditions / environmental risks.	47	21	25	13	25	23	154
3.8 PHR informs about disease prevention and health promotion.	46	20	24	15	26	23	154
3.9 PHR informs about the use of health services.	47	20	25	13	27	23	155
3.10 PHR informs about health system resources (personnel, hospital beds etc).	50	20	25	14	26	23	158
3.11 PHR informs about demand for medical services and the corresponding supply.	50	18	24	13	25	22	152
3.12 PHR informs about costs and financing in the health system.	50	19	25	13	25	23	155
3.13 PHR informs about cost-benefit ratios in the provision of services.	51	19	24	13	23	22	152
3.14 PHR informs about health-relevant developments in the past.	45	17	21	10	23	22	138
3.15 PHR informs about health-relevant developments in the future.	46	19	23	13	23	22	146
3.16 PHR informs about age-specific differences in health.	47	20	25	14	24	23	153
3.17 PHR informs about sex and gender-specific differences in health.	47	19	25	14	25	22	152
3.18 PHR informs about social inequality in health risks (e.g. differences in the health status or risk factors determined by social conditions).	48	19	25	14	24	23	153
3.19 PHR informs about the health of migrant groups.	48	19	24	13	24	23	151
3.20 PHR informs about context-relevant differences between regional entities (municipalities, regions).	47	19	25	13	22	22	148
3.21 PHR informs about international differences.	46	19	24	14	22	21	146

Chart 12: Structuring and Methods

	GER	FR	UK	IRL	MLT	HUN	TOTAL
4.1 PHR consists of data and statistics.	49	20	23	15	26	23	156
4.2 PHR includes detailed explanations of indicators, statistical methods and technical terms.	48	20	23	13	26	23	153
4.3 PHR consists of texts drawn up on the basis of data material.	48	19	22	14	26	23	152
4.4 PHR includes summaries of the most important information.	48	20	23	12	26	23	152
4.5 PHR attaches special importance to graphical and pictorial display of the most important information.	47	20	24	13	23	23	150
4.6 PHR gives links to sources for further information.	45	20	22	13	23	23	146
4.7 PHR presents high-quality data.	44	19	22	14	25	23	147
4.8 PHR is ment to be as comprehensive as possible.	45	20	22	12	25	23	147
4.9 PHR takes account of the different dimensions of health circumstances and problems.	44	20	20	12	25	23	144
4.10 PHR is clearly structured	46	18	22	15	25	23	149

Chart 13: Functions

	GER	FR	UK	IRL	MLT	HUN	TOTAL
5.1 PHR provides epidemiological data.	47	19	19	15	26	23	149
5.2 PHR provides data which was originally collected for administrative purposes by public administration, health insurances, health services and others (administrative data).	46	18	19	13	23	22	141
5.3 PHR provides data which was collected by research (research data).	47	19	18	14	25	19	142
5.4 PHR brings together data drawn from different sources.	46	19	18	14	25	20	142
5.5 PHR develops indicators for public health reporting.	44	19	21	12	25	22	143
5.6 PHR summarises the state-of-the art in research.	45	19	20	13	25	21	143
5.7 PHR summarises expert knowledge.	47	19	20	14	25	22	147
5.8 PHR provides scientific information in accessible language.	46	18	21	15	25	23	148
5.9 PHR provides systematic monitoring and measuring activities to record changes in the health status of populations.	48	19	20	13	25	23	148
5.10 PHR supports administrative planning processes.	44	18	17	12	25	22	138
5.11 PHR identifies areas in which political action is needed.	47	18	22	12	24	23	146
5.12 PHR supports coordination between health policy makers in the field of health care.	45	18	22	13	25	22	145
5.13 PHR supports policy making by developing proposals for policies.	43	19	22	14	25	22	145
5.14 PHR supports policy making by assessing the impact of policy options.	43	18	20	13	26	22	142
5.15 PHR evaluates health programmes	46	19	21	12	25	22	145
5.16 PHR serves health counselling for the citizens(e.g. health advisers, health visitors, health trainers).	46	16	17	9	26	22	136
5.17 PHR contributes to public transparency in health-relevant concerns.	47	18	20	12	26	22	145
5.18 PHR promotes public discussion about health policy.	47	17	21	13	25	22	145

Chart 15: Addressees

	GER	FR	UK	IRL	MLT	HUN	TOTAL
6.1 PHR results reach politicians.	42	19	22	14	23	21	141
6.2 PHR results reach relevant decision makers in administration and authorities.	43	20	21	14	23	21	142
6.3 PHR results reach relevant decision makers in health insurance funds.	39	18	16	7	18	21	119
6.4 PHR results reach relevant decision makers in associations of health professions.	41	19	18	11	21	21	131
6.5 PHR results reach relevant managers of medical and social care facilities (health centres, hospitals, nursing care facilities and services, helpdesks).	42	19	20	13	22	21	137
6.6 PHR results reach health care practitioners.	41	20	17	14	25	21	138
6.7 PHR results reach decision makers in organisations representing the interests of patients or handicapped persons.	40	19	19	10	23	21	132
6.8 PHR results reach media.	42	19	22	14	22	22	141
6.9 PHR results reach the interested general public.	41	19	21	13	21	22	137

Chart 16: Use

	GER	FR	UK	IRL	MLT	HUN	TOTAL
7.1 PHR is used for looking up specific information to provide answers to individual questions if the need arises.	44	20	20	13	22	23	142
7.2 PHR is used to get comprehensive information about a thematic area.	45	20	20	15	23	23	146
7.3 PHR is used for making sound political and administrative decisions.	42	20	21	14	22	22	141
7.4 PHR is used to substantiate positions in political conflicts with the help of arguments.	42	18	19	12	21	23	135
7.5 PHR is interpreted on the basis of different values and interests.	40	17	18	10	24	20	129
7.6 PHR is aligned with the interests of political decision makers.	39	19	17	12	23	21	131
7.7 PHR is contributing to change the consciousness of problems among health policy actors in the long run.	42	20	18	14	24	23	141
7.8 PHR is contributing to change the consciousness of problems in the general public in the long run.	43	20	19	14	24	22	142

Chart 17: Process

	GER	FR	UK	IRL	MLT	HUN	TOTAL
8.1 Public health reporting is characterised by continuity and regularity.	46	20	21	15	23	22	147
8.2 Public health reporting is up to date.	46	19	21	15	23	21	145
8.3 The topics to be covered by public health reporting activities are determined by those preparing the reports.	37	18	20	11	19	22	127
8.4 The topics to be covered by public health reporting activities are determined by bodies commissioning these activities.	37	19	19	13	20	22	130
8.5 There are regular contacts between those preparing the reports and the relevant user groups.	39	19	20	12	20	23	133
8.6 Objectives and issues of public health reporting are agreed in close cooperation between those preparing the reports and the bodies commissioning these activities.	36	18	18	12	21	22	127
8.7 Those preparing public health reports and users work together in joint projects.	37	20	19	13	20	22	131
8.8 In their work, those preparing public health reports take account of the requirements and problems of users.	41	20	18	12	19	22	132
8.9 The users know all about the requirements and problems of public health reporting	41	19	18	13	22	21	134

Chart 18: Roles of Those Preparing Public Health Reports

	GER	FR	UK	IRL	MLT	HUN	TOTAL
9.1 Those preparing public health reports are "service providers" for the sectors of policy and administration.	46	20	19	12	22	21	140
9.2 Those preparing public health reports are "service providers" for the general public.	47	19	19	12	21	21	139
9.3 Those preparing public health reports are independent scientifically qualified experts.	43	19	19	13	20	23	137
9.4 Those preparing public health reports are policy consultants.	41	17	18	12	20	22	130
9.5 Those preparing public health reports are "advocates" of the population's interests in health-relevant concerns	44	18	19	12	21	22	136

3.2 Difference „importance in principal“ and „as-is state“: Results ranked for “ranks for all items”

Chart 19: Products

Item	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
2.6 PHR provides all relevant information over the internet.	6,11	1,94	29	157
2.5 PHR provides regularly newsletters (paper format or online).	5,15	1,38	56	149
2.3 PHR provides comprehensive special reports (e.g. about the health of certain population groups, certain diseases/health problems).	6,1	1,12	68	165
2.2 PHR provides basic reports (comprehensive reports about the health of the population).	6,02	0,96	72	163
2.4 PHR provides short reports.	5,49	0,93	74	156
2.1 PHR provides publications which concentrate on the presentation of data with little commentary (e.g. in the form of statistical yearbooks for health care systems).	5,1	0,5	79	163

Chart 20: Contents

Items	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
3.13 PHR informs about cost-benefit ratios in the provision of services.	5,78	2,82	3	152
3.19 PHR informs about the health of migrant groups.	5,59	2,39	13	151
3.15 PHR informs about health-relevant developments in the future.	5,69	2,22	19	146
3.18 PHR informs about social inequality in health risks (e.g. differences in the health status or risk factors determined by social conditions).	6,28	2,07	24	153
3.7 PHR informs about health-relevant environmental conditions / environmental risks.	6,11	1,90	30	154
3.11 PHR informs about demand for medical services and the corresponding supply.	5,74	1,88	31	152
3.8 PHR informs about disease prevention and health promotion.	6,12	1,78	34	154
3.20 PHR informs about context-relevant differences between regional entities (municipalities, regions).	5,62	1,76	35	148
3.6 PHR informs about health-relevant behaviour and lifestyles	6,2	1,61	40	157
3.12 PHR informs about costs and financing in the health system.	5,86	1,53	43	155
3.21 PHR informs about international differences.	5,54	1,51	45	146
3.14 PHR informs about health-relevant developments in the past.	4,89	1,49	48	138
3.5 PHR informs about the subjective health status of populations (e.g. information about how people assess their health status).	5,69	1,48	49	152
3.2 PHR informs about socio-economic conditions.	6,28	1,37	57	158
3.4 PHR informs about morbidity (illness, disease).	6,62	1,36	59	156
3.9 PHR informs about the use of health services.	6	1,35	60	155
3.16 PHR informs about age-specific differences in health.	6,11	1,19	65	153
3.17 PHR informs about sex and gender-specific differences in health.	6,1	1,11	70	152
3.10 PHR informs about health system resources (personnel, hospital beds etc).	5,71	0,93	73	158
3.1 PHR informs about demographic conditions.	6,37	0,53	77	160
3.3 PHR informs about mortality (number of deaths etc.).	6,42	0,09	82	157

Chart 21: Structuring and Methods

Items	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)"	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
4.9 PHR takes account of the different dimensions of health circumstances and problems.	6,18	1,83	33	144
4.10 PHR is clearly structured	6,49	1,75	36	149
4.7 PHR presents high-quality data.	6,48	1,52	44	147
4.6 PHR gives links to sources for further information.	5,99	1,38	55	146
4.2 PHR includes detailed explanations of indicators, statistical methods and technical terms.	5,85	1,37	58	153
4.4 PHR includes summaries of the most important information.	6,44	1,33	61	152
4.8 PHR is ment to be as comprehensive as possible.	5,9	1,2	62	147
4.5 PHR attaches special importance to graphical and pictorial display of the most important information.	5,96	1,19	66	150
4.3 PHR consists of texts drawn up on the basis of data material.	5,79	0,92	75	152
4.1 PHR consists of data and statistics.	6,04	0,33	81	156

Chart 22: Functions

Items	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
5.14 PHR supports policy making by assessing the impact of policy options.	6,02	3,12	2	142
5.18 PHR promotes public discussion about health policy.	6,12	2,64	5	145
5.12 PHR supports coordination between health policy makers in the field of health care.	6,17	2,56	7	145
5.15 PHR evaluates health programmes	5,96	2,53	8	145
5.13 PHR supports policy making by developing proposals for policies.	6,14	2,52	9	145
5.17 PHR contributes to public transparency in health-relevant concerns.	5,91	2,52	9	145
5.11 PHR identifies areas in which political action is needed.	6,31	2,32	15	146
5.16 PHR serves health counselling for the citizens(e.g. health advisers, health visitors, health trainers).	5,49	2,27	18	136
5.9 PHR provides systematic monitoring and measuring activities to record changes in the health status of populations.	6,33	2,16	21	148
5.10 PHR supports administrative planning processes.	6,2	2,1	23	138
5.8 PHR provides scientific information in accessible language.	6,03	1,95	27	148
5.6 PHR summarises the state-of-the art in research.	5,44	1,73	37	143
5.7 PHR summarises expert knowledge.	5,62	1,5	47	147
5.5 PHR develops indicators for public health reporting.	6,15	1,47	50	143
5.3 PHR provides data which was collected by research (research data).	5,79	1,4	52	142
5.4 PHR brings together data drawn from different sources.	6,28	1,39	53	142
5.1 PHR provides epidemiological data.	6,43	1,17	67	149
5.2 PHR provides data which was originally collected for administrative purposes by public administration, health insurances, health services and others (administrative data).	5,62	0,5	78	141

Chart 23: Addressees

Items	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
6.9 PHR results reach the interested general public.	5,71	2,34	14	137
6.6 PHR results reach health care practitioners.	5,87	2,01	25	138
6.7 PHR results reach decision makers in organisations representing the interests of patients or handicapped persons.	6,09	1,94	28	132
6.5 PHR results reach relevant managers of medical and social care facilities (health centres, hospitals, nursing care facilities and services, helpdesks).	6,04	1,84	32	137
6.1 PHR results reach politicians.	6,2	1,72	38	141
6.2 PHR results reach relevant decision makers in administration and authorities.	6,56	1,56	41	142
6.4 PHR results reach relevant decision makers in associations of health professions.	6,14	1,44	51	131
6.3 PHR results reach relevant decision makers in health insurance funds.	5,95	1,19	63	119
6.8 PHR results reach media.	5,72	1,19	64	141

Chart 24: Use

Items	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
7.3 PHR is used for making sound political and administrative decisions.	6,22	2,57	6	141
7.8 PHR is contributing to change the consciousness of problems in the general public in the long run.	5,96	2,5	11	142
7.7 PHR is contributing to change the consciousness of problems among health policy actors in the long run.	6,12	2,12	22	141
7.4 PHR is used to substantiate positions in political conflicts with the help of arguments.	5,58	1,39	54	135
7.2 PHR is used to get comprehensive information about a thematic area.	5,91	1,12	69	146
7.1 PHR is used for looking up specific information to provide answers to individual questions if the need arises.	5,33	1,03	71	142
7.6 PHR is aligned with the interests of political decision makers.	3,81	-0,01	83	131
7.5 PHR is interpreted on the basis of different values and interests.	4,59	-0,26	85	129

Chart 25: Process

Items	Median "Importance in Principal"	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
8.9 The users know all about the requirements and problems of public health reporting	5,61	3,14	1	134
8.5 There are regular contacts between those preparing the reports and the relevant user groups.	6,07	2,73	4	133
8.8 In their work, those preparing public health reports take account of the requirements and problems of users.	6,09	2,4	12	132
8.1 Public health reporting is characterised by continuity and regularity.	6,47	2,31	16	147
8.2 Public health reporting is up to date.	6,51	2,3	17	145
8.7 Those preparing public health reports and users work together in joint projects.	5,5	2,18	20	131
8.6 Objectives and issues of public health reporting are agreed in close cooperation between those preparing the reports and the bodies commissioning these activities.	5,5	1,65	39	127
8.4 The topics to be covered by public health reporting activities are determined by bodies commissioning these activities.	4,6	-0,08	84	130
8.3 The topics to be covered by public health reporting activities are determined by those preparing the reports.	4,09	-0,67	86	127

Chart 26: Roles of Those Preparing Public Health Results

	Median „Importance in Principal“	Difference "Importance in Principal" (Median) and "As-Is State" (Median)	Ranks (All Items) Difference "Importance in Principal" and "As-Is State"	Numbers ("N") (without "do not know" and missing values): Difference "Importance in Principal" and "As-Is State"
9.5 Those preparing public health reports are "advocates" of the population's interests in health-relevant concerns	5,14	1,99	26	136
9.3 Those preparing public health reports are independent scientifically qualified experts.	6	1,55	42	137
9.2 Those preparing public health reports are "service providers" for the general public.	5,16	1,51	46	139
9.4 Those preparing public health reports are policy consultants.	4,37	0,63	76	130
9.1 Those preparing public health reports are "service providers" for the sectors of policy and administration.	5,5	0,44	80	140

3.3 Differences between „importance in principal“ and „as-is state“: Ranks for countries

Chart 27: Products

	TOTAL	GER	FR	UK	IRL	MLT	HUN
2.1 PHR provides publications which concentrate on the presentation of data with little commentary (e.g. in the form of statistical yearbooks for health care systems).	79	78	77	70	70	79	85
2.2 PHR provides basic reports (comprehensive reports about the health of the population).	72	67	78	72	60	70	62
2.3 PHR provides comprehensive special reports (e.g. about the health of certain population groups, certain diseases/health problems).	68	68	66	73	73	54	47
2.4 PHR provides short reports.	74	76	60	66	75	72	59
2.5 PHR provides regularly newsletters (paper format or online).	56	41	70	82	70	51	24
2.6 PHR provides all relevant information over the internet.	29	21	29	52	30	58	10

Chart 28: Contents

	TOTAL	GER	FR	UK	IRL	MLT	HUN
3.1 PHR informs about demographic conditions.	77	79	76	65	79	78	82
3.2 PHR informs about socio-economic conditions.	57	44	63	48	63	57	54
3.3 PHR informs about mortality (number of deaths etc.).	82	82	81	80	82	82	81
3.4 PHR informs about morbidity (illness, disease).	59	61	49	38	61	67	40
3.5 PHR informs about the subjective health status of populations (e.g. information about how people assess their health status).	49	64	33	29	77	49	36
3.6 PHR informs about health-relevant behaviour and lifestyles	40	33	47	30	76	56	33
3.7 PHR informs about health-relevant environmental conditions / environmental risks.	30	37	24	36	40	15	32
3.8 PHR informs about disease prevention and health promotion.	34	24	17	46	63	66	27
3.9 PHR informs about the use of health services.	60	66	41	74	49	36	48
3.10 PHR informs about health system resources (personnel, hospital beds etc).	73	80	68	62	65	51	58
3.11 PHR informs about demand for medical services and the corresponding supply.	31	40	27	55	10	28	23
3.12 PHR informs about costs and financing in the health system.	43	62	59	43	34	20	28
3.13 PHR informs about cost-benefit ratios in the provision of services.	3	3	4	16	2	4	8
3.14 PHR informs about health-relevant developments in the past.	48	58	48	64	42	60	22
3.15 PHR informs about health-relevant developments in the future.	19	4	20	52	25	30	18
3.16 PHR informs about age-specific differences in health.	65	53	68	54	43	47	75
3.17 PHR informs about sex and gender-specific differences in health.	70	70	67	70	36	49	66
3.18 PHR informs about social inequality in health risks (e.g. differences in the health status or risk factors determined by social conditions).	24	29	12	48	32	9	16
3.19 PHR informs about the health of migrant groups.	13	27	7	15	21	3	13
3.20 PHR informs about context-relevant differences between regional entities (municipalities, regions).	35	39	23	36	29	41	42
3.21 PHR informs about international differences.	45	36	34	39	56	76	52

Chart 29: Structuring and Methods

	TOTAL	GER	FR	UK	IRL	MLT	HUN
4.1 PHR consists of data and statistics.	81	81	80	78	66	80	84
4.2 PHR includes detailed explanations of indicators, statistical methods and technical terms.	58	59	38	79	53	37	44
4.3 PHR consists of texts drawn up on the basis of data material.	75	74	62	77	69	53	68
4.4 PHR includes summaries of the most important information.	61	65	49	25	50	44	73
4.5 PHR attaches special importance to graphical and pictorial display of the most important information.	66	72	38	35	72	43	72
4.6 PHR gives links to sources for further information.	55	69	57	60	34	32	51
4.7 PHR presents high-quality data.	44	45	31	47	30	65	61
4.8 PHR is ment to be as comprehensive as possible.	62	50	52	63	58	71	68
4.9 PHR takes account of the different dimensions of health circumstances and problems.	33	32	21	41	20	26	57
4.10 PHR is clearly structured	36	28	5	27	26	45	77

Chart 30: Functions

	TOTAL	GER	FR	UK	IRL	MLT	HUN
5.1 PHR provides epidemiological data.	67	55	64	50	55	63	70
5.2 PHR provides data which was originally collected for administrative purposes by public administration, health insurances, health services and others (administrative data).	78	77	83	75	67	73	83
5.3 PHR provides data which was collected by research (research data).	52	49	58	69	51	38	56
5.4 PHR brings together data drawn from different sources.	53	51	54	67	37	32	71
5.5 PHR develops indicators for public health reporting.	50	63	40	61	23	40	53
5.6 PHR summarises the state-of-the art in research.	37	30	35	51	15	28	65
5.7 PHR summarises expert knowledge.	47	53	51	57	43	23	55
5.8 PHR provides scientific information in accessible language.	27	26	25	21	27	38	43
5.9 PHR provides systematic monitoring and measuring activities to record changes in the health status of populations.	21	18	15	31	9	23	37
5.10 PHR supports administrative planning processes.	23	17	45	32	10	17	34
5.11 PHR identifies areas in which political action is needed.	15	8	18	17	16	18	28
5.12 PHR supports coordination between health policy makers in the field of health care.	7	7	9	8	7	31	6
5.13 PHR supports policy making by developing proposals for policies.	9	5	28	7	8	23	14
5.14 PHR supports policy making by assessing the impact of policy options.	2	1	3	2	6	14	2
5.15 PHR evaluates health programmes	8	20	10	13	10	8	3
5.16 PHR serves health counselling for the citizens(e.g. health advisers, health visitors, health trainers).	18	23	14	33	17	10	9
5.17 PHR contributes to public transparency in health-relevant concerns.	9	11	2	12	19	12	18
5.18 PHR promotes public discussion about health policy.	5	6	6	10	18	6	11

Chart 31: Addressees

	TOTAL	GER	FR	UK	IRL	MLT	HUN
6.1 PHR results reach politicians.	38	16	56	44	45	68	30
6.2 PHR results reach relevant decision makers in administration and authorities.	41	34	73	21	52	62	38
6.3 PHR results reach relevant decision makers in health insurance funds.	63	60	71	42	80	59	45
6.4 PHR results reach relevant decision makers in associations of health professions.	51	46	53	45	74	55	50
6.5 PHR results reach relevant managers of medical and social care facilities (health centres, hospitals, nursing care facilities and services, helpdesks).	32	22	43	19	40	61	38
6.6 PHR results reach health care practitioners.	25	12	41	23	45	45	30
6.7 PHR results reach decision makers in organisations representing the interests of patients or handicapped persons.	28	38	19	28	38	34	25
6.8 PHR results reach media.	64	57	75	40	68	75	40
6.9 PHR results reach the interested general public.	14	14	32	5	48	48	4

Chart 33: Use

	TOTAL	GER	FR	UK	IRL	MLT	HUN
7.1 PHR is used for looking up specific information to provide answers to individual questions if the need arises.	71	56	61	68	57	77	73
7.2 PHR is used to get comprehensive information about a thematic area.	69	52	73	57	62	74	60
7.3 PHR is used for making sound political and administrative decisions.	6	2	55	3	5	10	26
7.4 PHR is used to substantiate positions in political conflicts with the help of arguments.	54	43	71	59	39	69	48
7.5 PHR is interpreted on the basis of different values and interests.	85	83	85	85	81	84	80
7.6 PHR is aligned with the interests of political decision makers.	83	85	64	56	85	86	79
7.7 PHR is contributing to change the consciousness of problems among health policy actors in the long run.	22	15	36	19	32	35	17
7.8 PHR is contributing to change the consciousness of problems in the general public in the long run.	11	10	21	6	10	19	12

Chart 34: Process

	TOTAL	GER	FR	UK	IRL	MLT	HUN
8.1 Public health reporting is characterised by continuity and regularity.	16	42	11	14	4	21	5
8.2 Public health reporting is up to date.	17	19	26	8	1	21	46
8.3 The topics to be covered by public health reporting activities are determined by those preparing the reports.	86	84	86	86	86	85	86
8.4 The topics to be covered by public health reporting activities are determined by bodies commissioning these activities.	84	86	82	81	84	83	64
8.5 There are regular contacts between those preparing the reports and the relevant user groups.	4	9	16	11	10	7	1
8.6 Objectives and issues of public health reporting are agreed in close cooperation between those preparing the reports and the bodies commissioning these activities.	39	75	30	26	47	27	21
8.7 Those preparing public health reports and users work together in joint projects.	20	35	13	18	22	16	15
8.8 In their work, those preparing public health reports take account of the requirements and problems of users.	12	25	8	4	24	13	18
8.9 The users know all about the requirements and problems of public health reporting	1	13	1	1	3	1	7

Chart 35: Roles of Those Preparing Public Health Reports

	TOTAL	GER	FR	UK	IRL	MLT	HUN
9.1 Those preparing public health reports are "service providers" for the sectors of policy and administration.	80	73	84	83	77	81	78
9.2 Those preparing public health reports are "service providers" for the general public.	46	47	37	24	58	64	63
9.3 Those preparing public health reports are independent scientifically qualified experts.	42	48	44	76	54	2	67
9.4 Those preparing public health reports are policy consultants.	76	71	79	84	83	42	76
9.5 Those preparing public health reports are "advocates" of the population's interests in health-relevant concerns	26	31	46	34	27	5	35

Annex 4:
Opportunities and challenges
to realise a policy impact by PHR activities
in six European countries

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Annex 4.1: France

Bernard Ledésert

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1. General description of the health system in France

The actual health system in France was mainly developed since the end of World War II through a succession of different reforms.

Based on a Bismarck model, the social security system began to be implemented in 1945. The last phase of this implementation was achieved in 1998 when, with the creation of the “couverture maladie universelle” (Universal disease protection) all persons, living regularly in France are covered by the social security system for their health expenses. One of the main characteristics of the French health system is that it's based on a private / public mix of providers and mainly oriented to care with very little development of prevention and health promotion.

The long tradition of a centralized state is also found in the health system. The health policies are defined at the national level and implemented at the regional and local level. Until the mid of the nineties, all the main decision concerning the implementation of new health services were made at the national level by the Ministry in charge of Health. A process of regionalisation of the health system began in 1996 with the creation of a “Conférence régionale de santé” (Regional Health Conference). This conference defines health priorities at the regional level which are declined in a few number of thematic “Programme régionaux santé” (Regional Health Programs) by the representatives of the Ministry of Health. The same reform conduct to the implementation of a “Agence régionale de l'hospitalisation” (Regional Hospitalization Agency) in charge of the planning and organisation of the hospital care at regional level and the implementation of the “Union régionale des caisses d'assurance maladie” (Regional Union of Social Security Agencies) in charge of the planning and organisation of the ambulatory care at the regional level. In August 2004, a public health law was adopted by the Parliament. This law stressed on that the health policy of the nation is defined at the national level and is under the responsibility of the French government. With this law, health programs and health priorities are defined at the national level for a 5 years period. Health targets are defined in an annex of the law. Under the advice of a reformed Regional Health Conference, the representative of the government at the regional level elaborates a “Plan régional de santé publique” (Regional Public Health Plan), which is implemented by the “Groupement régional de santé publique” (Regional Public Health Group).

A new reform, which will be discussed in the Parliament at the beginning of 2009, will conduct to the implementation of a “Agence régionale de santé” (Regional Health Agency) at the beginning of 2010, grouping all the previous regional agencies and groups to harmonize at the regional level the different aspects of health policy (prevention, ambulatory care, hospital care, rehabilitation ...).

2. Public health reporting in France

These reforms had an important impact on the PHR activities. Before the 1996 reform, the public health reports were mostly elaborated at the national level, presenting national data and figures and giving a comprehensive view of the health status of the population and the health care system.

Circa 1996, we observed the introduction of comparisons of the national data with other countries and the development of regional reports with comparison firstly with the national level and secondly with the other regions. The harmonisation of the regional reports was conducted.

The 1996 reform conducted to the development of the regional health reports in order to select regional health priorities and to the development of specific reports linked with the national and regional health plans.

In the process of preparation of the public health law of 2004, public consultations were organised at the regional level with an impact on PHR activities. Different aspects can be highlighted from these consultations:

- a better coherence between national, regional and infra regional levels;
- the reinforcement of a territorialized approach of Health Priorities;
- the reinforcement of the capacity to determine Health Priorities and Health Programs at the regional level;
- the determination of long-term objectives;
- a better capacity to make diagnosis of the health status of the population at the local level.

A national group of experts was constituted in 2002-2003 in order to define a few number of health targets. As the group was composed of experts of the different health fields with a limited number of public health experts, 100 targets were defined.

For the following of the health programs and health targets defined by the law, changes in PHR activities were noticed both at national and regional level. The PHR activities are now organised in order to produce updated data linked to the targets.

At this time, it's difficult to predict the impact of the coming reform on PHR activities.

Several institutions and agencies product health reports in France, both at the national and regional level. Those institutions and agencies can be research institutes, governmental agencies, services of the Ministry of Health or of the Social Security at the national, regional or local level, non profit organisations (like the regional health observatories) or private firms.

Main producers at the national level are the

- Ministry of Health

- Haute Autorité de Santé (High Authority for Health)
- Haut Conseil de santé publique (Public Health High Comity)
- Institut de veille sanitaire (Institute for Public Health Surveillance)
- Institut national de prévention et d'éducation pour la santé (National Institute for Prevention and Health Education)
- Institut de recherche et documentation en économie de la santé (Institute for Research and Information in Health Economics)
- Fédération nationale des observatoires régionaux de sa santé (National Federation of Regional Health Observatories).

Main producers at the regional or local level are the

- Regional and departmental services of the Ministry of Health
- Regional and departmental councils (local elected bodies)
- Observatoires régionaux de la santé (Regional Health Observatories)
- Agence régionale de l'hospitalisation (Regional Hospitalization Agency)
- Union régionale des caisses d'assurance maladie (Regional Union of Social Security Agencies).

Different kind of reports can be identified:

- Reports on a specific public health topic, usually produced at national level, with presentation of guidelines. This kind of reports is mainly produced by the High Authority for Health in order to improve the practice of health professionals.
- Reports giving a general picture of the health status of the population and the health system. These reports are produced at national, regional or local level in order to give information to decision makers for the definition and implementation of health policies. At the national level, the main producers of these reports are the Public Health High Comity and the National Federation of Health Observatories but also services of the Ministry of Health or National agencies like the Institute for Public Health Surveillance or the National Institute for Prevention and Health Education. At the regional and the local level, the main producers of these reports are the Regional Health Observatories.
- Reports on the follow-up of health policies. They are produced at different levels. At the national level, it's mainly by the statistical office of the Ministry of Health and the Public Health High Comity. At the regional level, they are produced by the Regional Health Observatories and the statistical offices of the regional services of the Ministry of Health.

- Specific reports are also produced for the management of the health services. They are mainly produced by the Social Security Agencies at national or regional level and by the Regional Hospitalization Agencies.

3. Methodology

The methodology defined for the PIA-PHR project was based on group interviews and in depth interviews. We planned to organize one group interview at the national level and one at the regional level. It appeared quickly that, despite of the interest of the persons invited to participate to these group interview, it was quite impossible to find a proper date with a sufficient number of participants. Consequently, only face to face interviews were conducted in France.

Even if face to face interviews don't allow getting the benefice of interaction between participants, it's important to point out that, mainly at regional level, close relations exists between all the people which participation could be useful for the project: in-depth interview let them give some comments that they probably wouldn't have given during group interviews.

The interviews were conducted at two levels: the regional level (the persons interviewed were selected in the region Languedoc-Roussillon) and the national level.

For the regional level, 11 persons were interviewed:

- politicians (2): one person elected at the regional level, in charge of the health questions at the regional assembly and one person elected at the departement level, in charge of the questions of sport and elderly in the department assembly;
- staff members from public health authorities (2): the director of a local health agency from the ministry of Health, previously in charge of the definition of the health policy at the regional level and the deputy director of the department of mother and child health at the department level;
- officials from associations of health insurance funds (2): the director of the farmers health insurance fund at the regional level and the responsible of health promotion policies at the regional level of a non profit private health insurance (working in addition to the mandatory social security system);
- officials from associations of health professionals (2): the former president of the association of private hospitals at the regional level and the vice-president (as GP) of the regional union of private practitioners;
- self help groups (1): the regional representative of the union of the patients associations;

- persons being active in PHR activities (2): the person in charge of the health statistical department of the regional health agency of the ministry of health and a director of a regional health observatory (outside Languedoc-Roussillon).

For the national level, 9 persons were interviewed:

- politicians (1): one member of the national assembly, member of the commission in charge of the health questions;
- staff members from public health authorities (2): a person of the General Health Direction of the ministry of health in charge of the definition and implementation of the health policies at the national and regional level and a member of the department responsible of audits in the field of the health and social policies;
- officials from associations of health insurance funds (1): the person in charge of the health statistics for the social security fund at the national level;
- officials from health profession associations (2);
- self help groups (1): the president of the national cancer self help association;
- persons being active in PHR activities (2): a statistician working for the National High Health Council and the person in charge of the training of the civil servants of the ministry of health.

The interviews were conducted between August 2007 and February 2008 using a French translation of the interview guideline defined for the PIA-PHR project.

With the authorization of the participants, the interviews were recorded. They were transcribed and all the information gathered was made anonymous. The analysis was made following the structure of the interview guideline.

4. Results

4.1 Satisfaction with the supply of PHR

The users of public health reports as the producers agree to say that they observed a real improvement of public health reports and reporting system during the 5 to 10 past years. The quantity and the quality of the information which is now available have clearly improved. The access to this information is also easier. Even if the development of the web had a positive impact on the access to data, the philosophy of the providers of data has already changed: if some years ago they didn't want to give access to the data they collected, now exchange of data between producers and between producers and users is more common. There is probably in France a specific impact of the 2004 Public Health law: as this law has set on one hundred of public health objectives with targets to be achieved in a 5 years period, there is a need for data and information with a positive impact on PHR activities.

However, some of the persons encountered pointed out that, if there is a large amount of data and information at national, and most often at regional level, there is a lack of data at a more local level. If the data are well put into perspective at upper geographical level, it's not the case at the level of the "département" and even more at the level of the cities or in rural areas. For example, one user has made a distinction between two kinds of data/reports: the data/reports at regional level contain usually enough information and data in order to support health policy and decision making. At the opposite, at the local level, fewer data or reports are available. A large part of the data is already aggregated at an upper level with no possibility to split them at local level. Nevertheless, information and data are necessary for decision makers at this level and also for actors: there is a need for local diagnosis prior to action which it's not always possible to satisfy. In link with this point of view coming from decision makers, a producer stressed on the need for data at very local level in order to support the public health players at the local level. Due to this lack of information at a more local level, decision makers doesn't look forward for existing reports or data as they do it at the regional or national level. Finally the links between the data at the different geographical level is not enough investigated.

From another point of view, if "general" information is now usually available, specific information, data or reports on specific topics is more difficult to find. Usually, if the greatest public health questions are well documented, it's not usually the case if you search for information about specialized topics.

A user (at the level of the "département") pointed out that, from her point of view, there is a too large gap between the production of information by the producers and the need of information of the decision makers: most often, in the field of public health, the data and information produced are too old. She also discussed the quality of the data produced and, through its exhaustiveness and the representativeness of the information produced.

At the opposite, another user put forward that there is an overabundance of information and reports: the difficulty is to keep up with all this information. On the other hand, he says that, now, when he has to look forward for specific information, he usually found it.

Another point of view, put forward more by producers than by users, is that there is a lack of resources to use the large amount of data available at national or regional level. Therefore, those professionals pointed out more a under use of the existing data than a lack of specific data.

Concerning the type of information available, distinction is made between data used to monitor health services and data used in the field of health promotion and prevention: in the first case, the users and producers agree to say that most of the data needed are available, in the second case, they agree to say that there is a lack of data.

One of the decision maker we encountered put forward also the fact that, if it's quite easy to access to data, reports or information directly linked with health topics, it's more difficult to access to information or report in other fields in relation with health like employment or quality of housing for example.

The attitude toward PHR may also be different according to the position of the user or producer of data: at the regional or national level (focused in France on the definition of public health policies) there is more time and more opportunities to search for information and reports and to use it than at the level of the "département" (focused on the implementation of the public health policies).

To conclude on the satisfaction with the supply of PHR, the remark made by a producer can be pointed out: the quality of the data and information produced is directly linked with the quality of the information produced by the health professionals at the local level.

4.2 Utilization of PHR resources

On a general basis, according to the producers and the users, PHR resources are used firstly to define health policies and to adjust actions of health promotion and prevention, secondly to follow-up / evaluate those policies and action.

To achieve this goal, there is a need for updated information and for local information. On the other hand, a producer indicates that, even if the users are asking for such information, sometimes they prefer to don't use it, when they believe that the data or reports will not be in phase with their assessment of the situation.

From the answers we collected, it appears a utilization of PHR resources at a double level. Firstly, there is a need for general report or synthesis on a subject, mainly at national or regional level, that allows decision makers to have a general picture of the health status of the population or of a specific theme (i.e.: Alzheimer disease, nutrition ...). Secondly, they need information, data and report at a more local level or more accurate about a specific public health issue. All those elements permit them to have a diagnosis prior the definition of public health policies or public health targets. From this analysis, it appears that the need of information is not exactly the same at the national, regional or local level: even if it's based on the same kind of information or data, the differences rely on the way these information are put in perspective and related one to the other.

Concerning the utilization of public health reporting resources, one of the characteristics is that it is generally focused on the specific area of interest of the users: i.e. a manager of social security service in rural area use mainly information on health professionals and health problems in rural area. He's interested by more general information but, in practice, he doesn't use it on a regular basis.

Analysing the elements provided by the users, it appears that there is two types of users irrespective of their position in the health system: the first type of users use

mainly the data without paying a lot of attention to the comments and analysis made by the producers on the data. They prefer to construct their opinion from crude information rather than from analysis made by others, even if they have a good opinion of the producers. Most often, these users are public health professionals with a background in epidemiology and in the use of health indicators. Therefore, they also pay attention to the methodology used to collect data and to build the indicators presented. The second type of users doesn't look too much at the data and are more interested by the comments, recommendations and conclusions made by the producers. This second group of users have a high level of expectation on the quality of the comments made. They stress out that there is a need of engineering in this field.

From the point of view of producers, even if some years ago, the PHR resources were used mainly to have a general diagnosis of a public health topic or of a population in a given territory, the information is now more and more used linked with action. More precisely, if we want that the information produced is used, it's not only necessary to give the indicators linked to a specific topic or a specific population but it's necessary to give also elements on the actions that can be conducted and the effects it's possible to expect from these actions. Therefore, there is a more and more closer link between PHR activities and evaluation. The main difficulty in this domain is that, if the information is used by decision makers, it's necessary to give also recommendations but the producer must not take the place of the decision maker. Different options have to be presented by the producer and the necessity to make links with other policies stressed on.

4.3 Information needs of users

The need of information is firstly oriented to the diagnosis of a situation. These needs can be expressed at national, regional or local level. In some situations, rather than information to identify a new public health problem, the information is used to reinforce a previous analysis or to make more concrete a diagnosis made on an empirical basis. The need of information is also linked to the evaluation of health policies or actions. Furthermore, the information, from the user's point of view, has to characterize the health and social inequities and to point out the specificities of a territory, a population group, an organization in order to adapt locally the policies to the needs of the population.

From the producer's point of view, the information needs can differ from one user to another. For example, for a self help group member, the information is needed to identify what is getting wrong in the health system; for a decision maker, the information is needed to let him take the good decision with the lowest risk to be wrong. The producers point out also the fact that the users have to be clearer on their needs if they want the information produced help them.

The information is also needed to help decision makers to bring changes in their point of view on the different public health questions according to the changes coming from the scientists and experts.

More than information needs themselves, users and producers stressed on the question of the accessibility to data and information. At present, their analysis is that the data, reports and information are spread out between a lot of institutions and that it is difficult to collect the different information needed. They express the need of a limitation of the “entry points” to PHR using the internet facilities: a limited number of databases allowing to access simply to a large number of indicators available at different geographical level using the same procedures for the construction of indicators allowing fruitful comparisons, a library allowing to access to most of the reports, built either on a thematic point of view than on a geographical approach. This general information can be completed by more specific ones produced to answer to a specific question coming from users. But, to be really useful, such database or libraries have to offer tools to help the users in the use of the information, giving a hierarchy of the information presented, from the more important to the less important. One of the difficulties of such tools is that the level of hierarchy can vary from one user to another.

A need of popularization of the information coming from PHR activities is also expressed. Firstly, because most of the users are not public health professionals and have a little background in this field. Secondly, because in a democratic process of decision making the information must be shared between the decision makers, the professionals and the population.

In most of cases there is also a request for synthesized information. Even if there is still a need for comprehensive reports made from several tens of pages, graphs, tables or maps, there is more and more an expectation of the users for short reports (4 to 10 pages) giving the main information, with comparisons with other territories and taking in account the general context of a territory. To be used, a report must present simple conclusions and offer elements to give an answer to the public health problems they have stressed on.

4.4 Policy impact of PHR activities

The users and producers agree on the fact that there is an impact of the PHR activities on the health policies in France, at all geographical levels. Even if this impact already exist prior 2004, the new public health law adopted by the Parliament, through the definition of public health priorities and public health target on a five years basis, has reinforced the impact of PHR on policies.

At the regional level, the obligation to build a five year regional public health plan, shared out with the different decision makers and actors at the regional and local level, reinforced the need to a shared diagnosis and analysis of the health status of

the population and of the health needs. In most of the regions in France, the definition of the health priorities in these plans are based on an analysis of the situation made by the Regional Health Observatories from different sources of data. Prior this reform, such process already existed but was limited mainly at the national and regional level. The reform allows developing it furthermore at the regional level and at the local level.

Different kind of effects of PHR activities on the health policies have been given as examples by the persons we encountered (non exhaustive):

- Effect on the health structures and health professionals: identification of prioritized areas for the implementation of health professionals, adaptation of the hospitals means to the need of the population, implementation of new health or social services.
- Choice of the health priorities in a health plan at the regional or local level.
- Definition of the health policy of the Regional Council or the Departmental Council.
- Integration of a health approach in the policies to fight against inequities at the level of the city.
- Selection of proposal of actions to be financed in regards to health indicators in a territory.

On a more general basis, there is a consensus to say that the improvement of the description of the health situation has a positive impact on the process of decision making. There is now an awareness of decision makers and general population about general public health problems such as, for example, premature mortality or obesity.

But, on the other hand, there is still scepticism of the producers and users on the impact of public health reporting on health policies. If they give examples of positive impact, they point out, without giving specific examples, that in a large number of cases, reports doesn't impact positively the process of decision making due to the way the information is disseminated and, mainly, due to the fact that the dissemination of the information usually doesn't correspond to the period where the question related to it is a subject of concern of the decision makers and the population.

4.5 Factors influencing the impact of the PHR activities

To improve the impact of PHR activities, one of the main points is to facilitate the access to the data, the information and the report. Internet is one of the best mean to do it but, the large number of website presenting data or information can be counter-productive. As presented already above, bringing together the information in a limited

number of database and libraries offering tools helping the user to prioritize the information is helpful.

The development of links between users and producers is also an important issue to facilitate the use of the information produced and its impact on policies and the process of decision making. The producers have to listen to the needs of the users; these users could be either decision makers or local actors. Bridges must be laid between producers, decision makers and professionals acting near to the population. As there is difference of culture between these different categories of persons, it's necessary to develop a common background. The compartmentalization between them implies that, in some cases, the production of information and reports is regarded as luxury and not as a tool to help decision making. One proposal made by a user is to imply more the producers in the building of the local policies (the final definition of these policies remaining under the control of the decision makers). By this way, the development of links between producers and users at the local level can help to a better utilization of PHR resources and can improve the quality of the data and information coming from the local users.

The form of the PHR products has also an important role to play in their use or not use. The length of the document, its presentation and the vocabulary used are important points to be taken in account to improve the impact of the PHR activities. In reference to a picture used by a user, a report, to be used, needs to have a solid skeleton of data and indicators dressed with flesh made from comments. All this elements must be presented on a way allowing the majority of the population to understand them. Short technical notes (simple methodological advices, short elements on the process of data gathering ...) can also influence the use of PHR resources and their impact on policies. In the same kind of proposal, short reports, rather than comprehensive ones, giving synthetic information on topics well delimited can be helpful; it can be, for example, a short report giving an update of data on diabetes or deprivation or smoking habits.

Another way to improve the impact of PHR activities is to develop specific products for the different users. But there is a lack of resources and, furthermore, this solution can have a negative effect on the debates, the different categories of users having access at different levels of information.

A decision maker at a "département" level stressed that the information produced must be presented on a regular basis at the local level through meetings or symposiums. These presentations will allow local decision makers and professionals to (i) have a general view of the existing data and the way it's possible to analyse it for their use, (ii) facilitate the use of the information (and then its impact) at local level.

It appears also that the context is important: as indicated already above, the context created by the new public health law four years ago has positively improved the impact of PHR activities on decision making and the definition of health policies.

But one of the major points that can influence the impact of PHR activities is the time schedule where the information is produced. If the information is produced at a period when the topic related to it is high in the agenda of the decision makers and the population, its impact may be very important. But, even if the information produced is of good quality and well presented, if it's produced in a period where there is no interest for this topic, its impact will be low. In consequence, to let PHR activities have an important impact, the producers must develop tools allowing them to illustrate with data, indicators and other elements in a very short period the different public health problems that occur.

4.6 Proposal for the further development of PHR

One of the major points discussed by the persons is the development of links between the producers and users. The users have to be more precise in the expression of their needs and, on the other hand, the producers more clear on the possibilities they have to product reliable data and information.

The other point is linked to the dispersal of the information. For the development of PHR activities, there is a need for better links between the different producers of data, specialized in public health data or giving the contextual information needed for a good understanding of the health indicators.

A third point stressed out is the need for more local information, in link with the projects and actions implemented at the local level by the health professionals.

There is also a consensus to say that there is already a bulk of data available mainly at national and regional level and that there is not a need of new data at these levels but a need for a better use of the available data.

A tool to help the users to monitor the production of public health information, data and reports is also required, most of the users expressing their difficulties to sort out the good information in the "tsunami" of information as one user called it. In addition, simple tools allowing to access to the relevant information at the relevant period and at the relevant level is requested even if the users are clearly aware that such a tool is very difficult (and perhaps) impossible to develop.

4.7 How to support persons active in public health reporting

Two main elements were given as an answer to this topic: resources and networking.

From the point of view of the producers but also from quite all the users, there is a need of more resources to support the production of relevant public health data, information and reports. As there is a consensus on the fact that PHR activities are

activities requiring a high level of qualification, action to improve the level of qualification of the producers is also needed. These actions must improve also the ability of the producers to communicate the results of their job.

As the information is spread out between different organizations, networking activities is needed. The aims of these networking activities can be the development of cooperation between producers, the exchange of information, the sharing of common methodologies...

The best way also to support persons active in public health reporting is to clearly define the role and the responsibility of the users and of the producers. The producer works according to the methods and the information available. He has to produce the information with its interpretation and he must be responsible of the quality of the information he produce. But he doesn't have to substituting to the decision maker. In the other hand, the user has to respect the limits of the information given by the producer and he must be able to (or ask somebody else to) evaluate the producer.

5. Conclusion

From the in-depth interviews conducted in France, it appears that there was a clear improvement of the PHR activities during the 5 to 10 last years. The process of regionalisation of the health policies on one hand, the impact of the introduction of health priorities and health targets in the 2004 public health law on the other hand played an important role in this evolution.

However, there is still a need for improvement mainly on two sectors: (i) the availability of data and reports at a local level, (ii) the development of reports on less popular public health problems.

There is also a shared statement that PHR activities have already an impact on health policies and on the process of decision making in the health field even if it appears clearly that, in a large number of case, there is still an underuse of the information produced.

One of the difficulties the users and the producers have to face on is that the information and data are spread out between numbers of institutions and that there is a lack of utilisation of other information produced outside the health system.

At national and regional level, there is a large number of data available and there is now more a need of resources to analyse it than to collect new data. But at local level, there is still a need for more information.

In summary, to improve the impact of PHR activities and to support them, several elements have been pointed out:

- To limit the number of "entry point" to the information through a limited number of database and libraries presenting public health reports.

- To offer tools to help decision makers to prioritize the information.
- To develop networking activities between producers and to develop the links between producers and users.
- To give resources to producers for a better use of the existing data at national and regional level and for development of new data at local level.
- To develop tools allowing to access to pertinent and reliable data when it's needed.
- To improve the quality of the products of the PHR activities: short reports, association of data and comments, use of a simple vocabulary.

Annex 4.2: Germany

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1. PHR activities in Germany

In Germany, health policies and the health system are characterized by the federal structure of the state, the structure of the social health insurance system and a pluralistic constellation with important actors governed by public law. Even if there are some examples for PHR activities since the 19th century, namely activities by the “Kaiserliches Gesundheitsamt” around 1900 (cf. Schäfer 2003: 47) and the Government of the Federal State around 1970 (Bardehle/Annuß 1998; Stein 1998; Streich/Borgers 2002; Stein 1998: 20), it took until the middle of the 80’s that the fundament for the current status quo of PHR activities was started to be developed.

Today there are PHR activities at the national level, at the level of the federal states and at the local level. These are mainly conducted by public health service institutions like the Robert Koch-Institute, public health agencies and health ministries of the federal states and public health agencies at the local level. Further PHR activities are conducted by actors of the social health insurance system, e.g. associations of health insurances, other social insurances and governmental institutions (e.g. expertises by the “Sachverständigenrat”).

A first important step of the current development of the German PHR system was the establishment of the expert committee „Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen”¹⁰ in 1985. The committee was commissioned to assess the status quo of available health statistics and information (Streich/Borgers 2002: 233; Schwartz/Hoffmann 1995: 23). Available information and its presentation were assessed as poor and the development of a national PHR system was recommended. The work on the national PHR system started in the beginning of the 90’s with the project “Aufbau einer Gesundheitsberichterstattung des Bundes” (vgl. Trojan 2003: 63) and the work on the fundament was accomplished in 1998. The reporting activities have three pillars. Until now, two encompassing basic reports have been published. The basic reports are accompanied by a broad series of special reports. Health indicators for PHR are offered online (Ziese 2002).

At the level of the Federal States, the Health Minister Conference commissioned the work on a concept for PHR activities at the level of the federal states in 1987. The “Arbeitsgemeinschaft für leitende Medizinalbeamte” developed a set of indicators which was published in 1991 (3rd revision 2003). Federal states started to publish own public health reports, but beside the work on a common indicator set there is not

¹⁰ The expert committee was established to support the activities of the „Konzertierte Aktion im Gesundheitswesen“. The „Konzertierte Aktion“ has been established as a mixture between an advisory board for health policies and a organisational tool for governance. It represented the main actors of the “pluralistic” or “corporatist” health system. Meanwhile, the “Konzertierte Aktion” has been disband and the expert committee has become an advisory board for the ministry of health.

much coordination between the federal states: the reports differ by content, structure, indicators etc. The level of activity (number of published reports, regular reporting) differs as well. All in all, reporting routines have not been established yet.

For the local level, there are large differences between and within federal states. In the 90's, North Rhine-Westphalia attracted interest in cause of its public health law (1998), forerunning projects and respective activities. Health conferences were established at the level of the federal state and the local level, and PHR activities were conceptualised as an information tool to support the activities of the health conferences and public officials. Some local authorities have developed their reporting activities quiet well, others are still hesitant. But even here there is not much coordination between local authorities or local authorities and the federal state. There is no real "PHR system" existing.

Information delivered should support policy makers in their decisions and offer a scientific information base for sciences as well as the interested general public (Murza/Hurrelmann 1996: 14). But the discussion about the "philosophy" of PHR activities was influenced by two basic concepts (Kuhn 2005) and different expectations about the magnitude of their political dimension. On the one hand, debates about a more encompassing PHR system have been pushed by questions addressing the costs, effectiveness and efficiency of the health system (Forschungsgruppe Gesundheitsberichterstattung 1990; SVKAIg 1987; Schröder et al. 1986). Health economics and questions about health services and there (economic) effects were of major interest. Also, PHR activities were conceptualised as part of the policy cycle, as a tool for rational decision making and planning by delivering a regular monitoring and a contribution for the evaluation of health policies (Kellerhof 1998; Kuhn 2005).

On the other hand, there was a concept of PHR activities mainly delivering health information and "enlightenment" as well as motivate actors of the civil society. This concept was closely linked with WHO activities (promotion for networks for health, Ottawa Charta) and the will to attract interest for prevention and health promotion (Schröder et al. 1986; Kellerhof 1998; Noack 1990). It was also linked with the expectation about a renaissance of the community level as a locality for endeavours for health and health policies. It was aimed to sensitize and mobilize not at least the general interested public and to support participatory approaches. PHR activities should stimulate debates and discussion, not finish them as a technocratic instrument for planning (Thiele/Trojan 1990).

From adherents of both concepts it was recommended to establish PHR activities as an information tool to support health conferences as an organisational tool. Sometimes it was stressed that PHR activities should "only" be supportive for coordination and moderation and deliver the basis for a dialog and the possibility to reach a consensus. But sometimes it was also stressed that PHR activities would or even should have a more political dimension: More transparency seemed to counter

a dominance of providers and strengthen the position of public health officials (governments) against them (political pressure “top down”). Also, it was mentioned that PHR activities could stimulate political pressure for policy makers / people with political responsibilities (political pressure “bottom up”).

Characteristic features, opportunities and challenges of the current activities are:

- Federal States have own Public Health Laws and the regulations differ for PHR activities, as well for the level of the Federal States as the local level. For example, while there are no regulations for Sachsen, for some federal states they are very short (e.g. Baden-Württemberg) and more detailed for others (e.g. Berlin).
- Often (but not always) the major actors of the pluralistic health system are involved in PHR activities. At the national level, an expert committee with representatives from governmental institutions, public health services, health insurances, organisations of physicians, hospitals, welfare organisations, patient’s associations and sciences participate in priority setting for issues being addresses in health reports. A close cooperation and active involvement of potential audiences as experts is supposed to have positive effects on the acceptance and usability of reports as well as on the access to additional data sources (Ziese 2002: 12). In some federal states health conferences or similar institutions with a similar compilation of participants exist as well at the level of the federal state as the local level. They aim to coordinate activities in a fragmented and pluralistic health system, formulate health targets or priority fields for action and are supposed to use PHR activities / resources as an information tool.
- At the national level, the PHR activities are not conceptualized as a steering tool, but the main intention is to deliver the basis or infrastructure for independent reporting activities in a pluralistic health system, to deliver a flexible information system which can be adopted to current developments and used by different actors and for different purposes (Brückner 1998: 55; Ziese 2002). At the level of the federal states and the local level PHR activities are sometimes supposed to be closer linked with policy making.
- It has been stressed that the flexible and user friendly providence of indicators and information prepares the information system “to play an important role in the process of defining national health targets, and their evaluation” (Ziese 2002: 15). Health targets are formulated at the national level, at the level of the federal states and sometimes also the local level – but without systematic coordination between entities and levels, by different procedures and with differences in the involvement of PHR activities. All in all, there is no strong link between the development, implementation and evaluation of health targets and PHR activities.

- In the discussion about the implementation of a national PHR system it was argued to be necessary to start with a concept for PHR and to explore which information should be supplied. Another, succeeding position was to make the best out of available information for practical reasons.
- Until now, there was a lot of progress in compiling data and providing indicators. But still most of the data is administrative data from health insurances and other providers. Relevant information is missing (morbidity, relevant behaviour, quality of services etc.) and the possibilities for epidemiologic analysis are restricted. During the last years, surveys have been conducted and deliver additional information. They are an opportunity to close the information gap at least partially.
- While in many cases the comparability of data has become better, there are still limits to pool data from different health insurances, between federal states etc.
- Many institutions being involved in PHR activities offer reports and indicators online. But in PHR activities there is no coherence between the federal state, the federal states and local authorities.
- Many indicators cannot be broken down for the local level or sometimes even the federal states. The organisational structure of health insurances, physicians organisations, hospital organisations etc. differ from the political and administrative structure of the federal state and therefore data is sometimes not collected in line with state structures.

2. Methods

To explore and analyse the current policy impact of PHR activities, opportunities and challenges to maximise the policy impact and to develop ideas for a methodology and tool box for PHR activities in-depth and group interviews were conducted in the countries being represented within the project "PIA PHR". For Germany, interviews with 42 representatives of major audiences and with people being active in PHR were conducted between December 2006 and April 2007. The interviewees were active at the national, regional and local level (Chart 1). Most of the interviewees from the regional and local level are active in the German federal state North-Rhine Westphalia.

Chart 1: Interviewees

Level	Profession / Organisation	Code
no single level	Scientist / University, experiences with PHR activities, user	160107c
no single level	manager of a private research institute, experiences with PHR, conceptual development, user	300107b
no single level	manager of a scientific institute, conceptual development of PHR,	310107

	user	
no single level	interest representation for self help groups, health professional, conceptual development of PHR activities	240107
no single level	scientist, lecturer for PHR activities	010307b
no single level	scientist at a university, active in the conceptual development of PHR	220107b
no single level	scientific staff of a party, speaker of a working party for work, social affairs and health, member of a local parliament, user	200307
national	public servant, involved in national PHR activities, conceptual development, user of information from PHR activities	120207
national	scientist, involved in the development of national PHR activities, user of information from PHR activities	060207b
national / European	civil service (ministry), policy consultant, user of information from PHR activities	200106
national	Manager of a association for health promotion, prevention and health targets experiences in PHR activities, user	010307
national	trade unionist, experiences with PHR activities, user	120107
national	self help group, responsible for health politics, conceptual development of PHR, user	050407
national	association of health insurances, responsible for prevention, user	150107
national	association of health insurances, responsible for prevention, user	160107a
national	association of health insurances, responsible for health the workplace, conceptual development of PHR, user	060207
national	association of health insurances, active in PHR activities	150107b
regional	politician, user	300107a
regional	manager of a physicians organization, user	020407
regional	physician, responsible for health issues in a subdivision of a federal state, user	040407
regional	responsible for PHR activities in a federal state	160107b
regional	responsible for PHR activities in a federal state	110107
local	physician in a public health service	260307
local	experiences as a member in the local parliament, member of a local health conference, consultant for handicapped persons	220307
local	member of a local parliament, member of a health conference, health professional	080307
local	head of public health services, physician	160307
local	manager of a health conference, active in PHR activities, user	270207

local	sociologist, active in PHR, user	020307
local	scientific staff of a university, conceptual development of local PHR activities, user	070207
local	public health services, responsible for rehabilitation, experiences with PHR activities, user	220107a
local	Public Health service, physician, active in PHR	250106
local	Head of public health services, physician, user	120407
local	Sociologist, active in PHR in a municipality	X
local	Group-interview (workshop) with nine persons, either active in local PHR activities or the management of local health conferences.	W230407

Originally it was planned and outlined in the Grant Agreement to conduct two focus group interviews and additional in-depth interviews. For four reasons this was changed and most interviews were conducted as expert interviews:

- The number of interviewees would have been too restricted with two focus group interviews and only additional in-depth interviews. Also, there was the problem how to include representatives from a couple of different groups at the national, regional and local level in two focus groups only.
- When asked about their willingness to participate in a focus group interview, most of the people were reluctant in cause of needed time and effort. But the willingness to participate in an individual in depth interview was high.
- Some interviewees said that the anonymity of the in-depth interviews would be positive and there was the impression by the interviewer that interviewees were more open and free to give their opinions about the policy impact of PHR.
- Focus groups have the advantage to stimulate group dynamics and discussions. They allow analysing the interaction between people. But as the timeframe is restricted and it is not possible to discuss issues in detail with the experts involved. Most of the expert interviews took between 45 and 60 minutes and offered the opportunity to get more detailed information about the experiences and impressions of the interviewees on PHR.

The interviewees were contacted by telephone. The project was introduced by a short description and the aims of the interview were explained before the interviewees were asked about their willingness to participate. Only one person refused to be interviewed in cause of time and effort. After the arrangement of an appointment for the interview the interviewees got an e-mail with the flyer of the project and information about the project's webpage.

The interviews were conducted by telephone. An interview guideline was used. In the beginning the participants were asked about their permission to record the interview. All interviewees gave their permission. Anonymity was granted.

At first, the interviewees were asked to introduce themselves (professional background, experiences with PHR activities) before the main part of the interview started with the question about the satisfaction with PHR activities in general and at the European, national, regional and local level. The following questions were brought in flexible in dependence of the course of the interview:

- Which PHR resources are being used?
- Examples for PHR activities with a high and low policy impact?
- Factors influencing the policy impact?
- Experiences with PHR activities (and their policy impact) and agenda setting, assessment, policy formulation, implementation and evaluation?
- Priorities for the further development of PHR activities?
- Possibilities to support people being active in PHR?

Due to the flexible handling of the guideline, the interviews took different directions and had different priorities. The recorded interviews transliterated, summarised and analysed.

3. Satisfaction with PHR activities

The interviewees had different concepts of PHR activities. One interviewee mentioned that a very narrow definition of PHR would not be useful (120207, 18, 2-5). Others mentioned that PHR activities would be a data based reporting activity directed towards action in broadly defined health issues (310107, 9, 19-20). A further interviewee employed in public health services at the local level described PHR activities as a commissioned neutral presentation, linked with public health services and certain problems and questions (120407, 3, 31-39). It was also mentioned to define PHR activities as regular, periodically published reports: A single report would not be PHR (301007b, 5 f., 26-4).

Some statements address the characteristics of a „good“ report. It should be relevant („der Sache dienlich“) (01037b, 1, 19-30), detailed (160307, 4, 17-26), structured (01037b, 1, 19-30) and the database of the report should be comprehensible (160307, 4, 17-26). It should depict the status quo in the population (“Bestandsaufnahme”), deliver background information, offer a deficit analysis and support planning and priority setting (220307, 3, 23-28; 01037b, 1, 19-30). Recommendations for action were also mentioned, but this is seen as somewhat controversial (see later on). Information about social conditions and affairs of the population are seen as important background information which is needed to inform

the addressees of the report about social inequalities (160307, 4, 17-26). Reports should be enriched with information from additional literature and surveys (01037b, 1, 19-30). They should deliver new aspects (01037b, 1, 19-30).

In the beginning of the interviews, the interviewees were asked about their satisfaction with current PHR activities at the national, regional and local level and also European level.

Interviewees being satisfied with PHR activities stress positive developments (quality, amount of information, transparency, usability) within the last 20 years, expect further improvements (120207, 1 f., 25-21; 310107, 3, 7-33; 160107c, 2, 6-16) or are of the opinion that improvements are always possible (010307a, 2, 1-27). It was mentioned that reporting activities had been very data driven in the past and that they would be closer linked with policy making yet (120207, 12, 13-24). The implementation of (health) surveys was seen as an important improvement (160107a, 1, 24-26).

Another group of interviewees is not satisfied. Different opinions can be exemplified by statements about national PHR activities. Some interviewees state that information is delivered successfully to all relevant target groups through different channels. PHR activities are described as successful and impressive (220107b, 1, 29 ff.). It would have been possible to influence agenda setting at least a little bit and to rationalise debates (120207, 2, 14-24). Others criticise the first national report for Germany as vague and for the absence of recommendations for action (220107b, 6 f., 31-8). Contributions from social sciences would have been neglected in cause of political interests and potential conflicts (301007b, 9, 3-30). The intention of national special reports would not be clear – beside the very general intention to provide actual information of high quality to the general public (270207, 11, 22-34).

All in all, key words for critical statements concern

- the supply of information: availability and usability, contents, products, target audiences, dissemination, access, utilization;
- opportunities and challenges to realize a policy impact: lack of resources, to supply information timely, attracting interest, news value, comparative approaches, cooperation, institutionalisation;
- PHR activities in the policy cycle: realistic or escapist model, possibilities to rationalise debates, influencing agenda setting, possibilities to assess needs for action and to give orientation or even recommendations, possibilities to support evaluation.

4. From the availability of data to the dissemination of information and knowledge

4.1 Data

It is mentioned in the interviews that the availability of data and the possibilities to support decision making have become better over the last decades (WS 6 f., 27-26) and that it has been possible to bring data together from different sources (010307a, 4 f., 12-8). Potentials for further improvements are seen (010307a, 4 f., 12-8; 060207, 8).

But mentioned deficits also concern the availability, usability and compatibility of data (010307a, 4 f., 12-8). The bulk of data is derived from administration and the possibilities to use them for relevant epidemiological or other questions are valued as restricted (310107, 4, 6-14). Mostly data is not linked with individuals. Therefore, only ecological analysis is possible and it is a problem to analyse developments in time (310107, 6 f., 28-3).

While the availability of data is sufficient for mortality and inpatient care, the situation is insufficient for data on morbidity, outpatient care, the interfaces between outpatient and inpatient care (040407, 8, 32-39; 160307, 4 f., 34-5; 110107, 5; 040407, 8, 32-39) and primary and secondary prevention. There are difficulties to analyse the quality of health services (160107b, 4 f., 36-12 u. 110107, 5, 2-12), health inequalities or the health status of certain groups like migrants (010307a, 3, 4-16). Sometimes certain problems are known by experts, while data is missing to document them (270207, 8, 6-11).

While some interviewees stress the relevance for reporting activities addressing small geographical entities with their social, health and environmental conditions, the availability of data is assessed to be restricted especially for the local level (070207, 10 f., 41-14; 270207, 13, 19-28). For detailed information about occupational health the situation is assessed to be similar. Often it is necessary to use data for higher geographic levels to circumscribe problems on lower levels (060207, 1 f., 26-31; 150107b, 2, 11 f. u. 36 f.; 120207, 1 f., 25-21; 310107, 3, 7-33; 120107, 5, 24).

Especially for the local level a lack of resources for PHR activities and a necessity to use available resources effective and efficient are stated (310107, 8, 5-20). As far as data is collected at the local level, the quality should be ensured (reliability, standardisation) (270207, 10, 18-37). The interface between data documentation and analysis could be designed to support PHR activities (WS, 8, 31-40). The routine examination of children and pupils could deliver high value information if they would be linked with surveys considering the social situation of families, life styles etc. (260307, 13, 26-37).

The possibilities to compare geographic entities (e.g. federal states, European member states or communes) are valued to be restricted (310107, 7, 32-36 u. 14 f., 28-5; 120107, 5, 11-16). It is argued that the organisation of actors and decision making structures have negative effects on the data availability. For example, it is not always possible to bring data from different health insurances together while data from one health insurance is not representative for the population of Germany (060207, 1 f., 26-31; 150107b, 2, 11 f. u. 36 f.). Also, the organisation of health insurances is not in line with the political entities (communes, federal states (160307, 4 f., 34-5).

Even if social health insurance funds harmonize their data (160107a, 5 f., 19-4), data from private health insurances would still be missing. The number of people insured at private health insurances is small, but respective data would be important to get a valid description of the population's health (310107, 4, 6-14). It is also problematic to harmonize data between social insurances (old age insurance, accident insurance) (120107, 5, 31-36). The classification systems, e.g. of employment statistics, are sometimes not in line with needs of those being involved in PHR issues (150107b, 9 f., 35-6).

For a couple of reasons (e.g. to decrease health inequalities and to identify respective target groups) it would be useful to integrate data from health, educational and social statistics at the regional level (160107a, 1 f., 33-2).

Even if costly and time consuming, surveys like those being conducted by the RKI (and sometimes by local health authorities) are valued high as an additional information source besides administrative data (310107, 6 f., 28-3; 10307a, 3, 21-2; 260307, 12, 25-30; 010307b, 1 f., 36-15). In case of missing quantitative data expert interviews and the exploration of practical knowledge of local experts are recommended (270207, 3; 260307, 12 f., 37-5). The integration of findings from research would also be helpful and researchers should explore and explain the relevance of their findings for population's health (160107b, 4 f., 36-12).

It was questioned if more resources should be spent either to collect more data or to analyse available data (120107, 14, 21-23; 120207, 18, 8-9; 301007b, 12, 15-33). Even when lacks of data are considered for relevant areas, the purpose of collecting more and more data would not be clear in all cases (300107a, 1, 16-21). A not reflected extension of indicators would be expensive and not necessarily helpful (160107b, 4 f., 36-12). On the other hand, sometimes useful data would be collected, but not analysed (060207, 13 f.).

4.2 Content

The interviewees have different preferences about the contents of public health reports. For example, health inequalities (poverty or unemployment and health) are mentioned as an example of PHR activities influencing agenda setting (201206, 16 f.,

36-5; 220107a, 11, 1-11, 160107b, 12, 10-12). While some interviewees wish a stronger engagement on that topic (150107b, 11 f., 24-2; 150107, 1 f., 9-20; 120107, 1 f., 28-37; 060207, 3, 3-8), one interviewee is of the opinion that the issue has been already described well and satisfying and that it is being misused to determine the redistribution of resources by shrinking the freedom of manoeuvre for politicians (300107a, 7, 8-15).

Asked about their preferences for a stronger accentuation by PHR, some interviewees mentioned issues linked with actual health reforms and debates: Health services and financing (310107, 1, 10-33), waiting times, accessibility, freedom of choice (020407, 3 f., 18-17), monitoring of market results and the effects of a stronger competition especially on inpatient care (020407, 3 f., 18-17).

Others would like to get more information about prevention and health promotion, food safety and consumer protection (x; 160107b, 12, 10-12) as well as occupational health (160107b, 12, 10-12). It is recommended not only to report about health risks but also about factors with positive effects on health (110107, 14 f., 25-1).

It is also recommended to integrate social reports and public health reports (270207, 19, 24-38 u. 20, 6-29; 020407, 5, 4-27). But such an integration is also assessed as too complicated or too difficult in cause of the functional differentiation of administrative structures (120107, 6, 12-16; x, 19, 11-35).

Further issues mentioned to be of high interest but not satisfactorily treated by PHR activities are sex / gender and health (080307, 10, 29-34) as well as migration / culture and health (160107b, 12, 10-12; 080307, 10, 29-34).

Some interviewees wish reports with more qualitative and „lebensweltlichen“ information. They would like to get information about subjective cognitions (e.g. concerning experiences with in-vitro fertilization; 020407, 3 f., 18-17). For experts as well as the general interested public it is assumed of being helpful to link information about diseases and the status of population's health with information about social circumstances and their consequences for the development of health (120107, 7, 25-27).

It was recommended to complement the description of “more or less known” problems by examples of “good practise” for problem solutions (120107, 11 f., 36-2; 110107, 14 f., 25-1; 160107a, 4, 9-15; 120207, 11, 9-19). Proponents assume a positive impact on the motivation to act (080307, 11, 10-16). Opponents mention that those being active in PHR could be overstrained or that people with political responsibilities could refuse the presentation of examples for good practise because they do not want to be blamed for a suboptimal status quo. It is recommended to organise the PHR process in two steps. At first, a report with the analysis of the status quo and recommendations for action should be presented. At second and in agreement with policy makers the search for examples of good practise should start (160307, 17 f., 26-33 u. 37-2).

The interviewees have been asked about their preferences for more economic analysis in PHR activities, e.g. cost-benefit analysis. Some are not interested because for them it takes “investments” to reach something and the economic dimension seems to be of minor importance, at least in the beginning (080307, 10 f., 38-2). For others, available information is satisfying, e.g. for the fields of health promotion (150107b, 11 f., 24-2). Some would like more economic analysis (010307a, 18, 9-19; 220107a, 11, 1-11; 110107, 16, 27-30) and positive effects on the policy impact are expected because steering and results of steering would be mainly influenced by economic incentives and conditions. From this perspective it seems to be problematic that purposes of PHR activities have changed direction from a stronger economic approach towards a more medical perspective (301007b, 1 ff., 34-15; 150107, 10, 30-34).

But for cost-benefit-analysis also a couple of problems are mentioned:

- Health economics are assessed as not well developed in Germany, the models often not adequate yet (150107, 10, 30-34; 301007b, 1 ff., 34-15).
- While findings from health economic analysis are often abstract and hard to understand, politicians would sometimes be of the opinion to be able to keep up with expert knowledge at the level of everyday speech and singular experiences in their private surrounding (301007b, 1 ff., 34-15).
- Politicians would not have too much sympathy with health economics because different concepts and models have been functionalised for political reasons in the past (301007b, 1 ff., 34-15).
- Economic analysis has methodological problems. E.g. in the context of prevention there are a lot of relevant factors which are not directly linked with health services and which would not be considered in economic analysis (160107a, 10, 31-34).
- The effects of prevention policies are difficult to measure because they materialise much later (150107, 10, 37).
- Cost-benefit-analysis are not adequate for the juridical frame and the rationalities within the health system (020407, 11 f., 22-2).
- People being active in PHR are not qualified for health economic analysis. But they can deliver the information needed by health economists (310107, 9, 1-15).

4.3 Products

The interviewees were asked about advantages and disadvantages of different products of PHR activities. PHR activities can produce a couple of useful products (070207, 13, 21-28). There can be large and detailed reports for experts, summaries for politicians and flyers to inform about the report, its main findings and messages and to attract interest (160307, 12, 29-40 u. 14, 1-6; 010307a, 10, 13-14; 220107a, 6,

8-21, 220107, 12 f.). PHR activities can include very short reports which can be based on one or two graphs (260307, 18, 29-37).

One topic concerns differences between basic and special reports. For the interviewees, basic reports should be written to make the field accessible empirically (220107a, 4, 23-28), to choose issues for special reports (120107, 10, 11-16) and to summarise what has been implemented and realised. Basic reports could also be used to continue reporting activities on issues of certain interest (110107, 15 f., 31-11; 270207, 15 f., 36-6; 120107, 10, 9-16).

Large and detailed basic reports would be especially important for expert audiences. They are time consuming and laborious for people being active in PHR, and there is the danger that they overburden policy makers, do not attract interest or that they are not finished in cause of changing priorities (x, 19 f., 11-35). Special reports seem to be more appropriate to realize a policy impact (010307a, 4, 9-31; 160307, 10, 9-12). But also detailed and large special reports can overburden audiences (300107a, 1, 24-32; 301007b, 9 f., 37-21; 080307, 4, 15-30).

The capacities and capabilities of audiences should be considered. It should be easy to understand the main messages. Therefore, priorities should be set (270207, 17, 14-25) and information should be concentrated strongly (020407, 10, 1-11). Short summaries with a presentation of highlights, recommendations and links to more detailed information with not more than 10 pages should be produced (220107a, 3 f., 35-2; 160107a, 9; 010307a, 3 f., 15-2; 220307, 10, 9-14 u. 15, 14-22). It would be possible to divide large reports for producing a couple of additional short reports (301007b, 9 f., 37-21; 220107a, 4, 23-28). While people would often not read the whole report, summaries and recommendations should be disseminated broadly (220307, 7, 26-38).

Beside indicator based reports, not mainly indicator based reports were said to be necessary to explore issues more in depth or to handle issues for which indicators are not available (060207, 9, 30-38). A concentration on indicator based reporting activities could make the system too inflexible (120207, 18, 2-9).

Data graveyards would not make a report (310107, 3, 19-30 u. 3, 36-38). It would be a typical problem for indicator based PHR activities that the reports are hard to understand for target audiences if not presented adequately. The identification of new insights is much easier for educated and professional users than for policy makers. Impacts on steering are better realised by not indicator centred products of PHR activities like the special reports produced by the RKI or reports being published by social health insurance funds. They are more close to the qualifications and reading habits of „policy makers“ (060207, 5, 5-19) and should support interpretation, give information about consequences and ideas (310107, 3, 19-30 u. 3, 36-38; 160107a, 7 f., 39-8). The understanding for problems and the policy impact may be

raised by examples which support an understanding of the problem and raise concernment (250106, 14, 27-37).

The layout of reports should be attractive. But even then, they must not be high gloss or image papers only but entail scientific information (110107, 14 f., 25-1). The scientific quality is important (validity and reliability of data). The actual quality of data, methods, analysis and interpretation is criticised as not always adequate (060207, 9). PHR activities of high quality would not need a huge amount of data. Often a limited number of high quality data sets are sufficient (260307, 13, 26-37).

While reports should be based on a scientific foundation and health statistics, data have to be interpreted and the content, graphs and charts must be understandable for “normal“ policy makers who are not public health experts. On the other hand complex issues should not be oversimplified (080307, 8, 15-26 u. 11, 22-23; 300107a, 2 f., 34-3; 110107, 25, 21-24, 010307a, 3 f., 15-2; 160107c, 4, 3-4). Not at least at the local level reports must be understandable for “everyone” (270207, 16, 29-37).

Asked for improvements, the interviewees asked for an atlas of morbidity (040407, 8, 12-27) and an interactive cartographic supply of information (160107b, 11, 17-27). It was also recommended to publish regular short reports for short periods (110107, 15 f., 31-11) and more follow up reports (200307, 15, 10-32).

4.4 Different target audiences

Information and knowledge from PHR activities are being used by different audiences. This is for example being shown by the broad utilization of the online-supply of indicators and information by www.gbe-bund.de (160107b, 8, 28-32). Mentioned examples for audiences are employees of health insurances, hospital owners, the scientific staff of parliamentarians (310107b, 11, 24-27), physicians from in- and outpatient care and private persons (310107, 4 f., 35-7), students and scientists.

For some interviewees it is not necessary to differentiate the supply of information and knowledge for different target audiences. They propose the possibility to present information understandable for all audiences (310107b, 10, 16-17 u. 11, 3-16; 201206, 11, 4-10 u. 16, 25-33; 010307a, 15 f., 12-17; 120107, 9; 160107a, 11, 14-17) and to support policy making and public debates with the same products (160107a, 28-31).

Other interviewees are of the opinion that products developed by PHR activities should be differentiated for different audiences. To define the main audiences and their specific needs is mentioned as crucial by some interviewees (310107, 13 f.; 120207, 4 f., 33-3). Different needs would make it difficult to write a report (200307, 5, 1-2). Reports which try to find the “golden middle” would offer the chance to deliver something for all but run the risk not to have the right form for anyone. It would be

necessary to differentiate the content, products and language. While professionals are supposed to need a clear, scientific and exact language, „normal“ citizens – and in many cases policy makers – would need other forms of understandable information (040407, 9 f., 30-24). Sometimes the need to differentiate would be taken into account (150107b, 12 f., 33-2), but often it would be missing (220107b, 2, 17-31; 040407, 9 f., 30-24; 310107, 13 f.; 160107c, 7), not at least in cause of restricted resources (120207, 5, 8-13).

Asked about the main audiences, the interviewees came up with different priorities. Different priorities concerning the main target groups for PHR activities are influenced by experiences and ideas to realise a policy impact. For the interaction between PHR activities and policy makers in ministries or members of health boards of the parliament, the interviews deliver positive and negative examples. Often the interaction is experienced as complex, contradictory and paradox (060207, 12, 10-34).

Politicians are interested to know what independent professional experts are thinking. They are confronted with lobbying and interest driven information and are glad about neutral sources. A confidential relationship and the knowledge about the integrity of the expert is valued as important (301007b, 10 f., 39-20; 300107a, 2, 17-26 u. 3, 34-36) and information from PHR activities could deliver an objective and professional information for policy decisions (010307b, 4, 17-28). But there would also be situations in which policy makers do not want to be confronted with political pressure and more transparency would not always be desired. Established cliques for decision making would sometimes have an interest in handling issues for their own profit instead of looking for new insights and transparency (220107a, 11, 21-29). The trust in the own knowledge and the willingness to reflect own positions would also be of relevance. Some people would simply be sure to be right and base decisions on their feelings. They would not be interested scientific based information and maybe be anxious to be challenged by expert opinions (310107, 7, 10-13).

It was mentioned that rationalities of public health experts can differ from political rationalities. The political room for manoeuvre can be limited and policy making be determined by priorities, trajectories and other logics of politics and policies (010307b, 4, 17-28; 060207, 6, 9-13). Even if rational arguments are recognised in political debates, decision making is said to be often determined by agreements and compromises between parties (30017a, 4).

No government could work on all problems at the same time, and the recognition of problems and the assessment of their emergency are different between political parties (vgl. 220307, 4, 10-27). Available resources are used for priority fields for action and there is often no interest that additional priorities are brought on the table as a consequence of PHR activities. If there seems to be no possibility to treat the problem successfully, for example in cause of missing resources, it is rational for political reasons to try keeping the issue out of the public or political debate at least

for the moment, until there seems the possibility to handle it (250106, 8 f., 37-21). This would have consequences for the perception of opportunities and challenges for PHR activities (220107b, 4, 4-12).

Governments seem to be more interested in reports which can be used to demonstrate successful policy making, the opposition seems to be more interested in reports which articulate deficits (201206, 10, 5-14; 200307, 8, 6-21). For the opposition, it would be easy to use findings from PHR to articulate demands and to build up political pressure. Governments would not be flexible, would have to decide what to do with limited resources and to present policies as success (260307, 9, 1-6; 220107b, 5 f.; 160307, 11, 28-38). Often they would block political demands by the opposition by the argument of missing resources (300107a, 4, 13-26).

Therefore, governments would be interested in controlling the production and dissemination of information (270207, 15, 18-26; 160307, 8, 5-10; 070207, 12 f., 29-15). Beside the political struggle there would be further reasons. For example, if reports identify social disadvantaged areas with above average health problems, this could stimulate segregation. The identification of disadvantaged populations could stimulate discrimination. Problems could get worse (110107, 1 ff, 25-27; 201206, 4, 9-24).

For the local level it is argued that policy makers sometimes ignore findings from PHR activities because they do not see links with their responsibilities (WS, 6 f., 27-26). The relevance of local policies for prevention and health promotion would often not be recognised, local health policies would not be valued high (250106, 3 f., 29-5 u. 5, 8-13 u. 16, 7-26; 010307b, 11; X, 16 f., 10-2). This could change when local politicians recognise the possibility to profile themselves by activities in the field (250106, 13 f., 37-22).

The interviewees gave different and somewhat contradictory advices to attract interest for information and knowledge from PHR. Scientists and public health professionals should anticipate that their findings and advice might differ from the opinions, beliefs and priorities of politicians (050407, 11, 15-19). To maximise acceptance, those producing PH reports should think about realistic and practical consequences (050407, 9 f., 28-23).

On the one hand, neutral information is stressed as important for successful PHR activities. At least it could deliver the foundation for a political debate (260307, 16, 1-9; 240107, 7 f., 25-2; 310107, 5 f., 38-4). On the other hand, it would be a challenge to maintain neutrality (240107, 12, 20-32) because reports could not be free of values and sometimes professional statements about responsibilities would be asked for (201206, 18, 24-28; 201206, 8, 7-8; 010307a, 3 f.). And it is also recommended to use PHR activities to politicise and to build up political pressure (300107a, 7, 24-29; 110107, 7, 22).

Individual constellations seem to be important (301007b, 8, 1-9). In some interviews it is assumed that someone who delivers confidential information is in a better situation than someone who has to publish a report (040407, 12, 1-30). It has also positive effects if there is a qualified administration at the political level (301007b, 8, 13-36 and 10 f., 39-20). Tensions would be low if articulated demands drawn from PHR activities address responsibilities beyond the scope of those being responsible for and in control of PHR activities (8010307a, 6, 14-31).

Sometimes it was assumed that mostly PHR activities do not realise a direct policy impact but that there are more indirect channels. Mostly and with positive consequences for a policy impact (040407, 5, 30-39; 020407, 6, 30-41) information and knowledge from PHR activities would be filtered and diffused by the media, professionals, opinion leaders and other multipliers force politicians to action and increase their interest in information (10307a, 11; 010307a, 7 f., 38-42). It would especially be important to attract their interest, so that they (try to) feed the findings from PHR activities into the political process. Actors of the social health insurance system, e.g. health insurances and their associations, associations of physicians, hospitals, charity organisations etc. would as well be able to interpret and translate the findings from PHR activities for the government and the parliament as important for the implementation of policies. It is recommended not to look for reactions by the ministry or health boards, but by committees and boards as the “Gemeinsamer Bundesausschuss”, e.g. by patient representatives who would look for trustworthy data to bring these information in the political process (160107c, 9 ff., 33-5).

The actors of the social insurance fund based health system are mainly active at the level of the federal states and the national level. At the local level, health professionals and their networks could fulfil similar tasks (010307b, 8 f., 38-23). They could counsel local policy making and coordinate their own activities in parallel to public policy making. For the local level also, some interviewees see local agencies, local boards for health, the local parliament or the mayor as the main audiences and the support for local planning as the main purpose of PHR activities (260307, 6 f., 33-6; 270207, 14, 5-25; 070207, 6; 010307, 7). It is mentioned that it is sometimes difficult to attract interest in cause of many responsibilities and issues and that a detailed examination and debate could not be expected beside local boards for health (160307, 6, 7-25).

While common administrative structures would not support an intensive interaction between those being active in PHR and policy makers (160107b, 7, 21-37), the model of a health conference would offer the opportunity to optimize interaction, cooperation and coordination (160107b, 7, 21-37). It would not always be necessary to reach local politicians or members of the local health board to realize a policy impact. Sometimes it would have been possible to realize projects through cooperation in health conferences (250106, 3, 1-5).

A health conference should identify priority fields for action and commission PHR activities. The findings of PHR activities could be discussed and interpreted in the conference and recommendation could be given to policy makers (120107, 8, 27-35).

Positive and negative experiences with health conferences are mentioned. Some work very effective and allow shrinking perspectives (200307, 6, 11-14; 040407, 13 f., 24-34). Sometimes PHR activities are experienced as a support for cooperation in somewhat cumbersome health conferences and as a medium to reach consensus as well as to develop recommendations (080307, 5, 29-37).

In reality, recommendations by the health conference are sometimes based on the expert knowledge of its members and the interplay of PHR activities, health conferences and local policy making differs. Sometimes PHR activities are not linked with health conferences but with public administration, the local board for health or the local public health agency (220307, 1, f., 34-12 u. 3, 18-20 u. 3 f., 37-15 u. 5, 1-4 u., 11, 14-24, 14, 4-19; WS, 13, 1-7). In other communities PHR activities are linked with health conferences, but the public health service agency is the driving force of the health conference. The issues for PHR activities are mainly chosen by the agency and the health conference is “only” asked for affirmation (250106, 6 f., 39-9 u. 12, 3-11). Further conferences are not successful in coordinating activities. Sometimes the conferences are a pure meeting of different interest groups (200307, 6, 11-14; 040407, 13 f., 24-34) who mainly try to prevent agreements which they see as being of disadvantage for themselves. As far as agreements are reached they are a compromise of strong particular interests (310107, 9 f., 37-9). Sometimes there is no interest in PHR activities at all, sometimes reports are used to document their different recommendations (310107, 9 f., 37-9). Furthermore, the cooperation between the health conference and PHR activities is well but there are problems to cooperate with the boards of health and social affairs. Local politicians are not always interested in the work of local health conferences and they not always participate. Sometimes the health conference carries out health policies besides the local government (250106, 5 f., 33-9).

Following other interviewees, information and knowledge from PHR activities should be targeted to the general public and support the sensitivity for health issues, enlightenment, a reflexion about “every day” theories, public debates, the understanding for diseases¹¹, programmes, projects (160107b, 9, 3-18; 060207, 10 f., 40-11; 220307, 8, 6; 310107, 2 f., 27-2). If it influences the culture as people talk about health questions, a lot would be achieved. Accordingly, information and knowledge should not only be provided for decision makers (120207, 2 f., 26-3). Everyone should be able to find and understand information (010307a, 3 f., 15-2; 160107c, 4, 3-4; 220307, 6 f., 24-21) and be empowered to reflect complex issues

¹¹ For others informing citizens is not the main responsibility of PHR activities. There would be special information sources like health information (160107b, 9, 3-18).

(160107c, 7, 12-15). For this purpose, reports should be written popular (080307, 9, 19-30). Thematic reports seem to be better equipped than indicator centred reports (060207, 11 f., 35-2). It would be necessary to learn about the development of opinions, knowledge and attitudes, to analyse the consequences of an information flood and the reasons for resistance against scientific based information and knowledge which conflicts with own opinions and attitudes (160107c, 4, 3-4). Especially as far as health and health risks would be concerned, there would often a tendency for irrational behaviour (160107c, 6, 28-31).

Some challenges to reach citizens are mentioned (250106, 16, 31-40) and the media is said to have a strong influence on the public perception. It would need persons who are able to identify the relevance of an issue and place respective information in the media (160107a, 12, 5-16). Reports can produce curiosity and start a more detailed debate (080307, 8 f., 31-7), but a professional press work (press conferences, press releases when a report has been published or in reaction of an article or report in the media) would be important to attract interest of the media (010307a, 10 f., 38-21). It is also possible to place information in the media and organise a public debate to produce political pressure and motivate for action (080307, 9, 19-30; 070207, 16, 3-38; 201206, 10, 19-30).

Because journalists would not always be willing to take a closer look at the material (160107c, 2, 25-31), they would not always disseminate qualified information and their perception of newsworthiness could differ from a public health professional's standpoint of view (050407, 9 f., 28-23), the main message has to be presented accurately and it has to be taken care that journalists understand the main message. Sustainability is a problem; what seems to be of relevance for the news of today might be forgotten tomorrow.

A further position is to support actors operating on the health market. PHR activities should provide information and knowledge for market and entrepreneurial decisions (020407, 9, 24-29). At the same time, information about the health market should be delivered for a monitoring by those with political responsibilities.

Further, reporting activities to realise political influence or to disseminate information within the structures of own associations were mentioned (e.g. association of health insurances; 150107, 13, 24-27; 310107, 6 f., 18-18; or health promotion at the workplace; 150107b, 12, 18-22).

4.5 Dissemination

Reports should be offered in a paper version and an electronic version (160307, 13, 15-20; 120207, 5, 8-13; 020407, 10, 1-11). The content and the layout of reports are acknowledged as important factors for successful PHR activities. But the production of a report or another PHR product is only one step. PHR activities also comprise the

dissemination, discussion and interpretation of findings (110107, 25, 21-24). These steps should be given more attention (160107c, 15, 30-31).

If it is not an internal report, it is necessary to create publicity. At least the interest of target audiences has to be attracted. An active communication policy (110107, 7, 22) and people with political responsibility for PHR activities (not least because often they decide about dissemination strategies) are named as important for the dissemination of the findings (070207, 14, 9-22). It is recommended to look for possibilities to discuss the report in meetings. For a broad publicity the media should become involved, e.g. by press conferences and releases (200307, 10, 1-9) where a report is presented by a high rank public official (160107b, 8, 28-32).

This transition between PHR activities as a professional task and as part of the political and administrative process has to be kept in mind for the reflexion about the roles of people being active in PHR. Especially at the local level, these people are not only active for PHR. Most times they are working on PHR issues only part time but also on other issues beside PHR issues. Sometimes they are the coordinators of health conferences. Therefore it is not surprising that some of the interviewees see those being active in PHR as networkers (010307b, 9 f., 29-2), while others are of the opinion that mainly the heads of the public health agencies are the moderators and managers of processes (160307, 16, 12-17). Experts with different professional expertises should help policy makers to understand information delivered by PHR activities (300107a, 6, 36-37). Pure data would not be enough to deduce reality. Hypotheses and interpretation would be needed (020407, 5 f., 4-20).

Target audiences could not be presumed to be interested in information from PHR. Agents interested in transparency and being able to activate reflection and discussion in organisations and by actors who are busy to complete their daily and routine tasks are needed (020407, 7 f., 35-5). To realise a policy impact it might be helpful to learn from lobbying strategies (160107, 15, 37).

It seems to be useful to disseminate information about the existence of a report broadly and to provide supportive measures for people looking for information. One interviewee said that they only got information about a report of interest accidentally (310107, 1 f., 38-8). Some interviewees would like to get respective information by a newsletter, e.g. per e-mail. This could be the cause to take a look at a report, especially if the report seems to fit to actual activities (160107a, 2, 20-26 u. 9, 35-36). However, other interviewees are of the opinion that a further newsletter would not raise attention in cause of information flood (220307, 15, 4; 120107, 10, 33-34). It is also mentioned that a broad distribution at best has the effect that information is used by accident and very selective.

A fixed distribution list is assumed to be of advantage. Sometimes personal contact is critical to get attention for the main messages (310107, 14 f., 15-3). It should not be presumed that mailed reports are being read by addressees. One interviewee

mentioned that local policy makers could not even remember that a report was mailed to them. They did not read the report because they saw no links with their responsibilities and their work (250106, 4, 23-28). Multipliers and persons who can open doors are assessed as helpful (e.g. mayors; 250106, 5 f., 33-9). They should be contacted personally and the main message of a report should be explained to them. Personal contacts with target groups allow to compare the main message of a report with the perception of the audiences and can support cooperation. The dissemination of information can be secured and risks of misinterpretations can be lowered (110107, 7, 22; 160307, 12, 27-34; 080307, 8, 15-26 u. 10, 3-23; 220307, 9, 33-34).

Printed versions should only be distributed to a small number of addressees automatically. The broad public should be informed about the existence of the report, e.g. by a flyer. It should be possible to order the print version of a report for a symbolic price and it should be possible to download the electronic version without any payments (010307a, 10, 19-35). For some target audiences it could be useful to disseminate information through multipliers (e.g. health professionals) or to use visual displays, advertisements or the television (220307, 8, 17-39; 9, 21-26 u. 10, 39-40).

Beside the question how to transport information to target audiences there is the challenge to support people who look for information. The costs of an enquiry must not be higher than the expected benefit.

Interviewees seem to use reports mostly from the level of their professional activity (local, regional, national). The utilisation of information supplied at the European level is very limited. Given reasons concern language problems, limited resources and the impression that information needs would probably not be satisfied (050407, 7, 11-22).

The advantage of PH reports is seen in aggregated data collections (060207, 2, 35-41). Some interviewees rather use the internet (080307, 2 f., 4-6; 050407, 5, f., 5-20) and different databases (010307a, 2 f., 33-8). For pragmatic reasons information which does not seem to be of actual relevance for the work is ignored (150107, 4, 3-7; 010307a, 3 f., 15-2). Problems to select relevant information of high quality from all the information offered are mentioned. It was recommended to offer support for enquiries through the internet (300107a, 8, 1-11; 020407, 10, 4-11). Products of PHR activities should deliver information of the quality of data and methods (110107, 18, 1-18).

It could be helpful to offer an opportunity to ask questions and to get information by institutionalising a public health information centre (260307, 10 f., 30-11; 240107, 6, 21-42).

4.6 Utilization

Influenced by context and interest there are different kinds of utilization. For example, PHR activities are used as a tool with a documentary function to support administration and decision making (060207, 10, 18-32) or to monitor developments to identify problems (020407, 5, 7 f.; 040407, 1, 9-12 u. 3, 3-13 u. 3 f., 33-38). They are used to look for single information (060207, 10, 1-9; 050407, 7, 27-29) or for answers to certain questions (260307, 2, 23-24). Some people want to get an overview about an issue (060207, 10, 1-9; 310107, 2, 13-25, 29-33), others need a starting point for a more detailed examination and hope to get hints about additional information sources (120107, 5, 6-7). Some are using information and knowledge from PHR for scientific purposes (160107a, 3, 7-10), others for counselling activities (240107, 5, 27-28) or educational purposes (160107c, 2, 25-31; 070207, 1 f., 25-2). Some people look for arguments being helpful in political debates (120107, 2, 38-41), strengthening their own position (300107a, 4, 3-4; 070207, 6) or weakening other's positions (120107, 3, 22-25). PHR activities are also used to present own activities (050407, 3, 29) and legitimate them (050407, 3, 21-25).

For some interviewees there is a tendency to provide data graveyards without conclusions or impacts on policy making. As far as recommendations for action are delivered, they do not see any consequences for policy making (300107a, 1, 10-14; 020407, 1 f., 34-29; 120107, 1 f., 28-37; 201206, 2 f., 5-10; 300107b, 1, 16-29; 250106, 1 f., 35-28; 220107a, 1 f., 36-13; 160307, 1, 21-37; 070207, 2, 7-41; 020407, 4, 26-38; 160307, 1, 21-37). The impact of PHR activities is described as invisible and unknown (160107c, 2, 6-16). It is also mentioned that "data mass graves" can be (mis-)used for different purposes by selective and "flexible" interpretation (020407, 5 f.). In political contexts the supply of data is not interpreted in lines with the background and concepts of the respective reports. Instead of this, data are ripped out of their context (050407, 1 ff., 28-16; 3 f., 40-9).

To use the supply of information and knowledge by PHR activities effectively, audiences must understand which kind of information is presented for which purposes (160107c, 5, 3-12). At least in theory it should be possible for users to work with provided material like texts based by indicators, graphs and charts (300107a, 8, 1-11; 040407, 9, 5-16). While some interviewees are satisfied with the actual possibilities, others mention technical problems (150107, 11, 26-30). At the same time it should be acknowledged that users are very reluctant to use existing possibilities. Most of them prefer complete documents, maybe in cause of missing qualifications to interpret the material by their own (120207, 9-28). This could support the development of respective qualifications (160107c, 5, 3-12).

5. Factors with influence on the policy impact of PHR

5.1 Positive and negative examples

While for one interviewee the impact of PHR activities is underestimated (301007b, 4, 12-15), most of the interviewees are of the opinion that it is difficult to realise a policy impact with PHR activities. Many interviewees are sceptical about the assumption to realise a direct policy impact by PHR activities. The circulation of knowledge from the PHR activities and the realization of a policy impact are described as complex social processes (010307a, 7 f., 38-42) and the experience would show that PHR weaves more on detours (160107 b, 6, 17-19). If an impact occurs, this would mostly happen behind the back of the actors and could at best be analysed by historians in the retrospect (160107c, 10, 25-28). But asked for examples, more positive than negative examples have been mentioned.

Positive examples refer to situations in which the depiction of problems was followed by activities to solve them. Mentioned examples were disease management programmes (120107, 4, 34-39; 160107, 11, 15-22) and attention for health inequalities (120207, 4, 15-23). For the local level, a couple of interviewees reported positive effects for reports about the health status of children and adolescents and the analysis of data derived from regular examinations linked with school enrolments, concerning overweight as well as growing numbers of movement, eating and speech disorders (010307a, 4, 9-31; 080307, 3 f., 34-9; 160307, 3, 3-17; 270207, 4 f., 37-16; 220107a, 2, 20-34; 120407, 5 f., 12-28; 110107, 8, 20-25). Other examples concerned local psychosocial services, the integration of people with mental disorders, health promotion, violence in families, diabetes (220307, 5, 8-15; 080307, 3, 19-30) and stroke (220107a, 2, 20-34). Reporting activities would have had positive effects on the cooperation between local agencies (120407, 5 f., 12-28) and were used to reconfigure programmes of public health services (120407, 5 f., 12-28).

As an example for a low policy impact a WHO report with a ranking for health systems was mentioned. There was political resistance and the methods of the report were criticized (201206, 4, 3-21). It was also mentioned that it was hard to attract interest and stimulate activities by reporting about demographic change for quiet a while (150107b, 6, 5-12 f.). There is a higher interest for issues with shorter time horizons. Sometimes reports have no consequences because resources for activities are missing (080307, 4, 15-30).

5.2 Resources

Statutory regulations influence the policy impact. E.g. the public health law of North Rhine-Westphalia is said to have had positive consequences. But all in all, especially local PHR activities have not established themselves broadly (010307b, 2 f., 21-23). Often the importance is dependent from the engagement and assertiveness of

individuals (250106, 20, 3-25; 010307a, 9 f., 26-7) or the interests of local policy makers.

The policy impact of a report is influenced by the availability of resources, the willingness for action, open windows or already existing interest for an issue, the influence of lobbying groups, the political benefits to become active and the possibility to bring the issue together with the more general orientations of parties and by party programmes (220307, 5, 26-32; 160307, 3, 21-38).

A couple of interviewees criticized a lack of resources (personal resources: employees and qualification, financial resources, data) (120207, 11, 31-38; 010307a, 9 f., 26-7; 010307b, 1, 020307, 1, 9-20; 270207, 3, 26-33; 220107b, 1, 22-26; 060207, 12, 10-34). In many federal states, statutory regulations about PHR activities have not been linked with additional resources. Missing acceptance is one reason. Often PHR activities are not seen as very important at the local level (010307b, 8, 1-27; 270207, 13, 30-37).

For the local level there are examples that PHR activities are just conducted to fulfil statutory regulations. They are often carried out by employees of public service agencies who are not qualified and have to fulfil the task beside their original responsibilities. A lack of resources has negative effects on the integration of PHR activities in decision making structures. One interviewee reported that in the past it has been possible to organise health conferences to prepare PHR activities and discuss the findings. Due to a lack of resources this is not possible any more, at least to the same extent (160307, 5, 10-37). It is a major challenge to use limited resources effectively and efficient to maximise an impact. It should be clarified which effects can be expected by a report, which efforts are needed, if it is possible to draw on existing information or even publications and reports and if it is necessary to write a new one (WS, 5 f.).

PHR activities must be recognised as an important, usable, neutral tool which can be used by many interest groups (240107, 15, 4-18). If policy makers are not convinced about the efforts of PHR activities, they will not provide the resources needed for PHR activities to prove themselves as useful (160307, 11, 5-22; 010307a, 1, 26-4; 010307b, 2 f.). At the local level there are some cases where the opportunities of PHR activities are recognised by policy makers but it was necessary to invest to reach this stage (080307, 11, 8-28). If there is qualified personal, more possibilities for PHR activities and surveys can be conducted. To qualify those being active in PHR activities, all federal states should be members of the Academy for the Public Health Services in Düsseldorf (010307a, 12, 9-27). Units for PHR activities should be created in universities (160107 b, 12, 10-12). The cooperation with local experts and universities is described as being helpful (010307a, 1, 26-4; 010307b, 2 f.; 220107a, 12, 14-23). Therefore, larger towns have an advantage. It is also said to be of importance to develop professional curricula for people being active in PHR (070207, 12 f., 29-15). People being active in PHR should be qualified in statistics and know

about social circumstances (160307, 15, 28-37; 010307a, 9 f., 26-7). Meanwhile the number of educated public health professionals working for health insurances and medical associations has risen. This could be an intermediate step for a stronger role of PHR activities (160107c, 14, 24-26).

5.3 Attracting interest

It was stated that "impact" at first means to arise attention (311007, 5 f., 32-3) To attract interest, reports should achieve the main target groups and be written purposefully and problem-oriented (010307a, 9 f., 26-7). But sometimes people would be overburdened by the report, the flow of information or the lack of time in day to day business (080307, 4, 15-30). It is recommended to restrict PHR activities to fields of special importance in order not to influence the attention negatively (120107, 10, 23-29).

Whether the issue of a report attracts interest would be influenced by its topicality, its responsibilities, the understanding of the problem and its meaning as well as the availability of resources and instruments to solve a problem (270207, 4 f., 37-35). To deliver information how people are involved and affected is also mentioned as helpful. However, endeavours towards attention must not question the confidentiality of PHR through scandalising (110107, 17, 18-31).

While traditional reports tend to sink in the information flood, it should be made sure that the information finds attention (110107, 8, 20-32). Innovative reports would attract interest (040407, 5, 4-10). Eye-catcher and an appealing, striking layout would be helpful (160107a, 9; 010307a, 3 for., 15-2; 270207, 16, 13-23). Central messages and interesting results should be emphasised (310107, 14 f., 15-3). Unnecessary experiments with the technical possibilities should be avoided (310107, 14).

Certain topics achieve more easily an „impact" than others (WS, 8, 2-40). It is conceivable that some topics are rather interesting for a professional audience than for political decision makers or the public. Sometimes the attention of an audience can be increased if a topic is combined with other interesting issues, e.g. economic, social or ecological ones (201206, 17, 13-24) or age poverty (120107, 12, 15-17).

The prospects to realise an "impact" would be great if a report succeeds to illustrate personal involvement (310107, 5 f., 32-3; 120107, 7, 6-12). Data with local reference and/or comparisons of small geographic entities would attract interest frequently (250106, 19 f., 31-12). Surveys could contribute to increase the interest in findings from PHR activities (010307 b, 8 for., 38-23; 310107, 5 f., 32-3).

It is conceivable that regular (e.g. monthly) reporting activities with a determined sequence of issues might stimulate expectations, speculations and thereby interest. On the other hand it can be of advantage if a report is published outside of regular reporting activities as a singular event (310107, 7 for., 1-11).

There are different assessments about links between the newsworthiness of a report, attracting interest and realising a „policy impact“. On the one hand it is stated that PHR activities can provoke “aha”-experiences (e.g. by rankings about the burden of illness; 150107, 5, 1-10) and to present something new and exciting is expected to have a positive influence on the policy impact (300107a, 5, 9-14). On the other hand it is mentioned that the findings and messages of PHR activities would often be not surprising (201206, 18; 220107b, 4, 19-30; 110107, 9 for., 22-13; 120107, 3, 8-13). It would be a central question how PHR could be designed to offer something new instead of reproducing already known information and knowledge (110107, 17, 15-17).

This impression is challenged by the position that audiences would have different background knowledge so that the same content could be of different newsworthiness for them (310107, 3, 1-12; 200307, 14, 20-32). It would have to be considered that there are always new users with restricted knowledge, so that it is important to provide information and knowledge about factors influencing health again and again (070207, 6). Also, experiences with local PHR activities would demonstrate that an appealing preparation of topics which seem to be well known in general could initiate new ways of thinking and/or new dynamics - in particular when local data is presented (260307, 6, 23-30; 270207, 7, 29-37) and some local specific deviations could be referred to (WS, 13 ff.). International comparisons and/or comparisons between EU member states could have similar effects (060207, 4, 5-11). In fact, delivering local or other kinds of geographic data would produce new information, even if it just seems to reproduce well known professional knowledge (010307 b, 1 f.). Nevertheless, PHR should always try to emphasize new information and its relevance (110107, 14 f., 25-1).

Some interviewees question the significance of newsworthiness fundamentally (160107 b, 8, 28-32). Results of PHR activities would frequently not be spectacular, but with regard to a policy impact it would be important to get increasingly more detailed information to strengthen the arguments for professionals and associations which filter the information for political purposes, policy making and policy counselling (010307a, 5, 14-39).

5.4 Comparative approaches

Comparative approaches, e.g. comparing regions or suburbs (110107, 8, 20-25; 220107b, 1) or, in the past, the German Democratic Republic and the Federal Republic of Germany (201206, 3 f., 38-1), are assessed to be supportive to raise attention. Several interviewees want better possibilities to compare regions, between Member States of the EU (160307, 16 f., 34-19), for the national level between federal states, but also between health insurances, local districts, cities and suburbs, e.g. by using data from the routine examination of pupils (260307, 3, 12-32 & 10 f., 30-11). It would also be useful to compare the situation on different levels, e.g. the

local and the regional situation (270207, 3, 14-19). The proponents of comparative approaches assume to identify relevant differences and thereby new insights and ideas (201206, 7, 31-33) as well as extended pressure by “naming and shaming” (120207, 10, 8-17; 201206, 11 f., 38-2).

However, comparisons are methodically pretentiously and frequently difficult. A stronger unification of the database in particular for the local level is demanded. A unification of the reporting practice would also be helpful, e.g. by using the same indicators and an orientation on the same structure of chapters (160307, 12, 6-21). To compare reports for one geographic entity with reports for other geographic entities is mentioned as problematic, because in many cases especially at the local level there are no common definitions, data cannot be related to each other, certain specific circumstances dominate and PHR activities differ strongly (260107, 1 for., 37-4; 220107 b, 2 f., 34-29). Correspondingly reports from other geographic entities are seldom used as a source for comparative approaches (110107, 5, 19-28). This is valid in particular also for international comparisons: The compatibility of the data is restricted and decision making structures are different (120407, 3, 13-18; 160107a, 6 f., 21-5). It is also difficult to identify similar geographic entities (situation, problems; 110107, 5 for., 37-17) and/or to standardize the relevant background variables (310107, 15; 220107 b, 2 for., 34-29).

It is also a problem to interpret the results. They do not explain themselves and can lead to fallacies. Especially for untrained actors the results have to be explained very well.

It was mentioned as problematic to deliver information if there is no possibility to change something (e.g. earth radiation). Identified findings about differences in morbidity, mortality or health risks can produce political pressure and thereby provoke “hip shots” by political decision makers (020407, 13 f., 35-10; 250106, 10 f., 34-31).

Finally, political resistances to comparative approaches were mentioned, especially as far as small geographic entities are concerned (e.g. suburbs; 260307, 9, 30-34; 110107, 7 ff., 27-10; 220107 b, 2 for., 34-29; 160307, 4, 1-13). The resistance can be motivated to prevent political critique or by the expectation that findings could stimulate segregation and an extension of problems (260307, 6 f., 33-6; WS, 9 f., 32-5). Therefore the findings of comparative approaches are sometimes discussed internally at first. In general it would be of advantage to discuss findings from PHR with public officials first to find an agreement which information should be published and to prevent dynamics which could not be handled (260307, 9 f.).

5.5 Institutionalisation and cooperation

A legal regulation and coalition agreements defining a mandate for PHR activities, an adequate organisational structure (“Landesgesundheitsämter”, health conferences)

and the allocation of sufficient resources have been mentioned as important (220107 b, 7 ff., 30-9; 310107 b, 13, 11-20; 070207, 16, 3-38). The PHR should not be understood as an end in itself, but questions of the usability, the utilization and the translation would be of central importance (060207, 9). It has been recommended to strengthen the cooperation between those being active in PHR and the audiences of information and knowledge from PHR activities through feedback mechanisms concerning issues of interest, indicator sets, missing information and quality improvements (010307a, 12 ff., 37-7; 160107a, 8 f., 25-10). Before projects start, the questions and intentions as well as indicators to measure the realisation and effects should be formulated exactly (040407, 7, 19-26 & 12 f., 36-14; 120407, 8 f., 41-11). Audiences should formulate their information needs and use the findings from PHR activities (160107 b, 12 f., 31-19). Specialists can offer data and hypotheses to be discussed at the round tables. The results of the discussion can be documented in a final report (020407, 13, 10-27; 260307, 14 f., 20-3). It has also been suggested to establish a health conference at the national level to develop recommendations for action to be discussed in parliament (120107, 8, 27-35). The total process, including PHR, should be directed towards action and an evaluation of action. It should also include sector-comprehensive cooperation, round tables or other boards (220107 b, 7 ff., 30-9). The chances on a realisation of objectives increase through a target sponsorship model in which "godfathers" are designated and responsible for the realization of the objectives (070207, 3 f., 38-12).

Different problems of institutionalization were mentioned. The structure of the Federal Republic of Germany would be of disadvantage, leading to sectionalism (010307a, 13). Also, districts would have some disadvantages compared with district free cities in which the bundling of resources and the coordination of activities would be easier, e.g. because there is only one department for affairs of children and adolescents (160307, 11, 5-22; 080307, 7 f., 31-9; 270207, 18 f., 32-14; 120407, 7, 12-37; WS, 8, 27-31). The construction of the German pluralistic health system would make it difficult to coordinate data compatibility. While health insurances would be major players in health policies and health policy making, in cause of their organisational structure they would be mainly interested in the health of their insured and not in regional populations (120107, 4, 16-19). Further complaints concerned missing links between PHR activities and the development and conversion of health targets (120107, 1 f., 28-37 & 3, 33-41). Priority setting of topics and/or health targets is regarded as important (120207, 11, 9-19). The processes differ between the federal states (120107, 6 f, 29-20) and priorities being set at federal level are hardly picked up by the actors on local level. Frequently they are not even known (250106, 12 f., 38-19). It is named a political failure that topics are not always arranged systematically according to importance or possible benefits (040407, 5, 30-39). The definition of priority fields for action would facilitate the selection of topics for PHR activities and/or to evaluate the relevance of topics by PHR activities. At present the selection of priorities sometimes surrenders (310107, 13, 37-40 & 15, 10-13).

For the federal level, one interviewee mentioned difficulties for PHR activities which turned out from consecutive restructuring and assigning PHR activities to different departments (070207, 16, 3-38). The division of departments and corresponding professional subdivision would have disadvantageous effects (070207, 10 ff., 41-14). For considering health issues as cross sectional issues it would be useful if political decision makers would be responsible for several departments. PHR-projects must be supported from the top and within the whole institution. The staff must know about the significance of the PH topics (070207, 9, 16-31). PHR activities should be anchored as cross-sectional tasks. All relevant data from different institutions should be processed in a way that they could be used for PHR activities without great problems (010307 b, 8, 1-27).

Struggles about political control and conflicts around the contents of PHR activities were mentioned (310107, 9, 24-28; 070207, 7, 38). The perceived intensity of political control is assessed from very low to very high (300107a, 4 f., 31-4; 150107, 8, 10-13; 310107 b, 13, 27-35). If the PHR activities would be placed in the sphere of influence of political decision makers and under their control, it could be difficult to challenge the dominating political line, even by findings from PHR with high quality. For persons working on PH reports their might be problems if their career depends on the goodwill of policy makers (201206, 13, 15-21). On the other hand it has been said that working close to policy making maximises the chance to realise a policy impact. The incorporation into politics is not evaluated negatively per se, but regarded as a price for PHR activities not being conducted in an ivory tower (120207, 17, 3-8). Even if not independent, PHR activities could realise a policy impact by delivering qualified information, contributing to transparency and supplying a fundament for the communication and cooperation between different actors (160107 b, 6 f., 38-11).

While it was stated that often there would not be a satisfying communication between those being active in PHR and audiences (120107, 13, 12-13), cooperation has been mentioned as an important factor to realise a policy impact. The cooperation cannot be organised by those being active in PHR (at least not by them alone), but depends heavily on the engagement of public authorities and officials (160307, 8, 37 f.; 070207, 3, 30-34).

On the one hand problems with the cooperation between the levels and between local entities were reported (010307a, 11 f., 22-4), while on the other hand numerous examples for successful cooperation within health offices (010307a, 11 f., 22-4), between local offices (in particular between the health and the youth office; 010307a, 11 f., 22-4; 220107a, 6, 38-42; 260307, 7, 9 f.), between the health office and schools (010307a, 11 for., 22-4), communes (220107a, 9, 18-28), countries (cross-border projects; 250106, 9, 28-39), PHR activities and statistical offices, associations or the RKI were reported.

It is recommended to start with the exchange of positions and expectations between policy makers and those being responsible for reporting activities before the work on a report starts or recommendations of action are being developed (160307, 9, 4-8; 300107a, 3, 7-26). PHR activities should not be understood as an act of administration in the first place, but as a service, e.g. for a health board or a health conference (220307, 12, 32-34).

For the local level the cooperation with health insurances was described as not simple in cause of their organizational structure, but possible (x, 21, 32-15; 010307a, 8, 9-17). Cooperation between local offices could become complicated by missing agreements, competing problem perceptions or political directions (x, 21, 5; 300107a; 5, 17-2221). Conflicts and distrust between political representatives and the administration were also mentioned (300107a, 3, 7-29). Cooperation might be affected negatively by a lack of time (201206, 13 f., 29-7).

6. PHR activities and the „Policy Cycle“

6.1 A realistic model?

The interviewees assessed the significance of the model of a policy cycle very different. It was described as a reasonable model which hopefully would be realised at least in some places at the moment or could at least stimulate its realisation in the future (160107 b, 6, 17-19). It was reported that the model is used in health promotion at the workplace (060207, 6 f., 31-4). But the model was also described as unrealistic (120207, 15, 36-37; 150107 b, 10, 18 f.). There would not be a direct line from a clever insight to political action. Policy making would be influenced by a lot of factors (070207, 9 f., 40-3; 15, 3-25). Models of rational decision-making would disguise domination if they would not consider interest, political power and the consequences for PHR activities (160107 b, 14 f., 36-26).

Whether or in which extent PHR activities could realise a correction function and rationalise policy making is controversial and regarded as a question of the political culture. It has been recommended to analyse if problems are linked with knowledge gaps and representation problems or limits of a rational discourse (160107c, 29-31). Prejudices could be relocated through a report (201206, 18, 3-20) and PHR could rationalise debates by the providence of high-quality data and evidence-based knowledge (310107 b, 10, 1-4; 110107, 10, 19-31). In discourses often different numbers of heterogeneous quality are used and PHR activities could deliver authoritative knowledge (120207, 17, 10-14; 160307, 7, 16-34; 240107, 3 f., 28-29) as a fundament for conversations between the relevant actors with their different interests (160107 b, 9 f., 39-31), unfolding an indirect control effect (310107, 5, 29-32).

Other interviewees questioned the idea of an independent guardian of rationality and the providence of rational, unprejudiced and clear data interpretations. They argued

that PHR activities are not independent (in particular on the levels of the Federal Government and the federal states), would always express political interests and be agreed by the political leadership (020407, 12, 30 f.; 010307a, 9, 7-30). It could only be tried to minimise the irrationality by PHR activities (120207, 6, 27-40). For Germany actors who intervene to realise the correction function were said to be missing (060207, 13, 9-26).

6.2 Agenda-setting

Two kinds of assessment have to be distinguished: On the one hand PHR activities are used to monitor relevant developments and to identify new problems and needs for action. On the other hand PHR activities assess the state of affairs for topics which already have been set on the agenda.

Possibilities to contribute to agenda setting by PHR activities are seen as restricted by the interviewees (300107a, 5, 30-34). It is stated to be difficult to overcome (political) resistance, disinterest or irrationality. It seems to be more useful to identify political developments already taking place and write reports to support them. It is recommended to prepare reports which can be offered when the time is right. If it is not possible to raise interest of policy makers it might be possible to sensitize professionals working on the issue (220107a, 8, 4-17; 120207, 16, 22-36).

Some examples for reports with influence on action (220107 b, 4, 19-30) and policies (070207, 5, 5-37) are given. But in the perception of some interviewees it is rarely the case that not commissioned PHR activities contribute to agenda setting (160107 b, 6, 17-19; 070207, 5, 5-37). Frequently political actors would already have the impression that something should be done, that they need more information about the extent of a problem to deliver some ideas for action (240107, 4, 36-39; 250106, 1, 15-27), or they want to use information and knowledge from PHR activities to define priorities for a topic already of interest or to strengthen their arguments (220107 b, 4 f.; 110107, 9 f., 22-13; 160107b, 10, 10-30). If there is no previous interest, the willingness to the quarrel with findings from PHR activities would be more reserved. It would take a lot of engagement to attract interest and realise a – mostly indirect – policy impact (2220107a, 2 f., 40-2; 160107b, 5, 18-31; 310107, 7 f., 1-11; 260307, 5, 8-15).

For the local level the situation is described as more mixed. On the one hand it is said that resources to work on not commissioned topics are missing (x, 18 f., 14-2). On the other hand it is mentioned that non-commissioned PHR activities sometimes would have contributed to agenda setting (160307, 6 f., 33-8; X, 17 f., 27-2; WS, 6, 11-12). In these cases, the policy impact would not have been realised by a direct flow of information to local politicians, but mediated by local professionals, the administration or health conferences (220107a, 3, 10-13).

A topic can lose his topicality quickly and disappear from the agenda. It would be a challenge how to assure sustainability (260307, 4, 8-18 & 5, 8-15). Some kind of sustainability would be needed because sometimes it takes time until policy makers realise the importance of a problem and become active (120107, 11, 14-24). Sometimes problems are ignored for a long time, then something changes and there is a high interest for available information (010307a, 16 f., 32-36; 150107b, 5 f., 5-29 u. 10, 18 ff.). Problems with a long time perspective would have a low priority (150107b, 5 f., 10, 18 ff).

Because it takes time to finish a report the publishing might not overlap with actual political debates. One interviewee mentioned a „chronic asymmetry“: Information and data would always be delivered if not needed, while needed information is never available. Therefore, it would often be necessary to make decisions without sound information and knowledge base (020407, 6, 7-11).

There might be open doors for a report or a report can be commissioned to get information about an already interesting issue (300107a, 2, 3-11 u. 300107a, 5, 17-22). Anyway, information and findings from PHR activities must be supplied at the right time to support and influence decision making. A fast delivery of information and knowledge is possible when the issue has been treated before (310107b, 12; 120207, 14 f., 38-3) or if it is possible to use routine data easily (260307, 5, 19-38). It takes more time to work on a new issue. It was mentioned that the supply of information by PHR activities do not need to have the form of a report. Information and findings could be communicated during the work on a report and political reactions and interventions could be described in the report (201206, 14, 14-22). It is also possible that PHR activities are not in the first place organised to deliver information at a certain point in time, but that they offer a stock of knowledge which can be used when the time is right. From this perspective, PHR activities should not mainly be influenced by the actuality of an issue (301007b, 12, 5-10; 010307a, 16 f., 32-36).

6.3 Orientation towards action

PHR activities can support activities in fields which have given priority, deliver data material to start a debate, document intermediate states and contribute to the evaluation and the conversion of action recommendations (300107a, 4 for., 31-4). While PHR activities often would be restricted on a description of a situation, the development of realistic recommendations is mentioned as an important link between reporting activities and interventions (x, 13, 1-10). The interviewees agree to a large extent that PHR activities can and should identify new needs for action and analyse consequences of action (160107 b, 2 f., 31-5; 160107a, 3 f., 15-4; 150107 b, 5 f., 5-29 & 10, 18 ff.). However, they differ in their statements about the kinds of action recommendations PHR activities should deliver and the process to develop them.

For some it is no question that those being active in PHR should deliver recommendations for action as hypotheses to be discussed by policy makers. A discourse about different assessments of data is regarded as valuable (070207, 7, 38; 010307a, 10 f., 31-3). It would be the responsibility of the parliament and government to discuss action recommendations and set priorities (220107 b, 6 f., 31-8). In particular for honorary decision makers at the local level action recommendations from professionals would be very supportive (080307, 5, 3-23) and political decision makers would ask for action recommendations and professional knowledge (X, 23, 2; 200307, 5, 18-3).

Other interviewees assumed that persons with political responsibilities would not want any action recommendations in order to prevent political pressure (220107 b, 6 for., 31-8). PHR activities could support the development of action recommendations and health reporters could participate in the development of action recommendations (150107, 5, 30-32 & 7, 21-25), but in the end recommendations should not be developed by those being active in PHR alone, but by all stakeholders on the basis of PHR activities (010307a, 10 f., 31-3). It was seen as problematic that scientists could give action recommendations without political responsibilities or taking into account the availability of resources and other factors (070207, 7, 38; 120207, 7, 23-32; 240107, 11 f., 14-8; 260307, 7, 26-34).

PHR activities are supposed to supply the diagnosis, but it would be in the responsibility of policy makers to decide about the therapy. A report should not try to "dictate" anything to politicians. There are many factors influencing policy making, and dictatorship would also not be acceptable for democratic reasons. (160107 b, 6, 17-19; 120207, 8, 19-25; 150107, 5, 30-32 u. 7, 21-25). Reports should try to translate theoretical findings, facilitate a brainstorming or public debate with and by those involved in policy making and also support the development of recommendations for action (220107a, 5, 1-2; 120207, 6, 27-40; 220107 b, 6, 14-24; 220107a, 4, 15-17). The intermediate stage of an interpretation of the information from PHR activities would be important because insider knowledge beyond the scope of those being active in PHR activities would be needed (020407, 6, 9-21 & 8, 11-26). Those being active in PHR should realise whether they act in the core region or in the guard zones. The discussion about the selection of topics, findings from PHR activities or the development of recommendations for action belong in the guard zone. The corresponding information and knowledge base is to be reappraised in the core region of PHR activities with regard to decision situations (300107 b, 6 f., 13-36).

A participatory procedure e.g. in the form of meetings with public officials or health conferences has also the advantage to avoid problems of acceptance (120207, 8, 1-12). Recommendations for action would be based on consensus (010307 b, 5, 1-28; 150107, 7, 34-37). It would be useful to structure the discussion of the health conference and provide respective proposals, e.g. in the form of health reports

(200307, 6, 11-30). PH professionals should present their findings, but be careful with their perspectives on what should be done in order not to narrow their view too strongly. They should deliver a description and then raise the question "What to do now?" to the audience (260307, 8, 1-31). They could prepare a recommendation and present it on demand (270207, 4 f., 37-35). The discussion about recommendations and the recommendations could be documented in PH reports (310107, 4, 19-27; 8 f., 15-18; 270207, 8, 18-27).

6.4 Evaluation

PHR activities are rarely used for evaluation (010307 b, 5 f., 38-23). For some of the interviewees it is primarily a political decision whether evaluation in the sense of a monitoring is accepted (070207, 9, 1-22). Sometimes an evaluative approach could be refused by policy makers because findings are not always positive (201206, 8, 21-22). Policy makers would have an interest to evaluate projects and programmes they commissioned, but not in an evaluation of their own activities (110107, 11, 31-35). If PHR activities should be part of evaluative procedures and policy makers should take note of the results, it could be necessary to realise pressure (120207, 9, 3; 120107, 12, 8-19).

Other interviewees do not refer on political but methodological problems. For some evaluation needs specific data and also procedures and methods beside PHR activities (220107 b, 7, 13-24; 050407, 12, 15-40; 270207, 10, 18-37). For others PHR activities can carry out a rudimentary evaluation – not of projects (010307 b, 5 f., 38-23; 010307a, 8 f., 26-7), but in the form of a monitoring with routine data, even if there would be data problems especially for the local level (010307 b, 5 f., 38-23). If PHR activities supply information about health states in regions and it is possible to link this information with social data, health insurances could draw cautiously conclusions about the effects from their programs (160107a, 4 f., 33-5). It could be possible to use PHR activities to get information about the effects of the market events and to evaluate the respective reforms (020407, 8, 30-36), to create transparency for the supply and demand side and to monitor quality, demands, access etc. It would be conceivable that PHR activities and consumer protection activities work together more strongly. To what extent PHR activities should change from an instrument of governance to a consumer information and market monitoring system would depend on the future roles of the state and the market (310107, 10 ff., 18-39; 12, f., 25-10).

Decision makers should justify their decisions on the fundament of PHR activities and PHR activities could be used to contribute to the evaluation of decisions (240107, 11 f., 14-8). In future there could be more possibilities to use PHR activities for an evaluation and/or for the observation of changes. "Gesundheitsziele.de", the national health target program, did have the possibility to integrate items for the evaluation of health targets in the national health survey (120207, 8, 29-39). But until now follow

up reports necessary for an evaluation by monitoring would be rare (010307 b, 6, 29-38; 270207, 10, 10-13). Also, time is needed to monitor and analyse the effects of a reform or programme. Many times new reforms and programmes would be in place before effects of the older ones could have been monitored (020407, 6 f., 41-15). It would be difficult to give some evidence about the effects of policy making (120107, 11, 14-24).

7. Conclusions

Asked about possibilities to support those being active in PHR to realise a policy impact, the interviewees mentioned a couple of opportunities:

- calculate which topics and options for action are promising to realise a policy impact and which kind of PHR activities will be supported by politics (160107 b, 7, 21-37);
- think about the representation, direction and addressees previously, in order not to sit down in the nettles unintentionally or to move oneself unintentionally into a certain corner (260307, 15, 19-27);
- look at the needs and expectations of users or also what is wanted by political decision makers (160107 b, 11, 5-8; 120207, 12, 4-7), think about interest constellations and win-win situations and ways to support their supervisors (301007 b, 11, 26-41);
- attempt to moderate possible conflicts by not criticising decision makers openly, presenting recommendations modestly (201206, 13, 15-21) and reporting about negative and positive developments (201206, 6, 12-15);
- arrange the reports so that they are read with pleasure and disseminate them to relevant committees, boards or political parties (070207, 12 f., 29-15);
- put important topics on the agenda independently from the demand until one bumps into the border that unintended becomes not wanted (160107 b, 11, 5-8);
- show the magnitude of a problem (300107a, 6, 7-19);
- provide information timely (even if the actual relevance of a topic does not lie in the hands of the PHR) (010307a, 15 f., 12-17);
- organise the supply of information in a way that audiences find information they look for (040407, 14 ff., 39-29);
- use resources effective and efficient and decide if there are enough resources to write a basic report as the foundation of specific reports or to write special reports only (270207, 15 for., 36-6);
- provide data, indicators, graphs, charts and other material in a way that makes it easy for its user to process the material (060207, 3, 31-41);

- add qualitative methods (120407, 9, 11-25) and surveys (240107, 5) if possible;
- report about local entities and settings (150107, 8, 38-40), use comparative approaches.

The interviewees gave also some ideas how those being active in PHR could be supported in their work:

- give a helping hand for newcomers with information about the process of PHR activities (160307, 14, 27-36; 270207, 17, 36-37; 010307a, 12 f., 37-5).
- organise a professional exchange about PHR activities (160107 b, 15) and a networking by those being active in PHR (220107a, 10, 14-18);
- organise a coaching for the implementation and transfer of information and knowledge from PHR activities and about respective decision making: Is a report worthwhile, which medium is promising, how to work effective and efficient, how to achieve better results? (270207, 12 ff., 17-4; 270207, 18, 13-22; cf. 010307a, 12, 9-27)
- organise advanced training measures and workshops e.g. about what is already possible on a simple level? How to write a report with own data?
- open opportunities to learn from the kind and manner in which other reports are created;
- offer a(n) (online) library with public health reports (160307, 15, 5-13; 260307, 18, 8-9; 220107a, 10, 25-32);
- offer tips about new data sources, methods, literature (010307a, 12, 9-27), (new) indicators and their utilization (120407, 10, 25-39);
- offer tools for the layout, presentations, statistics and graphics as well as guidelines for reporting activities (260307, 18, 16-24; 120407, 10, 1-14), including software (like Epi-info, PHR-Map);
- cooperate in the work on modules and graphics: The wheel does not have to be invented again (220107a, 9, 33-39; 260307, 2, 31-36);
- provide a directory who works on which topics in PHR activities (120407, 10, 33-39);
- provide an appropriate, available database (160307, 14, 12-17; 260307, 17, 17-35 & 260307, 17 for., 38-2) and public use-files (260307, 2, 30-31);
- organise the dissemination of available instruments and knowledge (150107 b, 12, 8).

These recommendations show the importance to organise horizontal and vertical cooperation: Those being active in PHR on one level (e.g. local level) could work together on certain topics and develop respective concepts, they could specialise by

a division of labour; specialists on higher levels can give guidance by describing general trends, develop more general texts and offer tools and indicators to support PHR activities on lower levels.

The statements in the interviews suggest that PHR activities should follow some standards to maximise the chance to realise a policy impact. It also comes up that those being active in PHR only have restricted possibilities to influence the policy impact of their work. The institutionalisation of PHR activities, e.g. resources, but also obligations and political culture, are of major importance.

The heterogeneous and sometimes contradictory descriptions and recommendations are rooted in different regulations and practices of PHR activities and in different experience to realise a policy impact by PHR activities. However, they also express different ideas about policy making, decision making, policy counselling, the health system and “philosophies” of PHR activities. While these differences document that there is no dominant “philosophy” or kind of PHR activities at present, they can be used to construct a typology of PHR activities / philosophies with consequences for the opportunities and challenges to realise a policy impact.

At first it has to be acknowledged that there are different situations for PHR activities and decision making. PHR activities can be used for monitoring, not being linked with decision making directly. They can be used for planning procedures where decision making is determined by regulations, e.g. about the number of hospital beds in relation to population or incidents. But it is also possible to use PHR activities for priority setting, for assessments after priorities have been defined, to support policy formulation and to describe developments after policy implementation. The different situations are linked with different information needs to be considered in PHR activities.

Further, it has to be considered that PHR activities can be used to inform decision making about health reforms (decisions about regulations) and health policies within regulation. Health programmes are not only developed by actors of “the state”, but also by associations of health insurances, providers, charity organisations, self help groups etc. and by single insurances or provider organisations. Here also, the information needs and the challenges and opportunities to realise an impact are quite different because decision making differs between the poles of “technical” and “political” decisions.

With regard to policy making, the interviewees set different priorities for the main target groups: Ministries, parliaments, relevant actors of the health system and experts being policy makers by themselves or being able to give recommendations to policy makers. Some of them were of the opinion that PHR activities should at least become more directed to citizens. Thereby the concepts of society seem to differ, e.g. between civil society, market society, knowledge society etc.. And again these

differences, if linked with PHR strategies, have consequences for information needs as well as opportunities and challenges to realise a policy impact.

Also of relevance for the discussion about realising policy impacts are the questions who commissions reports from whom and for which purposes. Reporting activities always have a political dimension because either an institution is obligated to inform others about their activities, writes or commissions reports to convince others that there are problems and something should be done or obligates other institutions to report about affairs under their responsibilities. Reporting activities can become a tool for governance and building up political pressure from above (“top down”) or a tool to build up political pressure on policy makers, public officials, governments from beyond (bottom up). The political dimension explains the political conflicts and resistances linked with PHR activities.

The geographical level of PHR activities – national, regional, local – should also be considered when opportunities and challenges of realising a policy impact by PHR activities are discussed: On the one hand in cause of differences in responsibilities, the kinds of decision making, audiences, dimensions of political conflicts mentioned above, and on the other hand in cause of resources, qualifications and abilities of policy makers / decision makers and those being active in PHR. While policy makers (associations included) at the national level and also the level of the federal states have certain institutions and qualified experts not only for PHR activities but also to interpret findings from PHR activities and translate them for policy counselling, these resources are at least more restricted at the local level. Policy makers at the national level and at the level of the federal states are more critical to recommendations being included in PHR activities because they want to defend their freedom of manoeuvre and are able to develop their own recommendations. Especially at the local level actors are more dependent on expert knowledge, normally being delivered by the same institution which publishes public health reports (the local public health agency) or other experts, e.g. experts being involved in health conferences.

The different purposes of PHR activities and commissioning PHR activities, information needs as well as conflicts about the control of knowledge, the acceptance of recommendation and evaluation and the problem to communicate information and knowledge, to interpret it and to explore its meaning for different target groups lead to the central questions to link PHR activities and policy making. In the interviews it was recommended to organise a pluralistic process (120207, 12 f., 39-7) with close contacts with other professions and experts and discussions about information needs and ideas for recommendations (220307, 13, 19-36). It was also recommended to find an agreement about the main questions and purposes of a report (060207, 5 f., 29-2 & 7 f., 10-3; 160107c, 15, 17 f.), to interpret findings and draw conclusions together and evaluate PHR activities (160107 b, 11, 5-8).

Taking the interviews into account, the procedures (as far as linked with policy making) could be conceptualised this way:

- PHR activities need a knowledge stock to deliver information and knowledge timely. The knowledge stock must be based on available information, but the information should be structured by professional public health expert knowledge and concepts. Gaps should be identified and closed.
- Even if public health experts can monitor developments and ring the bell when they see the need for action, they are just one player and mostly not the most influential for priority setting. Also, for priority setting a lot of factors beyond the scope of professional public health knowledge can reasonably be taken into account. To develop the criteria for priority setting and to choose priorities relevant actors should participate in a cooperative process. Decision makers and public health professionals as well as experts for PHR activities should discuss criteria and possibilities to get the respective information by PHR activities. They should commission PHR activities by articulating well formulated and precise questions.
- After priority fields for action have been chosen, again decision makers should commission PHR activities by articulating well formulated and concrete questions. Those being active in PHR should deliver the respective information which should be discussed and interpreted in a common process with decision makers.
- Recommendations for action and policy formulation should be formulated by the relevant decision makers and stakeholders by referring to information and knowledge delivered by public health professionals. They should be published as a document accompanying the public health report or as a chapter of the report. It should be laid down how to evaluate the implementation and developments by further PHR activities.
- PHR should be conceptualized as a process which is not finished when the report is laid on the table but include the communication and dissemination of its findings. The main responsibility of those working on a report is to deliver information and knowledge to those which commissioned the report. Those commissioning reports should develop a strategy for dissemination.

This procedure can be followed for activities within organisations, in line with governance or campaigning. Beside cooperation and participation, a concrete commissioning of reporting activities seems to be of major importance. Before a report is written, the commissioners of a report and those writing a report should discuss the aims, objectives, political and administrative framework, information needs and central questions. To satisfy the commissioners they should, if possible, also discuss either the criteria for decision making or envisaged policy options to develop a common understanding about the information needs and PHR possibilities.

As far as the process is taken into account, it is an issue of major importance to link policy making and therefore also PHR activities of the different levels – to draw a line from the more general and abstract description of problems and policy making at the European or national level to more concrete activities at the local level. Here PHR activities at higher levels could support local PHR activities by setting issues on the local agenda, by the provision of information, knowledge and blueprints for PHR activities, but especially by an empowerment of comparative approaches.

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Annex 3.3: Hungary¹²

Csilla Kaposvari

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¹² The views expressed herein in the respective parts are the summary of the views of the interviewees, the author and not of TARKI.

1. Historical background of health services in Hungary

Hungary¹³ has a long tradition of health services since the 11th century with monastery related infirmaries. Provision of care with state participation was already present in the 15th century when town physicians were employed to make services available for the poor, which became country-wide by 18th century. The first public health act was passed in 1876. The practice of health insurance dates back to the second half of the 19th century. The National Social Insurance Institute was formed in 1927, and in the 1930s approximately one third of the population was insured. Until the Second World War, health care was delivered mainly through the private sector and in some state hospitals. Since 1948, the communist regime among others nationalized the funding and delivery institutions of the health care system. Private health insurance and private general practices were dismantled and centralized state services took over to provide free and universal health care services. In 1949, the Constitution of Hungary announced health as a fundamental right that was the responsibility of the state. For financing and delivery of health services the state became exclusively responsible. Private practice of medical doctors was allowed only on a part-time basis since 1972. In the 1980s reforms started to be introduced. The Social Insurance Fund was separated from the government budget in 1988 and the financing of recurrent costs of health services were transferred to the Social Insurance Fund. In addition, restrictions on the private provision of health care were abolished in the late 1980s.

In Hungary, health sector reforms go back to the second half of the 1980s. The major political, social and economic transition of the 1990s gave opportunity for larger-scale health sector reforms as well. The health care sector reform that aimed at changing the former, highly centralized, state socialist model resulted in a more pluralist health care system with responsibilities divided between various players. The previous hierarchical relationships have partly been replaced by contractual relationships where providers and purchasers were separated. Since the 1990s, social health insurance system became the predominant source of health care financing. Health services are funded primarily from the Health Insurance Fund that is administered by the National Health Insurance Fund Administration. The ownership of most health care facilities was transferred from the national to local governments; services are delivered predominantly by local government-owned public providers on contractual basis with the National Health Insurance Fund Administration. Local governments have become responsible for the provision of health care for the local population but they are allowed to contract out service delivery to private providers. Private

¹³ The Historical Background of health services in Hungary part was prepared based on Gaál P. *Health care systems in transition: Hungary*. Copenhagen, WHO Regional Office for Europe

providers have been established in growing numbers after the changes for example the GPs, dentists, diagnostic centers, pharmacies. The national government is the dominant regulator of health services, and in addition, it provides public health and some tertiary care services.

Reforming the health care system is a constant item on the political agenda since the political changes in 1989. Since 2006, reform initiatives were renewed where the main focus was the transformation of the health insurance system, to improve quality, cost-effectiveness, equity and accountability. Among other reform steps, it introduced a co-payment system, which later on was halted together with other legal regulations brought by these recent reform initiatives.

2. Developments in the health information system and health reporting in Hungary

The past decades of health care reform, decentralization and regionalization, the European Union membership since 2004 and the unfavorable health status of the Hungarian population constitute a situation that posing a growing demand on the country's health information system to provide timely, valid and reliable, policy relevant health information.

In very brief, in the Hungarian health information system primary data on health and diseases are produced at the point of service such as general practitioners, outpatient departments, hospitals, health nurses, etc. Health care services keep their own records and regularly provide data for the mandatory reporting systems according to the legislative regulations. e.g. they transfer data to state organs designated for such purposes mainly to the Health Insurance Fund Administration, the Central Statistical Office and/or to the institutes of National Public Health Service. Other main actors in the health system are the National Institute for Strategic Health Research, the Health Insurance Supervisory Authority, the national registries, etc., all of which take part in health reporting activities. Some data are collected routinely and obligatorily as defined by law. A major legal tool is the National Statistical Data Provision Act that has a health sector part. Other source of primary data and information are surveys managed by state organs, research institutes and universities on periodic or ad-hoc basis.

The past decade has brought many new initiatives in the health information and health reporting arena, major ones of which are listed below.

In 1998 a joint initiative of the Hungarian School of Public Health and the National Public Health Service created a network of sentinel stations based in primary care

facilities in four Hungarian counties. The aim was to establish a system that provides valid data on morbidity of selected diseases in Hungary¹⁴.

In 1999, with the help of the World Bank, the development of a health monitoring system has started that aimed to provide a mechanism for overcoming the weaknesses of the then existing health information system in order to provide regular, timely, valid, policy relevant and easily accessible information on the population's health status, health care use and access as well as other health issues. Part of this program was the introduction of national health interview surveys based on international recommendations and methodological standards. Health surveys have existed before however often did not provide national representative coverage and/or the methodological differences have not always allowed comparability in time or otherwise feasible. There were two waves of national health interview surveys under this program in 2000 and 2003. The next survey was scheduled to be in 2008 that is viewed as one of the major tool for monitoring the progress of the National Public Health Program since 2003. The program brought forward improvements in the public health reporting activities as well. A system of health reports has been introduced. A comprehensive public health report was published in 2004¹⁵ together with snapshot type of small reports for policy makers¹⁶, as well as regional public health reports for the 7 Hungarian regions in 2005¹⁷. Under the health monitoring program the development of an internet based health database has been started. This database is presently operated by the National Institute of Strategic Health Research after expansions and further developments are carried out to the system (IMEA: Internet-based Hungarian Health Data-warehouse, TEA: Itemized Health Services Data-warehouse¹⁸).

In 2003, as part of the Hungarian Information Society Strategy, a sectoral information strategy had been prepared with the objective of enabling the information and communicational capabilities of individuals and communities; and with improved information to enhance health system effectiveness and efficiency. Some elements of the strategy came to place however the strategy as such that could provide a basis

¹⁴ Gy. Szeles, Z.Voko, T. Jenei, L. Kardos, Zs. Pocsai, A. Bajtay, E. Papp, G. Pasti, Zs. Kosa, I. Molnar, K. Lun, R. Adany: A preliminary evaluation of a health monitoring programme in Hungary, *European Journal of Public Health*, Vol. 15, No. 1, 26–32

¹⁵ Népegészségügyi Jelentés 2004 .. [Public Health Report 2004], National Center for Epidemiology, Budapest <http://www.oszmk.hu/index.php?m=31>

¹⁶ National Public Health Update, 2003, National Center for Epidemiology, Budapest <http://www.oszmk.hu/index.php?m=31>

¹⁷ Regional Public Health Reports, National Center for Epidemiology, 2005, Budapest <http://www.oszmk.hu/index.php?m=31>

¹⁸ www.eski.hu

for more comprehensive and concerted developments for health information has somewhat become unrealized.

Health information forums (previously health statistics forums) that provided a national platform for institutions and experts to discuss related issues had been organized since 2001.

The WHO¹⁹ ran a study in 2005 aimed to assess and provide recommendations about the health information systems in some central European countries including Hungary. The research pointed out weaknesses and strength of the system at that time and made recommendations for improvements.

The integration into the European statistical system brought many improvements among others developments for example the data collection on death based on Eurostat guidelines since 2005. This involved capacity building and quality assurance procedures within the Central Statistical Office and the National Public Health Service. The European Health Interview Survey has been adapted and tested in the Hungarian language.

With the coordination of the Debrecen School of Public Health, a regional health observatory had been set up based on the UK model of health observatories in partnership with many regional organizations in the northern-eastern part of Hungary to monitor the health status of people living in two Hungarian regions and to serve as a model operation to the possible introduction of a region-based national system of health observatories in Hungary.

The National Institute of Strategic Health Research has been operating the Dr. Info system: a portal targeting the public and patients on health and health care issues as well as reform changes. The Institute has also operating an Internet based dataware house of health care services data.

Finally, the recent wave of the health care reforms has brought further developments in the health reporting arena. Among others, one example is the reporting activities of a newly established institute: the Health Insurance Supervisory Authority. Its activities include among others the supervision of access and quality of health care services and the development and reporting on quality evaluation system for health care providers operating under the health insurance system. The institute developed and launched a publicly available quality indicator system and publishes thematic health reports on issues in the center of interest for its main activities. The main issues covered by the quality indicator system are basic information and main structural data; capacity utilization; waiting list and access; patient safety and rights; quality

¹⁹ M. Bakacs, Cs. Kaposvari, B. Kiss, J. Vitrai, J. Vizi. *Assessment of the Health Information System in Hungary*, WHO Regional Office for Euro, 2005

referring system; extra convenience related services; employee satisfaction and work conditions and in-house health promotion activities.

3. The PIA PHR project and research

The aim of the PIA-PHR project was to develop a “health information tool box” which promotes the policy impact potential of the different products generated by systems of public health reporting. The project used the following operational definition: “Public health reporting is a system for collecting, organizing, analyzing, reporting, and disseminating data and information on health, diseases and their determinants in a defined population.” by Mans Rosén.

The research part of the PIA-PHR project included an Internet-based Delphi Survey of two rounds, focus groups and face-to-face interviews with various groups of health report producers and users in the project member countries including Hungary.

3.1 The Delphi survey

Recruitment of participants for the 1st round of the Delphi survey in Hungary mainly relied on previously established contacts from various health information activities organized or implemented by the Hungarian team. The start up lists of potential project participants have been updated in terms of contact information and reviewed taking into account the desired number of participants in each target groups. The unified list included a wide range of possible users and public health report makers in local, county, regional and national level and in different settings. In the 1st round 84 invitations have been sent out that grew to 92 as new participants have been identified. We strengthened recruitment through personal contact with the members of the national health monitoring network who helped with the local participants. The invitation letter, explanatory note and the PIA-PHR flyer sent out in the first email was translated into Hungarian to make communication easier.

In the 1st round a total of 23 people filled in the Delphi questionnaire from Hungary dominantly by participants coming from the civil service, universities and research institutes, and to a smaller extent from interest organizations, a health insurance body and medical facilities. There were users as well as public health report producers at all levels (local, regional, national, European). The low participation of politicians could be due to the timing of the 1st round as the parliamentary election and the establishment of the new government took place just before the first round. With the second round altogether 29 people participated in the Delphy survey, however overall in the 2nd round the participation was low within the project therefore a common decision by project partners was made to cancel the 3rd round of the Delphi survey.

3.2 Focus groups and face-to-face interviews

In the second part of the PIA-PHR research there were 2 focus groups and in-depth interviews conducted. Focus groups and interviews took place in 2007. The 1st group interview had 10 participants working on national level. Interview participants included representatives from public and private health insurance, key public institutes in health statistics, public administration and management for public health, public health research organizations and universities, health NGOs and representatives from the national development body. The 2nd group interview took part on sub-national level and consisted of 6 interviewees from regional, county and local level as well. Participants came from regional health councils, private health research and policy consulting, health administration from local level, local level public health NGO and regional public health service. The focus groups had an average length of 3 hours. Both focus groups were conducted in an independent place outside of offices. Both focus group interviews were recorded and transcripts were made.

In addition to the focus group interviews, we also conducted individual face-to-face interviews with 15 participants that consisted of public health experts active in PH reporting, high-level public administration and authority representatives, public officials from ministries, politician and the media. Individual participants came also from a mixture of national and sub-national levels. Individual interviews were conducted face-to-face and where permission was given recorded, transcription and notes for all interviews were prepared. To all interview participants anonymity was promised.

During the interviews, an interview guideline discussed and agreed by the project participants was used. The interview guideline and questions were translated into Hungarian. During the interviews the following issues were discussed:

- satisfaction with the supply of PHR (different levels, different aspects), information needs and coverage
- utilization of PHR resources
- examples for a high / low policy impact
- factors influencing the policy impact of PHR activities
- PHR and the policy cycle
- priorities for the further development of PHR, factors supporting PHR activities to raise policy impact.

Altogether in the focus groups and face-to-face interviews 18 interviewees came from national level, 6 from regional level, 5 from local level. 15 were public health experts involved in PHR activities, 11 came from public administration, 4 from associations, interest organizations and there was a high level politician as well.

3.3 INTERVIEW RESULTS

3.3.1 Satisfaction with the supply of PHR activities

The picture about the satisfaction with public health reporting activities given by the interview participants was mixed. Satisfaction about public health reporting as a complex system in general, its functions and its delivered products apart from some areas seemed to be low among majority of the interview participants. PHR functions were reported underdeveloped in general but especially in order to facilitate planning, monitoring, evaluation of programs and to support policy developments.

Positive opinions were voiced by interviewees about certain elements and areas of public health reporting namely having a long tradition of data collection and reporting in the area of infectious diseases, demography, birth and death statistics and health care data. The opinion was expressed by an interviewee that Hungary is able to produce data for the *“vast majority of indicators required by international organizations such the OECD or WHO that is said to be impressive even internationally.”*

The interview participants identified problem areas what we grouped as systemic, governance, content and technical type of problems.

Systemic problems

Some of those interviewees who voiced dissatisfaction mentioned the lack of a coherent health reporting system which could be the basis of the low satisfaction and impact in general. Interviewees found problematic that the health information system is fragmented with many actors taking part as data collectors, data managers, owners and reporters often with parallel activities and responsibilities. It was also voiced that the regulations for data keeping, processing and quality requirements could also be harmonized and strengthened. Interviewees noted some positive attempts in this respect for example the starting of the health monitoring program and a health information strategy that was prepared which could have improved the systemic problems of the health information arena if implemented or followed up. It was noted that *“One of the main problem is that a coherent strategy is missing, we do not know what the information demands are on the different level of decision making as they are not explicitly voiced while on the other side (PHR) we do not know how to help these. We have inherited a highly heterogenic system, reporting system to say so ..., one part of which is habitual and the other part is of course formulated in a systematic, structured way. We can say there were attempts to restructure the health information system within the sector, to redefine who are the primary and secondary data collectors, who reports what and to who, ... and there were initiatives also to further develop the system but it has not became the culture. ... We do not yet have the culture of reporting like in the UK for example, with*

comprehensive public health reports, they got used to it, they know how to use and interpret it. One reason for this also is that although we have many programs we do not have a public health strategy or program yet that could make the breakthrough in this respect.”

Governance

More general governance related problems that were brought up by the interviewees somewhat reflected also on the above mentioned issue. Some participants noted in relation to policy making the weaker tradition of making decisions based on strategic vision, the dominance of short term focus, and the often lack of habits and/or skills and/or motivation for information uptake. It was seen that among the different sectors the health sector had a relatively weak position to enforce interest. Furthermore, health information was rarely seen as having impact on other sectors. Healthy public policy or health impact assessment as concepts are barely understood in other sectors apart from a few experts who are dealing with these issues. It was also noted that indirect impact of health information on policy making through the media or civil society is not so strong.

Content related problems

Content and technical issues were grouped about availability, scope, access, timeliness, methodology and quality related problems. Public health reporting in Hungary was seen as mainly data driven and dominantly being “*disease data*”. Certain aspects such as having long time trends in mortality and disease data were seen positive. While data producers pointed out the timeliness and reliability of disease data, users however noted that health care data can only be used for administrative or financing purposes but more limitedly for epidemiological or public health purposes. In a few areas interviewees reported the weakness of regular and timely data that would be necessary for their work. These areas were health status and health needs, access to health care, and local level health data (small area), and additionally reliable morbidity data, data on health promotion, impact and effectiveness of public health or development programs, health system performance, determinants of health such as environmental data (e.g. air and water quality) or social-economic data on individual level preferably with linkages.

Data was reported especially needed but weak on health behaviour or complex issues such as health and poverty, health inequalities and/or the health situation of disadvantage population groups, e.g. the Roma people. Apart from the two national health interview surveys providing these type of data, the opinion was voiced that regular population health surveys that are based on harmonized methodologies and provide comparable data will need to be continued. The new EU harmonization

efforts and proposed statistical regulation involving health surveys were seen mainly among experts as a possible driving force for improvement.

Technical issues

Data access was reported often problematic and many times ad-hoc or based on informal contacts or often accessible on a pay-basis. Availability of data on local level and access to individual level data was reported difficult by many interviewees even for research purposes due to the strict data protection rules. It was noted that data linkages are not possible or very difficult although mentioned to be desirable by experts for good public health research and reporting. It was also voiced that information on methodology of data collection, processing or analysis is often not easily accessible together with the data itself which poses a problem when further used or interpreted.

While some data producers voiced that the data is not used and quality cannot be improved unless information of usability of the data and problems are fed back to the producers. The importance of knowing the limitations of available data and how to use it was pointed out by data producers; while report producers claimed that less attention is paid for data quality in state administration or policy making. Reputation of data quality depends highly on the source of data, while data quality in general is not being questioned although specifically seen as a problem.

3.3.2 Utilization of PHR resources

According to the interview participants, there seemed to be a divergent opinion between producers and users in terms of required and provided information and level of information. This gave the impression that report producers are not satisfied with the level of use of the reports while report users claim that information they would need for specific issues are either not available or difficult to access and/or if available the information is not adequate for their purposes. They claimed that often reports are in the form of statistical tables and basic information. On the other hand, report producers claimed that they are missing feed-back from users about data and information needs, including also sectors other than the health sector. Furthermore, some data collector institutes expressed the opinion of not having control over the content of official data collection program, only have the role of checking whether the collection fulfils the formal statistical requirements. Critical views about the level of aggregation and analysis were also voiced by some interviewees, which was said to be often inappropriate for user needs; especially in public administration where generally simple descriptive analyses are produced that could not be used for understanding or acting upon complex issues. Low capacity, interest and funding were mentioned as possible factors behind this. Information and reporting from the public sector were said to be good enough to present or describe problems, however

they were said to be less developed for the purposes of designing solutions, providing decision alternatives or monitoring decision impact or effectiveness.

In general producers pointed out that health information is used mainly by research institutes and academia, as well in administration or health management in different levels, but the impact of information in policymaking or politics was mentioned to be weaker especially on national level as voiced by some interviewees. Good examples of using health information in regional and local settings were mentioned in the preparations of the regional development plans and in elaborating the local health profiles. The use of EU financial resources through applications under the national development plan was also seen as a new and important demand for better health information on different levels, dominantly on regional and local levels. The need for better local level health data was many times pointed out.

The most frequently used and useful data sources mentioned for international or regional comparisons as well as in terms of easily accessible national level data along useful and standard indicators were the international databases of OECD, WHO-HFA and European Union projects. The most frequently mentioned Hungarian data source was the Internet-based data warehouse operated by the National Institute of Strategic Health Research, the National Insurance Fund data, the Hungarian Central Statistical Office portals, the National Public Health and Medical Officer Service who provide data on local level also but occasionally. In addition, academic institutions and their related projects such as the GP based HMAP program, research organizations were also mentioned as an important source for specific data needs for more complex issues.

Majority of interview participants mentioned the importance of media in health reporting however the picture was seen mixed. Participants noted that the media can be sensational in respect of health issues and sometimes “*running ahead of us*” ... of the institutes with competence in particular health issues. Positive media involvement in health problems was also mentioned for example with regard to dietary habits of school children and the quality of available food in school buffets that helped raising awareness about this problem and influence the agenda.

3.3.3 Impact of health reports on decision making, the relationship between users and producers, what to do to change the present situation?

The impact of health reports on policy making was seen weak and not explicit as already mentioned. Those active in health reporting mentioned that motivation among policy makers to utilize health information is low and/or invisible except for certain political periods such as election. Information uptake and use by politicians and decision makers was seemed to be headed by “*selection that is based on specific interests.*” The issue of trust and communication between health information

producers and users was said to be weak by a number of interviewees. In general trust was also reported low in these processes which raised the issue of credibility of information and the importance of knowing the information source. Some participants mentioned that information and PHR activities could have a bigger role if changes in the political culture and visibility of decision making such as strengthening accountability and transparency improved. It was mentioned that for this, more information is needed about policies, programs, implementation, impacts and effects. An interviewee expressed this as *“monitoring and evaluation is just not in our culture”*. Strengthening follow-up of implementation, monitoring and evaluation of policies and programs were thus seen as an area for substantial improvement. The need of strengthened civil control over these processes was also voiced by interviewees. In order to achieve this, forming the attitude of and targeting the public directly or through the media with reports and information, *“especially showing consequences and impact of no action or bad decisions”* were seen as important tools for enhancing accountability of policy makers in general and in relation to health. *“Increasingly putting the hard facts and evidence into the domains of public knowledge against which it is very hard to argue”* was mentioned by an interview participant as a way forward. Some interviewees mentioned that this would be more desirable in local levels where responsibilities, actions and actors are thought to be more visible and closer. Regulations on when and under what circumstances to use health information for decisions such as health impact assessment, based on the example of environmental impact assessment, was also pointed out. While some members emphasized that although regulations of reporting do exist however it is not always acted upon.

3.3.4 How to improve public health reporting in Hungary?

As mentioned above, some interview participants saw as the key aspect of improvement of PHR would be a more coherent health information system linked to a long term health strategy along with a switch in thinking towards health systems rather than the health care system. It is important that objectives and goals, means to achieve them, actions, competencies, actors, information needs, supplies, procedures and processes, capacities are clearly defined. People active in public health reporting on each level emphasized the need for regular and sufficient funding and capacity building for data collection, analysis and dissemination. In general, the need for changes not just within the public health arena but in the decision making culture was emphasized.

In terms of specific issues, the participants had many suggestions. Improvement in access to data and information through the Internet, access to complex databases or information warehouses where data is available along indicators together with interpretation and textual information. In addition, data should be available in a form that allows for conducting further or own analysis was also often mentioned by report producers. It was also mentioned that such information/data systems should be

easily accessible and usable for different user groups via user windows or Internet forums. It is important also that these information/data systems are positioned in a way that search programs can easily find them when looked for by lay people too. It was pointed out that for data provision the minimum requirements of clear information on source of data, methodology and contact information of people responsible for the data is essential and needs further improvement.

Furthermore, a common list of health indicators and method of computation and easily accessible health profiles for small areas, regions etc. are seen as useful tools that would enhance the utilization of health information and health reports. In terms of policy impact users considered relevance, timeliness, credibility and regularity as key factors for improvement. Therefore in order to realize a bigger policy impact, policy relevant data and information need to be collected, analyzed and presented in public health reports in a form suitable for the target groups. From the point of users, in addition to descriptive analysis and data, users, especially in public administration and actors in decision preparation would prefer to receive interpretation and textual information, and information on more complex issues. Comparison both international and within the country was mentioned to raise user's attention, as well as the need to convert health problems into cost and burden. Prospective health reports with forecasting are also rare in Hungary in general although the need for these was mentioned. Users also voiced their need for information on different interventions and their effectiveness, costs as well as middle and long term impacts. On the other hand, actors in health management, the media and public health experts that are users of health data and information themselves voiced their need for information on health determinants from other sectors linked together with health data.

Sufficient time to produce reports was also mentioned as an important factor. In terms of presentation, taking into account the needs of the target groups was emphasized. Both users and producers pointed out the importance of visual presentation and especially the use of spatial presentation. The need for different products and content focus, special reports, for different user groups were recognized and pointed out both by users and producers. As for policy makers and politicians concise, focused and solution oriented short reports were expressed to be appropriate and desirable. For the public, new and innovative ways of communication were seen needed, the skills of which lies outside the experiences of public health reporters.

In terms of information use, communication throughout public health reporting activities were seen as a key factor; better communication between producers and users of health reports and better communication in the dissemination of information seemed equally important. So called "*PR invasions*" in the suggested forms of newsletters, workshops, media events and different kind of personal interactions among the key actors were seen to be useful. Public health reporting were ideally seen as such pursued in working groups including experts of different disciplines and

the users itself, also the need of specialized communication staff, professional journalist or writers in the dissemination process was also seen helpful.

4 CONCLUSIONS

Hungary went through substantial political, social, economic, cultural and health care system changes in the past two decades. The relation to information has also transformed drastically compared to the previous times. These changes have brought new challenges and demands upon the health information system while the system itself - albeit improving step-by-step - still carries features inherited from the past. Majority of the interviewees expressed their dissatisfaction with health reporting activities. Hungary has a fragmented system with many actors often parallel activities. The activities and outputs that would support decision making is underdeveloped in the health information system. On the other hand, there was an agreement among the interviewees that information is rarely used in policymaking. The opinion has a special significance in light of the fact that the interviews were taken in the middle of the preparation phase of the recent reform of the health care system.

The need for a coherent health information system that is linked to a long term health strategy is voiced by many interviewees along with a switch in thinking towards health systems rather than the health care system. Improving the policy impact of health information requires a wide range of development within the health reporting processes itself and in the general processes of decision and policy making. These improvements are of high importance in order to improve the health of Hungarian people.

Based on the numerous interviews, it can be concluded that Hungary needs “better information, better decisions, better health”.²⁰

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²⁰ WHO Health Metrics Network

Annex 4.4: Ireland

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1. Description of public health reporting activities

1.1 Overview of historical development of public health reporting

In Ireland what we would now recognise as public health research, practice and reporting was established in the nineteenth century. From the 1800s onwards responsibility for law making and administration for all areas of life in Ireland was concentrated in London. Health policies in Ireland were therefore based on English models and socioeconomic thinking of the time.

From the nineteenth century countrywide systems concerning the health of the population began to be developed. These systems took the form of regionalised authorities overseen by central administrative bodies for Ireland, ultimately governed by the English government. In terms of public health, and public health reports, the system of regional sanitary authorities, was the most significant administrative body. The sanitary authorities gradually developed towards having population health as their main focus. The main focus of the sanitary authorities was dealing with epidemics. Many of the first public health reports concerned tuberculosis. Tuberculosis rates were falling in England and Scotland but not in Ireland. Infant mortality was also a concern for early public health reporters, as this was also much higher in Ireland than in England. There was recognition that these levels of death and ill-health were directly linked to the poverty of the country and social deprivation that the population was experiencing. From this time public health was established as a discipline recognising socio-economic causes of communicable disease.

Moves to what we would now recognise as modern public health reporting systems in Ireland took off with the establishment of the Department of Health in 1947. Ireland achieved independence from the United Kingdom in 1922 and a national parliament was established. The Department of Health was established to govern most aspects of health including the collection and dissemination of information relating to health. The National Health Council was established to advise the Department of Health upon its founding. From this time, therefore, public health reporting had a clear role in political decision making. During the 1960s the Department of Health was reorganised and several new advisory boards were established. These included the Medico-Socio Research Board, the National Drugs Advisory Board and the Health Education Board.

In 1971 new localised authorities for the administration of health were established. These were called Health Boards and created a separate and specific administration for health, which had previously been one of a number of areas governed by local authorities. As well as being responsible for the provision of health services the Health Boards also provided reports in public health on their regions of responsibility. In 2005 the ten regional Health Boards were replaced by one overall Health Service

Executive (HSE). For public health reporting, as with all health areas, this means that the HSE now takes a centralised approach to this, replacing reports produced by each region.

1.2 Who produces what, with what intention, on what level?

Health Service Executive

The Health Service Executive provides health and social services for the whole nation. Its activities in public health reporting include publications concerning evaluation of current healthcare provisions, plans for future changes or implementations, and reports on studies carried out on the health of various demographic groups or the impact or prevalence of various diseases or conditions.

Department of Health and Children

The report output of the Department of Health and Children is similar to that produced by the Health Service Executive. Reports concern policy, both current and future plans, demographic trends in health of populations and prevalence of disease.

Health Research Board

The Health Research Board is a state agency supporting and funding health research. As well as providing funding to other organisation and agencies to conduct health research and produce reports, the Health Research Board also produces its own research and reports. Recent reports published concern alcohol and drugs misuse, health and environment and mental health.

Health protection surveillance centre

The Health Protection Surveillance Centre is part of the Health Service Executive and provides surveillance, independent advice, epidemiological investigation research and training. Reports concern information about, and guidance on various infectious diseases.

Women's health council

The Women's Health Council is a statutory body established in 1997 to influence development of health policy to ensure maximum health and social gain for women. Reports concern various aspect of women's health both in Ireland and in the Developing world.

Central Statistics Office

The Central Statistics Office provides reports on 4 year census data and other national surveys conducted in Ireland.

Institute of Public Health

The Institute of Public Health was established to promote co-operation for public health on the Island of Ireland funded by the Department of Health and Children and Social Service and Public Safety (Northern Ireland). The Institute provides reports on health inequality, health impact assessment and population health.

Academic units

There are six academic units in the Republic which produce reports on a range of public health topics. These are sometimes commissioned, often by one of the agencies listed above, and sometimes based on investigator initiated research.

2. Results of interviews

2.1 Satisfaction with the supply of public health reports

Most participants of this study were positive about the supply and quality of public health reports for their needs, speaking about a wealth of reports that they received or could be accessed. There were, however, some aspects of public health reporting where problems were identified:

Timeliness of reports: The timeliness of public health reports was mentioned as a problem. Participants stated that public health reports on certain topics could be several years behind.

“I think sometimes the public health information, if this is the right way of saying this, isn’t always up-to-date, in terms of public health figures, you know, recently I was reading a story about TB and the latest up-to-date figures were on provisional data from 2005 and it’s now 2007, I mean there are reasons for that, in that you know people have to go through treatment and all this sort of stuff before they actually come out with figures, but em, and it’s the same with, I don’t know if you’d call them public health figures, but you know, for, you probably would actually, even things like hospital acquired infections and all that, that’d be public health information, those figures are always kind of out of data, or often out of date by the time they’re published.”

Another issue identified was that participants could not always find public health reports that were either specific to Ireland or specific to certain counties:

“Well we always try and use Irish data or European, but sometimes it just isn’t, I-I mean, as you get closer to the nation level it gets worse and worse and worse,”

* Direct quotations from participants are presented as shown

“Em, yeah our biggest problem would be this, this localisation, the one I’ve just mentioned em,”

“That things aren’t down to small enough detail?”*

“Yeah, it, er, the coarseness of the, of the spatial data is to, means it’s very difficult to, to correlate that with any sort of environmental issue when the environmental issues, in the main are being looked at a little bit more, more closely, now it appears that problem will start to go away in 2009 or 10, whenever postcodes appear, but up to that we struggle, we will struggle to make good use of public health data, for environmental issues, now you can probably use it on a national level, but when you are trying to drill down any further, you, at the county level and then you start wondering exactly what are you’re showing,”

A problem identified by one participant was that sometimes reports that would have been of interested were not available in English, or only a small proportion of it was available. Various participants mentioned the type of public health reports they felt were not sufficiently available. These were reports regarding GP consultations, reports that concerned the general health of the population (rather than a heavy focus on hospitals) and reports concerning bio-statistical analysis and health economics.

2.2 Utilisation of public health report resources

Participants mentioned a variety of public health reporting resources that they used. Reports on health inequalities were mentioned by several participants. Reports presenting statistical data were most frequently mentioned, therefore reports compiled by the Central Statistics Office were of particularly importance. In terms of how reports were accessed, the internet was cited a primary means, with many public health reporters either e-mailing reports to interested parties or reports being available to download from websites. Participants used public health reports for a variety of activities depending on their occupations. Several participants described public health reports as key resources needed to create pressure for policy change:

“what we are about is trying to influence policy, and the ways in which we do that are though, er, the concept of having more information and better information part, of the skills and tools people need in terms of capacity building and then how can we plug that in to try and, you know, make a difference, at a policy or programme level, in terms of what’s er, what’s being disseminated, distributed and developed in a broader context,”

+ Direct quotations from ourselves are presented as shown

2.3 Examples of high/low policy impact

The 2004 workplace smoking ban was identified by most participants as an example of a public health reporting that had a high policy impact:

“so you take the smoking, smoking ban in this country that’s an excellent example of public health and policy coming together, and making a fantastic contribution to the health of this country,”

Though the smoking ban was cited as a success, some participants could describe public health reports with which they had been involved that had failed to have a policy impact:

“some of the commissioned research that you’re commissioned to do, some, some will be taken on board and the results looked at and worked on some you don’t think, it, it, it’s my experience they haven’t been really, despite the work being commissioned the, nothing has happened on foot of the report being, written, a good report being written and submitted and launched etcetera, etcetera”

“So you’ll have gone through a whole process of trying to get the, the information out there and...”

“Or the people who commissioned it may not even pick it up and, and run with it that’s, I mean for example the drugs study, the drugs and driving we showed, we did the study with, it was for the minister for the environment, launched for him, got a lot of media exposure absolutely nothing happened, I wrote it up in the, er, and published it last year, a big flurry of media attention again and I was saying to all the media ‘I did this two years ago’, ‘this is two years old’ the, it’s not quite the same stuff it’s just I’d done more for the article but the point was nothing had happened on, on that, at all even though they’d commission the work to be done, you know,”

“Nothing in terms of like policy change?”

“Nothing in terms of policy change yeah,”

Reports which present conflicting accounts and recommendations about public health issues were mentioned by several participants as something that lowers policy impact.

“if you have a conflicting message, Very confusing,”

“that’s bad?”

“Yeah, yeah,”

“Em, so what do you do if there is a conflicting message?”

“Well I mean again it’s, I suppose, y-you do have to look at the evidence base, people want black and white answers but you can’t always have black and white answers, em,”

“But in public health, I mean, a lot of things are grey areas,”

*“Some, some of them are debatable yeah, and I mean, I think it is a balance between being vain, well ***** whatever the word is, about a particular finding or tempering it with, at least ensuring that people know both side of the issue, and it can be difficult, cos people do like...”*

“Black and white?”

“Black and white and sometime you’re right that there are no black and white answers,”

“So where there is, em, there isn’t just one single message would you say there’s a lesser impact?”

“I think so yeah,”

Finally reports which presented clearly defined solutions to a clearly defined problem were thought to be more likely to have an impact:

“I think when you have research which proves that there’s a particular problem, and it provides you with a reasonable solution then it is, you know, it is quite easy to get it accepted and you can get a policy based on that because your, your policy is based on the solution not on the research, where you have research which doesn’t give you a solution, which clearly identifies a problem but doesn’t provide you with a solution then it’s very difficult to, to, to develop a policy to solve that problem, “

However it was also discussed that a report may deliver clear findings and recommendations but because of political agendas and economic policy may, not be developed:

“I think it’s very difficult when you’re looking at the balance between public health research and the economic environment, em, so if your public health research is impacting on something that, for the country has a huge economic, em, value, em, I think it’s difficult to sell that, em, I mean for some reason the, the smoking, worked, for a number of reasons, because people were ready and there were, sort of, I suppose, health awareness and the message was so clear but even in doing that the fight with the, tobacco companies etcetera was fairly lengthy, so again when you’re looking at things like, the management of chronic illness, you know that a lot of the management of chronic illness is down to lifestyle, and yet obviously what we’re going to have will be the drug companies

wanting their particular intervention to be funded whereas we might get the bigger bang from our buck by funding some of the health promotion areas, which goes back to my point about actually needing very strong and robust health economics, inputs into the public health research because otherwise you won't sell it,"

2.4 Factors influencing the impact of public health reports

Participants' views on the factors which influence the impact of public health reports on policy can be broken down into four main areas:

Before a report is written: A number of participants argued that for public health reports to have a significant impact on policy collaboration is needed between those conducting research and the target audience. This could mean that there should be involvement from a target community if the project concerns health promotion or the health of a particular community. In cases such as this it was regarded that there would have to be 'buy-in' from the start of a project for an impact to occur. This idea was described in reference to a new study concerning the health of Irish Travellers.

*"the travellers study that's been em, commissioned, ... it was a strategy set out by the traveller community and the department of health strategy, it was a ***** strategy ***** , the travellers groups and the department of health set out the tender for, the study, we're going to be doing this study and, then, that will hopefully have buy in, and will carry a lot of weight in both the department and the travelling community because it has been set out, the framework has been set out by them, you know they're not, they're, they've buy in into the way that the studies being done, err, and it's not, so hopefully that will have a big impact, "*

Similarly it was felt that for a study to have an impact on policy, then policymakers should be included in the planning and management of a project from the beginning.

"if we can include somebody from the likes of the Department of the Environment in a steering group or project, that the information gets taken up much better, em, or someone from our own staff whose involved in the policy implementation, policy development activities, em, so we can see that yes you can make a difference and you can get an impact in policy from research, em, you've to pursue it quite actively and push quite hard on it, em,"

How the public health report is written: Various views and opinions were given about how public health reports should be written. Many participants discussed the need for concise, easily understandable reports:

"if public health research is presented in accessible manor, in a format that's digestible, in a format that's easily

understandable then it's likely to increase its impact, but it also has to be relevant to the people that you're trying to influence so I mean if you are like people in policy making positions and people in environments where their decisions impact upon public health, and what makes them amenable to that er, to that research then it's if they can get it succinctly, if they can digest it succinctly and if they can understand it, like I mean if they can, if it's presented, like what we would try to do, not that we always succeed, but we try to get our report er, presented in a very succinct manner you know, so that you don't have a huge big tome, you have something that's kinda, er, no more than twenty or thirty pages, like you know, and that is, you know, that will give you the key points"

One participant described how in her organisation report summaries were sent out to relevant parties as well as full reports:

"last year we looked at our reports, I mean we try not to produce very big reports but you know there'd be twenty, thirty pages or something like that and we produce research summaries, they were literally, you know, four pages, you know, em, like an A4 folded, and that had all the information that was in the report in these four pages and, you know, would have sent them out again, sort of as again raising awareness of that stuff that was there"

As well as concise reports, participants also discussed the need to have reports that were written and presented with a target reader in mind. This meant that a report for a policy expert would need to be different from a report aimed at the general public.

"I think that you need to provide different versions to communicate that information to different audiences"

"present your data at a variety of different forums, particularly if its something that's pertinent to different people,"

"I think that there's an awful lot of information out there and some gets delivered by the web but useful stuff gets lost but a lot of it, probably ninety percent is useful to somebody but ten percent is useful to me but it gets lost in the deluge of other stuff so, there's something in targeting what you have to the people"

The issue of the recentness the information contained in a public health report was thought to impact upon how influential a report would be. Similarly, participants described situations in which they had been asked to comment upon various public health issues. Having up-to-date public health reports was described as essential in being able to give an accurate and prompt reply and, therefore, potentially have an impact on policy formation.

“be ready for the opportunities, so if we’re asked to advise on, say, road safety measures, we advise on road safety measures,”

“Quickly?”

“Quickly, immediately, in other words if we’re given, say, can you do a report in ten days time on road safety suggestions for the forthcoming strategy we sit down and do it,”

“Ten days?”

“Yes,”

“That’s quick?”

“Yes, we do it, we do it, and we’ve done it, in collaboration with academic departments and ourselves, so we have to, we have to be ready to move very quickly,”

However: Although participants regarded that many things could be done to increase the impact of public health reports there was also an opinion that factors other than public health evidence can, and do, impact upon policy formation. Firstly, there was awareness that some public health issues are more fashionable and grab the imagination and attention of the public and policymakers. In discussion about why some public health reports have a greater impact one participant said:

“sometimes it’s just got to do with it grabbing the imagination of a particular, policy maker or a particular politician”

Also, there was discussion of how politics and economies could prevent public health recommendations being implemented:

“(it) goes back to how you believe that policy is made, you know, er, and policy, er, systematic policy making using all the evidence available and arriving at a cold informed decision in the light of all that evidence is not always the way that policy is made so, policy is often made, kind of, on the hoof or reactively or whatever or there isn’t the specific capacity within the department to analyse all the er, data and come up with a kind of a policy that is best, em, that is best for that particular time, it’s politically influenced it’s time driven, it’s time bound, it’s party influenced, it’s adopted by one particular party and then another party may, you know, come into power and maybe they have different views, or whatever you know, so there’s a lot of er, a lot of reasons why, er, policy isn’t, em, I suppose, policy isn’t er, as effective as it might be or as, responsive to need as it might be or as responsive to the evidence as it might be, you know, policy in light of the evidence or policy despite of the evidence, you know,”

Prioritisation of issues within the health service could also influence which public health reports and recommendations become acted upon.

“with the, at the moment all they’re concerned about is if you have, if you did some public health research and you could cure the bed crisis situation you would be taken on board, nothing else is really taken on board at the moment, if you could solve A&E you’d be em, that’d be the best research but, it, other things em, are kind of down the pecking order I suppose in terms of priorities”

2.5 Public health reports and the policy cycle

Interview participants expressed various views about the role of public health reports in the policy cycle. Some participants doubted the impact that public health evidence has upon policy formation:

“I think it’s really random, I mean I think it’s, it’s, the whole process of policy making, er, personally I think it’s not evidence based, you know,”

“At all?”

“Not that much, at least in our area, you know,”

Others felt that public health reports were used in the planning of public policy:

“in the strategic planning, for policy that they would look at the evidence base, em, and often, to be fair to the HSE, now when they’re planning major strategies and initiative they actually get public health input and do they ask people to do research into particular areas”

A common view was that publicising a public health report increases the likelihood of influencing policy. The politician interviewed for this study stated that she did not proactively seek out public health reports. For this participant public health reports were something other people had to make her aware of. For this reason she emphasised the importance of making sure that a public health report was in the public sphere:

“I think it always helps to have publicity around them, you know, I mean to have a formal launch and invite, I mean that’s often how politicians find out that a major piece of research has been done because it is launched and we’ve invited as public representatives along to that launch and we’ve become aware of whoever has been involved in the production of, em, of the reports speaks about it and, you know, it’s a way of drawing the attention of politicians to it and making it slightly more of a, em, you know, bring it into the public domain and making the findings, the broad findings at least known,”

For a public health report to become part of the policy cycle, the importance of lobbying and putting pressure on policymakers was also discussed. While the importance of informing policymakers about a public health report and its findings was emphasised, it was also noted that lobby groups, relevant NGOs and statutory bodies should also be involved so that pressure can be put on policymakers to respond to a highlighted public health issue.

“policymakers can often ignore, if they don’t want to, er, take heed of the findings, of the research they don’t have to, but the more the wider public and particularly interest groups and stakeholders are aware of those findings then that provides them with, I suppose the kind of, em, you know, the arguments and the, the, the supporting evidence they need to push and to try and, and get the policymakers to support particular changes in legislation”

The interviewee discussed how her organisation, as a statutory body, could not itself engage in lobbying. However she discussed how they did provide information, reports and support to NGO’s who could engage in these activities.

“we can’t lobby or campaign because we’re a state agency and that’s not our role but we would really try to always build our links with the NGO and the community sector, because they can do that and we can provide information, and we can provide supports”

It was regarded that increased awareness of a public health report and its findings would increase the impact upon the policy cycle. The media, therefore, becomes an important factor to consider. It was felt that the messages the media delivers could have an important impact upon which issue become addressed in policy. In this study we were able to interview the health correspondent for a major broadsheet newspaper. This participant talked extensively about how public health reporters could maximise the newspaper coverage of their reports. The main message from this participant was that the timing of when reports were launched and when they were received by journalists was extremely important. Firstly, one needs to consider the day of the week on which a report is being published:

“if there was a big report coming out and but that it were, was, given to one of the Sunday newspapers, for example, in advance, like, not mentioning anyone in particular Sunday Tribune, Sunday Business Post, Sunday Independent whatever, right, suppose it was given to all the Sunday newspapers in advance, em, and then the daily newspapers are coming out Monday, Tuesday, they mightn’t bother doing much on them, because it’s all ready been in the Sundays, do you know what I mean? So, whereas if it was launched on, em, I think for someone who might be publishing a public health report, you know, for maximum, I think, exposure, if it’s of interest then it’s

probably a good idea to maybe publish them on Thursday where you can get some, well it doesn't matter what day of the week really it depends,"

"But a weekday?"

"A weekday yeah, sometimes a lot, well a lot of them will say well we'll publish them on a Monday because we want to get it in the health supplement as well as everywhere else right, and sometimes people say they want, you know, they publish them on a weekly, on a day of the week when all the newspapers are coming out and when it'll be in every newspaper and every news bulletin but also, when the weekend newspapers also want to, you know, to follow up, you know, from the point of view of their feature pages and doing in-depth analysis and all that, so for someone publishing a report I would say they're better off to do it on a weekday,"

Secondly, the time of day when a report is launched or delivered to a journalist will impact upon how much coverage it is given:

"there might have been some reports, maybe, where you'd see, you know, they're published late in the day and someone had to get to grips with three hundred pages, like at four o'clock in the afternoon, I mean I think that's ridiculous, and, you know, I think if they, they, this goes back to, you know, getting exposure for their report again, you know, there's no time better than publishing them at about ten o'clock in the morning, we would have time to look at them"

One reporter indicate that when the health service has bad news to report it will purposely release reports to the media late on Friday afternoon, knowing that there will be less media coverage:

"the HSE constantly do these thing, like on a Friday afternoon at three o'clock and stuff,

"To release a report?"

well there's, they're the worst possible ones, you know, in the hope that they won't get as much publicity,"

She goes on to say:

"there's often less space in Saturday's newspapers than there would be during the week,"

"So they do that quite cynically if they have bad news, they'll release it on a Friday afternoon?"

"I believe so yeah, because you don't wake up on a Saturday morning and have morning Ireland analyse all these things, and it's forgotten about by Monday,"

She gave an example of a public health report which received a lot of coverage. She described how this report was embargoed until a certain date but she received an advance copy which enabled her to read it and have stories planned out for Monday. This prior warning and being given time to read the report in detail was described as a very effective way of gaining media coverage for a report:

"I had that report on, on, erm, on a Friday afternoon and I though 'Ok I'll bring it home over the weekend'.....so actually, so when I came in on Monday morning I was able to say 'Look there are these various in this report it's a big issue' you know, talk about it at the news conference and see what the editor thinks about it, that sort of thing, and, so, we end up doing about two pages on it, I could look up the data you want only just for an example for you, so, but because there was so much stuff in it then we ended up then, myself and the social affairs correspondent, like I did about three or four stories and he did about three or four stories, and then there was pictures because we, someone went to the press conference (The report was launched by the minister for health) and then some grafts or whatever from the report as well, I mean there's an example of getting maximum expose for a report because people have had time to look at it"

Along with the timing of a report's launch, there also needs to be some consideration of a press release than accompanies a public health report. A well written press release was described as an opportunity for public health reporters to increase the potential of their report to receive media coverage, by providing a ready made article for busy journalists:

"when we studied journalism all those years ago, people told us that a press release is essentially writing a story for the journalist, so for those newspapers that are in a real hurry and maybe have forgotten to do the story or anyone to do, they can pick it up and think"

"Cut and paste?"

"Cut and paste at the last minute in the evening, now in a major health report that wouldn't happen, but you, if you em, have in that press release as if you were tell the story, this is what the story is, to the man on the street, that's what the press release should say,"

She goes on to say

"the journalist who gets it then if they're in a hurry or, you know, oh the deadline's coming up, they could just literally, would they just lift, lift what's written?"

“They could do yeah, that could happen, that’s not unknown to happen, I see press releases coming into our newspaper all the time and I can look at newspapers sometimes and see them written word for word,”

“And that’s, yeah that’s a good way of getting what you want being published?”

“It is yeah, absolutely, but I mean, I think in a major report, that wouldn’t happen because you would have had time to read it, whereas, em, I think that, if it’s a smaller report that maybe not many people have that much interest in, em, where, might, nobody might have gone to the launch or whatever, and you see this press release, it sounds interesting, that isn’t overly scientific, that isn’t full of jargon that is easily understood by everybody including the news editor who never actually studied science, whatever, you know, it’s probably the best way,”

It was felt by the participants, overall, that the role of public health reports in setting the agenda and formulating public policy was dependent wide exposure of the report leading to pressure for policymakers to act. As such, targeted dissemination to politician, NGO’s and statutory bodies was necessary. Dissemination to the media in order to inform the general public is also important in creating an issue and awareness of a public health report.

2.6 Supporting people active in public health reporting

Several issues were raised which, if addressed, would support those active in public health reporting. Firstly, it was felt, by some participants, that public health is regarded as lower status than other areas of medicine. It was suggested by some that if those active in public health were given greater status public health reports and recommendations would have greater status and therefore greater impact.

“I think we would have huge impact if we became consultants in our own right, I think we would also, em, have a lot more impact in health service as a whole,”

“Consultants in your own, like what...?”

“Well, at the moment we’re titled specialists in public health medicine so, if we became consultants in public health medicine we’d be on par with all the other consultants and we’d possibly, maybe, have a greater impact on policy,”

She goes on to explain why becoming consultants would be an important development:

“And why do you think, how would it increase the impact?”

“Because consultants are listened to,”

“And specialists aren’t?”

“Em, well you have to make you case and, and then after a while you might get listened too, em, sometimes consultants will question what you’re doing and will, sort of, ‘what are your qualifications’ so, you know, it’s important the development”

Beyond individuals there was also a feeling that public health medicine was not given as much attention by funding agencies and the general public.

“one of the issues for me is that there’s a lot of money thrown at biomedical research, while we don’t have as much support, or even as much confidence in, what you’d loosely called health service research and yet we’re the health service provider, that’s the kind of research, a lot of the time we actually need,”

Beyond this, another issue discussed by several of the participants was a lack of information about on-going research which was not at the stage of being written up into reports. It was felt that knowledge about early stage projects would be very useful for people active in public health and also public health users. It would facilitate greater cooperation between agencies and individuals and greatly assist those active in public health reporting.

“we could be embarking on new research next month or the month after or next year which we feel is absolutely, em, vitally important for us to do and the Health Service Executive could have done it a month before hand,”

“So do you think that more communication needs to take place or what would you say?”

“Yeah, I think, I think as a start an awful lot of companies do an awful lot of research as a start if we were made more aware of where this data is actually being stored, then we can actually start looking at that and then working on communications with the various different departments,”

“So create some sort of central access point?”

“Yeah”

and again,

“we’re involved with a European project, em, you know, we go off to Luxembourg twice a year and when, one of the reasons why we go is not only to do with the specific project but because you learn so much, about what else is going on, you know, but, what about all the people that did manage to wangle their way on a project, or, don’t have the money to go to Luxembourg twice a year,”

One innovation which has been developed with the specific purpose of assisting those working within public health is Health Atlas Ireland. This web-based software package allows researchers and public health practitioners' access to raw data and provides a mechanism which answers queries in relation to this data. One of the creators of this package described how the software was developed with the precise aim of assisting those active in public health:

“we realised that people have been going to a whole lot of different areas to find out census data, cancer data, hospital data, em, mortality data, whatever, to really different agencies and em, each of these seeks, each of these agencies in contact with a range of individuals across the country asking similar questions again and again and again so we said ‘Well hang on, this should be integrating more’ number two is they need to use, have similar tools when they access the data, in a similar way, to get similar numbers, no matter who does the analysis,”

2.7 Further developments in public health reporting

Desired further developments in public health reporting focused on how public health reports could have more of an impact on public policy. Participants had various ideas and some discussed the approaches they had used in relation to achieving this.

A commonly expressed view by most of the participants was that communication amongst and between public health reporters and policy makers should be improved. It was suggested that more small scale meetings or discussions groups should take place as these facilitate more interactive dialogue:

“I think, em, small, em, forums, say, em, twenty, thirty people rather than large conferences, a conference just with a, you know, a person giving a lecture at a conference with a hundred people, a hundred and fifty people in there, he stands up for twenty minutes, or she, to give their presentation people don't really want to ask too many questions or get caught up in the, in the debate, which can be quite detailed, so if they were limited to, say, thirty people in a room and it was a forty minute informal discussion I think you'd get far more out of it,”

And from a different perspective:

“but one of the things that I think maybe is apart from creating the opportunities to have, er, dialog between the, lets say, the users and the producers in that clinical term, but also between the, er, to have dialog cross departmentally and I don't think that, there is still a lack of joined up, er, operationalised, er, policy or operationalised programmes across the department that type of thinking doesn't permeate”

There was also some suggestion that those active in public health reporting ought to take a more proactive approach in trying to generate policy change.

“being braver in terms of like advocating more for wherever, it’s like, em, alcohol policies or em, education policies, you know, or being more er, assertive, or being more er, I suppose strident in terms of trying to get that message across about being a really, really important issue, you know.... having the data, having the information, having the research, but also that’s no use if it’s just going to sit in a report on a shelf, you know,”

Another suggestion was that where reports were written and recommendations made, governments should be made to justify their response to these reports. This participant argued that the European Union provides millions of Euros in funding for member countries to conduct health research and deliver reports. Therefore member governments should be expected to provide reasons if they did not act in relation to the findings of a report:

“you’re really talking about lots of money being invested in research and not really seeing sometimes, a result for it and em, and I think that also that goes back to the accountability bit, you know, governments, all governments are giving the EU lots and lots of money to fund this research and then, what do they do with the results, you know, and is there maybe an accountability gap there too, em, that if the research is funded and it shows this, then how can you justify that you didn’t change what you were doing as well,”

Finally, there was discussion by one participant of the measures that his organisation had considered and put in place to attempt to achieve a greater impact for its reports. It was felt by this organisation that those active in public health (and other sciences) need more awareness of how policy is made in order to be able to affect a change in policy:

“what we’re planning at the moment now is we’re in negotiations and discussions with a company in the UK which specialise, they’re called Knowledge Bridges, specialise in, em, trying to join up science to policy, em, so, we’re just wondering how aware is, any researcher...how is a researcher aware of how they can make their piece of research, this report, change policy, so that people understand how policy works, it’s very rare that anyone would say to a scientist, you know, ‘You should make that impact on policy’ but how do you do it? What does, what does the impacting on policy mean? What does it look like?”

He goes on to describe other initiatives that his organisation has been involved in which aimed to link science with policy:

“there’s a few European commissioned sponsored initiatives, there’s a thing called Bridging the Gap, we sponsored a health conference here in Dublin a few years ago as part of the Bridging the Gap series and it has a sister, sort of movement, called Science meets Policy, er, and these are all about trying to get science into policy and this project SKEP, S-K-E-P, came out of that, the thinking came out of that to bring all these research funders together, try and think how can we get, we’re all pushing a lot of money into environmental research and how to get bang for your buck so to speak, so we’re talking to our people, I suppose, at that level trying to see how we do it, em, and they had some people that have come over and reviewed our, sort of, dissemination and policy impact, sort of, measurements so they looked at how do we evaluate policy impacts and other impacts of our research”

He described some of the changes that his organisation was considering to improve their impact on policy:

“as a, one project is finishing the person’s eye is on the next project, so at the very time that, as I see it, at the very time that, that there is a product to deliver the system has told the researcher to move on to the next thing, so if you’re doctor whoever-you-might-be in the department of environmental science here, just as this project winding down you’re already thinking now am I going to go to the EPA for another grant, am I going to go to the Framework Programming in Europe or, or whoever I’m going to go to, and that’s the very time that that you’ve got a, you’ve actually got a project to deliver,”

“So it’s like you don’t have the, the time kind of thing to be able to get out there with it cos you have to be thinking about what you’re going to be doing next?”

“Yeah, and that’s something else that we need to start thinking about us that, should we be providing funding that goes past the end of the project, we would say the end of the project is when the report is delivered,”

“Yeah, when it’s all done,”

“but we’re also starting to think now that’s exactly the time we could do with two more months of body,”

3. Main dimensions of public health reporting activities

The study revealed several main issues. The first point to be noted was the discrepancy in opinion about the importance of journal publications between some producers (particularly those working in a university environment) and those involved

in policymaking. Several public health professionals felt very strongly that public health reports were of limited use. They were frequently despairingly referred to as 'grey literature'. Publication in journals was regarded as *the* legitimate type publication. Peer reviewed journals were regarded as publications that would have an impact. Policymakers, however, actually said the opposite. The politician interviewed for this study said that she did not use journal publications, reports were described as providing the information that she used. She regarded journal publications as belonging to the academic world, rather than the realm of public policy. Therefore there seems to be a mismatch concerning the perceived importance of public health reports. Compare the following quotes:

“a lot of research is, goes unpublished and becomes part of the grey literature which people never see, unfortunately”

“I think there is a tendency for stuff to be published in a report, never becomes a published article, hence it's lost in the grey literature, you only know about it if you know about it, and you can't source it otherwise unless you, someone says 'Oh I think there was a report done on that',”

*“most, er, senators and TD's have researchers working for them, and the researchers would be aware, you know, of publications in particular areas that are relevant to the TD's portfolios or to the senators portfolios but, em, a lot of the research that is done would, wouldn't extend I, I don't think to academic journals, I don't, em, I, I'm not aware that, that, you know, the researchers that work for me, we have ***** party researchers who work for all the TD's and senators, and I'm not sure, unless they were particular of a certain academic, em, you know, journal that was of, of relevance to a particular area, I'm not sure that they widely, er, you know, searched the academic, er, journals,”*

“So they would more go after reports?”

“They would exactly,”

Another theme that emerged strongly from interviews was a perception that communication between the parties involved in public health reporting (users and producers) is insufficient. Several participants stated that they would like to know what research is being conducted and by whom at the current time. They would like to be able to easily contact a person involved with a public health report in order to learn more about a report or collaborate with its authors. It may, therefore, be the case that more networks or opportunities need to be in place for producers of reports, NGO's, statutory bodies and politician to come together. As it was felt that wide dissemination of reports was needed for significant impact on policy, this could be a crucial change.

Finally, from those who have experience of policymaking it would appear that public health reports do impact upon the formation of policy, however there are many other issues which also impact upon policy formation. Participants were aware that their voice and their reports would form part of conflicting demands on policymakers. It was therefore perceived that simply producing a report is not enough. Public health reporters need to find some way of promoting their report, whether through media exposure, supporting lobby groups or providing funding mechanisms to allow researchers to promote their work. In this way it was felt that public health reports could have an impact.

Annex 4.5: Malta

Amanda Salib

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Health is a cross-cutting issue and it tends to go into all policies. Consequently it becomes paramount to look at Public Health from a more holistic viewpoint. There seems to be a general consensus that the quality of public health data in Malta compares well on the international arena; however it is significant to have more timely and visible deliverables, channelled in the right manner and to the right people. Ownership of Health Information tends to be fragmented. For the sake of more integrative and complete data, there needs to be more liaising between the different Ministries, departments, agencies and other sources of information. For PHR activities to receive more attention, information needs to be published in a way that it is newsworthy. Ultimately more funding has to be committed towards PHR.

1. Introduction: A historical glance

Put simply, Public Health is all about making a difference to the population's health. In turn Public Health Reporting is all about providing targeted health information to politicians, policy-makers, donor agencies, NGOs, universities, medical schools, health professionals, journalists and the public at large – in other words, anyone with a professional or personal interest in health issues.

While adhering to improving the quality and supply of health information to the different audiences, the central aim of the EU project PIA PHR is to better communicate public health intelligence and information to policy makers and politicians, ultimately being the main decision makers in any democratic country. An important challenge for medical health reporters is to turn scientific and technical language into words that everyone can understand. Few are the policy makers, politicians and general newspaper readers or television viewers who will bother to turn to the dictionary to decipher technical terms - they'll just 'switch off' to the story and find something more digestible.

Since the 14th century the Maltese Islands have been graced by a series of hospitals. It was especially during the reign of the Order of the Knights of St. John (1530-1798), renowned for being great *hospitalliers*, that healthcare gained its momentum. Even if designated as charitable institutions, these hospitals soon became dependent on state subsidies, catering especially for the poor and the neediest with not enough money for subsistence. The Hospital or the Sacred Infirmary was founded in 1532 and built in 1573. Grand Master Frà Raphael Cottoner continued the Hospitaller tradition by enlarging and improving the premises to eleven wards for five hundred patients with a school of Anatomy and Surgery, a school of Pharmacy and an illustrious medical team, which was a remarkable enterprise of world-wide renown, the first international hospital in history²¹.

²¹ <http://www.orderofmalta-malta.org/index1full.htm>

To assist the government and hospital authorities in becoming more efficient and to offer a better service, soon the need was felt to start collecting data and issue reports. First demographic data dates back to 991, while population counts made during the period of the Knights of St. John were conducted in association with the importation of grain from Sicily free of export duties²². Civil registration of births was introduced in Malta by Napoleon Bonaparte in 1798, while mortality statistics by cause of death started to be published regularly by the Chief Police Physician, in 1872 under the British rule. A Government Notice issued in 1871 required all physicians and surgeons to submit information to the Superintendent of Police of any communicable disease. Traces of maternity data dates back to as early as 1841²³. Originally the main intention of collecting health-related data was purely administrative and budgetary; nonetheless, especially from the 20th century onwards public health data began to be mostly utilized to support various health services.

An important development took place in 1986, when the Department of Health in conjunction with the WHO introduced a computer-based Individual Health Profile aimed as a person-based record for all patients who made use of government medical services, with the aim of providing readily available clinical information to medical practitioners on the patients they were treating, of scheduling appointments and follow-up procedures, of managing immunization and other preventive programs, and of conducting surveys and research. This profile was eventually evolved into the Patient Administration System still in use today.

Especially during the past 2 decades, in Malta as in the rest of the developed world, many activities have been launched to generate and deliver health information. Advancement in medicine, technological development, higher patients' expectations, an ageing population, further quests for evidence-based decision-making and European Union membership are amongst the most important drivers of health information.

2. Research Package

The research package for this project included a Delphi Survey of three rounds, Expert face-to-face interviews and 2 Focus Group events carried out in France, Germany, UK, Ireland, Malta and Hungary. For the first Delphi Survey, in Malta approximately 65 persons coming from various health-related fields were contacted and 38 persons took the interest and contributed. Considering that Malta's population size compared to the other participating countries is minute, our response rate was very successful - more than 50% response. However the overall participation rate for

²² Savona-Ventura C.: Civil Hospitals in Malta in the last two hundred years. *Historia Hospitalium*, 1998-99, 21:p.45-63

²³ Ibid.

the second round of the Delphi survey has been low. From a total of 200 persons²⁴ who participated in the first round only 57 filled the second round questionnaire. Therefore, on a unanimous consensus under the guidance of Loegd, the third round was cancelled.

Overall approximately 140 persons participated in the focus group and in-depth expert interviews. Locally 48 interviewees²⁵ took part mainly on a national level. Both focus groups had a duration of 150 minutes each, while every expert interview lasted roughly 35 minutes. As was recommended, both group and expert interviews were conducted outside the Department of Health Information and Research, choosing more independent places. All interviews were recorded and transcripts were assembled. Among the persons who took part, one finds public health experts, consultants, professional associations, health NGOs, journalists, health administrators, private hospitals, clinicians, psychiatrists, nurses, social workers and politicians.

Ultimately the main aim of conducting both the Delphi survey and the group/expert interviews was to develop a Methodology and Health Information Tool Box, composed of tools and guidelines aimed towards producing public health reports that meet the needs and expectations of both the authors and the users, whilst at the same time increasing the policy impact on both decision-makers and politicians.

The two main limitations of this research project were:

1. The under-representation of national politicians; and
2. The absence of participants on a regional and/local level of health reporting.

Owing to the fact that in Malta one can say that we have only one tier of government – central government, it was difficult to find participants from the local & regional level. When it comes to national politicians several attempts were done to convince a number to participate, however in most instances it was unsuccessful.

The key questions discussed with the various participants mainly dealt with:

- Satisfaction with the current situation concerning the supply of health information and knowledge
- Information needs and coverage
- Utilisation of resources
- Possibilities of making the supply more supportive
- Impact of public health reports on politicians and policy-makers.

²⁴ Malta – 38; Germany – 62; France – 22; UK – 32; Ireland – 17; Hungary – 29

²⁵ 15 persons - 1st Focus Group; 14 persons - 2nd Focus Group and 19 persons - Face-to-Face in-depth interviews

- Interaction between user groups and those active in PHR
- Maltese health reporting vs. European health reporting

3. Satisfaction or otherwise with the current supply of PHR

In general there seems to be an accord that the quality of the existing public health reports is good and satisfactory. Besides the plurality of the public health researchers and reporters are generally in possession of good analytical skills with myriad experience in such a dynamic explorative field. However the quantity of health information is not enough. There's a vacuum of health information or not adequately available information for instance when it comes to sexual health problems; suicide and suicidal attempts; elderly mental health and domestic violence on the elderly; private provision of health care; environmental health; health of minority groups and patients with rare diseases; primary health care and general practice. Theory on small states argue that in small states, with generally less commuting, information is more easily available, accessible, and not lost along the way. Nevertheless generally administrative costs tend to be higher, due to indivisibilities and the inability to take advantage of the economies of scale of large production.

The Maltese main public health actors are public health experts working within the Ministry for Social Policy. A number of other Ministries/Authorities/Agencies having a health-related function include the Malta Environment and Planning Authority, the Ministry for Family and Social Solidarity, the Ministry of Education, Youth and Employment and the Ministry for Rural Affairs and the Environment, amongst other contributors. Even though decentralization is one of the major issues discussed in the ongoing health service reform, the before mentioned entities all form part of the Maltese public sector and participants pointed out that it's important to have more independent reporters. Albeit private health care providers have grown considerably in the past decade, still their contribution towards health research is narrow.

It's important to have more timely data, whilst taking more into consideration the completeness and accuracy of the information. It's a pity, that more often than not, a first-class report is done on an ad hoc basis and never followed up again. There needs to be more commitment and regularity. The two underlying causes of tardiness and/or one-time reports are the lack of human resources and finance. Besides there was a general feeling that sometimes the producers themselves do not feel useful or rather are not fully aware of the importance of the project undertaken. It's a shame that sometimes you come across websites with EU statistics and for Malta the information is not made available. Another big confusion with public health reporting is that from time to time there is inconsistency in the reporting of statistics, were for instance you have the WHO quoting a figure, while the EUROSTAT is quoting

another figure, for the same year and cause. Nonetheless probably we are moving forward especially since becoming an EU member.

Even though as formerly argued, the health information which is coming out locally is on the whole acceptable, however it suffers from the problem that it has to compete with so many other venues of information, not necessarily related to health but coming from major powerful companies such as fast food multinational outlets. And usually on the whole information coming from these companies is not that positive and somewhat contradictory. To contend and combat with such powerful information sources, it's important for public health reporting to be continuously repeated.

Another highly debated concern was that related to the channelling and dissemination of information. It was argued that the deliverables are not visible enough to get to know about them. In a nut shell, the right information is not being channelled to the right people, at the right time, in the right manner and format. One way of conveying information is through direct marketing, were you build up a set of customers, you see what they're interested in and subsequently you deliver what they need to receive. Or else you market strongly to the wider public, so that people get to know of the information through other means like for instance newspapers or television.

A further apprehension is that often a health issue is hitting the local media only when the European Union issues its press releases. Then rightly so Malta is taken by surprise. For instance when lately there was the good news that Malta has the lowest rates of accidents and injuries, why did we have to wait for the European Union to point this out to us? If it was pointed to us before, we could have got mileage out of it. On the contrary, when there is an area were Malta isn't performing up to expectations, we shouldn't wait for the EU to point it out to us, at the same time that it tells the other 26 EU member states. It's a must that policy makers know about it in advance, so that if it is required to come up with a package of measures to improve the situation, Maltese decision makers are already vigilant.

Unfortunately among General Practitioners (GPs) there's a common feeling that they are being 'sidelined'. Owing to the fact that GPs are always at the forefront, discussing a number of health issues with the public, it's important for them to be well informed and updated. As highlighted, *"GPs depend deeply on official sources of statistics; nevertheless we rarely receive official documents such as changes in medication and modifications in criteria."* It is very grim when GPs do not know that a particular drug is stopped or that the dosage is changed.

4. Users of health information

Health information at the moment is being used a lot by students and clinicians, mainly for their private assignments. However the most frequent users of health information should be internal, such as health administrators, nevertheless the

culture of evidence based decision making is still somewhat diffident. Owing to the fact that potential users of health information are not using health data, over the years, health information has become peripheralised. Politicians are current users of health information, yet, more often than not, for their own 'special' scopes. As was pointed out by a public health reporter, *"Giving the politician knowledge doesn't mean that you're going to change his/her attitudes, beliefs and behaviour."*

Then again, voluntary organizations can be potential users of health information, however many times it is not employed because they don't have the funds and the personnel to undertake projects. *"Voluntary organizations can be an excellent vehicle to get the information to the right users"*.

The importance of the press shouldn't be undermined. The press ought to learn to use the right sources of health information. Sometimes the media does not understand certain medical terms and as a result it tends to twist facts. As pointed out by a journalist, *"...there should be experienced personnel who explain things to the media for the sake of more accuracy in reporting to the public."*

5. Utilization of public health reporting resources

Both users and producers of public health reports were asked to catalogue from where they get the necessary health information they necessitate. The internet featured as the most important medium. However, a number of participants accentuated that complimenting the internet, *"...hard copies of publications are also very important and it's a pity that today due to the world-wide-web we are trying to do without them."*

Official reports, reference documents, having access to an updated library of books, news channels such as BBC and CNN, being part of professional associations, together with the attendance of conferences and meetings were all cited as important sources of information and knowledge. Equally important is to have a good inventory of contact people who can easily supply the necessary information, *"Having a list of reliable experts is indispensable... It is a good idea for both users and producers to join professional bodies as they help to keep in touch with colleagues and often organize helpful visits and briefings..."*

An interesting suggestion was that before engaging on a new research project it's important to first dig up old reports i.e. go back to history of the country in question and investigate why certain reports were not acted upon.

6. Advantages of using health reports

Public health data help reporters to be more credible - unless you back up what you say by statistics you can't be convincing. Health data is also an important tool to strengthen a position in a somewhat controversial situation. For instance, health statistics are highly employed when discussing Environmental Impact Problems. To

get the point across, public health reports are also exploited as a lobbying tool. Besides, reports can act as an awareness – raising mechanism revealing that there is a particular emerging problem, while at the same time determining possible hypothesis and explaining trends.

Realistic policy proposals and policy evaluations can only be attained through the use of health reports – *“It’s important for politicians and decision-makers alike to keep such reports stored in their mind when attending meetings and events so as to use them to contribute towards evidence-based policy making.”*

Other possible uses of health reports are:

- To refer patients to the relevant source;
- For prevention purposes;
- To take care of the population’s well-being;
- For lecturing purposes;
- To educate children in schools;
- To criticise local structures, *“...especially by those who are not employed by government...”*;
- To look at what other countries are doing and for comparative purposes.

The medical field is dynamic and not static and thus incessant education becomes a must. As cited by a number of participants, *“Public Health resources help to update knowledge...The use of PHR resources is a must when it comes to continuous medical education.”*

7. Impact by PHR activities

Among the questions posed - Do certain PHR activities have an effect or an impact? Are public health reporters arriving to the politicians? Should certain public health reports be discussed in Parliament?

There was a general feeling that unfortunately in Malta many times it is crisis intervention, were a mishap has to arise for the authorities to act. More often than not politicians act when the public is frustrated; however the problem is that the public is not really well informed. A higher level of impact can be realized when both the media and voluntary organisations pay attention to the public health problems identified by PHR and publicize their findings. Past experience shows that when a public health report is disclosed to the press then the impact is guaranteed. In the words of one of the participants, *“If you want politicians to act then leak it to the press, your head will roll but at least action will be taken.”*

It is crucially important that the marketing and the packaging are carried out effectively. It is a must to have a healthy production cycle where producers have

targets to meet and on the other hand users know what to expect and when. Regrettably often reports are done and then left to rot over the shelf, but once and if they come in good hands they can have an impact. It is important for reporters to be capable of selling the right information to the politicians and policy makers. Furthermore it's significant that there is someone who can explain the importance of such reports to different target groups. Without promotion it is difficult to generate an impact. If no one knows that particular information exists, no one is going to need it.

There needs to be more reports targeted towards administrators and bureaucrats, in addition to the informative and epidemiological ones. A number of participants called for the need of more progress reports particularly for the sake of implementation. In Malta it is doubtful how much civil service policy makers influence the politicians; many times it's the other way round. There are a lot of areas in which policy makers should have a more active role. *"On the other hand policy makers cannot be excessively dogmatic i.e. they think that while they are always right, politicians are always wrong and only focused on winning votes."*

Furthermore it was argued that public health reports should also be discussed in Parliament, bearing in mind that the multiplicity of the politicians cannot understand such reports and thus the help of experts is inevitable.

Although it is evident that public health reporting impact is low on decision makers and politicians, on a more positive note, one can mention a number of instances when public health reporting did have an effect. For instance the law banning smoking in public places was enacted in Malta before the majority of the other EU countries. Furthermore data from an ESPAD study found that the use of alcohol amongst young people is very high and such figures helped to back up the recent change in law regarding the selling of alcohol to the under 16s. In both cases politicians through public health information took the lead and acted. In addition, when the Health Promotion Department issued information about measles, to try to promote vaccination, it had a tremendous positive impact on the people's uptake of vaccines. It's important to keep both politicians and the general public more up to date or rather in a better position to understand the magnitude of a health problem/challenge.

8. Role of media in public health reporting

It emerged that there seems to be a lack of trust between journalists and public health experts. In Malta as news-worthy the media does not prioritize health enough. It's important for public health reporters to keep journalists as their partners, however many times the media rather than going after what's most important, it tends to run after what's most sensational.

When the media misinterprets a result, then it can be very dangerous for the public. As was cited by a psychiatrist, *"In the US it happened with anti-depressants for*

children...The media said that it increased the risk of suicide, however other studies showed that it wasn't medically true. In fact when anti-depressants in children drastically decreased, after 5 years studies showed that suicide rates among the young increased." It's important for the media to try to be fair and above all, responsible, *"Be wary of medical scare stories which can sow public panic."*

In the words of one of the journalists who participated in the focus groups, *"It's very important for the media to criticize the government. In Malta we have a very gentle media compared to other countries...It's important that if there's an issue, the media does not hide it because then the repercussions would be worse...Overall the media is not doing enough to disseminate health information and teach the public...Unfortunately many times it is not so easy for journalists to get the information, even though we're small and strictly speaking it should be uncomplicated."*

Once journalists manage to elicit the information, an important challenge is to turn scientific and technical language into words that everyone can understand. However, should writing more user-friendly reports be the responsibility of the public health expert or of the journalist? Everyone wants his/her work to be understood, yet far too many reporters/journalists sprinkle their stories with language that confuses. This is a great deterrent to public health impact.

It is important for the journalist to adopt the role of a watchdog, with one of the most vital duties being that of keeping track of situations and follow-up on stories. For example, if local government announces a series of proposed measures to improve public hygiene such as through water filtration plants, public information and/or new food production regulations, once the plan is announced and the journalist reports it, the role of the media does not stop there. It is in the interest of the readers that the journalist monitors the progress, *"...and if things are going wrong with the plan, tell your readers – but be scrupulously fair."*

During both the in-depth interviews and the focus group events it was often argued that in order to get the attention of politicians, it is important to first and foremost inform the public. Through the media politicians may feel more pressure to act. However reporters should keep in mind that, *"People will only care about an issue provided they are given reasons to care."* For instance, a story about damaging the ozone layer could seem removed from peoples' daily lives unless the reporter explains the potential health threats in human terms.

9. The role of health-oriented NGOs in the Maltese Public Health arena

In Malta, similar to other EU member countries, the involvement of NGOs in policy making is a fairly new governance activity. As formerly argued, NGOs are not being utilized sufficiently and they can have the potential to arrive better to the policy

makers. The fact that many times NGOs are independent, it helps. Habitually NGOs are run by people who are rocking in the same boat, either they themselves or a person close to them. Thus making them more practical and in a superior situation to understand a health problem in a more holistic manner. *“In a nutshell, the public health priorities, health management, health prioritization, and issues around poverty, human rights, justice, equity, rights and responsibilities take on new meanings and new dimensions, with the participation in decision-making of those who may be affected”*²⁶ NGOs can also act as watchdogs, reporting back on gaps and proposing ways to improve the situation based on sound field experience.

As pointed out by a renowned Maltese NGO, *“We are autonomous from the state and we provide more credible contributions to decision-makers...We foster participatory democracy and enhance citizenship... We can contribute towards more cost-effective public-health oriented policies...Along the years important health concerns were raised on the political agenda primarily because of the insistence of perseverant NGOs...”*

In 2007, the Malta Health Network was formed, with the main aim of representing in Malta, in the EU and Internationally the interests of patients and health of the community, while developing better coordination, collaboration, and capacity building through exchange of best practice among health Non Governmental Organizations and patient representation groups. Around 37 NGOs already form part of this network. *“Malta Health Network seeks to contribute and influence health related policies and National Action Plans...It seeks to contribute and influence EU health related directives and policies... Malta Health Network seeks to support health NGOs to disseminate health information... Dissemination of information on health matters among the general public, and more specifically among the media, policy makers, Parliament, University Students, parents and educators.”*²⁷

In a speech during the set up of the Malta Health Network, the previous Maltese Health Minister Dr Louis Deguara , addressed NGOs and patient representation groups as *“...You are the voice of the patient...”*²⁸

For health-oriented NGOs carrying out health research is important, *“We use research to prove that our services are feasible and truly needed i.e. there is a market for them. For instance following a research exercise it emerged that there should be more services especially targeted for persons with disability following a traffic accident...And we’re now catering for such need...”* However research costs

²⁶ Stahl T, Wismar M, Oolila E, Lahtinen E, Leppo K (ed) (2006), *Health in All Policies – prospects and potentials*, Finnish Ministry of Social Affairs and Health, European Observatory on Health Systems and Policies; Finland

²⁷ <http://mrc.org.mt/page.asp?p=17222&l=1>

²⁸ <http://www.independent.com.mt/news.asp?newsitemid=60523>

money, “...we would like to participate in research but it’s difficult to get the necessary finance...if we go to the Department of Social Policy or to the Finance Ministry, we usually manage to get funds for tangible goods like new equipment for the disabled or a new room for particular interactive activities, however when we ask money for the purpose of carrying out research, it’s so difficult to convince government.”

In Malta many times there’s an overlap between NGOs’ purpose and the services offered. Maybe it would be better, in terms of cost, experience and human resources, for similarly oriented NGOs to cooperate and combine forces.

10. Issue of transparency

Quoting a public health expert who participated in one of the focus group events - “Since that much of the reports are not made public it does not really lead to transparency. Many times we are afraid to publish certain information because many data providers only give the data on the premise that it’s not made public. Health information should not be regarded as blame putting so as not to scare people... The fact that we are small and it’s easy to identify and blame persons makes it more difficult to publish certain data.”

“When government meetings are open to the press and the public, when budgets and financial statements may be reviewed by anyone, when laws, rules and decisions are open to discussion, they are seen as transparent and there is less opportunity for the authorities to abuse the system in their own interest.”²⁹ However transparency does not only imply openness and communication, but also accountability. If certain information that needs to be published will point to a particular person, then it would be ethical to consult with the person before publishing, “... However the person concerned should not be allowed to stop the publication...he/she should just be prepared for the onslaught...” was argued by one of the participants.

11. Interaction between users and producers

There seems to be a mismatch between producers and users of public health and there needs to be more liaising. Conferences, focus group events and joint research projects are alternative ways of enhancing communication. It is important to make people aware of each others needs, expectations, strengths and weaknesses. There was a general critique that most of the health reporters just sit down and write the report, without seeking whether there is a factual need for such information and what the users expect. However lately in Malta the process of consultation is becoming more widely applied and has become a prerogative and an obligation. If users are

²⁹[http://en.wikipedia.org/wiki/Transparency_\(humanities\)](http://en.wikipedia.org/wiki/Transparency_(humanities))

involved from the very early stages, producers will indirectly be encouraging them to access the study once it is completed. As cited during one of the in-depth interviews, *“A public health report made by an expert without any consultation with others runs the risk of becoming just the personal opinion of the expert...I don’t trust such reports.”*

Investigating whether or not there is a need for a particular study to be undertaken is important, however on the other hand producers cannot be excessively pragmatic. Even if they do not have a clear picture of how information is going to be applied and used, still it’s important for the data to be published and disseminated because you can never predict the uses that can be made of specific health information. *“...You cannot be too much utilitarian in the sense that you say – Is there a market for this information? Or even taking it further and say – Will there be a public health action as a consequence of this information?”*

On the other hand a number of health reporters argued that there is not much interest from the side of users when it comes to generating feedback – *“If you issue a draft report for consultation and very few respond to it or appreciate the effort, then next time you wouldn’t be much motivated.”* Additionally a health information producer conferred, *“It is very rare that the users/stakeholders themselves take the initiative and provide the information.”* However producers cannot expect people coming with a list of needs, but they themselves have to go out into the field and look for these needs. A proposal to counteract such disparity could be that users have to be involved not only at the beginning but consistently and in an ongoing fashion. *“Many times there is lack of participation from the part of the users due to the fact that publication of information is not always sustained on a regular basis.”*

During one of the focus group events, an interesting query cropped up – Who shall be involved in the discussion phase? Producers need to be rational and make a professional judgment as to whom to include in the consultation process, *“...however we cannot become too much ‘populist’ like the newspapers...”* It’s ethical and imperative that before producers publish their reports, they get the approval of the data providers who many times are the users themselves (such as in the case of NGOs) or else the report would be ineffective. This will also help to increase the trust and commitment between users and producers.

Rightly so, one of the partakers remarked, *“Good data producers always have the users’ mind. If you want your data to be utilized hundred percent, to be published and eventually to lead to newly added knowledge, then think from the users’ perspective. After all at the end of the day every producer is also a user.”*

The challenge is that most of health information is being held by various departments, in other words, it is fragmented. In order for people in public health to produce the reports they wish, while adhering to strict statistical recommendations, it is important to make agreements beforehand with the data holders as to exactly in

which format they require the data. There should be more cooperation among the different sectors. This is one of the eventual aims of the Department of Health Information and Research, intending to ultimately evolve into a clearing house of health information across wider areas.

12. Concluding Remarks

Public health is the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being. Public health acts on the knowledge that health is a fundamental resource to the individual, to the community and to society as a whole and must be supported by soundly investing in living conditions that create, maintain and protect health³⁰.

The quality of a country's public health very often has a direct relationship to the country's level of economic wealth, with the wealthiest countries usually registering higher life expectancy, lower infant mortality rates and better quality of life. Low income is related to poorer housing, poorer diet, fewer social amenities, and worse working conditions – all detrimental to a person's mental and physical health.

On the other hand, improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness³¹.

Quoting William Pollard, *"Information is a source of learning. But unless it is organised, processed, and available to the right people in a format for decision making, it is a burden not a benefit."*

Deliverables should be made more visible. Delivering public health information to policy makers doesn't necessarily lead to action, unless findings are politicised and newsworthy. A possible way of writing a report and receiving more attention is to stress the repercussions of not acting on something or else by accentuating the advantages of implementing change. Another way of increasing impact is to give an economic flavour to public health reports i.e. include financial implications of acting or not acting. However health topics cannot always be assigned a monetary value.

The importance of more cooperation between users and producers is indisputable; however do we have the necessary resources to make it interactive? Quoting one of the participants, *"It would be futile i.e. rising expectations in vain, if we invite the*

³⁰ Kickbusch, Ilona (1989), *"Good planets are hard to find."* Copenhagen (WHO-EURO, Healthy Cities Papers, No 5), 13

³¹ World Bank (1993), *"World development report 1993"*. New York (Oxford University Press)

voluntary organizations to put forward their suggestions when we know that we don't have the capacity and means to help them." In a small country like Malta, with a limited number of experts and the same people wearing many different hats, work always goes around the same circle of people.

NGOs work at grass root levels and they can effectively help to shift responsibilities. In many European Countries, there is a vibrant feeling that citizens want to be more and more involved in the decision-making that affects directly their health. Information is power. Public health reporters should feel obliged to offer more user-friendly information and to provide the space and infrastructure for NGOs, the media and the general public to contribute.

Apart from NGOs who undoubtedly contribute towards social and economic change, following certain comparative/coercive studies, many times the EU is being the main catalyst for change. In Malta, the EU helped to finance a number of research projects, amongst which the European Health Interview Survey.

Consequently, maintaining closer links between PHR providers and users makes it much easier to realize an impact especially when policy makers are already interested in a problem.

The role of the media in realising a higher policy impact is essential. There should be more trust and reliance between public health experts and journalists. It's important for public health reporters to keep journalists as their collaborators, however many times the media rather than going after what's most important, it tends to run after what's most sensational. While adhering to its duties and informing the general public, the media needs to develop a stronger social conscience.

Quoting a public health expert who contributed to this study, *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."* It is only through health research leading to more evidence – based policy making that the enjoyment of the highest attainable standard of health can be accomplished.

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Annex 4.6: England

Claire Bradford

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1. Introduction

There is a long tradition of public health reporting in England. These have mainly focused on mortality statistics reports. Prior to the 19th century in London Bills of Mortality were the main source of mortality statistics, designed to monitor deaths from the plague, they ran from the 1660's to 1830's. From the 19th century on there have been an increasing number of regular public health reports including³²:

- Annual report of the Register General for births deaths and marriages in England
- Medical Officer of Health reports
 - 1847 first MOH report by William Henry Duncan (for Liverpool)
 - 1848 Public health act establishing posts of MOH in local authorities
 - 1856 first annual report of the Chief Medical Officer of Health
 - 1972 Local Government Act brought post of MOH to end
- Director of Public Health reports

In the 21st century there are a number of producers of public health reports for a wide range of audiences. They include:

National	Regional/local
Department of Health	Primary Care Trusts
Health Protection Agency	Health Protection Units
Association of Public Health	Strategic Health Authorities
Observatories	Public Health Observatories
King's Fund	Local authorities

Health policy in England is determined centrally and implemented at regional and local level. Regional and local NHS organisations are required to use centrally allocated funds to commission services to improve health and reduce health inequalities locally.³³

³² http://library.wellcome.ac.uk/doc_WTL038911.html

³³ www.dh.gov.uk

2. Methodology

2.1 Procedure for interviews

As required, two group interview events were planned in early 2007. For England there were to be one “national” event based in London; with representatives from national organisations and central government, and one “local” event in the north east of England with representatives from regional and local organisations. Despite apparent interest in the study from invitees it was not possible to arrange a group event with sufficient participants for either of the proposed groups. The pressure of work commitments were the main reason in those willing to take part. It was therefore decided to undertake a series of one to one interviews. By conducting only one to one interviews there was individual in depth discussion and analysis of the interview questions. However, this format did not allow for interaction between participants as would have occurred in the group scenario.

2.2 Interviewees

Eleven “one to one” interviews were undertaken. The characteristics of the interviewees are summarised in table 1. There were 5 users, 2 producers and 4 who were both users and producers. 6 respondents worked at local or regional level, 4 at national level and 1 at both local and national.

All participants took part in the interview after giving signed informed consent. They all commented that it was an interesting topic. This may well indicate that those that agreed to take part were a highly self-selecting group.

2.3 Analysis

All interviews were transcribed and the results made anonymous. All interviews were then analysed based on the structure of the interview guidance and key points identified.

The report includes references to the transcribed interviews. The first number in the bracket refers to the interview number and the second number the paragraph from the interview.

Table 1 Characteristics of interviewees

ID	Role	Organisation	National/local	Relation to PHR	User/producer/both
1	CEO	Primary Care Trust ³⁴	Local	CEO of organisation responsible for improving health and reducing health inequalities	User
2	Director	Public Health Observatory	Regional	User and producer of PHR at local regional and national level	Both
3	Civil Servant/Epidemiologist	Government Department	National	User and contributor to PHR at a national level	Both
4	Public Health Physician	Health Protection Agency	Local	Producer & contributor of PHR	Producer
5	Director of Public Health	Primary Care Trust	Local	Producers of annual director of public health reports and other public health reports.	Both
6	CEO	Primary Care Trust	Local	CEO of organisation responsible for improving health and reducing health inequalities	User
7	Manager	Centre for Public Scrutiny	National	National support for local government scrutiny	User

³⁴ Primary Care Trust in England is the organisation responsible for commissioning health care and working to improve the health and reduce the health of the population it serves.

				of health and healthcare	
8	Public Health Physician	Government Department/Primary Care Trust	National & Local	Implementation of national intelligence strategy. Public health consultant at Primary Care Trust.	Both
9	Public Health Physician	Public Health Observatory	Regional	Writing, editing PHR. Using PHR at regional level e.g. strategic development	Producer
10	Civil Servant/Health Economist	Government Department	National	Responsible for improvement in health and delivery of healthcare at national level.	User
11	Civil Servant	Government Department	National	Director of National Knowledge Service	User

3. Analysis of interviews – Users analysis

Users of public health reports (PHR) want access to clear concise reports that meet the needs of their organisational objectives e.g. demographics, patterns of ill health, effectiveness of programmes to reduce common diseases, quality of life issues (1,10;2,3). If it is not possible to have a clear concise report that is understandable by the non-public health specialist/general manager they need access to a specialist who can interpret the information rather than have to read and interpret a lengthy detailed report.

3.1 Satisfaction with current situation by users of PHR

Users are reasonably satisfied on the whole with the provision of PHR. However users view PHR as frequently being historical in nature and giving insufficient information on current situation. (7,8) To be effective for users PHR need to contain both the historical context, the evidence base of what works and the current situation. (7,8)

Users identified that the main topics of PHR are on health improvement/health promotion. There are perceived gaps in health inequalities, primary care information and support for commissioning for population health. (6,8; 10,3) There is inadequate health inequality information at smaller geographical/population groups or communities. (6,12) English health profiles were stated as being good examples of effective PHR (7,12)

3.2 Information needs of users of PHR

The major information needs are geographical and at regional and national levels. Regardless of how big the population being assessed users and decision makers need to know:

1. Health of the population
2. What inequalities there are?
3. What can be done to improve the situation (10,5)

Users usually get national level data from Public Health Observatories (PHOs) and the Department of Health Statistics/Public Health Departments. Good examples of PHOs acting at national level include London Health Observatory ethnicity work and Yorkshire and Humber Public Health Observatory diabetes work. (10,6)

Users at local level use local public health teams and the public health observatory for information on local population and comparisons to other populations. Good examples include

- English community health profiles for good standardised quality data to all across England.(1,12;10, 6)

- National/specialist reports for disease specific information e.g. APHO indications reports. (1,12)

There is a risk that only data owned by health service is used in reports when important public health data may be available for other government departments or local agencies. (6,17) For national work, users identified a need for high level information at that level to pick up trends and priorities e.g. toolkit for Smokefree England. (7,12) For local action users identified a need for information at as small geography as possible particularly if to support community development and leadership role of local government in addressing health inequalities. (7,12) PHR are important for assessing health impact of interventions (6,15)

The national Health profile of England³⁵ and local English health profiles³⁶ are extremely useful as they provide local/regional and national picture and can be used for bench marking and comparison enabling the sharing of best practice. (10,12)

Of minor importance or even counter productive for users are highly technical public health reports. This is not because the subject is unimportant but because the message is presented too technically so that is it only understood by specialist public health professionals and not wider professional or public groups. Communication of the message then becomes an issue of use of professional language. (1,14;2,7)

“If there is not an easy translation it does not get digested, becomes professionalised and the dissemination potential is lost. The message has to be simple.”

PHR are perceived by users as being very large and very statistical and written for specialist rather than generalist audience. (7,8)

There is incomplete information currently in terms of public health economics (1,23; 1,39;4,2) This leads to difficulties in targeting resources effectively to the groups most in need.(6,12)

Local registers of congenital birth defects result in good national level reports (by CESDI and CEMACH) but are hard to use at local level. (10,11)

Effects of PHR at a national level are slow to have demonstrable effect on health improvement activities and health investment priorities. (1,41;. 4,4)

3.3 What could be done to make supply of information more supportive?

PHR are used for developing/setting priorities, policy proposals, assessing the impact of policy options and evaluating policies, identifying spending priorities. (1,17; 6,12)

³⁵ <http://www.renewal.net/Documents/RNET/Research/Healthprofileengland.pdf>

³⁶ www.communityhealthprofiles.info

PHR are used to understand population status and how it might change, morbidity and mortality, disease prevalence. PHR are used for picking priorities for health scrutiny at local level by local government and looking for new ideas and insights into what has happened in other parts of the country. (7,15)

“Public health information is a science in itself and often lay people have difficulty in understanding technical and scientific information from other groups so it’s needs to be simple and articulated at level that is meaningful for the decision makers”

“English Health profiles are good because they are simple brief and had a nice balance between graphical information and textural information” (6,21)

There are two main issues for users to make information more supportive for users these are: the use of information and secondly the clarity of the message.

Use of information

In order for audiences to be able to receive information from PHR there is a need to prepare the professional environment in order to ensure that the audience is able to understand its value. (1;62; 6,21) Very few people in general management in the NHS have public health training and skills. (6,21) There is a danger in over professionalising information handling skills. It may be better if generalists are used to present PHR to a general non-specialist audience.(1,62) Organisational boards are very reliant upon other people preparing briefings for them. The quality of these reports is very important in terms of both style and content.(6,35)

The increased availability of tools and datasets on the web may increase the use and understanding of population data but only if it is accompanied by appropriate training. There is a need to use data better; there are lots of data collected that are not used. (10,18) Key gaps in population data availability include primary care and ethnicity. (10,18) There is also a need to make sure that there are effective minimum population datasets including ethnicity so that data can be used effectively. (10,19)

Users identified that there is probably a lot of unused information that could help public services improve health. It isn’t used because outputs are not easily digested. It would therefore be better to have less academic presentation and also ensure that those in the NHS workforce have a better understanding of public health issues.(1,52)

There are lots of different data collection systems but it is usually very difficult to link them together to get the added value from the information. (10,20)

Clarity of the message

Users need to be involved at an early stage in identification of topic for PHR in order to make sure that the most important local topics are covered in local PHR. E.g. local government to develop relationship with PHOs so as to be able to influence the work programme. (7,38)

Plain simple English is required for PHR. Authors of PHR need to recognise that there is lots of complexity in the information but effort is required to make it readily understood. This is a complex task but it is possible and an example of this is the English health profiles. (10,15)

PHR need to be accurate and understandable and suitable for a wide audience. (10,16) PHR must have a clear message with technical backup in terms of quality assurance of the data and validity/accuracy. (10,16)

The format for the delivery of information depends on the audience. If it is for a non-specialist audience then it should be a combination of text and the most significant data. (1;4;6,17)

The traffic light system may be overused in the UK but can be very helpful in identifying areas that need to seek further information to understand why the performance is either so much better or worse than comparators. (7,28; 7,30) It is best to have a simple written document that can be presented by the expert and issues discussed in person – “*after sales service*”. (7,32)

There is a need for better signposting of good quality PHR on the web so that people can find public health information when required. (7,44) At present in the UK, public sector organisations may be paying to access public health information that is already publicly available and free but because they don't know where to look, and end up paying using tax payers money. (7,50) Better marketing of PHR information and data sources is required. (7,52)

Impact of PHR on public policy making

It is important that there is evaluation of information and previous action so that decision makers can understand what has or has not worked and why. (1,46;6,33)

National public policy on smoking is an area where there has been enormous change over the last 5 years with a programme of action now having a positive impact on health. However, childhood obesity and alcohol abuse are areas that there has been less public health reporting until relatively recently.(1,41)

Health impact studies on smoking, breast feeding and flu vaccinations in a local area identified the need for action particularly about targeting the most deprived neighbourhoods. As a result of the studies interventions were put in place. (6,33) At a local level regular public health analysis and reporting was used to implement a plan to target those areas most in need and track and measure the resultant improvement over 5 years. (1,41) Policy evaluation has been used to identify local delivery of diabetic retinopathy screening services and provision of infertility treatment.(1,46) A national consultation exercise can also be used to develop local plans based on evidence of best practice from elsewhere in the country. (1,46)

Further examples of effective PHR on policy making at nation level include Wanless report and the Choosing Health white paper. (10,22)

Technical work at Department of Health is leading to public service agreement targets relevant to health and wellbeing. (10,23) One area that needs to be improved is public health economics.(1,39)

Interaction between producers and users of PHR (user view)

There is a wide spectrum in the public health profession of ability to synthesis key messages and get them over to an audience.(1,62;6,47) Similarly there are some key decision makers in public policy who are unable or unwilling to take public health messages on board. Therefore, on both sides there are risks to the message failing.(1,62) In general terms, this means that more resources in terms of time and effort are required in synthesising both a clear and simple message and preparing the audience to receive it and understand it.(1) One way forward would be to have regular interaction between both the users and producers of PHR.(1,62) An alternative would be to ensure that non-public health professionals were involved in commissioning PHR.(1,62)

Within public sector organisations in England the public health function is not always as integrated into the activities of public sector organisations. Individuals may select areas of interest that are potentially of academic interest rather than being key organisations priorities. At a local level public health specialists have not been sufficiently engaged with the commissioning agenda.(6,47) However because public health includes such a wide range of topics it can be difficult for an organisation to have ready and reliable access to public health expertise in all topic areas.(6,47)

In order for the interaction to work well at a local level there is a need for both qualitative and quantitative information and expertise and skills that can interpret information and apply knowledge to the issue that is being considered. Written information cannot replace good quality skilled public health specialists in an organisation.(6,49)

There is a need to make sure that the audience is involved in the preparation of reports at an early stage to make sure that it is what they want/need and that it will be capable to addressing the questions/needs that they have.(6,49)

At local level the annual report of the director of public health provides an opportunity for interaction with decision makers and wider audience. (10,37) The quality of the resulting interaction is more important than the written document. Audiences need to understand the content and therefore it is crucial that public health professionals are able to interpret the information in an appropriate way for their audience.(10,37) Public health professionals need to engage with both policy makers and communities. (10,38)

4. Producers analysis

4.1 Satisfaction with current situation by users of PHR

At a national and regional level supply and quality of reports is good.(9,31, 3,6) PHR usually good technically but poorly marketed. (11,6)

There is a huge amount of information available and waiting to be used. But it is imperfect, often incomplete and can be difficult to interpret once analysed. (2,6) There is an important role of Public Health Practitioners (PHPs) to use data that is currently available whilst advocating for a better range and completeness of information. (2,6) Within the NHS there is a vast amount of information which is used in inefficiently and ineffectively in the production of PHR. (9,6) There is a lack of strategic production of PHR leading to inadequate data availability, duplication of effort. (9,6) The huge depth and breadth of knowledge from PHR results in difficulties in access for users. (8,8)

There are important gaps in information for PHR at local level and small population groups either geographical or other communities. There are also gaps in long term condition morbidity areas e.g. musculoskeletal, neurological disorders and mental health problems. (8,8) However, there are a number of areas where there is access to good information for PHR including cancer, infectious diseases and mortality information. (8,8) There can be a lack of standardisation of reporting of health surveillance information due to different organisations being involved in health protection surveillance producing reports in different formats. (4,6) It can be difficult to know what type of information is useful for users as opposed to what producers think is useful (4,6)

Vast epidemiological reports with lots of data are probably of no use to the audience that PHRs are trying to influence. Decision makers might be unable to discern how good or bad the picture is or what should be done next.(5,6)

PHRs may be used by a complex range of users in terms of geographical area, skills, reasons for using reports etc. This can result in concern that PHRs do not address all the needs of users. For example, at a local level there is often a desire for small area analysis as well as very recent data which can be extremely challenging to fulfil. (9,31)

4.2 Information Needs

Comparative information

PHR reports are important for assessing performance related to agreed standards and in comparing organisations and populations. (11,8; 8,10)

PHRs also supply information to compare differences in health within communities and geographies. This is important because local organisations may have the power

to change the relative deployment of resources within their sphere of responsibility (8,10) For example by looking at the difference in health of individual sub-areas of its population there may be a needs based redeployment of primary care resources. (8,10)

Support for commissioning

PHR need to supply information on effective and cost effective public health interventions including housing, regeneration as well as health care based interventions. (8,11) PHR should inform the commissioning of health improvement for population. (5,8) Commissioners need headlines of chapters of Director of Public Health Annual Report (DPH AR) backed by appropriate evidence to show that the investment or reallocation of resources will make a difference. (5,8) PHR information also required for performance management/target delivery. (5,8)

Ideally information in PHR should be used to inform the commissioning of services, ensure that appropriate services are in place. However at present PHR may not actually provide the right kind of information to fulfil this role. The provision of PHR should be more active. (4,10)

Resources used

PHR reports are important for assessing the impact of policy implementation, horizon scanning, raising awareness and helping prioritisation. (11,9)

PHR can be broadly be used at two levels. Firstly, producing information to be analysed and interpreted in greater depth by the customer and secondly to undertake the analysis and interpretation and produce recommendations based on the finding to be used by the customer. (9,33)

PHR at a national level are used by professional audience for identification of a key problem and the intervention required where that is relevant to their area of work for example Chief Medical Officer reports. (3,11) The Health profile of England provides professional audiences with key facts and figures with a limited amount of commentary but lots of illustration. (3,11)

PHR utilisation depends on the audience. The general public need evidence based information on which they can make informed choices. (3,13) The professional audience also need evidence based information but in more detail with data, analysis and references. (3,13) The London Health Forecast is based on whether London agencies are implementing national policy and what impact hat with have on their ability to reach national targets. (2,9) A quarterly public health performance indicator set is published for all PCTs in London. (2,9) This enables PCTs at a glance to see how it is performing in comparison to the rest of London, the neighbouring PCTs.

Resources that are not used or are perceived as unhelpful

There is a risk that users will try to use a single PHR for multiple purposes, which it was not designed to do and can lead to problems. For example if a local PHR uses a

lot of synthetic estimates this might be useful for raising awareness and advocating for more resources. However the same indicators cannot be used for time trend analysis or setting performance targets because the methodology of synthetic estimates does not enable trend analysis or use for performance targets.. (9,10) Therefore it is vital that there purpose of the report is clear to the potential user.

Due to lack of strategic delivery of PHR at a local and regional level there can be confusion with different data sets being used, different timescales etc. This can be a problem for users and produces concerns about quality assurance and reduces confidence in the product. (9,16; 5,13)

PHR with information about an area that an organisation can do little to influence are likely to be unused. (8,13) Audiences may be less interested in personal reflections of authors and want to get to the detail of actions required or recommendations. (4,12)

All information can be useful however it depends on how it has been presented on whether it is used by the audience. Key issues are whether audience has been consulted before PHR produced and whether producers overestimate the level of understanding of the audience. (5,13)

Hospital episode statistics and their analysis have been reported as disappointing because of the perception that the data are not timely enough to be useful for commissioners and providers. (2,11)

4.3 Utilisation of PHR

Most PHRs that are effective are used for advocacy in strengthening a position. (9,33, 2,20) An example of this is using information on mortality and morbidity of alcohol related problems at both local and national level as a tool to improve strategic planning and allocation of resources to tackle the impact of alcohol on public health. (9,35)

Utilisation of PHR reports might be greater if different sectors were able to join to gather their organisation information e.g. police and health service in producing alcohol profiles. (5,15) Users are often looking for certain information in a PHR but it will be different information depending on their needs e.g. police or local authority might use PHR to assess local alcohol licensing applications.(5,15)

Although access to data and data analysis tools via internet is important especially for PHPs; decision makers want a concise written report which

“they can slam down on the table at a meeting and carry around in a brief case.”
(9,35)

At a local level decision makers will look to annual reports of public health and health profiles as the main first reference point for information about the health of their population. (8,16; 2,20)

Specialist PHRs have a role in informing users of considered view of new or future issues relating to population health. (4,16) This is as an important role as descriptive historical information. (4,16) Health protection PHRs are seen as useful sources of information on infection rates, trends of infection and information related to vaccine preventable diseases. This might be difficult to put in a concise report so producers need to consider enabling access to more detailed information for those who want in e.g. via internet. (4,14)

In England so much policy is centrally driven that locally PHR can only be used within the context and direction of the national policies. Therefore PHR are used to support the implementation rather than development of policy proposals. (5,21) At local level in the NHS evaluation is undertaken of action plans rather than policies. This is because the policies are set nationally. (5,24) Sometimes PHR are said to be evaluations of policies but in fact are statements of what has been done not the impact. (5,24) Evaluation of policies locally therefore is an area which is underdeveloped. This is for a variety of reasons including the imperative to get onto the next policy without sufficient time being given to evaluation of what has gone on before. (8,31) Health profiles can be used as evidence in health impact assessment of impact on small geographies. (2,20)

Local authority officers and members will use PHR for information as well as ideas and insights and to support need for local action. (3,19)

PHRs can be used for performance management of PCTs and health care provider's e.g. mental health. (2,20) PHR can be use to support health impact assessment process especially taking into account existing inequalities issues. (2,24)

The general public may use PHRs in order to make informed choices about their own actions. (3,19)

4.4 Effects/impacts PHR

An effective PHR is one which clearly identifies needs and interventions and it can be a very powerful tool with demonstrable impact on decision making and resource allocation. However, it needs to be well produced and well presented. (8,18; 3,23) This is particularly important in highly controversial and political situations for example reorganising of acute healthcare services. (8,21) Effective PHR is an opportunity for organisations to market their work as well as new threats to population health. (4,28; 3,23)

Organisations need to have confidence in their PH leaders if they are to use PHR with confidence and as a basis for decision making and resource allocation. (8,23; 3,23)

Health equity audit can be used for development of policy proposals e.g. public health analysis of needs with regard to the provision and deployment of primary care. (8,25)

It is important that PHR review and evaluate the impact of previous reports as public health often is a long term agenda. (3,27) The review of recommendations and monitoring of progress are both integral parts of good PHR. (3,27) It is possible to have measurable hard outcomes from implementation of effective PHR. For example; improvement in primary care for patients after they have had a heart attack. It is possible to monitor uptake for prescribing of aspirin and statins as well as a reduction in subsequent heart attacks. This was implementation of public health driven policy about cardiovascular disease with measurable effects. (8,33)

PHR can identify key areas for action but then need a business case to demonstrate what action will deliver and resources required. (5,28) Too often PHR will identify issues and what needs to be done but does not close the loop to show the evidence of effectiveness (or not) of the intervention. (5,28)

4.5 Delivery of information

“PHR should be like a layered wedding cake with a fairy on the top that doesn’t take up much space and everyone knows what it is.” (2,26)

Multiple formats are important and the format must depend on the customer. (11,11; 3,33, 2,26) Therefore with a targeted approach the customer will get which ever piece of the “layered cake” which is appropriate to their need and skill at interpretation.

Producers need to balance the ability to present information in a way that is useful for the user in terms of timeliness and smaller communities with the opportunity cost of the time taken. (4,30) Producers need to be clear as to the purpose of the PHR in order to make sure that the balance is right between effort and effectiveness. (4,30) Producers of PHR don’t do enough thinking about their audiences or asking them formally whether they understood the message or how it could have been done better. (5,30)

Sometimes PHRs use too many statistics and not enough pictures. (5,30) If PHRs are too sophisticated, the message gets lost. (5,30) Occasionally PHRs will think that the information has all been heard before, however, PHRs should remember that there are always new audiences, or those who have not understood the message. (5,30)

There is no one single method of delivering the message in a PHR that is adequate of itself. PHRs need to use a variety of methods both written, presentational and web based. (8,35; 3,33) A DPH annual report has been produced which was all presentational based with presentation material and handouts rather than a paper report and this evaluated well. (8,35)

4.6 What can be done to make health information more supportive?

It is important that producers are aware that many customers “*need what they don’t want and want what they don’t need*”. (11, 13) Producers of PHR need to make time to communicate with the audience. (2,28) Producers need to clarify with the user what they need to know so that producer can identify correct data and analyse it appropriately to help answer the need/question. (2,28) Producers and users of PHR need to try to speak the same language. (2,28) PHRs must be clear about what their objectives are and demonstrate how these have been met. (11,14)

Producers need to recognise that health information in PHR is important to a range of government agencies beyond the Department of Health. Also other non-health departments have access to information which is important to the public health and should be included in PHR. (9,12; 5,32)

The use of more user friendly formats can be highly effective e.g. children and young people reports..(5,32) Health protection PHRs can be used by a broad audience and it is difficult to do this with a single format report. (4,32) In terms of monitoring infections control there is probably value in short regular automated reports for organisations with responsibility for the delivery of effective infection control.(4,32)

PHRs need to be targeted to the organisations that have an ability to influence the outcomes. (4,32) PHRs at local level should contain local relevant information to be meaningful to users at the local level. (3,37) PHRs need to be linked to commissioning timetable in order to be able to influence the delivery of services. (4,32)

There are some crucial gaps in the availability of information at both a national and local level e.g. smoking prevalence at local level, breast feeding data. It is not clear however how the PH community can influence the collection of this information at a national level so there are robust high quality data sets for use across the country and not relying on small surveys. (9,37) There is a need to have single source of information for PHR as at moment there are a number of places where producers of PHR might be able to find information. (8,38)

Users of PHR need to be better skilled at interpreting common forms of PHR graphics and more consistent use of language to describe common PH issues e.g. risk. (8,38)

England now has an Information and Intelligence strategy³⁷ which is looking at improving the collection and use of information in order to meet user’s needs. (3,39)

³⁷

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075488

At national level there is a good system of reporting on health surveys, risk factors and health outcomes. At a local level there is a less systematic approach and this has resulted in an absence of good information on some critical risk factors at a local level. (3,39) Inequalities information at a local level could be improved especially about socio-economic inequalities and ethnicity and age inequalities. (3,39) There is a need to include international comparisons of information. One locality may be the best in the country but relatively poor in comparison to Europe so sometimes need to both look to smaller geographical areas as well as wider comparisons. (3,37)

5. Impact of PHR on public policy

Director of Public Health annual reports can be used as both a tool and a weapon in the war against disease and health inequalities. (11,15)

In order to increase the effectiveness Director of Public Health reports there should be integration of public health information into the core of the health and healthcare commissioning team. (11,16) The reports should provide the required information and evidence leading to the production of a knowledge based commissioning plan. (11,17)

At local level a report on asylum seekers and health identified an area where there was little knowledge or understanding. The report was able to identify some important recommendations a number of which have been implemented. (9,40)

Chief Medical Officer for England's (CMO) reports are very focussed topics with explicit recommendations and actions. (3,51) They can act as a catalyst in change, developing and changing policy. They can also highlight both problems and solutions. (3,51) A good example is the Chief Medical Officer for England's report (2002) on passive smoking and banning smoking in public places which had an impact on the passing of legislation to ban smoking in public places in England. (8,46; 4,36; 3,51)³⁸

Health protection PHR on surveillance programmes have informed vaccination and screening programmes. (4,36) Avian flu planning is an example where national and international information has identified a need for action. (5,41)

Department of Health Inequalities unit has done some detailed work to identify actions that health organisations should take to have an impact on inequalities. (5,41) Health impact assessments as a form of PHR may influence public policy development. (9,42)

38

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_400643

2

5.1 Factors influencing utilisation

Table 2 shows summary information in factors influencing utilisation of PHR for both users and producers

Table 2

Users	Producers
<ul style="list-style-type: none"> • Affordability • Relative value for money, • Acceptability to cohort or wider community of policy proposal • General political climate (1,50) • Timing of publication of reports (7,62) • Level of marketing of reports (7,52) • Negative influences include large complex reports and the lack of expertise and time to digest and understand the messages by non-public health specialists. (6,35) • Information for performance management (10,27) 	<ul style="list-style-type: none"> • Drive, leadership and commitment of individual PHPs. (11,19; 4,36) • Timeliness as perceived by users. (9,46; 4,36, 3,53) • Timeliness in terms of organisational readiness to make change recommended by PHR (8,42; 4,36) • Received by the right audience who are in the position to change policy (3,53) • Receptiveness of audience to message (8,44; 8,48; 3,53) • Strength of message – needs to be presented clearly, be evidence based including evidence about effectiveness. (8,4; 3,53) • Politics at national and local level (,44) • Resource allocation (5,44) • National targets (5,44) • Organisational stability (5,44)

5.2 Legal & administrative regulations concerning supply and utilisation of PHR

In England there are a variety of regulations related to data and information but these are not specific to PHR. A summary is shown in table 3.

Table 3

Regulation relating data and information
<p>Data protection Act (1998)</p> <p>Freedom of Information Act (2000)</p> <p>Copyright</p> <p>Research ethics committees</p>

Information standards board for NHS
Information Centre – guardian of information
Caldicott guardians – supply of information
Data protection act & Disclosure rules (2,30)
Freedom of information act (2,30)

There has been a statutory responsibility for Directors of Public Health to produce an annual report. However there appears to have been little enforcement of this in the past and no requirement that organisations take action based on the content of the report. A legal imperative is probably not helpful. A legal requirement is unlikely to change hearts and minds of decision makers.(8,52)

5.3 Interaction between users and producers of PHR (producer view)

PHRs need to think of knowledge as a commodity and then they need to market it in the same way as other commodities.(11,23) Good communication, evaluation and feedback required from users to producers to ensure quality improvement of PHR in future.(4,50; 3,66)

To improve interaction producers need to ensure that PHRs are targeted to users and this probably requires a number of different formats for each different audience e.g. commissioners vs. general public. (4,44, 3,66) Producers need to do their best to have a good understanding of what their audience expectations and requirements are as well as the level of their audience understanding of public health. Producers and users need to have an early common understanding of what the PHR end point/objective is so that the PHR is produced to meet agreed outcomes. (4,48,3,66; 2,37)

A good PHR will have both meaningful analysis and information on effective action to be taken and specifying who is to take the action. (2,38) A good DPH annual report can be a core document for multi agency strategic planning for health improvement at a local level. (9,24; 8,56; 2,38) However this requires high levels of inter-organisational; trust and respect. The most influential PHR are the ones that are done when the organisation needs it and this might not be every year especially if the planning cycle is for example three yearly. (8,56)

If a Primary Care Trust does not have an effective DPH annual report then the organisation cannot have an effective programme of work to improve the health of the population. (11,25) The clear split between commissioner and a range of different providers may have an impact on interaction. The challenge is for

commissioners to use PH information in their commissioning process effectively. (5,48)

5.4 Other comments

In England there is an increasing market place for health information with PHR reports being produced by both public sector organisations as well as commercial companies. This can result in difficulties for users to understand the strengths and weaknesses of different sources of PHR and adds in an additional; factor for reduced effectiveness of PHR. (9,26)

Health profiles can be used very effectively with new organisations to highlight areas for action using routine data. (2,42)

6. Summary of findings

To be effective PHR should:	<ul style="list-style-type: none"> • Describe the health of the population • Identify health inequalities • Identify what can be done to improve the situation • Be clear and concise and avoid jargon • Be readily accessible (internet & short portal reports)
Information in PHR should:	<ul style="list-style-type: none"> • Be high quality and timely • Use all available data sources
Producers of PHR should	<ul style="list-style-type: none"> • Ensure PHR are written for the target audience • Ensure that clear language is used • Work with policy makers in advance of producing PHR to understand their requirements • Evaluate effectiveness/impact of PHR • Work to reduce the gaps in public health information e.g. effectiveness/cost-effectiveness, smaller populations

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Annex 5.1: Conference Flyer

Answer by fax:
Please register by August 15th 2008.
The number of participants is restricted on eighty.



Expert Meeting

The "Policy Impact" of Health Reporting: Opportunities and Challenges

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Date: September 4th 2008

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Expert Meeting
Invitation and Programme



The "Policy Impact" of Health Reporting: Opportunities and Challenges

September 4th 2008, Düsseldorf, Germany



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NRW Institute of Health and Work (LIGA.NRW) European Public Health Centre (EPHZ)	The 'Policy Impact' of Health Reporting: Opportunities and Challenges	
<p>Outcomes of the EU Project "Policy Impact Assessment of Public Health Reporting" (PIA PHR) (funded by the EU Commission, Grant Agreement No 2004109)</p> <p>Over the last twenty years, health reporting has undergone substantial developments in the EU – at the European, national, regional and also at the local level. The range of information services has expanded considerably.</p> <p>Experiences with the opportunities and challenges of providing audience targeted information to support decision-making processes were collected and previously discussed at several international meetings on health reporting in Bilthoven / The Netherlands (1998), Berlin / Germany (2001) and Bielefeld / Germany (2003).</p> <p>The project "Policy Impact Assessment of Public Health Reporting" analysed factors influencing the "policy impact" of health reporting. It considered different concepts and requirements of health reporting activities in six European countries and at different decision-making levels (local, regional and national). At the expert meeting, which is also the final project conference, the outcomes of the project and current development plans including innovations and challenges of health reporting in different European countries will be presented.</p> <p>The meeting is designed for both decision makers for improved population health and those active in health reporting.</p> <p>The conference language will be English.</p>	<p style="text-align: center;">Programme</p> <p>11:00 – 11:15 h Opening / Welcome Dr. Kerthara Lehmann, President of the NRW Institute of Health and Work (LIGA.NRW), Germany</p> <p>11:15 – 12:00 h Between monitoring, policy advising and innovation management: Factors influencing the "policy impact" of public health reporting Prof. Dr. Helmut Brand, Maastricht University, The Netherlands</p> <p>12:00 – 12:45 h Break (Lunch)</p> <p>Effective Health Reporting: Examples and Problems</p> <p>12:45 – 13:05 h North Rhine-Westphalia: Indicator based health reporting with interactive tools Dr. Wolfgang Hellmair, LIGA.NRW Germany</p> <p>13:05 – 13:25 h England Regional Intelligence for health improvement Dr. Claire Bradford, North East Public Health Observatory, United Kingdom</p> <p>13:25 – 13:45 h France Do changes in the public health system imply changes in PHR activities and their policy impact? Dr. Bernard Lédret, Fédération Nationale des Observatoires Régionaux de la Santé, France</p> <p>13:45 – 14:00 h Break</p> <p>14:00 – 14:20 h Malta Promoting a high Public Health Policy impact in the small island state Amanda Sajo, Ministry of Finance, the Economy and Investment, Malta</p>	<p>September 4th 2008</p> <p>14:20 – 14:40 h Hungary: Health reporting and health reforms Csilla Kaposvári, TARKI Social Research Institute Inc., Hungary</p> <p>14:40 – 15:00 h Ireland On the situation of health reporting Prof. Dr. Anthony Staines, Dublin City University, Ireland</p> <p>15:00 – 15:30 h Break (Coffee)</p> <p>Supporting Effective Health Reporting: Projects and Instruments</p> <p>15:30 – 16:00 h The importance of regional public health reporting activities in Europe in the light of regionalisation and devolution in the UK Prof. Dr. John Wilkinson, North East Public Health Observatory, United Kingdom</p> <p>16:00 – 16:45 h Information, ideas and arguments for investments into health and regional developments: Presentation and discussion of an application based on the project "Policy Impact Assessment of Public Health Reporting" Dr. Kai Michelsen, LIGA.NRW, Germany</p> <p>16:45 – 17:00 h Conclusion and outlook Prof. Dr. Helmut Brand, Maastricht University, The Netherlands</p> <p style="text-align: right;"><small>This programme will be updated at www.pia-phr.nrw.de.</small></p>

Annex 5.2: Opening

Eleftheria Lehmann

Ladies and Gentlemen,

Dear colleagues,

it is a pleasure to welcome you to our expert meeting in the premises of LIGA.NRW here in Düsseldorf. This meeting is the final conference of the EU-funded project “Policy Impact Assessment of Public Health Reporting”.

Restructuring Public Services is a main objective of the NRW government. The merger of the former Institute of Public Health and the State Institute for Occupational Safety and Health into our NRW Institute of Health and Work at the beginning of this year is a mark of this reform process.

Both institutions have had a tradition in health monitoring. For LIGA.NRW this issue is also an important area of activity. We are not only interested in watching current developments at the European, national, regional and local level. We have an interest to be engaged too. In doing so

We want to discuss experiences about the opportunities and challenges linked with monitoring health issues and having an impact on policy making.

We want to support mutual learning and profit from it.

And we want to participate in shaping the future of public health reporting as far as our work is involved.

Ladies and Gentlemen, over the last decade, there has been growing awareness that more and better information and knowledge considering public health issues is needed to support policy making. Some driving forces may explain the growing interest, i.e.

Upcoming changes in the population's health

Rising attention paid to prevention and health promotion, *and last but not least*,

Struggling for quality, effectiveness and efficiency of the health system

The social dimension of health has also become a major issue:

The World Health Organisation brings the interrelations of health and wealth into focus.

Both the new EU Health Strategy and EU Structural Funds Policies address the links between health, economic growth and employment

We must take the challenge to narrow health inequalities within and between states!

The growing interest in information and knowledge about the population's health offers a big chance for health monitoring. And beside this, enhanced health statistics and new technologies offer further opportunities to disseminate high quality information as a prerequisite for what we call "good governance":

Reporting on population's health means

In a more **technical sense** to deliver an information platform for discussion and sound decision making

In a more **political sense** to legitimise these decisions by rooting them in high quality information and the best available knowledge and to assure transparency.

It can be an important tool for governance if it supports the development of a common understanding and the achievement of a better cooperation and coordination between the many actors involved in managing health systems, prevention and health promotion.

Similarly, at the EU level the "open method of coordination", if applied to health policies, needs an encompassing foundation of information and knowledge to discuss targets, to think about strategies and how to meet them.

It is well understood that "learning from each other" and stimulating activities call for data comparability and indicators within and between Member States and regions.

Ladies and Gentlemen, in the Member States, investments in health statistics and reporting on population's health have been undertaken and the Public Health Programmes have been used to fund respective projects. Some of these projects are represented at this conference. Please take a look at them during the breaks and use the possibility to discuss the work and the findings with those who have been so kind not only to attend but to support this meeting with information about their projects.

There are also many challenges connected with health monitoring. The major challenge is to meet the needs of target groups, e.g. potential users/beneficiaries of health monitoring, and not at least to satisfy those who decide about the allocation of resources and investments in reporting on population's health.

The discussion about challenges is not new. The subject has been addressed at various conferences and meetings in the past e.g. in Bilthoven ten years ago, in Berlin in 2001 and in Bielefeld 2003. The fact that reporting activities rely on health statistics and that health statistics are a necessary precondition but not sufficient to make a policy impact is also documented by a number of presentations and workshops.

For institutions working in this field it is very important to prove that reporting on population's health is a valuable tool and that investments are justified. Therefore,

We must look for ways to satisfy the information needs of target groups.

We must convince decision makers that reporting on population's health is a tool of high value by proving its capacity and performance.

We must learn from past and current experiences.

We must explore the opportunities new technologies deliver for innovations in reporting on population's health.

Our discussion about opportunities and challenges should at the same time reflect differences in strategies, health systems, health policies and decision making structures between states and geopolitical levels. And we should think about strategies to promote the effectiveness and efficiency of reporting activities by working on mutual learning as well as horizontal and vertical integration.

In short: We must make the best out of restricted and sometimes scarce resources.

I hope that this meeting with the discussion of findings from the European funded project "Policy Impact Assessment of Public Health Reporting" and the discussion of the experiences from six European countries will be supportive in this respect.

Let us take up some ideas which enable us to move forward in achieving a high impact on policy making in public health.

Thank you for your attention.

Annex 5.3: Between monitoring, policy advising and innovation management: Factors influencing the ‚policy impact‘ of public health reporting

Helmut Brand

1. Background

The opportunities for public health reporting (PHR) activities have become better. But still there is the question how reporting on population's health can and should be configured. It has to be clarified how PHR activities are placed between health statistics, monitoring and policy counselling. It has to be analysed how to meet the needs of different audiences and to disseminate information effective. Opportunities and challenges to support policy making have to be analysed. Expectations to realize a policy impact by PHR activities have to be clarified.

The project "Policy Impact Assessment of Public Health Reporting" is geared towards developing a methodology for PHR activities and a health information tool box which supports those being active in PHR to realize a policy impact. It is funded by the EU Commission (Grant Agreement N° 2004109) and aims

- to understand decision-making processes, needs, expectations of different user groups in different European countries on the national, regional and local level;
- to learn about appropriate and effective ways of disseminating information and knowledge and
- to enhance the policy impact of PHR activities
- to develop a respective tool box for those being active in reporting on population's health.

2. Methods

Literature about interface problems between the production and utilization of scientific knowledge and research has been studied. An online-survey about the as-is state of characteristic features of public health reports and respective activities and their importance in principle has been conducted followed by guideline based in depth and group interviews. Interviewees were representatives of relevant target groups and people being active in reporting on population's health from the local, regional and national level in six European countries (France, Germany, Ireland, Hungary, Malta, United Kingdom). They were asked about their satisfaction with the supply of PHR activities, their utilization of PHR resources, examples of PHR activities which had a high / low policy impact, factors influencing the policy impact, contributions of PHR activities in the policy cycle, priorities for the further

development of PHR activities and possibilities to support those being active in reporting on population's health.

3. Findings

Public health reporting activities are placed between health statistics and other sources to create new information and knowledge and policy counselling. The major aim is to integrate existing information and knowledge in a conceptual frame and disseminate it to different target audiences. Beside target groups it is decisive that PHR activities satisfy the aims of commissioners of PHR activities. Reporting activities are a first step to translate, transform and amalgamate scientific based knowledge for practise, like policy making (health policy reforms, programmes) or other kinds of decision making, but in many cases further steps are necessary.

The findings from the interviews show differences between PHR activities, related with different opportunities and challenges to realize a policy impact. There are a) specific national circumstances, b) differences between the local, regional, national level, c) PHR activities which are conducted in a more political or managerial environment and d) different links between reporting activities and policy making with influence on dissemination strategies. Those differences influence the utilization of information and knowledge from PHR activities (information, ideas, arguments).

Information and knowledge from PHR activities must be accessible, intelligible, confidential, able to raise attention and delivered timely. Beyond others, the impact of reporting activities is influenced by factors similar to those addressed in innovation theory. Political needs and interests might differ from public health professional's perspective. People with political responsibilities try to prevent the emergence of political pressure which can be the result of PHR activities. There can be a struggle over the control of PH knowledge and reporting activities.

Preconditions for effective PHR activities are adequate resources, health statistics and other information sources. People being active in PHR can be supported by the delivery of "models of good practise" (process, design of products, concepts, methods, utilization of new technologies) and activities to support the development of good practise (cooperation, mutual learning). Cooperation between institutions at the same (e.g. local) level is helpful. It is possible to foster a process of specialisation and division of labour: The development of conceptual approaches, "example reports" and the more ambitious work with health statistics could be delegated to certain institutions which deliver forms for others. Also should "higher" levels (regional, national, European) take care about the conceptual work, the availability and comparability of data and support a comparative approach. The possibilities to compare points in time, populations and regions should be improved. They allow an assessment about the status quo, illustrate gaps, illustrate that something could be better situation and build up political pressure to do something. It would be helpful to

work on the comparability of information delivered by different reports, e.g. about different local entities.

PHR reporting activities should support people to get an impression of the magnitude of a problem to help them in setting priorities. If possible, they should clarify how people are affected by health problems. To deliver information for the local level seems strongly to motivate for action when possibilities for intervention exist. But until now the local level seems to be often the weakest. At all levels the concepts for PHR activities / reports should reflect existing decision making structures to bridge the gap between professional public health perspectives and policy making.

A promising approach to bridge the gap between scientific knowledge and practise is to organise communication between target groups to prepare the commissioning of a report (to specify why a report is being commissioned and which questions should be answered) and to organise a second round where the findings of the preliminary report are presented, interpreted and discussed (to develop a common understanding, draw conclusions, develop recommendations for action) from different perspectives, professional backgrounds, different kinds of scientific knowledge and expertises. The results of the second round should be added to the final report. This strategy links the analysis of problems and the development of a common understanding with the presentation and discussion of possible solutions and delivers the foundation for an evaluation of the implementation of interventions.

The dissemination strategy should incorporate dissemination activities by those commissioning the report, interest organisations and the media. Professional public relations strategies are necessary to prevent misunderstandings and secure an adequate presentation of findings of a report by the media. Beside a dissemination to target groups, for an assessment of a policy impact it has to be considered that information and knowledge reach decision makers on intricate paths. Also, beside “active” dissemination “passive” dissemination is very important. People looking for specific information should be supported to satisfy their needs. To support the dissemination through different channels it should be easy for people to use existing indicators, statistics, charts and graphs for their own purposes (e.g. further reporting activities).

4. Conclusions

Even if it is possible to enhance the chance to realise a policy impact by supporting those being active in PHR by adequate investments in resources and the development of a tool box, there are further and maybe more important factors with influence on the policy impact beyond the sphere of professional reporting on population’s health. The transfer from scientific knowledge to knowledge for action and the effective dissemination of findings from PHR activities should be supported by those commissioning PHR activities and other stakeholders with expertise for policy making.

Annex 5.4 North Rhine-Westphalia: Indicator based health reporting with interactive tools

Wolfgang Hellmeier

Health information is an important subject within the tasks of LIGA.NRW. A permanent working group of the institute is working on this topic. The group maintains a data base about different aspects of health in NRW, monitors several indicators of health in NRW using the data base and presents health reports of different types, ranging from elaborated textual products to tables of indicators. Main users are policy makers on state level – mainly the Ministry of Health – and public health specialists in local health authorities. The information should also be understandable and interesting for the general public.

LIGA.NRW presents tables of indicators on the web since 1991 using the framework of the common indicator set of the German states. Gradually bar charts and maps were added. These indicators are meant for users who want to do their own analyses without having to use the individual data. Especially public health specialists from local health authorities use the indicators for local health reports.

During the last months a new tool has been increasingly used for the presentation of indicators on the web. The tool provides some “templates” where each template contains several different modules, e.g. bar charts, time trends, maps, etc. All modules of a template are linked and by moving the cursor about one of them, the corresponding parts of others are highlighted. This feature enables the user e.g. to start with the region at the top of a bar chart and to identify the region at the map immediately.

LIGA.NRW presents different templates, useful for different analyses. Main aspects are

- description of regional profiles by some key indicators,
- simultaneous analysis of time trends in different regions,
- correlation of two selected indicators over the regions presented,
- funnel plots to assess the significance of regional deviations from the state average

Taking these templates together, they offer the main elements of health reports in condensed format: They show deviations from the state average, regional comparisons and trends. Target values for certain indicators may also be included if they exist. The templates offer much more information than non-interactive maps. One can look for details which would not be mentioned in a textual report and it is very easy to identify outliers, where a certain health problem is urgent or where prevention programmes should be installed with high priority.

In the future LIGA.NRW will develop the templates further. We will include textual information for an indicator and for individual regions and we will offer links to related products on the web.

Annex 5.5 England: Regional intelligence for health improvement

Claire Bradford

“Health data are essential for monitoring the health of the population and for evaluating the effects of health interventions. Yet the information collected nationally is often poor and there is no regular mechanism by which a PCT or LA can gather reliable information on its own population.” (Wanless 2004)

Information and intelligence are vital if decisions for health improvement and healthcare are to be robust and evidence based. Information is required both to assess the state of a population’s health and to evaluate effects of any intervention provided. Information should be available at the appropriate population level for the decision makers. Depending on the problem this might be at any level from national through to neighbourhood or even at a personal level.

In England the regional level is currently that described by the government offices for the regions. These offices represent 11 Whitehall departments and are the primary means by which a wide range of government policies are delivered to the regions. For the National Health Service there are 10 Strategic Health Authorities (the South East Government region is split into two Strategic Health Authorities). The majority of commissioning of healthcare and health improvement is however carried out by Primary Care Trusts which are generally co-terminous with local authorities and each SHA will have a number of Primary Care Trusts. In England the Public Health Observatories are co-terminous with the Government offices for the regions. Information and intelligence is therefore available at a number of different geographic/population levels in England. For the purposes of this paper the focus will be on what is available at the regional level.

Regional Indications Reports

The Association of Public Health Observatories was commissioned by the Chief Medical Officer for England to produce a series of Indications of Public Health In the English Regions reports on the state of public health in each region. The subjects covered to date have included: ethnicity and health; child health; mental health; alcohol and older people. Two future reports will be on substance misuse and communicable disease. These reports undertake an in depth analysis of the data available on the chosen topic and facilitate easy comparison across the English regions using a variety of graphical representations. The information on these reports have helped to steer health policy.

Health Profiles

Health profiles were first published in 2005 in response to the identified need for easy access to quality health data for decision makers at local authority level. They have now been updated for the third time with the 2008 publication. Health Profiles provide a snapshot of health for each local council in England using key health indicators, which enables comparison locally, regionally, nationally and over time. They are designed to help local councils and the NHS decide where to target resources to tackle inequalities in their local area. The 2008 publication include for the first time an in-depth regional analysis of the indicators including a “tartan rug” display, local variations analysis and a spine chart for the region. There is also for the first time an interactive website to facilitate further local analysis.

Joint Strategic Needs Assessment (JSNA)

“Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in the light of existing services, and informs future service planning taking into account evidence of effectiveness.” It is a statutory duty for local councils and primary care trusts to undertake JSNA and it will lead to stronger partnerships between communities, local government, and the NHS, providing a firm foundation for commissioning that improves health and social care provision and reduces inequalities.

Collection and interpretation of the dataset required is an challenging task. Although JSNA needs to be done at a local level in many regions expertise and resources are being pooled to ensure timely access to a robust dataset. APHO has produced a resource pack to help with the key challenges of this duty.

Regional Health Intelligence Networks

Health intelligence capability can be seen as a scarce resource in many regions in England. This and the requirement of effective and efficient working practices has led to the development of regional public health networks in a number of the English regions. These have generally been led by the PHOs.

Public Health Intelligence North East (PHINE) is a new concept to help get the best possible use of the regional health intelligence resources. It is led by staff in NEPHO and all health intelligence analysts and public health specialists are eligible to join regardless of their employer. The aims of PHINE include: providing effective links between information specialists/analysts in the region; creating a basis for sharing of expertise and good practice; avoidance of duplication and completion of an agreed work plan.

Challenges of regional intelligence in England

There are a number of well developed reporting mechanisms for regional intelligence within England. However the challenge as always is to ensure that the resources used to produce the intelligence are used both effectively and efficiently. Therefore there must be clarity as to the purpose of regional analysis and comparison, there must be clarity about who the target audience is for the information and that it is presented in an appropriate manner for the decision makers. There must be clarity about data availability and quality so that the decision makers understand the basis of their informed decision. Finally the challenge for public health specialists is to ensure that the message of the regional analysis is clear and targeted at those with the authority and power to make changes necessary to improve health and reduce health inequalities.

Annex 5.6: France Do changes in the public health system imply changes in PHR activities and their policy impact?

Bernard Ledésert

In France, it's important to keep in mind that, particularly since the 17th century, the political organisation of the country is centralised with an important role of the central administration on the implementation of the different systems, the health system being also concerned.

More recently – ie since the mid nineties – France have experienced different health reforms giving more power at the regional level, those different reforms having an impact on the public health reporting (PHR) activities.

Firstly, in 1996, Regional Health conferences, constituted by 200 to 300 different actors in the political, administrative and professional fields related to health were implemented. The activities of the conference were based on annual meeting allowing the identification of health priorities at the regional level and the implementation of Regional Health Programs under the responsibility of the representatives of the national health administration at the regional and departmental level. At the same period, the health reform conducted to the creation of Regional Hospitalisation Agencies (Agence régionale de l'hospitalisation – ARH) in charge of the planning and the organisation of the hospital care under the control of the Health ministry and of the Regional Social Security Unions (Union régionale des caisses d'assurance maladie – Urcam) in charge of the planning and organisation of the ambulatory care under the control of the central social security organisations.

In 2004, the public health law clearly specified that the Health policy is defined at the national level and it's the responsibility of the Nation. With this law, health programs and health priorities are defined at the national level for a 5 years period. Health targets are defined in an annex of the law. Under the advice of a reformed Regional Health Conference, the representative of the government at the regional level elaborates a Regional Public Health Plan, implemented by the Regional Public Health Group (Groupement régional de santé publique – GRSP).

A new reform, under preparation, will conduct to the creation at the end of 2009 of the Health Regional Agency (Agence régionale de santé – ARS), grouping all the previous regional agencies and groups to harmonize at the regional level the different aspects of health policy (prevention, ambulatory care, hospital care, rehabilitation ...).

Those different reforms had an important impact on the PHR activities.

Before the 1996 reform, the public health reports were mostly elaborated at the national level, presenting national data and figures and giving a comprehensive view of the health status of the population and the health care system.

Circa 1996, we observed the introduction of comparisons of the national data with other countries and the development of regional reports with comparison firstly with the national level and secondly with the other regions. An harmonisation of the regional reports was conducted.

The 1996 reform conducted to the development of the regional health reports in order to select regional health priorities and to the development of specific reports linked with the national and regional priorities.

In the process of preparing the public health law of 2004, public consultation were organised at the regional level with an impact on PHR activities. Different aspects can be highlighted:

- A better coherence between national, regional and infra regional levels;
- The reinforcement of a territorialized approach of Health Priorities;
- The reinforcement of the capacity to determine Health Priorities and Health Programs at the regional level;
- The determination of long-term objectives;
- A better capacity to make diagnosis of the health status of the population at the local level.

A national group of experts was constituted in 2002-2003 in order to define a few number of health targets. As the group was composed of experts of the different health fields with a limited number of public health experts, 100 targets were defined.

For the following of the health programs and health targets defined by the law, changes in PHR activities were noticed both at national and regional level. The PHR activities are now organised in order to produce updated data linked to the targets.

At this time, it's difficult to predict the impact of the coming reform on PHR activities.

In conclusion:

- Due to the changes in the health system, an evolution of the PHR activities was observed
 - From a general description of the health status of the population
 - Trough a comparison with the national / European level and the other regions of the country
 - To reports focused on a large number of health targets
- PHR activities are an information tool to support decision making by the public administration (Regional Health Conference, Regional Hospitalisation Agency, Regional Public Health Plan ...)
- The definition of health target have an important effect on PHR activities
- There is a collaboration between the national , regional and local levels for PHR activities

There is a positive impact of a good description of the health situation on the process of decision making

Annex 5.7 Malta: Realising a high public health policy impact in a small island state

Amanda Salib

1. Maltese Health Information – A Historical Glance

Since the 14th century the Maltese Islands have been graced by a series of hospitals. It was especially during the reign of the Order of the Knights of St. John (1530-1798), renowned for being great *hospitalliers*, that healthcare gained its momentum. Even if designated as charitable institutions, these hospitals soon became dependent on state subsidies, catering especially for the poor and the neediest with not enough money for subsistence.

First demographic data dates back to 991, while population counts made during the period of the Knights of St. John were conducted in association with the importation of grain from Sicily free of export duties³⁹. Civil registration of births was introduced in Malta by Napoleon Bonaparte in 1798, while mortality statistics by cause of death started to be published regularly by the Chief Police Physician, in 1872 under the British rule. A Government Notice issued in 1871 required all physicians and surgeons to submit information to the Superintendent of Police of any communicable disease. Traces of maternity data dates back to as early as 1841⁴⁰. Originally the main intention of collecting health-related data was purely administrative and budgetary; nonetheless, especially from the 20th century onwards public health data began to be mostly utilized to support various health services.

An important development took place in 1986, when the Department of Health in conjunction with the WHO introduced a computer-based Individual Health Profile aimed as a person-based record for all patients who made use of government medical services, with the aim of providing readily available clinical information to medical practitioners on the patients they were treating, of scheduling appointments and follow-up procedures, of managing immunization and other preventive programs, and of conducting surveys and research. This profile was eventually evolved into the Patient Administration System still in use today.

Especially during the past 2 decades, in Malta as in the rest of the developed world, many activities have been launched to generate and deliver health information.

³⁹ Savona-Ventura C.: Civil Hospitals in Malta in the last two hundred years. *Historia Hospitalium*, 1998-99, 21:p.45-63

⁴⁰ Ibid.

Advancement in medicine, technological development, higher patients' expectations, an ageing population, further quests for evidence-based decision-making and European Union membership are amongst the most important drivers of health information.

2. Research Package

For the first Delphi Survey, in Malta approximately 38 persons took the interest and contributed. Considering that Malta's population size compared to the other participating countries is minute, our response rate was very successful - more than 50% response.

When it comes to the focus groups and in-depth expert interviews, locally 48 interviewees⁴¹ took part mainly on a national level. Among the persons who took part, one finds public health experts, consultants, professional associations, health NGOs, journalists, health administrators, private hospitals, clinicians, psychiatrists, nurses, social workers and politicians.

The two main limitations of this research project were:

- a. The under-representation of national politicians; and
- b. The absence of participants on a regional and/local level of health reporting⁴².

3. Realising a high Public Health Policy Impact

Health is a cross-cutting issue and it tends to go into all policies. Consequently it becomes paramount to look at Public Health from a more holistic viewpoint. There seems to be a general consensus that the quality of public health data in Malta compares well on the international arena; however it is significant to have more timely and visible deliverables, channeled in the right manner and to the right people. Ownership of Health Information tends to be fragmented. For the sake of more integrative and complete data, there needs to be more liaising between the different Ministries, departments, agencies and other sources of information.

For Public Health Reporting activities to receive more attention:

- Every health care professional should realise that his/her work is not just diagnosing and treating the patients, but collecting the data regarding patients right after that patients have been seen and diagnosed.

⁴¹ 15 persons - 1st Focus Group; 14 persons - 2nd Focus Group and 19 persons - Face-to-Face in-depth interviews

⁴² Owing to the fact that in Malta one can say that we have only one tier of government – central government, it was difficult to find participants from the local & regional level. When it comes to national politicians several attempts were done to convince a number to participate, however in most instances it was unsuccessful.

- PHR reports should not only be data-driven but should also offer a good deal of recommendations for action.
- Simply delivering the information to policy makers doesn't mean that there will be action. Action is usually taken when issues are politicized.
- Health Information needs to be published in a way that is newsworthy.
- There should be more journalists who are specifically trained to report public health issues.
- There should be more frequent organisation of health conferences and seminars.
- Policy Makers need to have a closer relationship with health producers so that information is made available in an easy and efficient way.
- More independence in public health reporting.
- Less ad hoc reports and more routine and repeated reports.
- Reports should not only highlight facts but also indicate the way forward to redress the situation.
- There should be 'popular summaries' to be understood by the public and also by policy makers who are not in the remit of health. Many times it's the public that pushes for policies and changes.
- Use of more shocking advertising especially in the case of preventive advertising.
- Ultimately more funding has to be committed towards Public Health Reporting.

There was a general feeling that unfortunately in Malta many times it is crisis intervention, were a mishap has to arise for the authorities to act. More often than not politicians act when the public is frustrated; however the problem is that the public is not really well informed. A higher level of impact can be realized when both the media and voluntary organisations pay attention to the public health problems identified by PHR and publicize their findings. Past experience shows that when a public health report is disclosed to the press then the impact is guaranteed. In the words of one of the participants, *"If you want politicians to act then leak it to the press, your head will roll but at least action will be taken."*⁴³

There seems to be a mismatch between producers and users of public health and there needs to be more liaising. Conferences, focus group events and joint research projects are alternative ways of enhancing communication. It is important to make people aware of each others needs, expectations, strengths and weaknesses. There was a general critique that most of the health reporters just sit down and write the

⁴³ Quoting a PIA PHR participant

report, without seeking whether there is a factual need for such information and what the users expect.

4. Concluding Remarks

Public health is the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being. Public health acts on the knowledge that health is a fundamental resource to the individual, to the community and to society as a whole and must be supported by soundly investing in living conditions that create, maintain and protect health⁴⁴.

Quoting William Pollard, "Information is a source of learning. But unless it is organised, processed, and available to the right people in a format for decision making, it is a burden not a benefit."

⁴⁴ Kickbusch, Ilona (1989), *"Good planets are hard to find."* Copenhagen (WHO-EURO, Healthy Cities Papers, No 5), 13

Annex 5.8 Hungary: Health reporting and health reforms

Csilla Kaposvari

In Hungary, health sector reforms go back to the second half of the 1980s. The transition period of the 1990s introduced larger-scale health sector reforms as well. The health care sector reform that aimed at changing the former, highly centralized, state socialist model resulted in a more pluralist health care system with responsibilities divided between various players. The most recent health care reform wave had a focus on improving quality, cost-effectiveness, equity and accountability. The reform steps from 2006 among others aimed to cover the areas of reforming the health insurance system, the hospital and health care structure, the introduction of a co-payment system, pharmacy liberalization and many other changes. As national consensus was not achieved, major elements of these were cancelled. A new government program to continue reforms on a slower speed have been introduced.

Periods of health reforms are seen as posing heavy demand on the health information system to provide timely and accurate information for the planned changes. The existing health information system on the other hand developed with a smaller speed and apart from some notable changes had many difficulties to provide the necessary information if needed.

The PIA-PHR research

There were two focus group interviews conducted in Hungary, one in national level and the other on regional/local level. Participants were both from public health report producers and users from different types of institutions.

Some main problems that were identified by the PIA-PHR interview participants:

Satisfaction with health reporting among interviewees in general was mixed. Apart from certain areas that were seen positive such as long tradition of data collection on death, infectious diseases were mentioned while reporting was found weaker for complex issues and in the area of evaluation, forecasting, impact assessments that would support more activities like planning and policymaking. The health information and reporting system was seen fragmented with many actors and parallel activities. Users and producers seemed to have mix-matched expectations. While producers voiced that information needs are often not clearly defined or known in the system that makes their activities difficult, user expressed that the level of analysis often simple, data oriented and not always appropriate for decision-making or the targeted groups. Not enough time, capacity and funding was mentioned to be as a set back in public health reporting activities. Reporting activities were seen irregular and underdeveloped especially in the area of health status, such data from national health surveys. Interviewees also pointed out the weaknesses of the public policy culture that is characterized by the importance of informal relations, rare evaluations,

weaker accountability and transparency as well as sometimes lack of interest and/or demand and/or skills in uptake of information in the policymaking processes. According to the PIA-PHR research, health reporting in general did not have a strong policy impact.

On the other hand, new developments and improvements can be seen in health reporting that were brought by the reforms. Just one example to mention: The newly set up Health Insurance Supervisory Authority developed and introduced a national indicator and reporting system for health care quality and performance measurement and a series of health reports with topic of interest.

Annex 5.9 England

The Importance of Regional Public Health reporting activities in Europe in the light of regionalisation and devolution in the UK

John Wilkinson

The United Kingdom is a complex country – or set of countries. The UK comprises four countries, namely England, Wales, Scotland and Northern Ireland. Over the past twelve years, devolution of powers has become a prominent feature of UK politics. When it came to power in 1997, the current labour government gave a commitment to hold referenda in the devolved countries on the question of whether to establish more powerful (elected) government institutions in each of the four countries, The government also gave a commitment to consider the development of directly elected regional assemblies in England.

Scotland and Wales both voted in favour of devolved powers in their respective countries, although the proposals for a Welsh Assembly Government did not go as far as the proposals which were on offer in Scotland. Although it was interesting to note that the Scottish referendum did not favour devolving tax raising powers to the Scottish Parliament. The situation in Northern Ireland was radically different because of the long history of violence in the country and although the concept of a power sharing assembly was agreed in the 'Good Friday Agreement' of 1999, it wasn't until 2007 that a power sharing executive was set up which seems destined to last – there had been previous attempts but these had all been short – lived.

England is also complex. In the end the government decided to hold a referenda in one region only (the North East) - where the proposal was rejected. There have been many reorganisations of the management of the health care system in recent years. There is now a strong focus on a market approach with a purchaser provider split which is not a concept accepted in Scotland or Wales (but is in Northern Ireland). In England the responsibility for assessing health needs and commissioning healthcare lies with (152) primary care trusts, which also have responsibility for primary care. These bodies are unelected; all have a director of public health. Many of the directors of public health are joint appointments with the local authorities. This is important for two reasons, local authorities are democratically elected and secondly although not responsible for health care, do have responsibilities for ensuring the well being of their populations.

At a regional level in England are structures which also can have a major impact on the health of the population. These are the Regional Government Offices – which hold representatives of central government at a regional level, their regional development agencies – which are responsible for promoting economic development

in their regions and the regional assemblies. The regional assemblies are currently undergoing change and by 2010 will have been abolished and replaced by Regional Chambers. These will comprise a membership of the democratically elected councillors from local authorities in the region.

What are the implications for health reporting?

The existence of a director of public health in every primary care trust often in a combined post with the local authority is hugely significant. In addition each Director of Public Health is statutorily required to produce an annual report of the health of the population and to present it at a public board meeting of the Primary Care Trust. At regional level, there is also a regional director of public health which is a combined post in most cases with the Strategic Health Authorities which also operate at regional level and are responsible for the performance of the health and healthcare system in each region.

The local authorities and the primary care trusts are therefore used to receiving information on the health of their populations.

What is becoming more apparent is the importance of making comparisons not only within the United Kingdom, but further afield. Health problems are similar in all parts of the UK, though of course worse in some parts compared to others. Most European countries are also facing up to similar problems. However, we know that there are lessons to be learnt from different parts of Europe. England has one of the highest teenage pregnancy rates in Europe, particularly when compared to Holland. The obesity epidemic does not appear to have hit France to the same extent of other European countries. At the same time, we know that national averages hide important differences.

If we take England as a case study, the health in the South East of England is consistently better than the North East. But what is of importance for the South East to be aware of is, is the way in which its common health indicators appear against similar regions in Europe. To emphasise the importance of making European comparisons, one region in England recently decided to set health targets that would be the best in Europe.

Health reporting is intensely political, in the UK; there is considerable sensitivity about the differences in health measures between the four countries of the UK.

The European context is a highly important arena for health reporting. Not only does the EU have a formal competency in public health, it is also a major funder of health programmes, and what is more important is the economic support it is able to give to regions as the recent WHO⁴⁵ report from the Commission for Social Determinants

⁴⁵ World Health Organisations. Closing the Gap in a Generation. Geneva 2008

emphasised the important link between health and the economy. To this end projects such as PIA have a great importance in understanding the differences in approaches between member states. Links to other projects such as ISARE and I2SARE which are identifying a common set of health indicators at a subnational level are also hugely significant if we are to achieve social justice in Europe in the years to come.

Annex 5.10 Information, ideas and arguments for investments into health and regional developments

Presentation and discussion of an application based on the project „Policy Impact Assessment of Health Reporting“

Kai Michelsen

1. Background

Linkages between health and wealth are analysed, e.g. in WHO publications. The opportunities and challenges to link investments in health with economic growth, employment and strategies of regional development are discussed. Framed by the Lisbon Agenda, those issues have been integrated in the EU Health Programme and in EU Structural Fund policies – beyond others to promote competitiveness and employment by investments in health technologies, to support regional development by investments in health services, to close health gaps within and between states and to master the consequences of demographic change (healthy ageing, healthy workforce).

EU Structural Funds which support regional development have indirect influence on health and can be used for direct investments in health. To set public health issues on the agenda and to support sound decision making (including assessment, policy formulation and evaluation) regional information about economic and social conditions, health and the health system as well as ideas and knowledge about policy options are needed.

2. Aim

To link public health issues with strategies of regional development is still an innovative approach. It is necessary to deliver and disseminate information, ideas and arguments. Besides public officials, respective lobby groups, the media and the interested public are relevant addressees for agenda setting. To compare the own region with others can support the willingness to act and allows mutual learning from experiences. There are information gaps for some regions and areas of interest. The information needs concerning the utilization of EU Structural Funds might support the interest to close the gaps.

Following the findings of the EU funded project “Policy Impact Assessment of Public Health Reporting”, a pilot-application is being developed to support decision making about investments in health by EU Structural Funds. “To support” means to motivate for action, to raise attention for the possibilities to use EU Structural Funds for investments in health, to give ideas and arguments about problems and approaches for solutions (where to invest), to deliver information about the procedure for applying

for budgets from the EU Structural Funds, to deliver information for the proposal and its evaluation by decisions makers. Also, such an application should support the discussion about linkages between health and wealth or economic growth and employment.

3. Approach

The work on a pilot-application which is based on interactive, geo-demographic software has started. The application will give examples to deliver information about health, economic and social conditions for NUTS regions and allows comparisons between regions. It will provide guidance to handle the application and to interpret the information delivered. It will inform about policies and programmes already being in place and thereby about possibilities to use the EU Structural Funds for investments in health.

The application will include links to other information sources provided by the EU commission, projects funded by the EU commission and others, e.g. EUROSTAT regional statistics, ESPON, ECHIM, ISARE, EUPHIX, Profiles of the Regions etc, European Observatory, DG REGIO, DG SANCO etc.

The application is conceptualised to support “work in progress”. Until now there are large deficits in regional statistics. But probably there are enough indicators to stimulate at least some activities. Also it is possible that such an application motivates PH professionals to close the gap. The conceptual work (which indicators are important; how to interpret them?) has also to be continued. Discussions about the application and a discussion forum as part of the application will be supportive for the further development.

To use geo-demographic software offers new possibilities for PHR activities, e.g. at the European level. It is possible to describe problems, trends and issues at general (European) level and combine this with guidance for an interactive online applications which allow the interested audiences to take a look at the status of their country, region, maybe also municipality. European reports could be combined with the possibilities to compare regions and produce regional and local reports, thereby contributing to a flexible utilization of information and the dissemination of local information in line with users needs.

Annex 6: Tool Boxes to bridge the gap between research and policy making

Nicole Rosenkötter

According to the grant agreement a „tool box” should be designed as an additional outcome of the project. The “tool box” should support public health professionals and the realisation of a policy impact by PHR activities. In the following different tools and already existent tool boxes are compiled. They address mainly the issue to realise a policy impact with research and scientific knowledge. The recommendations are not always in line with the findings from the project PIA PHR: It is questionable if people being active in PHR can be or should become policy entrepreneurs by themselves. But it is also sure that policy entrepreneurs are needed. It is a major question who is supposed to bridge the gap between research and policy making.

As mentioned by Stone et al. (2001) checklists are often developed according to the model of a policy cycle which displays a linear line from knowledge generation to knowledge utilisation. Although this assumption is often criticised as unrealistic, the following compilation of items from different checklists can give advice of activities which might facilitate a policy impact. Several bullet points of the checklist below were mentioned as supportive in the interviews conducted in the project PIA PHR, others were controversial.

Research Creation and Policy Analysis

- Evaluate quality and timeliness of research
- Evaluate contribution of research to policy debates and public policy problems
- Identify critical gaps in policy knowledge
- Engage potential users of the research in defining research questions
- Evaluate how research contributes to policy in a utilitarian way as well as to knowledge advancement and ‘enlightenment’
- Review the progress of research periodically
- Maintain excellence and research standards

Communication and Dissemination

- Understand policy makers information needs
- Construct research results in a way that makes ideas useful (eg. timely reports, use of non-technical language, executive summaries, etc.)
- Develop clear policy recommendations in research product

- Promote policy entrepreneur skills
- Develop a systematic dissemination strategy (including advocacy and campaign techniques)
- Build channels of communication (web-sites, publications, media liaison, etc)
- Organise workshops, conferences and other public or professional events
- Tailor research products to different audiences
- Target findings to user groups or stakeholders

Knowledge Utilisation

- Understand the policy process
- Build relationships of trust with subjects and users of research
- Develop links and networks with politicians and bureaucrats in policy communities
- Involve decision makers and managers in implementing, monitoring and interpreting the study
- Help build capacity within government to absorb research
- Encourage public debate and the involvement of the subjects of research in data collection and interpretation.

Besides those checklists, a whole bunch of checklists and strategies to disseminate research findings into policy can also be found in other documents dealing with knowledge translation and dissemination. Valuable information can be found in

- Start D, Hovland I. (2004): Tools for policy impact – A handbook for researchers. London: Overseas Development Institute
http://www.odi.org.uk/rapid/Publications/Documents/Tools_handbook_final_web.pdf

This handbook includes for examples tools for supporting communication or for influencing policy. A main checklist with items relevant for gaining a policy impact can be found in the following table:

What researchers need to know	What researchers need to do	How to do it
<p>Political context:</p> <p>Who are the policymakers? Is there policymaker demand for new ideas? What are the sources / strengths of resistance? What is the policymaking process? What are the opportunities and timing for inputs in formal process?</p>	<p>Get to know the policymakers, their agendas and their constraints Identify potential supporters and opponents. Keep an eye on the horizon and prepare for opportunities in regular policy processes. Look out for – and react to – unexpected policy windows.</p>	<p>Work with the policymakers. Seek commissions. Line up research programmes with high profile policy events. Reserve resources to be able to move quickly to respond to policy windows. Allow sufficient time and resources.</p>
<p>Evidence:</p> <p>What is the current theory? What are the prevailing narratives? How divergent is the new evidence? What sort of evidence will convince policy makers?</p>	<p>Establish credibility over the long term. Provide practical solutions to problems. Establish legitimacy. Build a convincing case and present clear policy options. Package new ideas in familiar theory or narratives. Communicate effectively.</p>	<p>Build up programmes of high quality work. Action research and Pilot projects to demonstrate benefits of new approaches. Use participatory approaches to help with legitimacy and implementation. Clear strategy for communication from the start. Face-to-face communication.</p>
<p>Links:</p> <p>Who are the key stakeholders? What links and networks exist between them? Who are the intermediaries, and do they have influence? Whose side are they on?</p>	<p>Get to know the other stakeholders. Establish a presence in established networks. Build coalitions with likeminded stakeholders. Build new policy networks.</p>	<p>Partnerships between researchers, policymakers and policy end-users. Identify key networks and salesmen. Use informal contacts.</p>
<p>External influence:</p> <p>Who are main international actors in the policy process? What influence do they have? What are their priorities? What are their research priorities and mechanisms? What are the policies of the donors funding the research?</p>	<p>Get to know the donors, their priorities and constraints. Identify potential supporters, key individuals and networks. Establish credibility. Keep an eye on donor policy and look out for policy windows.</p>	<p>Develop extensive background and donor policies. Orient communication to suit donor priorities and language. Cooperate with donors and seek commissions. Contact (regularly) key individuals.</p>

Source: Start (2004)

Moreover, other methodologies like health needs assessment (HNA), health technology assessment (HTA) and health impact assessment (HIA) aim to gain policy impact and have developed tool boxes which are useful for public health reporting. Handbooks on HTA for example provide useful information and tools

- to assess the evidence in scientific literature,
- to conduct a peer review of reports
- to interact with the media

They also describe the decision making process and list facilitators and barriers for decision making. Strategies for researchers are proposed to influence the decision making process:

- Kristensen FB, Sigmund H. Health Technology Assessment Handbook. Danish Centre for Health Technology Assessment, Copenhagen 2008
http://www.sst.dk/publ/Publ2008/MTV/Metode/HTA_Handbook_net_final.pdf
- Garrido MV, Kristensen FB, Nielsen CP, Busse R. Health Technology Assessment and health-policy making in Europe – current status, challenges and potential. WHO 2008 <http://www.euro.who.int/Document/E91922.pdf>

Other checklists and tool boxes have been developed for community health assessments. These tool boxes are coming predominately from the US. They handle issues like how to prioritise community health issues, to identify and mobilise resources or to take actions to facilitate change:

National Association of County and City Health Officials (NACCHO). Mobilizing for Action through Planning and Partnerships (MAPP). NACCHO. Washington 2008
<http://www.naccho.org/topics/infrastructure/mapp/index.cfm>

Public Health Foundation. Healthy People 2010 Toolkit – A fieldguide to health planning. Public Health Foundation. Washington 2008
<http://www.healthypeople.gov/state/toolkit/>

New York State, Departement for Health. Community Health Assessment Clearinghouse. New York State Health Departement. Albany 2008
<http://www.health.state.ny.us/statistics/chac/>

A trend to easy accessible online health data can be recognised. These databases contain raw data or visualise the data to support health monitoring. On international level gapminder (www.gapminder.org) is impressive software to visualise for example health indicators and economic data. Further sources are:

- New Cronos, Eurostat (www.eurostat.eu)
- OECD Health Database (www.oecd.org)
- Health for all database of the WHO, Regional office for Europe (www.euro.who.int/HFADB)
- Regional Statistics – Eurostat regional yearbook 2008
http://epp.eurostat.ec.europa.eu/pls/portal/url/page/PGP_MISCELLANEOUS/PGE_DOC_DETAIL?p_product_code=KS-HA-08-001

The EU Health Portal offers access to many documents and statistics (http://ec.europa.eu/health-eu/index_en.htm). Furthermore, DG SANCO funded projects like ECHIM (European Community Health indicators; <http://www.echim.org>, <http://www.healthindicators.org>) or ISARE (Health Indicators in the European Regions; <http://www.isare.org/>) develop indicator sets or compile health indicators relevant for European health monitoring on national or regional level. EUPHIX, the European Public Health Information and Knowledge System, presents structured European public health information and gives a special insight into similarities and differences between EU Member States (www.euphix.org).

But also on national and regional level similar activities can be recognised. The Netherlands have for example huge experiences in providing commented health data (National Public Health Compass, Dutch Health Atlas). Online accessible databases sometimes also with commented health information) can be found in various countries (e.g. Austria, Belgium, Czech Republic, Germany, Hungary, Norway). On regional level for example North Rhine-Westphalia (Germany) provides online accessible tools which visualise health data for health monitoring and health comparisons.

During the project PIA PHR a collection of national and regional public health reports established by the predecessor project EVA PHR was expanded (www.pia-phr.nrw.de). Reports can be searched by country or by topic (keywords). National online databases or information systems were also added.