World Health Organization
REGIONAL OFFICE FOR Europe

Fourth meeting of the focal points of the Small Countries Health Information Network (SCHIN)

Iceland
27 June 2018

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ABSTRACT

The fourth meeting of the focal points of the Small Countries Health Information Network (SCHIN) was hosted by the WHO Regional Office for Europe under the auspices of the Fifth high-level meeting of small countries on 27 June 2018 in Reykjavik, Iceland. Its aim was to discuss developments and updates since the previous meeting of the focal points and to reach agreement on further action points. The results of the surveys on small country policy priorities and the indicator shortlist for the health systems performance assessment were also presented. Meeting outcomes included identification of next steps in the establishment of the final health system performance assessment indicator set, agreement on the calculation and reporting methods to be used for rolling averages and updating of the workplan. Focal points also discussed the drafting of a joint statement by SCHIN to the WHO Regional Committee for Europe.

KEYWORDS

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ABBREVIATIONS

EBoDN	European Burden of Disease Network
EHIG	European Health Information Gateway
EHII	European Health Information Initiative
EVIPNet	Evidence-informed Policy Network
HIS	health information system
HSPA	health system performance assessment
ICD-11	International Classification of Diseases, 11th revision
JMF	joint monitoring framework
SCHIN	Small Countries Health Information Network
SDG	Sustainable Development Goal

EXECUTIVE SUMMARY

The fourth meeting of the focal points of the Small Countries Health Information Network (SCHIN) was held on 27 June 2018 under the auspices of the Fifth high-level meeting of small countries in Reykjavik, Iceland.

At the third meeting, participants had discussed the application of rolling averages methodology, data collection difficulties in small countries, next steps in the development of a joint indicator set for small country health system performance assessment (HSPA) and updates regarding the health information system (HIS) support tool.

Participants discussed the following topics during the fourth meeting:

- updates from the WHO Secretariat on recent health information developments in the Region;
- the results of surveys on policy priorities and HSPA indicator shortlisting;
- the methodology to be applied for the calculation and reporting of rolling averages and selection of the indicators for these;
- the issuing of a joint statement by SCHIN members to the WHO Regional Committee for Europe regarding the importance of strengthening HISs as a foundation for health systems.

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Participants of the 4th SCHIN meeting, Reykjavik, Iceland, 27 June 2018

The outcomes of the meeting were the following:

- rotation of chairmanship of the group to another Member State;
- an agreed approach to using the rolling averages;
- next steps identified for the joint set of HSPA indicators;
- a reviewed and updated workplan for SCHIN;
- a meeting report summarizing the discussions, conclusions and new action points.

INTRODUCTION

The fourth meeting of the focal points of the Small Countries Health Information Network (SCHIN) was hosted by the WHO Regional Office for Europe under the auspices of the Fifth high-level meeting of small countries on 27 June 2018 in Reykjavik, Iceland (see Annex 1 for the agenda). Participants included representatives from all eight members of SCHIN – Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro and San Marino.

The meeting built on the work carried out since the third meeting of the focal points, at which participants had discussed the application of rolling averages methodology, data collection difficulties in small countries, next steps in the development of a joint indicator set for small country health system performance assessments (HSPAs) and updates regarding the health information system (HIS) support tool *(1)*.

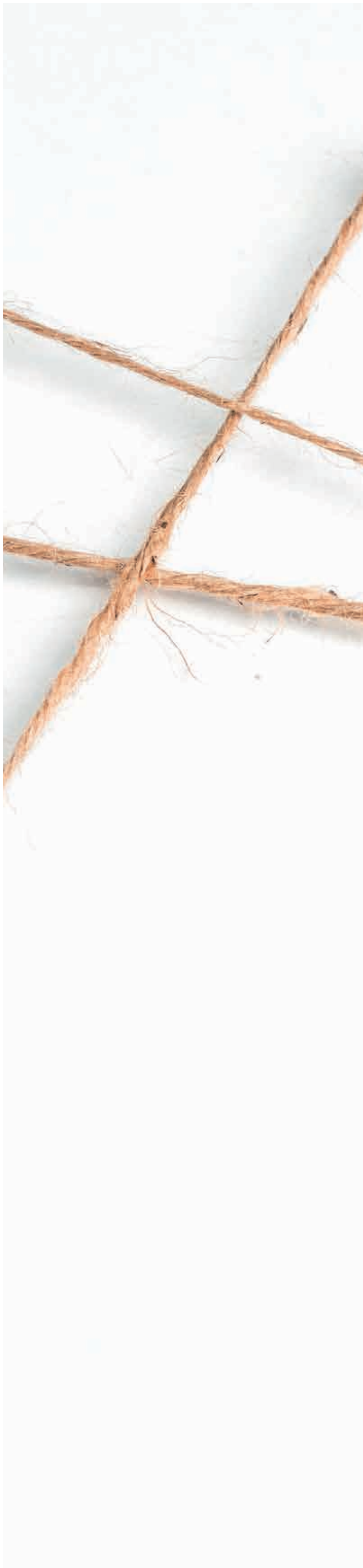
The participants were welcomed by Dr Claudia Stein (Director, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe). At the start of the meeting the outgoing Chair of the Network, Professor Neville Calleja (Director, Department of Health Information and Research, Ministry of Health, Malta) passed on the role to Dr Sigríður Haraldsdóttir (Head of Division, Health Information, Directorate of Health, Iceland), who will chair the Network from 2018 to 2020.

The WHO Secretariat thanked Malta for leading the group through many milestones and welcomed Dr Haraldsdóttir of Iceland as the new Chair. The WHO Secretariat also expressed gratitude to Ms Natasa Terzic, who confirmed her willingness to continue in her role as co-Chair of the Network.

Dr Beatrice Farrugia was elected as rapporteur. The agenda and programme were adopted.

The objectives of the meeting were as follows:

- to rotate the chairmanship of SCHIN;
- to update focal points on recent developments in health information in the Region (including the joint monitoring framework);
- to seek consensus on a joint set of indicators for small country HSPAs, based on common priorities;
- to discuss and agree on options for using rolling averages (including calculation and reporting).



UPDATE FROM THE WHO SECRETARIAT ON RECENT DEVELOPMENTS

The WHO Secretariat updated the focal points on a number of relevant recent developments and new initiatives in the WHO European Region.

The European Health Information Initiative (EHII) *(2)* has grown to 39 participants. The Initiative is considered pivotal for coordination and harmonization of health information in the WHO European Region. The Secretariat encouraged Member States not yet part of the Initiative to join, enabling them to contribute to the European health information agenda by means of membership in the EHII steering group. Members attend one in-person meeting and two teleconferences each year, and membership does not involve a financial contribution.

The joint monitoring framework (JMF) *(3)* is to be presented at the next session of the WHO Regional Committee for Europe and considered by ministers at a panel discussing the Sustainable Development Goal (SDG) roadmap. If approved by the Regional Committee, the JMF will be implemented by Member States. The reduced reporting on the three frameworks, including the SDGs, agreed at the JMF expert group meeting will lead to a lower reporting burden on Member States. In addition, WHO will filter requests for data reporting and will not ask countries to report the same indicator more than once. The vast majority of the JMF indicators are routinely collected and do not involve additional surveys. Member States are free to report fully on all three frameworks if they wish. The JMF was presented to various forums, including the United Nations Economic Commission for Europe in April, and the developments were positively received.

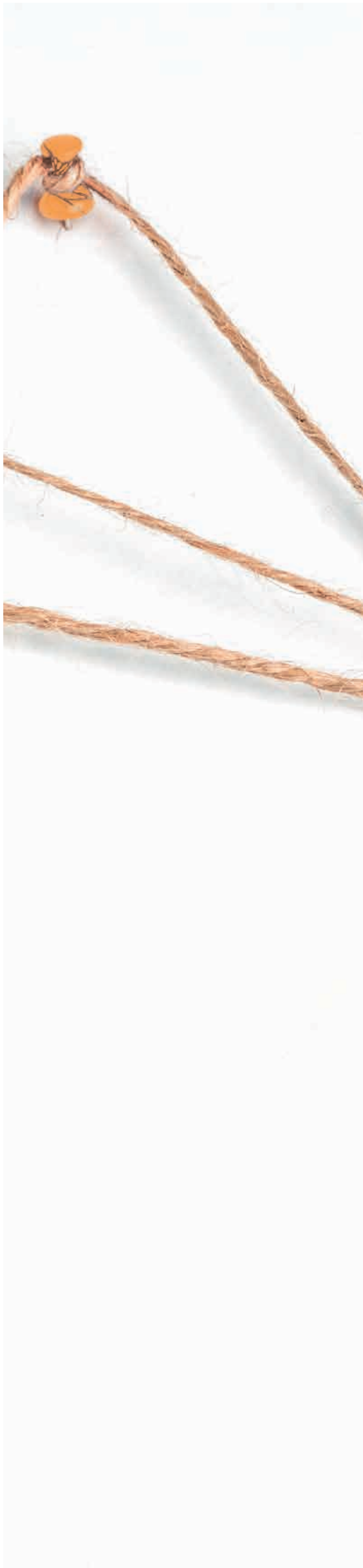
The European Health Information Gateway (EHIG) *(4)* is undergoing a continuous update process and will soon have new features enabled, including automatic upload of data from Member States. It provides access to many other types of information, including policy documents, themed searches and a tool for the simultaneous interrogation of multiple databases. Printable PDF files of indicators for Health 2020, WHO's European health policy, can be generated by the EHIG, and it is also available as a mobile application.

Country profiles and highlights on health and well-being profiles for five Member States in the European Region were published in the past year or are in preparation. The profile for Georgia was published *(5)*, and profiles for Malta and the Russian Federation are at an advanced stage, while those for Turkey and Serbia are in initial phases. The WHO Secretariat drew the focal points' attention to the call for papers on health information issued by the Regional Office for Europe's peer-reviewed journal *Public Health Panorama (6)*, and encouraged them to submit a joint paper from SCHIN countries. The deadline for submission is September.

Publications issued by the EHII have seen significant growth in the number of Health Evidence Network synthesis reports issued since last year. One of these – *Cultural contexts of health: the use of narrative research in the health sector (7)* – received a British Medical Association Medical Book Awards "highly commended" recognition in 2017. The European health report 2018 is also in preparation and will be launched just prior to the next session of the WHO Regional Committee for Europe. The key messages of the report are that evidence needs to be accessible for all, even lay audiences; that new forms of evidence are required for the 21st-century context; and that both qualitative and quantitative data should be considered mainstream evidence.

Developments in the measurement of well-being are continuing. Well-being indicators in use at present are very basic and are considered to be in their infancy. The EHII is working with an expert group on cultural contexts of health, which has now been convening for four years, to expand the well-being chapter of the country profiles. This initiative is spearheaded by the University of Exeter, United Kingdom, which is the WHO Collaborating Centre on Culture and Health.

Well-being indicators could differ for each country, incorporating narratives relating to cultures and traditions. This implies that these indicators will take on a qualitative element, presenting a different way forward for health information in the Region that may serve as a template for all country profiles. Evaluation of the work is ongoing, including work on mechanisms and tools for the utilization of cultural contexts in policy-making. The expert group is also exploring cultural determinants of health. Another expert group has recently been set up to explore novel concepts in Health 2020; it has put forward three ways of measuring community resilience both qualitatively and quantitatively.



The report *On the road to Health 2020 policy targets: monitoring qualitative indicators. An update (8)* measures target 6 of Health 2020 (setting national targets and goals to align with Health 2020) using qualitative indicators.

With respect to capacity-building activities, the Autumn School on Health Information and Evidence for Policy-making *(9)* gives small countries an opportunity to share information and exchange best practices in health information developments, thanks to the interest shown by Autumn School participants in the methodological approaches being developed by SCHIN to address statistical issues surrounding small numbers in health reporting by small countries.

The WHO Secretariat stressed the important role networks play in the EHII, providing the public health capital to make connections between Member States and keep things moving forward. The EHII encompasses seven networks centred around different bases, such as geographical area or specific themes. The activity of these networks supports the implementation of the Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region *(10)* at the national level.

These networks include the Evidence-informed Policy Network (EVIPNet), which now boasts 21 members and has started to produce concrete results, such as the Estonian legislation on sugar-sweetened beverages *(11)* and the Polish brief on strengthening primary health care *(12)*.

The European Burden of Disease Network (EBoDN) is similarly expanding quickly, and is close to finalizing a manual for conducting burden of disease analysis at a national level, using a methodology compatible with global burden of disease principles. The manual is a result of the memorandum of understanding EBoDN has signed with the Institute for Health Metrics and Evaluation. The WHO Secretariat reiterated that the aim of the EBoDN is to support the EHII, and invited Member States to consider joining if they had not already done so.

The European Health Research Network, which was launched in November 2017, offers training on tools relating to health research and supports countries in carrying out mapping exercises in preparation for the development of national health research strategies. It was established at a multicountry meeting in Sofia, Bulgaria, under the auspices of the EHII. Network members comprise a mixture of public health practitioners, researchers and academics nominated by their respective ministries.

The Action Network on Measuring Population and Organizational Health Literacy has also been established recently, with the aim of harmonizing the measurement of health literacy in the European Region. It is accountable to the EHII and has set out a concrete plan for the construction and piloting of a health literacy questionnaire, as reflected in the Vienna Statement on the measurement of population and organizational health literacy *(13)* issued by the Network.

Another network accountable to the EHII is the health information network of the Commonwealth of Independent States, which comprises eight countries of the former Soviet Union; it meets virtually via webinars and collaborates on all areas relating to the EHII.

July 2018 sees the launch of the South-eastern Europe Health Information Network under the auspices of the EHII. Further, with the support of the WHO Regional Director for Europe, a high-level task force on "big data" is being set up. It is proposed that this initiative should also be taken up at a global level, in coordination with the work at the regional level.

After these updates from the WHO Secretariat, the Chair asked the focal points whether they had any comments or questions.

Regarding the initiative on health, culture and well-being, Malta commented that it would be very useful to harmonize a quantitative element that all countries can measure to map well-being, thereby maintaining a comparative element – for example, in situations where it is necessary to adjust models for culture. The WHO Secretariat clarified that, when this issue was discussed at a session of the WHO Regional Committee for Europe four years ago, the only subjective measure of well-being agreed upon was life satisfaction. The Regional Committee had asked for more work to be done in this area. In preparation for the next session, material is being put together to demonstrate the options available, including a catalogue of indicators. A request will also be tabled for reporting to be extended to include country-level reporting on well-being in addition to region-level reporting, but at present the Region is not yet unified on this matter.

On the issue of big data, Malta also commented that a precondition for discussing this area is tackling data privacy issues. The strong potential small countries have for linking datasets at the individual level is seriously threatened if these issues are not adequately addressed. The focal point also noted that

Malta has developed an experimental legal solution in collaboration with the national Data Protection Commissioner that will allow safe linkage of data. In view of the fact that other small countries have shared similar concerns regarding data privacy, this legislation could serve as a pilot for the high-level task force on big data.

The WHO Secretariat offered to share the concept note for the task force on big data with the focal points on a confidential basis for any comments. The Secretariat commented that small countries could play a leading role on this issue thanks to strong intracountry connections that allow developments to occur quickly.

San Marino agreed with Malta's intervention regarding data protection and added that there is confusion about this field, together with blockchain technology.[1] Many private enterprises are introducing blockchain technologies, with databases and data warehouses calling up data from research projects. It is therefore critical to understand what becomes of the data that citizens entrust to governments. San Marino also explained that the country had an interest in the use of DNA samples, but concerns were raised regarding the security of this precious data and what it might be used for once it went beyond national confines. San Marino further noted that concerns regarding identifying data are also very relevant to small countries; these concerns were echoed by Luxembourg.

Andorra commented that problems are often encountered due to "siloed" health data, with fully anonymized entries complicating matters in the health system, particularly when even data on dates of birth are anonymized. Furthermore, different departments/hospitals use different anonymization methods, precluding the matching of health and economic data.

1 "A digital database containing information (such as records of financial transactions) that can be simultaneously used and shared within a large decentralized, publicly accessible network, or the technology used to create such a database" (Merriam-Webster online).

Montenegro commented that big data could be seen as an opportunity to integrate health sector databases and produce evidence beyond routine statistics and indicators. This would require a clearer legal definition of the term "big data", together with the incorporation of big data issues in strategies that use electronic means to deliver health-related information, resources and services (e-health).

A briefing followed on the areas the task force on big data planned to tackle. The WHO Secretariat noted that if small countries feel they have a role in this expert group, their contribution would be welcomed. Focal points were invited to reflect on the role SCHIN could play in this task force. Malta suggested that the Network had a valuable contribution to make on governance issues, as these tend to be more straightforward in small countries; SCHIN members could also provide relevant examples. The WHO Secretariat put forward the suggestion that the Network chair could form part of the task force representing the views of SCHIN.

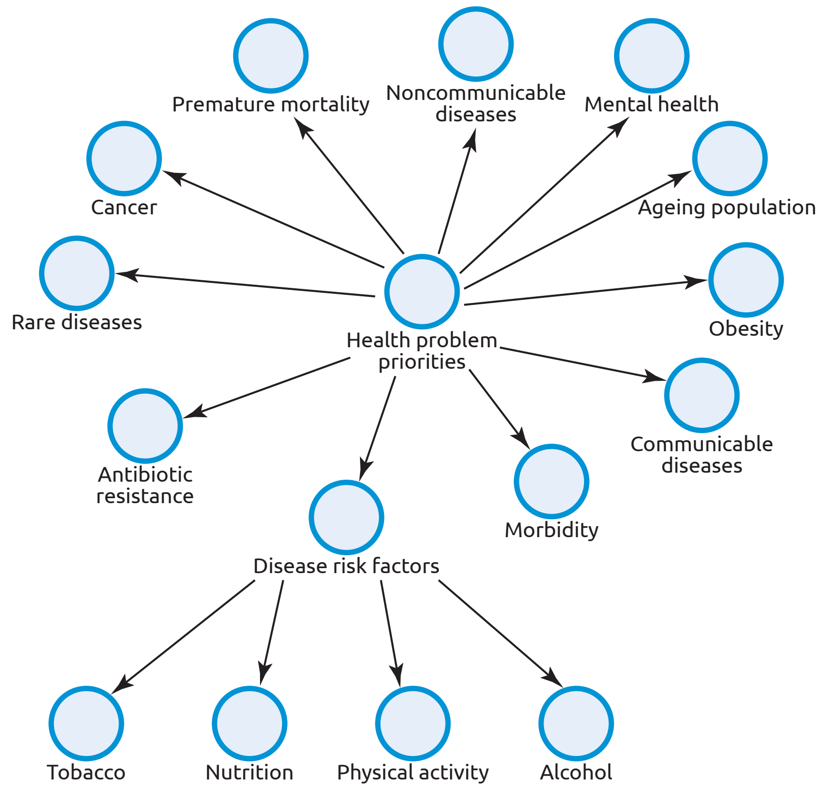
RESULTS OF SURVEYS ON POLICY PRIORITIES AND HSPA INDICATOR SHORTLISTING

Malta presented the work done over the past year during its tenure as SCHIN Chair. The results of the online survey of health policy priorities circulated to all focal points were analysed in a structured manner. The priorities mentioned all fell under two overarching dimensions: health problems and health strategies. Within the health problems dimension the clear emphasis was on noncommunicable diseases and related risk factors (see Fig. 1).

The main health strategy priorities to emerge from the responses were:

- health promotion and disease prevention
- governance
- HISs
- integration and collaboration
- access to health care
- health inequalities
- health care quality and patient safety
- health resources.

Fig. 1. Health problem priorities emerging from the health policy questionnaire distributed to SCHIN focal points



To establish a shortlist based on these policy priorities, all available indicators in the EHIG were filtered. From a starting-point of 1511 indicators, removal of duplicates and those not reported by any SCHIN members led to a reduced list of 287 indicators. A team of public health specialists from Malta was recruited to map the indicators onto the priority domains identified: they could be mapped onto up to two domains, but some might not map onto any. From the reduced list of 287 indicators, 156 were mapped onto at least one domain by the team (Table 1).

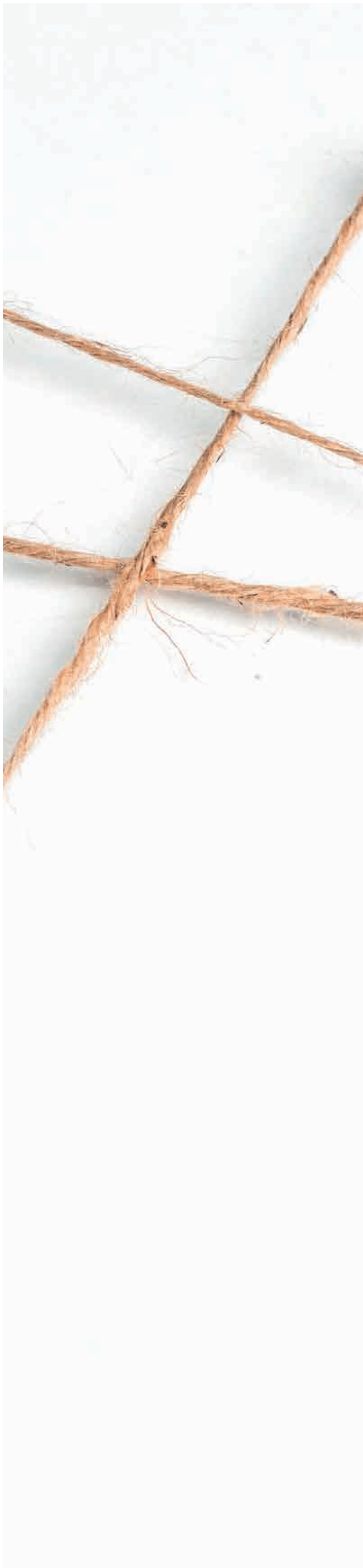
Table 1. Mapping of candidate indicators to HSPA domains

Domain	Indicators chosen by 4–7 participants	Indicators chosen by 5–7 participants for population and health care, 6–8 participants for diseases
Health promotion and disease prevention	115	86
Governance	42	18
HISs	0	0
Collaboration	14	8
Access	53	18
Quality	32	17
Human resources	21	20
Total	**277**	**167**

For the most part, the indicators mapped cleanly onto the domains. For two of the priority areas, however – HISs and collaboration – the mapping was more problematic. There appears to be a paucity of suitable indicators for HISs, and most of the indicators for collaboration selected by the scorers relate to intracountry, whole-of-government collaboration (such as road traffic fatality and occupational disease statistics) and not collaboration between Member States.

In the next stage of shortlisting, scorers were asked to rank the 156 indicators that had been mapped to domains, choosing the eight most important indicators for each domain and ranking them. Scoring was based on indicator relevance, ease of data collection and data availability.

Malta presented the resulting shortlists, noting the significant overlap with the JMF indicator set denoted by the indicators marked in red (see Annex 2 for details of all the shortlists). A decision regarding the number of indicators to be used for each domain had not yet been made as it was felt that this should take into consideration the views of the other SCHIN focal points. Malta noted with satisfaction that while few indicators in the JMF relate to governance, these ranked highly in the shortlists. In total, 34 JMF indicators were among the shortlisted indicators.



The focal points were invited to reflect on the following:

- indicators that overlap with the JMF indicators;
- whether they wished to eliminate any indicators;
- whether any non-JMF indicators should be included in the shortlists;
- overlap with the JMF indicators in the shortlists;
- consistent ranking of the JMF indicators near or at the top of the shortlists;
- the level of additional data collection burden according to the number of JMF indicators included in the shortlists (since Member States have already committed to submitting JMF indicators);
- alignment of the indicators with the priorities of small countries;
- the original mandate for the exercise – namely, establishing a "reduced" traditional HSPA framework that is comprehensive but manageable and meaningful for small countries;
- the potential added value of the indicator set for understanding the small countries context as a reason for considering a focus on non-JMF indicators;
- data availability and reliability issues that may affect some countries, such as Monaco and San Marino, owing to difficulties in establishing population denominators;
- the possibility of reporting on the indicator set on a rotating basis.

Responding to data availability concerns, Malta noted that this should not be a major issue as availability was taken into consideration during the shortlisting process. The WHO Secretariat added that data availability for the 41 JMF indicators is almost a given, but these data are only updated once a year and therefore the Secretariat cannot comment on their recency.

Malta gave a brief overview of its HSPA methodology *(14)* to explain the potential value: each indicator in the set is scored on both the time trend for local data and how it fares in international comparisons. Scores are combined and averaged for each HSPA domain and a traffic-light system is then applied. This is one of many possible approaches

and has been effective with local policy-makers, producing striking visuals. Comparing performance against the average among small countries is another possibility to be considered.

Focal points were invited to reflect on decisions to be made, including whether this should be adopted as a joint exercise by small countries, whether any changes to the suggested domains were merited and whether any domains should be split. The WHO Secretariat suggested that time be allowed for digestion of the data presented and discussion within countries, followed by a Webex meeting dedicated to this issue in the autumn. All focal points concurred and also agreed to send in their feedback regarding the indicators via email. Malta kindly offered to draft confidential initial reports of a comparative assessment of the small countries using the tentative domains, once the chosen indicator set is established. These could then be discussed at the fifth meeting of the SCHIN focal points, to be held under the auspices of the Sixth high-level meeting of small countries in San Marino in March 2019, where a final plan can be established.

The next steps identified were:

- Malta to circulate soft copies of the shortlisted indicators for each domain to the focal points;
- focal points to send in their feedback regarding the indicators via email;
- after submission of feedback, the WHO Secretariat to organize a Webex meeting to discuss this issue;
- Malta to draft a confidential initial comparative assessment of small countries using the chosen indicator set for discussion at the next meeting of the SCHIN focal points.

DISCUSSION AND AGREEMENT ON OPTIONS FOR USING ROLLING AVERAGES

The WHO Secretariat presented a concept note and options for reporting moving averages and proposing suitable Health 2020 indicators; these had been circulated to participants prior to the meeting. The journey undertaken in the production of the concept note and in drawing up scenarios for different rolling average time frames, methods of calculation and methods of reporting was described. Methods of application of rolling averages employed by the Organisation for Economic Co-operation and Development and the European Commission were examined, with a view to determining whether any

were suitable for the small countries. These bodies use rolling averages to smooth trends and for reasons relating to data quality, not because of small numbers, however, so it was felt that the methods are not well suited to the needs and purposes of SCHIN. A shortlist of indicators that lend themselves to the application of rolling averages was also drawn up, consisting of two core and eight additional indicators.

The EHIG *(4)* is currently equipped to handle the application of rolling averages but this functionality has not yet been launched to the public. At this point, decisions are required regarding:

- which indicators rolling averages should be applied to
- how rolling averages should be calculated
- how rolling averages should be reported.

All focal points agreed that the simple rolling average methodology suggested by WHO in the concept paper should be pursued. This was considered the most transparent and easily understandable method. No objections or suggested changes were made to the shortlisted indicators.

Possible methods of calculation of rolling averages were then discussed, with focal points agreeing on the reference year-centred option. The acknowledged disadvantage of this option is the delay in reporting of the rolling average values (a value for the year after the reference year is required to calculate this type of rolling average). In the case of missing data points, individual data points will be used instead of the rolling average.

Concerning the choice between three-year and five-year rolling averages, the WHO Secretariat suggested that variability between data points for SCHIN countries could be measured automatically by an algorithm. This would mean that if one or more SCHIN members have variability over 30% in an indicator, a five-year rolling average will be applied to all SCHIN countries to retain comparability. All focal points agreed with this proposal.

Discussion then proceeded to how rolling averages will be reported and displayed on the EHIG. The WHO Secretariat clarified that the Gateway can only display one value for an indicator at any one time, so actual values and rolling averages cannot be displayed on the same graph. Focal points agreed that displaying both sets of data at the same time would not be the ideal option, as it could confuse policy-makers and other users. It was therefore agreed that the application of rolling averages should be an option at the user level (allowing a user to choose whether to see either actual values or rolling averages for a SCHIN country on a graph, but not both at the same time). The WHO Secretariat confirmed that this should not be a problem from a technical point of view.

Harmonization of the application of rolling averages and whether the rolling averages should be calculated at Member State level or centrally was then discussed. The WHO Secretariat commented that the viability of scaling up the methods chosen needs to be kept in mind, as there may be interest in adopting these methods beyond SCHIN. Malta suggested that if it is possible for the calculation of rolling averages to be carried out by the system itself, this would be preferable and would also increase the credibility and transparency of these methods. The WHO Secretariat clarified that Member States would be free to carry out double-checking at the country level. Luxembourg commented that double-checking may be problematic if different population figures are used at WHO and country levels.

Malta suggested that the information regarding decisions about rolling average methodology made at the SCHIN meetings could be included as metadata in the EHIG. This suggestion was unanimously supported by the focal points and WHO Secretariat.

The WHO Secretariat presented a summary of the discussion and confirmed the focal points' agreement on the following:

- to apply the reference year-centred simple moving average option for the calculation of rolling averages;
- to apply an algorithm to determine automatically whether a three-year or five-year rolling average will be calculated;
- in the case of missing data points, to use individual data points instead of the moving average;
- WHO to carry out calculation of rolling averages centrally;
- application of rolling averages to be an option at the user level on the EHIG;
- information about SCHIN rolling average decisions to be included as metadata in the EHIG.

As a next step, finalization of the agreed rolling average methodology and implementation of the agreed methods is planned for the third quarter of 2018.

REVIEW OF THE WORKPLAN

The participants reviewed the workplan. Most items had been discussed during the review of SCHIN activity at the start of the meeting. Other items added to the workplan were increasing SCHIN involvement in EHII capacity-building events and considering drafting a publication for *Public Health Panorama* in 2019, and it was also updated with the action points agreed (see Annex 3).

The WHO Secretariat informed the focal points that the workplan would be circulated after the meeting for any comments. They were also encouraged to start thinking of potential new items for SCHIN to take up at the next meeting. Malta suggested that this could include sharing of experiences about big data and data privacy.

OTHER BUSINESS

Participants discussed a proposal put forward by Andorra for SCHIN to issue a joint statement to the WHO Regional Committee for Europe regarding the importance of strengthening HISs as a foundation of health systems. Discussion took place during the Fifth high-level meeting of small countries *(15)* of the "three i's" described as health system pillars ("include", "invest" and "innovate") at the conference for the 10th anniversary of the signing of the Tallinn Charter *(16)*. Andorra argued that "inform" is the fourth "i", and in fact needs to be first in the sequence. Focal points were in agreement.

This statement could have two objectives: to highlight both the importance of HISs in small countries for strengthening health systems and the potential role of small countries as "laboratories" for health information development, since they can carry out analysis and obtain results faster than larger countries. Andorra explained that it was important to prepare such a statement to be tabled at the 68th session of the WHO Regional Committee for Europe in September and invited feedback and suggestions from the other focal points and the WHO Secretariat to bring together a consistent text.

The WHO Secretariat commented that such a statement would be very welcome. Monaco pointed out that since the statement would be made by countries and not by the focal points per se, it would need to be cleared by the relevant health ministries. It should therefore be put together without delay and would ideally be around 2–3 minutes long. SCHIN Member States could make declarations adding on to the statement. Andorra agreed to suggest to the country's health minister that they take up this leading role.

Malta suggested that a preamble could be added to thank WHO and the EHII for streamlining the small countries approach. The WHO Secretariat suggested that a draft should be circulated between SCHIN countries by the end of the following week; all focal points were in agreement.

Malta brought up the launch of the International Classification of Diseases, 11th revision (ICD-11) *(17)* and registered interest in learning more about it. The WHO Secretariat noted that this issue was also raised in the EHII and information will be presented at the EHII meeting in March 2019. An implementation plan for all WHO regions is being formulated with WHO headquarters. Member States will have until January 2020 to implement ICD-11. This issue was added to the agenda for the next meeting of the SCHIN focal points in San Marino in March 2019.

CONCLUSIONS AND NEXT STEPS

The Chair thanked all the participants for a fruitful meeting (see Annex 4 for the full list). The WHO Secretariat thanked both the outgoing and incoming Chairs for their work and congratulated the group on its remarkable achievements.

The fourth meeting of the SCHIN focal points achieved the stated objectives. Action points for the focal points and the WHO Secretariat were identified and added to the SCHIN workplan (see Annex 3).

Priority action points for SCHIN are the following:

- focal points to decide on drafting of a joint publication for *Public Health Panorama* (March 2019 issue);
- Malta to circulate soft copies of the shortlisted indicators for each HSPA domain to the focal points;
- focal points to send in their feedback on the indicators via email;
- Malta to draft confidential initial comparative assessment of small countries using the chosen indicator set for discussion at the next meeting of the SCHIN focal points in San Marino in March 2019;
- Andorra to propose leading on the joint statement to the WHO Regional Committee for Europe to their minister of health and to put together a draft to circulate to focal points within approximately a week of the SCHIN meeting.

Priority action points for the WHO Secretariat are:

- finalization of the agreed rolling average methodology and implementation of the agreed methods – planned for the third quarter of 2018;
- work on involving SCHIN countries in WHO capacity-building events.

Organization of the next meetings was discussed. It was agreed that the WHO Secretariat will organize a Webex meeting for SCHIN focal points in the third quarter of 2018 (date to be communicated) to finalize the list of indicators for the small countries HSPA. The date of the next in-person meeting was to be decided. A proposal was made to conduct it back-to-back with the Sixth high-level meeting of small countries in San Marino in March 2019.

Preliminary agenda items for the next meeting include:

- the task force on big data and data privacy issues
- the launch of ICD-11 and its implementation.

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ANNEX 1. MEETING AGENDA

Wednesday 27 June 2018

Welcome, opening remarks and rotation of SCHIN chairmanship
SCHIN Chair, Professor Neville Calleja, Director, Department of Health Information and Research, Ministry for Health, Malta; Dr Sigríður Haraldsdóttir, Head of Health Information Division, Directorate of Health, Ministry of Welfare, Iceland; and Dr Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe

Nomination of the rapporteur

Adoption of the agenda and programme

Update by the WHO Secretariat on recent developments in the Region (including the JMF)
Dr Claudia Stein, WHO Regional Office for Europe

Towards the development of a joint set of indicators for small countries:

- Presentation of the results of surveys on policy priorities and the HSPA indicator set, led by Malta
  Professor Neville Calleja, Director, Department of Health Information and Research, Ministry for Health, Malta
- Discussion and agreement on the next steps
  All participants

Discussion and agreement on the options for using rolling averages (including calculation and reporting):

- presentation of the concept note and options for reporting moving averages and proposing suitable Health 2020 indicators
  Dr Claudia Stein, WHO Regional Office for Europe
- discussion and agreement on the options for using rolling averages
  All participants

Review of the workplan and proposals for new items
Chair

Joint statement by SCHIN to the WHO Regional Committee for Europe
Dr Josep Romagosa, Technician on Health Information Services, Statistics Department, Ministry of Finance; and Chair

Next steps and date of the next meeting
Chairperson

Any other business

Closing remarks
Chair and WHO Secretariat

ANNEX 2.
SCHIN INDICATOR SET SHORTLISTS

Note: the JMF indicator set is denoted by the indicators marked in red.

Health promotion and disease prevention	Score
Proportion of regular daily smokers in the population, aged 15 years and over	**51**
Age-standardized prevalence of obesity (defined as body mass index (BMI) = 30 kg/m^2) in people aged 18 years and over (WHO estimates)	**30**
Incidence of female breast cancer	**25**
Age-standardized prevalence of overweight (defined as BMI = 25 kg/m^2) in people aged 18 years and over (WHO estimates)	**24**
Pure alcohol consumption, litres per capita, ages 15 years and over	**21**
Incidence of cancer	**19**
Incidence of trachea, bronchus and lung cancer	**18**
Proportion of children vaccinated against measles	**15**
Incidence of cervix uteri cancer	**12**
Incidence of HIV	**9**
Incidence of measles	**9**
Age-standardized death rate (SDR), ischaemic heart disease, all ages	**8**
Average amount of fruits and vegetables available per person per year (kg) (variant)	**7**
Incidence of syphilis	**7**
SDR, cerebrovascular diseases, all ages	**7**
SDR, malignant neoplasms, all ages	**6**
Incidence of gonococcal infection	**5**
Proportion of infants vaccinated against poliomyelitis	**5**
Microbiological foodborne diseases per 100 000	**4**
Proportion of infants breastfed at age 6 months	**4**
Average number of calories available per person per day (kcal)	**1**
Prevalence of mental disorders	**1**

Governance	Score
Public-sector expenditure on health as proportion of gross domestic product (GDP) (WHO estimates)	**54**
Total health expenditure as proportion of GDP (WHO estimates)	**50**
Public expenditure on health, purchasing power parity, in United States dollars (PPP$) per capita (WHO estimates)	**41**
Private households' out-of-pocket payments on health as proportion of total health expenditure	**40**
Total health expenditure, PPP$ per capita (WHO estimates)	**38**
Public-sector expenditure on health as proportion of total government expenditure, WHO estimates	**25**
Public-sector health expenditure as proportion of total health expenditure (WHO estimates)	**24**
Private-sector expenditure on health as proportion of GDP (WHO estimates)	**19**
Private-sector expenditure on health as proportion of total health expenditure (WHO estimates)	**14**
Total pharmaceutical expenditure as proportion of total health expenditure	**7**
Public pharmaceutical expenditure as proportion of total pharmaceutical expenditure	**4**
Public inpatient expenditure as proportion of total inpatient expenditure	**3**
Total inpatient expenditure as proportion of total health expenditure	**3**
Salaries as proportion of total public health expenditure	**1**
Total capital investment expenditure on medical facilities as proportion of total health expenditure	**1**

Integration and collaboration	Score
People killed or injured in road traffic accidents per 100 000	**62**
Deaths due to work-related accidents per 100 000	**60**
People injured due to work-related accidents per 100 000	**57**
Road traffic accidents with injury per 100 000	**52**
New cases of occupational diseases per 100 000	**26**
SDR, accidental falls	**25**
SDR, motor vehicle traffic accidents, all ages	**23**
SDR, transport accidents, all ages	**19**

Access	Score
Proportion of children vaccinated against measles	46
People receiving social/disability benefits	34
Proportion of disabled people of working age engaged in regular occupational activity	29
Proportion of infants vaccinated against poliomyelitis	27
Proportion of all live births to mothers aged under 20 years (variant)	23
Proportion infants vaccinated against invasive disease due to Haemophilus influenzae type b	22
Availability of social support	19
Proportion of infants vaccinated against hepatitis B	19
Proportion of infants vaccinated against diphtheria	16
Proportion of infants vaccinated against rubella	15
Proportion of infants vaccinated against mumps	12
Incidence of mental disorders	10
Proportion of children of official primary school age not enrolled	10
Proportion of infants vaccinated against tetanus	10
Proportion of population with access to sewage system, septic tank or other hygienic means of sewage	10
Proportion of population with homes connected to water supply system	10
Proportion of infants vaccinated against pertussis	8
Absenteeism from work due to illness, days per employee per year	4

Quality and safety indicators	Score
Maternal deaths (cause of death data)	56
Caesarean sections per 1000 live births	40
Perinatal deaths per 1000 births	39
Estimated infant mortality per 1000 live births (World health report)	32
Early neonatal deaths per 1000 live births	29
Early neonatal deaths with a birth weight of 1000 g or more	29
Fetal deaths per 1000 births	18
Infant deaths per 1000 live births	17
Perinatal deaths (national criteria)	14

Quality and safety indicators	Score
SDR, females, complications of pregnancy, childbirth and puerperium, per 100 000	**14**
Dead-born fetuses with a birth weight of 1000 g or more	**12**
Proportion of births attended by skilled health personnel	**11**
Estimated maternal mortality (WHO/United Nations Children's Fund/United Nations Population Fund estimates)	**7**
Late neonatal deaths per 1000 live births	**3**
Perinatal deaths 1000 g and over	**2**
Postneonatal deaths per 1000 live births	**1**

Health workforce	Score
Physicians per 100 000	**64**
General practitioners (physical persons (PP)) per 100 000	**59**
Nurses (PP) per 100 000	**57**
Dentists (PP) per 100 000	**29**
Pharmacists (PP) per 100 000	**23**
Midwives (PP) per 100 000	**17**
Practising caring personnel (personal care workers)	**15**
Practising physiotherapists	**14**
Proportion of physicians working in hospitals	**14**
Physicians, medical group of specialties (PP)	**13**
Physicians, surgical group of specialties (PP)	**7**
Physicians, paediatric group of specialties (PP) per 100 000	**6**
Physicians, obstetric and gynaecological group of specialties (PP) per 100 000	**3**
Physicians graduated per 100 000	**2**
Nurses graduated per 100 000	**1**

ANNEX 3. WORKPLAN

No.	Priority activities	Core deliverables	Lead/ responsible parties	Time frame (year and quarter)										
				2016			2017				2018			
				II	III	IV	I	II	III	IV	I	II	III	IV
1	Information exchange on a regular basis													
1.1	Formalize exchange of good practice through peer support and WHO support	Use of WHO's HIS support tool at the country level	All	x										
		Set up Sharepoint system for SCHIN	WHO											
		Set up discussion forum among members (currently not feasible)	SCHIN members											
		WHO Regional Office for Europe to adapt and evaluate gatekeeper function	WHO		x					x				
		Encourage establishment of global gatekeeper function at WHO headquarters	WHO								x			
2	Joint analysis, visualization and decision-making support													
2.1	Establish joint reporting and/or online platform for data exchange	Explore country grouping for SCHIN reporting	WHO					x						
2.2	Enhance reporting of SCHIN countries	Explore rolling averages for SCHIN countries	WHO	x										
		Propose concepts/scenarios for SCHIN	WHO		x									
		Discuss and agree at focal points meeting in Monaco	All		x									
		Consider publishing methodology	All			x								
		Pilot application of rolling averages and keep SCHIN members informed of progress	WHO						x	x	x	x		
		Finalize methodology and implement agreement	SCHIN members and WHO									x		

No.	Priority activities	Core deliverables	Lead/ responsible parties	Time frame (year and quarter)										
				2016			2017				2018			
				II	III	IV	I	II	III	IV	I	II	III	IV
		Analyse all Health 2020 indicators where the number of cases is below 10 for all SCHIN countries	**WHO**			x					x			
2.3	Establish joint HSPA framework for SCHIN countries	**Conduct mapping exercise of existing indicators based on the Central Asian Republics Information Network list**	**All**					x				x		
		Discuss feasibility of indicators within SCHIN							x					
		Propose joint indicator set								x				
		Develop joint HSPA framework	**Malta**	x	x									
		Establish subgroup of focal points to discuss HSPA indicator set	**Malta**						x					
		Send first survey on policy priorities (mid-September)	**Malta**						x					
		First (virtual) meeting of subgroup to discuss survey results	**All**							x				
		Second survey on policy priorities (December)	**Malta**							x				
		Second (virtual) meeting of the subgroup to discuss results and propose indicator set	**All SCHIN members**							x				
		Use JMF indicators and remainder from Malta survey to discuss with national counterparts	**WHO and SCHIN members**									x		
		Finalize list in a Webex conference	**WHO and SCHIN members**										x	
3	**HIS assessments and indicator selection**													
3.1	Perform national HIS assessments using rapid assessment first and support tool later	**Share, summarize and publish short HIS assessments for *Public Health Panorama issue* March 2016**	**SCHIN members with one lead**	x										

No.	Priority activities	Core deliverables	Lead/ responsible parties	Time frame (year and quarter)										
				2016			2017				2018			
				II	III	IV	I	II	III	IV	I	II	III	IV
		Present results at Monaco meeting	SCHIN members					x						
		Member States conduct HIS assessments (no current time frame)	SCHIN members											
		Update tables in *Public health panorama* paper	SCHIN members			x								
		Discuss the above with ministers internally and consider presenting SWOT (strengths, weaknesses, opportunities and threats) analysis at next high-level meeting	SCHIN members			x								
		Discuss HIS assessments with countries on bilateral basis	WHO			x								
		Finalize revisions of the HIS assessment tool and distribute to Member States	WHO								x	x		
		Draft joint publication for *Public Health Panorama* issue March 2019	SCHIN members										x	
4	**Knowledge translation**													
4.1	Identify knowledge translation needs for SCHIN	Conduct HIS assessment and gap analysis (no current time frame)	WHO											
4.2	Consider involving SCHIN in EVIPNet Europe	Chair of SCHIN to discuss with EVIPNet lead at WHO Regional Office for Europe	Malta	x										
		Agenda item on EVIPNet at focal point meeting in Monaco	WHO		x									
4.3	Link EVIPNet and SCHIN	Review next steps at focal points meeting in Monaco												
		Identify common theme within SCHIN for EVIPNet approach	WHO and SCHIN focal points				x							
		Share existing selection of themes with SCHIN and SCHIN to indicate preferences	WHO and SCHIN focal points			x								

No.	Priority activities	Core deliverables	Lead/ responsible parties	Time frame (year and quarter)										
				2016			2017				2018			
				II	III	IV	I	II	III	IV	I	II	III	IV
4.4	Create mechanism of peer support including study tours and technical support missions	**To be discussed further**												
5	**Capacity-building**													
5.1	Link EVIPNet Europe with SCHIN	**Review at future meetings**	**WHO**											
5.2	Involve SCHIN countries in WHO capacity-building events	**Review at future meetings**	WHO							x		x		
6	**Other**													
6.1	Interim teleconference with SCHIN members to discuss high-level meeting and next SCHIN agenda	Ad hoc	**WHO with Chairs**				x						x	
	Virtual meeting (teleconference or Webex) with SCHIN focal points		**WHO with Chairs**								x			
	Agree on content of joint statement to the WHO Regional Committee for Europe and draft text		**SCHIN and Andorra**									x		

ANNEX 4. LIST OF PARTICIPANTS

Andorra

Dr Josep Romagosa Massana
Public Health Officer
Promotion, Prevention and Health Surveillance Unit
Ministry of Health
Statistics Department
Ministry of Finances

Cyprus

Dr Vasos Scoutellas
Coordinator
Health Monitoring Unit
Ministry of Health

Iceland

Dr Sigríður Haraldsdóttir
Head of Division
Health Information
Directorate of Health

Luxembourg

Dr Nathalie De Rekeneire
Head
Health Information Department
Health Directorate
Ministry of Health

Malta

Dr Neville Calleja
Director
Department for Policy in Health – Health Information and Research
Ministry of Health

Monaco

Mr Alexandre Bordero
Director
Department of Health Affairs
Ministry of Health and Social Affairs

Montenegro

Ms Natasa Terzic
Director
Center for Health System Development
Institute of Public Health

San Marino

Dr Gabriele Rinaldi
Director
Health Authority of San Marino
Ministry of Health and Social Security

WHO Regional Office for Europe

Dr Claudia Stein
Director
Division of Information, Evidence, Research and Innovation

Dr Beatrice Farrugia
WHO Consultant (SCHIN Rapporteur)
Division of Information, Evidence, Research and Innovation

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
E-mail: eurocontact@who.int
Website: www.euro.who.int