decline given that unemployment was already starting to increase in 2007, and it is stressors such as those arising from job loss that contribute to poor mental well-being.[4] It was for this reason that, in our sensitivity analysis, we tested the effect of the crisis starting in July 2007, based on unemployment. In fact, this did yield a similar result to the main model (although not exactly the same as Librero et al. seem to suggest by rounding them both up to 8%).

We are not clear what Librero et al. meant by stating that we 'set a final time of crisis: December 2009 (20% unemployment)' in the other sensitivity analysis, as this model was based on GDP (and the temporary increase in 2010) and not unemployment.

We agree with Librero et al. that further research should model the association between unemployment and suicide, although, as we highlight in the original article, this has already been investigated extensively and there is a well-documented association between the two.[5] The aim of our study was, however, to establish whether there was an increase in suicides in Spain in this financial crisis, rather than to investigate the effect of one particular manifestation of the crisis.

We also agree that the associations we describe cannot be considered as definitively causal as with any observational study. In fact, in the opening sentence of our 'Interpretation and Implications' section, we state that 'Our study alone cannot establish whether the association found between the financial crisis and suicides is causal'. Nevertheless, we disagree that one should resist publishing alarming results; publication should not be based on the results that are found but rather the importance of the question and the merit of the study. Irrespective of whether these results are alarming, they should be used to aid informed decisions that maximize public health and well-being.

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doi:10.1093/eurpub/ckt215
Advance Access published on 13 January 2014

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European Journal of Public Health, Vol. 24, No. 2, 184–185

The realisation of a European health information system—time to get the politicians involved

The 2013 European Public Health Conference (EPHC) in Brussels brought together representatives of the European Commission's (EC) Directorate General for Health and Consumers (DG SANCO), the European Regional Office of the World Health Organization (WHO-EUR), the Organisation for Economic Co-operation and Development (OECD) and EUPHA. The aim of the round table discussion was to explore how the diverse European health information initiatives could be integrated to create an infrastructure that is comprehensive, functional and sustainable.

So far, the EC has given financial support to projects to develop common European instruments for health interviews and examinations and the development of health indicators. However, despite many individual successes, these have yet to translate into an integrated system that enables policymakers, researchers and citizens to obtain a comprehensive, timely and consistent picture of the health of Europe's population. This suggests a lack of vision and commitment by Europe's leaders, a view that has been communicated to Commissioner Borg by the European public health community.[1] As long ago as 2010, the EC and WHO, since joined by OECD, agreed a roadmap towards a single European Health Information System. Despite several individual initiatives, concrete action has so far been lacking.

Those present in Brussels examined the possibilities to develop such a system under the current EU health mandate. Article 168 (2) of the EU Treaty states that '... The Commission may, in close contact with Member States, take any useful initiative to promote [...] the preparation of the necessary elements for periodic monitoring and evaluation.'[2] yet the EC does not seem to have taken the opportunity available to it. This is despite the clearly stated intention of all its Member States, enshrined in their support for WHO EURO's Health 2020 policy, which requires monitoring of agreed health targets, a task that should be incorporated in a single monitoring system.[3] Yet, these words have not been matched by action.

Policy making on EU level can follow two political routes.[4] The low politics route, in which action is initiated by professional concern and developed by expert groups, has been tried for many years but has failed. This suggests that it is now time to pursue the high politics route, in which action is initiated by political leaders. Of course politicians need to be convinced by us, the public health community. But if we believe that information about the health of our fellow citizens is needed to achieve transparent and cost-effective policies, we have a duty to formulate a strong case that can convince our national politicians to take action in the institutions of the EU and WHO. Together we can achieve a new health agenda for Europe[5] underpinned by timely and accurate health information.

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doi:10.1093/eurpub/cku012
Advance Access published on 24 February 2014

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