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REGIONAL OFFICE FOR EUROPE

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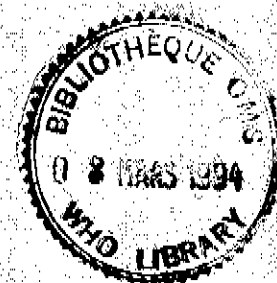
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## REVISION OF HFA INDICATORS AND MONITORING PROCEDURES

Report on a WHO Working Group

Copenhagen  
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SCHERFIGSVEJ 8  
DK-2100 COPENHAGEN Ø  
DENMARK

TEL.: (45) 39 17 17 17  
TELEFAX: (45) 39 17 18 18  
TELEX: 15348

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1994

EUR/HFA TARGET 35

## TARGET 35

### HEALTH INFORMATION SUPPORT

*By the year 2000, health information systems in all Member States should actively support the formulation, implementation, monitoring and evaluation of health for all policies.*

#### ABSTRACT

The meeting reviewed a draft document prepared by the Regional Office for the 1993-1994 health for all monitoring exercise. The document provided the framework and the statistical indicators to be used by the WHO Member States in the European Region. This review aims to ensure that:

(i) the recently updated (1991) targets for health for all are adequately reflected in the monitoring framework; (ii) the statistical indicators are sufficiently specific and comprehensive; (iii) the links between indicators of different groups are more explicitly defined; (iv) further ways are identified to increase international comparability of data.

The group has put forward several general recommendations, inter alia that:

(i) situation assessment is concise but flexible; (ii) harmonizing health interview surveys as a source of data for health for all indicators should be encouraged; (iii) all new indicators should possibly be field tested before general implementation; (iv) indicators for appropriate care require further work as these targets have been most extensively updated; (v) WHO should follow a policy of requesting the necessary data even if these are not readily available in some countries; (vi) health for all monitoring and related data analysis, should increasingly take into account the relative size of the population subgroups compared and the health impact achieved, or expected.

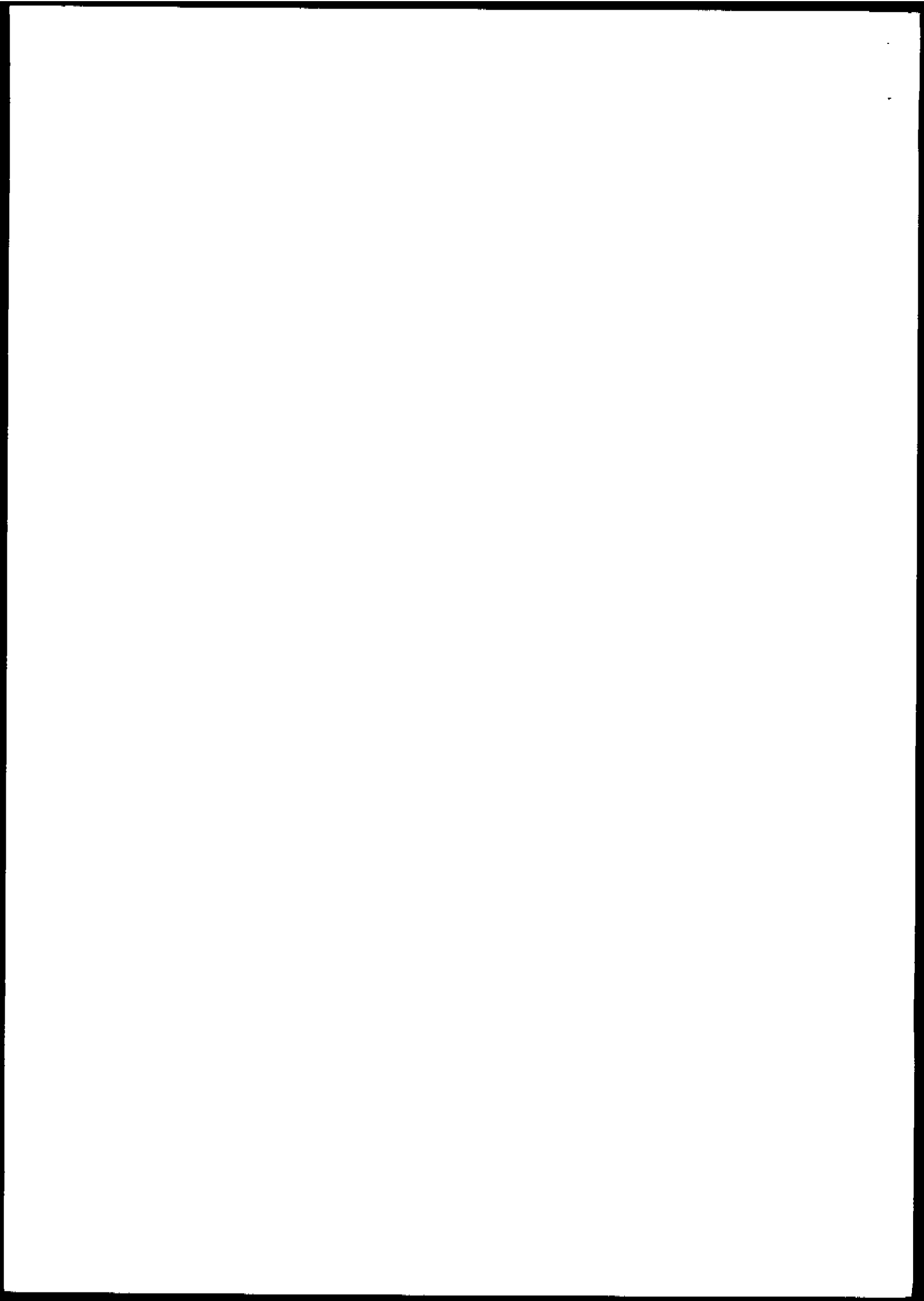
Further to these and other general recommendations, the group proposed numerous specific improvements of the health for all monitoring framework and indicators, which are reflected in the report.

#### Keywords

HEALTH STATUS INDICATORS  
HEALTH FOR ALL  
HFA STRATEGY COORDINATION  
EUROPE

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## 1. Introduction

At its thirty-fourth session in September 1984, the Regional Committee for Europe adopted, together with the 38 regional HFA targets, a set of indicators. These indicators were revised twice; following on the results of the evaluation in 1985 and also following the monitoring of progress towards the regional health for all targets in 1988.

Taking the results of these activities into account, the Regional Committee at its thirty-seventh session in 1987, adopted a revised list of indicators<sup>a</sup> and at its fortieth session in 1990, endorsed the "HFA indicators and evaluation framework for the European Region of WHO 1990-1991". The latter was used in the second HFA Evaluation which took place in 1990/1991.

The revisions which were carried out, with many institutions and individuals participating, have resulted in notable improvements in the system of indicators and monitoring procedures in terms of relevance and effectiveness of the exercise through greater clarity, simplicity and flexibility and more specifically through:

- more precise definition or guidance for use of indicators;
- finer selection of relevant indicators;
- replacing the non-quantitative indicators with a flexible set of reference points (situation assessment).

However, there is still a need for further revision and improvement of the HFA indicators and monitoring procedures and the working group was convened, in Copenhagen (the WHO Regional Office for Europe) to advise on the topic. Dr M. Danzon, Acting Director, Programme Management, opened the meeting and welcomed the participants on behalf of the Regional Director.

Nine temporary advisers and several staff members of the Regional Office represented both the scientific and practical concerns about monitoring health for all strategies at different levels.

## 2. Scope and purpose

The need to have a working group on this issue emanated from the following:

(a) HFA targets have been updated; a draft list of new and revised statistical indicators has been approved for application, as appropriate, but this needs to be reviewed and finalized. This means that:

- the statistical indicators must be specified;
- the descriptive reference points must be adjusted to the target statements.

The Regional Office prepared a draft document for review by the group, with particular attention given to the overall balance of the selected indicators.

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<sup>a</sup> "Revised list of indicators and procedure for monitoring progress towards Health for All in the European Region 1987/1988".

(b) The analytical potential of the indicators has so far been limited to evaluating single targets or, at the best, groups of targets. But the "horizontal links" between different groups of indicators e.g. mortality, disability, lifestyles, health services, have not been explicitly defined. For monitoring purposes, an attempt should be made to uncover the relationships between the indicators so that these could be systematized.

(c) While the amount of potentially useful data and databases is increasing in Member States, their compatibility and comparability remains a major impediment. The group was asked to advise on what could be done to further the necessary harmonization.

(d) The role of the monitoring exercise, and of the WHO Regional Office for Europe as a health information centre, are not entirely clear in operational terms. This, and the latter problem, are obviously interrelated and depend on the changing environment in Europe. The group advised on the direction of international collaboration in the area of health information.

### 3. Background for the working group

The group considered a detailed analysis of the 1990/91 HFA evaluation with regard to procedures, data availability, products and other uses of the exercise. Special attention was paid to the new situation in Europe, exemplified by the existence of an updated health for all policy, and a large number of new Member States.

The revision of the monitoring framework for the European Region of WHO had also to be seen in the context of the monitoring of the global health for all strategy. The effectiveness of the exercise has increased, as is indicated by the improvement in information, and the development of health strategies at country level. For the forthcoming monitoring exercise at global level, it was important to address the question of whether or not the targets were achievable and the relevant activities effectively implemented. It must be stated more clearly that countries were expected to monitor their national strategies; WHO Regional Offices their regional strategies, and WHO Headquarters the global strategy. In this way, our main task would be the monitoring of inputs, process, outcomes and outputs. WHO Headquarters had revised the common framework which now also included global indicators of the World Summit for Children. With respect to the monitoring process itself, it was advisable to form multisectoral groups at both country and regional levels.

The question was raised as to what the difference was between the monitoring and evaluation exercises. While the evaluation should be more analytical and produce a report for wider distribution every 6 years, the monitoring was initially intended to be a mid point assessment for a more restricted audience with a limited distribution of documents. Nevertheless, the countries had always been free to carry out more exhaustive monitoring exercises and in fact the difference is not substantial at present (at least as far as the European region is concerned).

One difference is the extent to which data requests are submitted to the countries. As part of the monitoring exercise, the requests for data from countries could be fewer and, more use could be made of other sources instead. In future, there may be a need for annual monitoring reports on the state of global health. New areas of interest in the global monitoring are, "quality of care as related to primary health care," "healthier lifestyles" (life expectancy is increasing, but disability-free life expectancy is probably not), "strengthening of information on resources" and "financing of health services."

It was pointed out that low comparability of data between countries should not be overemphasized because the primary purpose of the monitoring was to make time comparisons within countries and not necessarily between countries - although the latter would also be highly desirable.

Related to the above was the availability of data in the new Member States. For some indicators, it was unlikely that, at present, any new Member States would have data of a reasonable quality. Some members of the group felt that, the situation being as it was, to request such data would mean to ask for the impossible. It was the opinion of the majority of the group, however, that countries should be encouraged to use their resources to search out such data by means of special studies, research projects, etc., and to thereby gradually improve the information systems they have. This could be done by means of more clear definitions and guidance on the relevant indicators, and encouraging the use of data for policy making and management, which would improve the quality of data. WHO should not lower the reporting standards requested because of the present difficult situation in some countries. The policy should be to request the necessary data, not only the actually available data.

#### 4. Review of HFA indicators and monitoring framework

The working group considered the following issues in their discussions:

- how appropriate were the proposed reference points for target situation assessments, especially vis-a-vis the updated HFA targets;
- need for new indicators, and reasons for deletion of some indicators;
- data collection procedures, especially whether and how countries could be asked for selected data items;
- how to overcome existing problems with availability of data, especially at central level, and problems with data comparability.

Special emphasis was given to indicators for: quality of life, accidents, mental health, nutrition and physical exercise. These areas underwent relatively more substantial changes in the updating of the health for all targets.

In preparing for the meeting, the Regional Office conducted extended internal consultations and submitted to the group working papers with proposed changes in each area of targets: health status, healthy lifestyles, healthy environment, appropriate care and health development support.

##### 4.1 Indicators of health status (targets 1 - 12)

The Regional Office has been working on methods to measure equity in health for some time, but more specific recommendations could not be made at present. Nevertheless, it was felt unacceptable not to propose at least a minimum set of indicators for the main target on equity, especially in view of the statement that differences have to be reduced by at least 25 % . Therefore, the group suggested that some indicators be specified for equity comparisons: life expectancy at birth and at age 65; infant mortality and a few standardized mortality rates. In addition, more emphasis should be put on the long-standing request for disaggregated data in order to assess equity.

In the forthcoming monitoring exercise, selection of indicators would also be required for the proposed use of assessment charts, to be based on trend assessments for only a limited number of indicators, mainly mortality.

Several indicators of health status are to be measured by means of health interview surveys. The group proposed that WHO should cater for countries which conduct such surveys and recommend the inclusion of certain questions from interview surveys, when these were available.

With respect to individual new and modified indicators proposed, the group made recommendations which are given in Annex 1.

With respect to the situation assessments by target, the following recommendations were made:

- the language should be further simplified, and examples used where appropriate;
- concise situation assessments should be requested;
- it should be ensured that all points in the target statements and proposed lines of action were reflected in the situation assessment.

A general recommendation, for the future, was to field test any proposed new indicators and situation assessment points, in two to three countries.

The Regional Office presented a proposal for monitoring health related quality of life. The proposal was to provide the Member States with guidance on how to report on the quality of life issue by means of a taxonomy of quality of life measurements and examples, without going into any specific recommendations about preferable measurement instruments at present. The taxonomy should allow for accommodating the immense variety of indicators and measurement instruments that are used by countries with different cultures and levels of development. It is based on the working definition of Quality of Life (QOL) derived from the health for all strategy. QOL is conceived as the ability to develop and use the full potential of people - physical, mental and social. The relevant dimensions of any particular QOL measurement could be found in: the indicator one is attempting to measure, the kind of measurement, and the actual uses of the data. The countries would be invited to report on their practices of quality of life measurement along the lines of the above taxonomy.

The group viewed the proposal for monitoring QOL as a good interim approach which could help to keep the issue of QOL alive without being the answer to this complex problem. It was noted that QOL should be related to the overall concern of the health for all strategy for a socially and economically productive life. An important distinction was made between QOL overall, and QOL of the disabled. The group suggested that a note be prepared for the Regional Committee on the work which had been done and that it be included in the annex to the document on the monitoring framework. The group also recommended that an economical way of keeping the concern alive be identified - probably by establishing a working group which would meet periodically. For both "equity" and "quality of life" proxy indicators could be sought as an interim solution - especially in countries with a weak information base. Finally it was stressed that quality of life be related to socially productive life.

#### 4.2 Links between HFA indicators

This objective of the working group was dealt with in several presentations in relation to each target group. The discussion pointed to the different aspects of links of indicators. One element was the need for a more detailed review of the links. While these links were quite straightforward in some areas, others were difficult to elucidate and may require substantial additional effort. Another aspect was data collection. This would require surveys or information systems which would allow for the linking of different variables in meaningful combinations. Furthermore, the aspect of how to use the data had to be clarified - the analytical aspect. One relatively easy method would consist of grouping together the causes of death which are related to specific factors. More sophisticated analyses would involve modelling techniques. A more economical alternative would be to look for additional indicators which help to relate different aspects by combining these into one measure e.g. accidents and alcohol consumption, avoidable deaths (by preventive or curative interventions), tobacco attributable mortality. It was recommended that the latter be officially included as a HFA indicator.

The importance of further work in this direction was endorsed by the group, especially with regard to two practical uses:

- support for decision makers in planning programs and interventions, and
- support for preparing more analytical and comprehensive reports on public health issues.

#### 4.3 Indicators of healthy lifestyles (targets 13 - 17)

The following criteria were suggested for the adoption of targets in this group. These should be: credible, selective, measurable, timely, balanced and ethical. The respective indicators should be: more closely linked to the definition of healthy lifestyles<sup>a</sup>, more closely linked to the Ottawa Charter; more clearly linked horizontally; more dynamic as opposed to static. One general recommendation was to soften the distinction between indicators which countries are requested to report on, and those which they are not requested to report on. This results from the non-availability of data on the "new countries" in international data bases and other common data sources, which previously provided data for (nearly) all countries, for some indicators. For the "new countries" there was a need to fill the data gap.

While the principles of the Ottawa Charter were adequately reflected in the situation assessments, it was felt that an attempt should be made to obtain some numerical data relevant to target 14, without explicitly specifying these as statistical indicators, e.g. number of healthy schools, healthy cities (those that have joined the initiative).

Health education and health education authorities should, as far as possible, be related to the health services activities in the country reports (target 15). It was also considered important to emphasize the notion of the right to access of information.

Responses by Member States to the statistical indicators of illicit use of drugs were very limited and it was recommended that better ways should be sought to measure these indicators.

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<sup>a</sup> Lifestyles was defined as "... way of living based on the interplay between living conditions and individual patterns of behaviour as determined by sociocultural factors and personal characteristics."

With respect to several lifestyles indicators, it was considered important to indicate more clearly that measurement guidelines were presented in the annex to the main document and to stress the role of health surveys.

Although some data from health interview surveys could be obtained direct from institutions conducting such surveys and could result in better coverage, this could also cause some confusion. Therefore, the process of adequately informing and involving the Member States needed to be reviewed, as did the way these indicators were presented in the monitoring document.

#### 4.4 Healthy Environment (targets 18 - 25)

A lot of data has already been collected by WHO for the "Concern for Europe's Tomorrow" (CET) initiative, therefore it was important to:

- avoid duplication, rationalise monitoring
- use CET data and other conference material already collected
- collect only:
  - qualitative information and/or standardized self-assessments and
  - quantitative information only from countries which have either reported insufficiently or not at all to CET.

With respect to the individual new and modified indicators proposed, the group made recommendations which are presented in Annex 1.

More generally, the group felt that it was necessary to describe better all new concepts introduced in this chapter, e.g. ecological sustainable development. If available, a glossary of new terms/concepts was recommended to be attached.

It was recommended to standardize, as far as possible, the reference points in the target situation assessment. In many cases the reference points were considered to be too numerous. Standard points could be: new policies, new managerial solutions, new activities, new information/monitoring developments, examples and overall situation assessment of the target.

Special emphasis was placed on the need for information about environment from health interview surveys. These type of indicators need to be included and the recommendation was made that WHO should, in the next three years, set up a working group to produce recommendations. Finally, the group reiterated the need for standardization of issues, concepts, definitions and measurements in the future.

#### 4.5 Indicators for Appropriate Care (targets 26 - 31)

Several important points were made in the presentations and in the discussions following them.

- (a) WHO needed to present more information on the non-use of collected data in the monitoring reports and other products. Member States needed to know why data were not used e.g. missing or poor quality.
- (b) The possibility of standardizing situation assessments should be considered. This would facilitate the supply of information and enhance the possibility of aggregating and comparing information. The working group, however, accepted WHO's wish to retain flexibility and to enable Member States to address reference points according to the local situation. It was agreed that the proposed structure for situation assessments in the previous section on environmental indicators would be considered further by WHO (though for the future).

- (c) In relation to equity of health care, the group recommended that WHO should consider using measures which reflected the relative size of the sub-groups compared. This point also applied more generally to equity measures and the capacity to benefit from health care interventions (possible impact).
- (d) In relation to monitoring of quality of care, the group suggested that quality of care indicators also be chosen with regard to expected health impact. In those areas where substantial impact was expected, databases should be set up - possibly based on routinely collected data.

It was important to stimulate professions concerning "strategic quality markers".

Current indicators focus on 3 areas:

- Chronic diseases (diabetes)
- Oral health care
- Surgery (surgical wound infection).

The process of data collection has been to:

- agree on definitions
- endorse basic minimum data sets
- ensure tools available
- specify centre(s) for data analysis.

With respect to individual, new and modified indicators proposed, the group made the recommendations presented in Annex 1.

#### 4.6 Indicators for research and health development support (targets 32 - 38)

Again the need to clarify better basic HFA principles and concepts was discussed and the suggestion made to look for details in the country reports which may help to validate the information received.

Different sources could be used to complement each other (top-down and bottom-up investigation) but the potential conflict between officially approved and fresh/free information needed to be carefully considered. A related problem was the dilemma of comprehensive versus meaningful/interesting information and reports.

The above points were generally felt to be very relevant for this group of targets which are basically "horizontal" and were understood as "tools" for achieving previous more specific targets. Consequently, these targets have implicit links to many others. More substantial specific recommendations are given in Annex 1.

#### OECD Data

Various issues arose concerning OECD data:

- (a) quality and comparability of data (which were recognised to be improving);
- (b) WHO's role in the formulation and development of health care activity data (as opposed to financial data);
- (c) the scope for the OECD data to become official HFA indicators rather than supplementary (99) indicators.

At the Working Group meeting, it was suggested that the following principles should apply:

- no duplication
- use what is available
- specify which indicators are needed for the monitoring exercise
- The Office would need to resolve clearance. WHO headquarters may need to be involved in clearance with governments.

#### 5. Future development of health monitoring in Europe

Health monitoring will be an important element of any health strategy and programme, and at all levels. Future developments will depend on the appreciation of the role of monitoring by the health administrations. Furthermore, the countries should more clearly spell out what their needs and expectations are. Health indicators will form an important part in developing the monitoring systems of any governmental and nongovernmental organization with a mandate in health. However, it would be necessary:

- to identify and agree on the objectives of health monitoring;
- to agree on arrangements to avoid multiple collection of data (which is the lead agency for what kind of data).
- to improve the briefing of HFA monitoring and evaluation counterparts in Member States.

Some organizations are complementary with respect to health matters to the main WHO function, e.g. ILO and OECD, while others may share, in the future, main health functions with WHO, e.g. CEC.

A very basic task was the development of proper health information systems, including developing their usefulness for monitoring and evaluation of the state of public health. The latter must conform with epidemiological principles and methods. One of the important resources and contributors was for example the network of the International Epidemiological Association.

The group discussed the frequency of the monitoring and evaluation rounds. For HFA monitoring it was considered sufficient to carry out 3-yearly cycles, and there was no support for shorter intervals. Countries were of course free to decide on the timing of their national, and subnational, monitoring.

The group agreed that WHO had a central role in health information in general, and should become more visible as a lead agency in this area. One way to do this was better advertising of the information WHO can provide. In the longer term, basic data sets should be agreed upon which would enable linking and harmonization of WHO databases with national developments.

#### 6. Summary of conclusions and recommendations

##### 6.1 Situation assessment

Situation assessment should use simpler language, and provide examples where appropriate. Requests to Member States for situation assessments should explicitly state that these should be concise. All aspects of the target statements and proposed lines of action should be precisely reflected in the situation assessments so that these were more comprehensive. However, the list of reference points should be kept as short as possible.

Situation assessments offer the opportunity to introduce numerical requests in the monitoring exercise at an early stage. These would assist in developing further statistical indicators in due course.

Finally, WHO should look at the possibility of developing some form of common structure for the situation assessments.

#### 6.2 Health interview surveys

Health interview surveys are the only way to measure several indicators, particularly health status indicators. WHO should encourage countries performing such surveys to include certain questions, where possible following the definitions and standardized methodology that will be included as an annex in the HFA indicators and monitoring framework. Furthermore, these guidelines should include environmental questions, for the future.

#### 6.3 Field testing

Also for the future, field testing should occur for any proposed new indicator and situation assessment points, if necessary just in 2-3 countries.

#### 6.4 Cross referencing

Cross referencing is important to better illustrate interrelationships of indicators. It is recommended that this is made explicit, both in the monitoring framework, and in the monitoring and evaluation process.

#### 6.5 Glossary of terms

A glossary of terms should be considered, as not all key concepts are well defined, a typical example being "ecological sustainable development". Many other terms in the target statements would benefit from better definition.

#### 6.6 Non-use of requested data

Non-use of requested data should be explained to the Member States. Information on what data was not used would improve feedback to countries.

#### 6.7 Indicators for appropriate care

WHO should look further at indicators for appropriate care (targets 26-31), because this area has undergone the most thorough revision in the target update. Further work needs to be done for the group of targets as a whole.

#### 6.8 Data collected direct from statistical offices

Data collected direct from statistical offices and other sources rather than ministries of health of the Member States should be confirmed by the ministries.

#### 6.9 Monitoring of equity and health care

Monitoring of equity and health care would benefit from measures that reflect the relative size of the subgroups compared. Quality of care should take into consideration the health impact (gain) expected. These points also apply to the choice of indicators in other areas.

6.10 Policy to request the necessary data

WHO should have a policy to request all necessary data, rather than selecting only readily available data.

6.11 Distinction between statistical indicators requested from countries

There should be some softening of the distinction between statistical indicators that countries are requested to report, and not report.

6.12 Monitoring quality of life

The proposed guidance for monitoring quality of life should be included in an annex to the main document, as a first step. However, further work is needed, possibly by a working group having relevant expertise.

6.13 Linkages between indicators

Linkages between indicators are very important both to support decision-makers in planning interventions, and to support more analytical reports. On the reporting side, aggregates of data related to a particular cause, e.g. smoking, could be used immediately.

6.14 WHO's role in formulating and developing health care activity data

WHO's role in the formulation and development of health care activity data, as opposed to financial data, needs to be clarified vis-à-vis OECD's role. Quality and comparability of OECD data is improving. Therefore, there is scope for selected OECD data to become official HFA indicators.

6.15 WHO/EURO proposals for the monitoring process

WHO/EURO proposals for the monitoring process were approved, but it was very important to provide good guidance, and as much as possible, to simplify the exercise further. Specific briefing meeting(s) for the counterparts in Member States would be especially beneficial.

Annex 1

**Specific recommendations for particular indicators  
and situation assessment points**

**Target 2**

Indicator 8.2 on gender differences in social indicators should be included under target 2, and the indicators specified more explicitly.

Health carers with their special needs should also be included in target 2.

Reference to "improving social contacts" should be added to the situation assessment.

**Target 4**

Chronic conditions (4.8) should be measured by incidence and prevalence; the specification "selected" should be omitted and conditions presented by ICD codes, usually at chapter level.

Indicator 4.6 on hereditary and genetic disorders should be supplemented by congenital disorders;

**Target 5**

With respect to target 5, both process and outcome measures were needed, and the recommendations of a recent WHO Regional Office for Europe Working Group should be fully implemented.

**Target 6**

Hip fracture incidence (3.4) should be included under target 6.

Data on dementia, as available from epidemiological studies and other sources, should be requested under target 6 but with cross-reference to target 12.

**Target 7**

Childhood asthma should be included under target 7, but only with respect to attack rates (not lost schooldays); in addition, reference should be made to all HFA indicators relevant to health of children; the World Summit of Children initiative should be adequately reflected and explicit reference be made to it in target situation assessment 7 (a).

**Target 8**

Under target 8, an indicator is required for middle-aged women - possibly also elderly women.

**Target 12**

Indicator 12.3 on long-term patients (over 1 year) in mental health institutions has been accepted as an indicator that could help to identify differences in mental health services which are worth exploring.

#### Target 17

Indicator 17.3 on narcotic drugs was still important and should not be deleted. Instead, in order to improve quality of data better definitions should be asked for.

#### Target 18

Point "g" should specify "major" environmental health hazards.

#### Target 19

Point "c" should specify "implementing" policies.

Points "f" & "g" should be re-formulated to assess the effectiveness of collaboration between environment and public health workers.

#### Target 20

Indicator 20.7 relating to home water supply should be deleted.

Indicator 20.11 should be left as currently formulated.

Indicator 20.13 should move "bottled water" to after "safe water-supply systems".

Indicator 20.14 should replace "quality standards" with "guideline values".

#### Target 21

Reformulate point "d" to imply action rather than awareness; also encourage provision of statistical data.

Point "g" is a new reference point: "where surveys of quantitative information on indoor air pollution and climate are available, please specify".

WHO to reformulate indicator 21.7 to enable assessment of households where at least one non-smoker is present, excluding entirely non-smoking households, and where possible, identifying the presence/absence of children.

#### Target 22

Cross-references to other targets are to be given as far as possible. This is already mentioned in the present document.

#### Target 23

The WHO Regional Office for Europe should:

- further pursue in-house discussions;
- consider limiting the number of reference points;
- re-assess the ready availability/non-availability of certain information requested, particularly points "j", "k", "l";
- if information is readily available to WHO, try to reformulate as a statistical indicator to enable information to be fed back to Member States, making a note that the data are from CET, or other specified sources.

#### Target 24

Cross-reference should be made to social networks/contacts (to be covered under target 2) which are to be measured by means of health interview surveys.

#### Target 25

It was important to add "and other work-related diseases" after workers' health - this will then include working days lost in reference to point "e".

Indicator 25.2 relates to incidence of a wide range of diseases in relation to occupation. WHO should attempt a selection of well defined occupational diseases. WHO should formulate as a reference point incidence of all major groups of diseases as related to industry, occupation and gender.

WHO should consider the proposed extension of indicator 25.6 in relation to the IARC carcinogen list.

Indicator 25.9 should be extended to include monotonous work and psycho-social stress but individual constraints should be separately specified and definitions requested.

#### Target 26

A check-list of policy items might be worth amending. An interesting measure would be salary levels of health professionals in PPPs.

#### Target 27

The extent of private primary health care is to be included as a reference point "d".

Indicator 27.1 should be amended to read "percentage of total health services expenditure".

Indicator 27.5 to be reformulated so that source of funds is specified as "total and, where possible, split in terms of public or private".

#### Target 28

Consideration should be given to specifying how to evaluate one aspect of the referral system; time between referral and first appointment (reference point "d").

Reference point "f" required review of the use of the phrase "long-term and satisfactory relationships".

Consideration of additional indicators was required.

#### Target 29

WHO to further consider the proposals to collect quantitative data: indicators measuring capacity (e.g. hospital beds per unit population, by specialties); availability and accessibility of health care institutions and services relieving the hospital sector; indicators of medically inappropriate in-patient care (these indicators possibly to be in the form of situation assessment reference points).

WHO should consider further the possibility of collecting quantitative information such as Coronary-artery By-pass Grafts or Kidney Transplants per million population as well as use of information such as frequency of population being hospitalized linked with primary health care consultation rates.

### Target 30

Statistical indicators are available for this area of growing importance and need to be reviewed by WHO for possible inclusion.

Several further issues were identified:

- need for further development and in-depth analysis;
- current indicators represent stop-gap;
- need to develop better indicators of infrastructures and organization and management of health systems;
- a number of projects on health service indicators at sub-national level could be the basis for development;
- the reference points could include a request to Member States to make proposals concerning how best to establish a database for evaluation and monitoring in this area.

### Target 31

As with other targets in this chapter, further consideration by WHO is strongly recommended.

The following points may be useful:

- measures and efforts to stimulate health workers to keep records on a scale which is adequate to the requirements for quality assessment;
- an indicator of drug expenditure as a proportion of non-salary expenditure;

In future, consideration should be given to extending the list of "avoidable deaths" indicated.

### Target 32

Reference point "a" should be replaced by a simpler question like: "Has a national health research policy been adopted?"

Point "b" should become: "is it based on strategies in line with HFA?". Then, the following could be inserted: "What are the major sources of funds for health research?"

Point "d" should include: representatives of the population.

A semi-quantitative addition could be made to the situation assessment in terms of:

- research funds as % of national expenditure on health
- % of funds for health research devoted to public health research.

### Target 33

Reference point "a" should ask about specific, comprehensive and detailed HFA policies (drafted and endorsed). After "c" another question could be inserted e.g. "what have been the processes and criteria used for prioritization?". Point "g" should ask "how has the participation of the general population been organized?".

(a) and (b) could be linked: "Have Member States implemented policies in line with HFA? Have in addition specific targets been set?"

### Target 34

Indicators to this target need to be reviewed after the meeting in relation to indicators on appropriate care.

#### Target 35

A question could be added on information services on statistical health data and their relationships with documentation centres on health.

#### Target 36

Situation assessment should mention the following questions:

Has clear strategy for human resource development been negotiated with the educational and professional groups, in order to deal with the supply (over-or under) of the different categories of health personnel, over-specialization, or inefficient use?

Has the training of health professionals adequately prepared them for making partners in sectors other than health, and has the training of other professional groups adequately prepared them to become partners in health issues?

Point "a": last sentence: delete "plan"; insert "programme".

Point "a": WHO to consider reformulation of this reference point because of confusion regarding the use of words "basic" and "continuing education".

#### Target 37

Duplication of situation assessment for this target and target 33 should be avoided.

Point "b" should include clarification of "channels" to include mention of meetings/books/TV, etc.

#### Target 38

Situation assessment should include:

- a list of the major public reports, white papers, etc. if any;
- in point "d", "regulations" is too limited and should be completed by "reports", "public debates", "recommendations"; specific reference to "confidentiality" should also be included;
- the trend in whom is sued, physicians, other health professionals, services, managers, etc.;
- reference point "f" should include patient rights.

It was proposed that the reference points be reordered: d, c, b, a, e, f.

Possible statistical indicators could be:

- number of legal complaints per year;
- average premiums for physicians medical insurance, in % of average gross income.

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**Note:** The Regional Office recognized that improving the HFA indicators was a complex process that had to be based on a clear consensus among and commitment by the Member States. Given that there had not been time to discuss many of the relevant issues, the proposed few new statistical indicators were not presented to the Forty-third Session of the Regional Committee. However, work with our governing bodies, on improving the indicators system will continue along the lines set out in this report.

Annex 2

LIST OF WORKING PAPERS AND BACKGROUND MATERIAL

Working papers

- |                |   |
|----------------|---|
| ICP HST 153/1  | Provisional list of working papers and background documents   |
| ICP HST 153/2  | Scope and purpose   |
| ICP HST 153/3  | Provisional programme   |
| ICP HST 153/4  | Provisional list of participants  |
| ICP HST 153/5  | Indicators to monitor HFA targets with respect to health outcomes   |
| ICP HST 153/6  | Indicators to monitor HFA targets on healthy lifestyles   |
| ICP HST 153/7  | Indicators to monitor HFA targets on healthy environment  |
| ICP HST 153/8  | Indicators to monitor appropriate care  |
| ICP HST 153/9  | Health for all indicators and monitoring framework for health for all development   |
| ICP HST 153/10 | HFA indicators and monitoring framework for the European Region of WHO 1993-1994  |
| ICP HST 153/11 | The inter-relationship between lifestyles and health outcome indicators by Dr H. Markowe  |
| ICP HST 153/12 | Recent developments in the health strategy and their potential impact on health monitoring systems (using The Netherlands as an example) by Dr H. Haveman |
| ICP HST 153/13 | HFA indicators on health status and their relation to other indicator groups by Professor Y.M. Komarov  |
| ICP HST 153/14 | HFA Indicators for research and health development support (targets 32 - 38) by Dr Edith Pons   |
| ICP HST 153/15 | Health monitoring in the European Region and its relevance for the work of the International Association (IEA) by Dr Johannes Mosbech                     |
| ICP HST 153/16 | Summary of data availability as provided by countries for 1990/91 HFA Evaluation by Dr R. Prokhorskas   |
| ICP HST 153/17 | Indicators to monitor HFA targets on Healthy Environment by Dr Finn Kamper Jorgensen  |
| ICP HST 153/18 | Indicators for Appropriate Care and their relations to other indicator groups by Drs J. John, A. Mielck, W. Satzinger, W. van Eimeren.                    |

Background material

1. HFA Indicators and Evaluation Framework for the European Region of WHO (1990-1991).
2. Health of Europe, Summary of the Health for All Evaluation
3. Targets for health for all, Summary of the updated edition, September 1991

Annex 3

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

Sir Donald Acheson

Visiting Professor in International Health, London School of Hygiene & Tropical Medicine,  
London, United Kingdom (Chairperson)

Dr H.B. Haveman

Senior Policy Adviser, Ministry of Welfare, Health and Cultural Affairs, Rijswijk, Netherlands

Dr Jürgen John

Chief, Health Systems Analysis Group; GSF-MEDIS-Institut, Neuherberg,  
Federal Republic of Germany

Professor Finn Kamper-Jorgensen

Director, Danish Institute of Clinical Epidemiology, Copenhagen, Denmark

Dr Yuri M. Komarov, Director General, Research Public Health,

Ministry of Health of the Russian Federation, Moscow, The Russian Federation

Dr Hugh Markowe, Director, Central Health Monitoring Unit, Department of Health, London,  
United Kingdom (Rapporteur)

Dr Johannes Mosbech, Consultant, Department of Health Statistics,  
National Board of Health, Copenhagen, Denmark

Dr Edith Pons, Medecin Inspecteur de la Santé, DDAS du Nord, Lille, France

OTHER ORGANIZATIONS

Commission of the European Communities

Mr Martin Lund, Directorate-General Employment, Industrial Relations and  
Social Affairs, Commission of the European Communities, Luxembourg

OBSERVERS

Professor M. Davies, 1 Matityahu Street, Jerusalem, Israel

Dr Lis Keiding, Community Physician,

c/o The Danish Institute for Clinical Epidemiology, Copenhagen, Denmark

WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr J. A. Bury  
Regional Adviser for Training and Research in Public Health

Dr M. Danzon  
Director, Country Health Development

Dr Hanna M. Hermanova  
Regional Adviser, Elderly, Disability and Rehabilitation

Dr A. P. Hovanesian  
Short Term Professional, Cooperation with CCEE

Dr V. Jungclaus  
Short Term Professional, Health Services

Mr A. Nanda  
Regional Adviser, Epidemiology, Statistics and Health Information

Dr A. Nossikov  
Epidemiologist, Epidemiology, Statistics and Health Information

Dr R. Prokhorskas  
Statistician, Epidemiology, Statistics and Health Information

Dr Anna Ritsatakis  
Country Health Policies

Ms M. Shabanah  
Technical Officer, Epidemiology, Statistics and Health Information

Dr Anne-Marie Worning  
Medical Officer, Quality of Care and Technologies

Dr J. Zakonyi  
Project Officer, Concern for Europe's Tomorrow

Dr E. Ziglio  
Regional Adviser, Health Promotion

Headquarters

Mr M. Subramanian  
Chief, Global Support Programme, GSP/HQ

