Regions for Health Network
Evaluation of health policies and plans

Twelfth Annual Conference
Valencia, Spain, 11 November 2004
ABSTRACT

Evaluations are becoming an increasingly necessary component of health policy development and planning. In the modern climate of constrained fiscal and human resources, evaluations serve as a tool to guide the development and planning of effective policies. It is crucial to know whether existing health policies and plans are indeed appropriate to match the needs of the regions, and to secure a strong evidence base on which to shape future plans. Evaluation is more essential than ever before to determine the extent to which health policies and plans have been or are likely to be successful in achieving predetermined objectives.

The objectives of the conference were to promote greater awareness of the importance of evaluation; provide an overview of effective evaluation methodologies; and to engage conference participants in discussion and agreement on effective evaluation strategies related to the improvement of healthy life expectancy, health services, public engagement, and health equality.

Keywords

HEALTH POLICY
REGIONAL HEALTH PLANNING
EVALUATION STUDIES
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EUROPE
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Introduction

Purpose

Evaluations are becoming an increasingly necessary component of health policy development and planning. While methods and approaches may vary according to specific areas of focus and desired outcomes, all evaluations aim to influence the decision-making process. In the modern climate of constrained fiscal and human resources, evaluations serve as a tool to guide the development and planning of effective policies.

The process of devolution over the past few decades has increased the importance of regions. For some regions, decentralization as a process and management strategy is not new, for others, it is a recent concept. For all, it is crucial to know whether existing health policies and plans are indeed appropriate to match the needs of the regions, and to secure a strong evidence base on which to shape future plans. Evaluation is more essential than ever before to determine the extent to which health policies and plans have been or are likely to be successful in achieving predetermined objectives.

The objectives of the conference were to:

- promote greater awareness of the importance of evaluation;
- provide an overview of effective evaluation methodologies;
- engage conference participants in discussion and agreement on the role of strategy and on effective evaluation strategies related to the improvement of:
  - healthy life expectancy
  - health services
  - public engagement
  - health equality.

Context

Each year, the WHO Regions for Health Network (RHN) organizes an Annual Conference on a timely topic for the regions. This 12th Annual Conference focused on the topic of evaluation as it relates to health policy development and planning at the subnational level.

In the new and changing Europe, there is an increasing trend towards decentralization and devolution to the subnational level. Regions in Europe find themselves with new roles and responsibilities for health – and new challenges. Developments in the European Union – the new public health policy and enlargement – will add to these, affecting health policy and systems development in both current and new member states. Enlargement in 2004 which included ten new countries mainly in central and eastern Europe has resulted in a European Union with great variations in health systems, policies, resources and population health status. The implications of this for the accession countries, their neighbours and the rest of Europe merit careful discussion. Regions must be ready to tackle the new challenges.
Outcome

The outcomes of the conference were to:

- identify a wide range of evaluation examples relating to many dimensions of health policy and practice, and the many benefits;
- identify key elements in managing the evaluation process;
- clarify the relationship between policy, planning and evaluation;
- provide practical examples of evaluation relating to three key areas and some of the issues that they generate:
  - health services
  - public engagement
  - health equality.

Summary

The meeting opened with a welcome from Mr Vicente Rambla Momplet, Regional Minister of Health of Valencia. There followed an address delivered by the Coordinator of the Regions for Health Network, Ms Wendy Tse Yared.

Three presentations set the scene to provide essential background for later discussions, 1) examples of evaluation in European regions, 2) evaluation of health reports and management arrangements in different parts of Europe and 3) the value and availability of information to help in planning and evaluating health systems and policy. Mr Alfonso Bataller, General Director for Development, Quality and Patient Care in the Valencian Regional Ministry of Health, spoke on the Evaluation of the Valencian Health Plan. Dr Helmut Brand, Director of the Bielefeld Institute of Public Health in North Rhine Westphalia spoke on two European projects: EVA – the Evaluation of national and regional health reports, and BEN – Benchmarking regional health management. Dr André Ochoa, Director of the Aquitaine Regional Health Observatory also spoke on two topics: Health indicators in the European Regions (ISARE), and Evaluation of a social and socio-medical policy for the ageing population at the subnational level in France.

Four presentations from regions followed. Valencia presented an integrated public health management information system, Catalonia presented their Health Plan evaluation, South Tyrol presented on some of the issues essential to understanding the impact of a diabetes programme, and Västra Götaland presented on the use of health economics in evaluation of the impact of a health promotion programme.

Following the plenaries, there was an opportunity for participants to choose among facilitated discussion groups, comparing evaluation issues with regard to: health services; public engagement and health equality – and identifying issues and examples of good practice. Each group fed back to an afternoon plenary session.

The meeting was closed by Mr Rafael Peset Pérez, General Director of the Valencian School of Health Studies (EVES).
Presentations and discussion

Opening
The hosts, the RHN and the new agenda

Mr Vicente Rambla Momplet, Regional Minister of Health in the Valencia Regional Government welcomed those present and introduced Ms Wendy Tse Yared, the coordinator of the Regions for Health Network.

Ms Tse Yared presented that the Network now contains 33 regions from 19 countries. This is the only Network at WHO that represents the regional level, allowing members to work together and complement national efforts to develop efficiency and effectiveness.

The three main objectives of this conference on evaluation were increasing awareness of the importance of evaluation; providing an overview of effective evaluation methodologies; and engaging conference participants in discussion and agreement on the role of, and on effective evaluation strategies related to the improvement of healthy life expectancy; health services; public engagement and health equality. WHO and the RHN were grateful to the organizers for their excellent work and to the delegates for their participation.

Session 1: Setting the scene – methodology for evaluation

Three presentations addressed major issues relevant to evaluation as a practical issue.

1. Evaluation of the Valencian Health Plan

Mr Alfonso Bataller, Director General of Development, Quality and Patient Care, in the Valencian Regional Ministry of Health made the presentation. The Health Plan is the strategic instrument for planning and programming the Valencia health system, and brings together the assessment of the population’s health needs and the basic health objectives and priorities for health policy. The Plan is a legal requirement and there is a permanent Health Plan Office to coordinate and evaluate the Plan.

For follow up, coordination and evaluation of the Health Plan, there will be a permanent Health Plan Office with four people working in it. The principles used in drawing up the Plan are a) to secure the participation of the community and social interests and of health professionals in prioritization and execution of the Plan, and b) intersectoral cooperation with and between the interests, including associations, local government, scientific societies, and other Regional Ministries.

There are five stages in the process:

- health status analysis – including health markers, Delphi opinion polls, a professional opinion study, a health survey and a sexuality survey;
- establishing priorities – using a technical committee (and applying the Hanlon method);
- setting targets – using a full technical committee, and groups of experts for each area;
- implementation – through the agents;
• the evaluation cycle – through the Health Plan Office, follow-up committees and inspection.

The Plan’s structure is based around general objectives, targets, and intersectoral cooperation and make use of a number of tools and tracer markers. The general objectives related to equity and health, and healthy public policies. The health gain targets comprise 11 priority areas of activity, 78 Health Plan targets and 128 lines of action.

The 11 priority areas include eight relating to medical issues – cardio-cerebrovascular, cancer, HIV-AIDS, respiratory, osteoarticulare, mental health, traffic accidents, and vaccines, plus three others – habits & lifestyle, environment & settings, and social health. Habits & lifestyles include tobacco, alcohol & drugs, food & nutrition, sexual health, and exercise. Environment & settings include working health, the environment and food safety.

Evaluation is being led by the Health Plan Office, and overseen by a Multidisciplinary Follow-Up Coordinating Committee, and by 20 Health Areas Evaluation Coordinating Committees. In addition, there is intersectoral coordination and a review of sources of information. The overall evaluation of the Plan involves assessing the degree to which targets are fulfilled and the degree to which set activities are accomplished. The results are included in an Annual Report to the Valencia Regional Health Council.

Of the 78 targets, 52 have been achieved, 19 partially achieved and seven are unachieved or unevaluated. Of the 128 lines of action, 92 have been achieved, 27 partially achieved and nine are unachieved or unevaluated. Success has been achieved particularly in relation to lifestyle and vaccination.

The intersectoral cooperation “Health Promotion Plan in our setting” involves a number of separate elements. There are committees dealing with Health Education, Analysis of Emerging Health Problems, the Impact of New Technologies on Health, Environmental Health and Family Health Committee, and projects on health promotion in companies and in the prison setting.

The legal basis for developing the Plan was Valencian Law 3/2003 on the Valencia Regional Health System. Other important tools are training undertaken by the Valencian School for Health Studies (EVES), health research, partnerships for health, international cooperation, community and professional participation, improvement of quality, technological evaluation and information systems. Tracer markers used are immunizations, nosocomial infection, perinatal health, the percentage of losses in organ donation, the proportion of diabetics with good control, potentially avoidable hospital mortality and vaginal birth after caesarean and caesarean rate.

Mr Bataller also set out the timescale for the Health Plan for 2005–2009, which was under development. This would involve a number of elements – evaluating the previous plan, formulating the new strategies, assessing the health situation, identifying the actions areas and defining the lines of action, public debate, and securing political approval. Publication was programmed for December 2005. In its work the Health Plan Office would be supported by a Management Council and a Technical Committee. It would work with Multidisciplinary Committees and with work groups to support intersectoral engagement, and with Health Area Evaluation Committees and with a Medical Consultative Committee, Health Councils and the public on territorial engagement and participation.
In response to a query on grounds for change from four years for the previous Plan to five for the new one, Mr Bataller explained that the four years had passed very quickly and there was general support for a longer period. There was a need to organize to deal with new problems such as immigration, emerging diseases and new drugs, and the fact that other regions in Spain are adopting a 5–6 year period.

2. Benchmarking regional health policies and reports – experiences from European projects

Dr Helmut Brand, Director of the Bielefeld Institute of Public Health in North Rhine Westphalia, spoke on two European projects. These were related to the elements of the policy action cycle – assessment, policy development, action/assurance and evaluation.

The first was EVA – Evaluation of national and regional health report.¹ A part of the Health Monitoring Programme of the European Union, this involved collecting national and regional public health reports in order to evaluate them against the expectations of policy makers and identify best practice models of effective health reporting (“assessment” in the policy action cycle). The Assembly of European Regions definition of ‘region’ was used to select the regions participating. The project contained five elements – collecting the reports; setting criteria for reporting; ascertaining the expectations of users; analysis of the reports against the criteria and expectations; and identification of the best practice model.

In total 54 national health reports were collected and 118 regional reports, and 57 reports were analysed using seven dimensions:

1. comprehensiveness: coverage of different health issues
2. structure: presentation of information
3. policy orientation: support for health policy
4. conceptual approach: development of concepts in contrast to data-driven
5. integrative approach: interrelation of different health issues
6. prospective approach: identification of trends, health targets and future aspects
7. data: quality, comparability, validity.

National reports were stronger on integration, while regional reports were stronger on policy orientation – being closer to the implementation process. For each of the seven areas a best practice model was identified.

Simultaneously, a qualitative analysis of semi-structured interviews with policy makers on every level was carried out to get an insight into the experiences, ideas and expectations of these particular user groups. In the first part the policy makers were asked about their knowledge and thoughts about their respective health reports:

What did/do you like or dislike?
What was missing?
Have you quoted parts of it in speeches or statements?
Have you discussed it?
Do you know of political consequences due to the report?

¹ http://www.eva-phr.nrw.de
The second part of the interview concentrated on individual requirements of an “ideal” health report:
What would a perfect health report contain?
How should it be formatted?
What are the most important topics?
Which style is the best?

Analysis showed a gap between the reports and the views of policy makers. Health reports differed widely and tended to include lots of issues and indicators, while policy makers wanted analysed information about health status and determinants linked to the provision of health care and finances, future health trends and an evaluation of implemented activities. *The Public Health Status and Forecasts* documents from the Netherlands were among the best reports.

The second project, **Benchmarking Regional Health Management** was aimed at extending knowledge of regional health policies with respect to governance of health programmes and processes, administration of regional public health authorities, financing institutions and providers and institutional arrangements for monitoring activities (‘policy development’ and ‘assurance’ in the policy development cycle). It had intended to support a learning process among European regions using the variations between different regional health care regulations and activities. Measles immunization and breast cancer screening were the examples chosen. One was a simple prevention intervention and the other a more complex screening service. The project looked at how an overall objective led to different structures, processes and outcomes in different regions. Detailed questionnaires, additional background information and face-to-face interviews were used to gather the relevant information on the health policies in eight European regions. The analysis showed an immense variety in the organization, implementation and evaluation of these programmes.2

The participating regions gained knowledge and understanding on different ways of working and on how to improve their own prevention and screening programmes. Although their socio-economic and historical backgrounds were very different, it was possible to undertake an international or interregional benchmarking with the aim of identifying ‘good practice models’.

A key finding was that a questionnaire was not enough to discover what was happening; much more analysis was required to understand how a system worked in a given situation. The variations at regional level were greater than those identified at national level. There must be more emphasis on outcomes, rather than just process, but it was important to realise that establishing a mature process takes time.

In conclusion, to support continued learning among European regions and to achieve more transparency across the different regional health systems, it would be beneficial to involve a far larger group of regions, and give special consideration to political and socio-demographic backgrounds as well as epidemiological developments. This would allow comprehensive benchmarking and the identification of good practice models for each group, enabling regions to implement changes according to the procedures most similar to theirs. The follow-up project BEN II aims to achieve this and was still open for RHN members to join, and the uptake of evaluated interventions in different regions would be compared.

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2 [http://www.ben-rhm.nrw.de](http://www.ben-rhm.nrw.de)
In response to questions, Dr Brand emphasized the potential importance of reports as a means of engaging politicians’ interest and understanding relating to health issues. The political importance of the reports could be greater than their technical significance, and their length and level needed to reflect this. BEN I had been a feasibility study that had disclosed what does not work as well as a very surprising variation in practice. The results were being incorporated into the second study.

3. Health Indicators in the European Regions (ISARE) and Evaluation of a social and socio-medical policy for the ageing population at the subnational level in France

Dr André Ochoa, Director of the Aquitaine Regional Health Observatory also spoke on two topics. The first was Health Indicators in the European Regions (ISARE). This project was based on a view that national averages hide important variations and that the regional level is important in health policies and in the management of the health system. It aims to gather useful information about health indicators in the regions of the European Union.

ISARE has completed two phases. The first examined the broad availability of information and studied 130 indicators across nine areas. The second phase defined and collected data and established an experimental database. The 130 items in ISARE I were refined into a set of 17 data elements all the regions of all the 15 participating countries were to provide along with a list of 21 data elements from one region in each country. Examples were presented on availability and quality of data collected relating to health professionals, health facilities, demographic and socio-economic variables, mortality and prevention. The analysis looked at the availability of the data, its conformity to the definition used, its suitability for policy, and its quality. On this basis some of the data was accepted, and some not. A demonstration was provided on how the database was constructed, and how data can be displayed, using maps and graphs. The links to the European Union’s Health Monitoring Programme were also noted.

The ISARE II project demonstrated that the construction of a health database at the regional level was possible. In terms of quality, there was good regional and temporal comparability, but, while infra-national comparability is possible, international comparability is less reliable. There remained some issues to sort out in terms of defining regions in a way that was generally acceptable.

The presentation on Evaluation of a social and socio-medical policy for the ageing population at the subnational level in France described how French “départements” are responsible for developing policies for the elderly, disabled, youth, and other vulnerable populations, through five-year programmes.

Since 2002, France has a law in place that these programmes must involve both implementation and evaluation. Because in the Gironde département the policy for the elderly had been agreed prior to 2002, evaluation was not included in the planning and had to be incorporated after its implementation. There were many difficulties that arose through having to add in evaluation at that late stage.

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3 http://www.isare.org/
4 demography, socio-economic variables, mortality, health status, morbidity, health professionals and facilities, health care utilization, health determinants and risk factors, and poor living and working conditions
A process was adopted to analyse the relevant policy document and identify the implementation stages. For each stage, indicators were identified to evaluate it, and these would be used to monitor the implementation of the policy over the next five years. For example, the programme for the elderly contained three important elements: integration and prevention; developing services; and coordination. In the services element there were two objectives:

- to develop services to help older people who stay at home, and
- to develop services to improve the social structures for the elderly.

Each of these contained seven proposals and indicators had been developed for some of these:

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<th>Proposal</th>
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<td>to develop services to help older people who stay at home:</td>
<td>- number of nurses per 1,000 inhabitants over 65 and number of communes</td>
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<td></td>
<td>without nurses;</td>
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<td></td>
<td>- number training;</td>
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<td></td>
<td>- number and rate of places;</td>
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<tr>
<td>- to improve nursing performance;</td>
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<tr>
<td>- to develop training;</td>
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<td>- to create new forms of placement;</td>
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<td>- etc.</td>
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<tr>
<td>to develop services to improve the social structures for older people</td>
<td>- number of emergency ‘beds’;</td>
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<tr>
<td></td>
<td>- number of new places</td>
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<tr>
<td>- best organization to receive the elderly in a social emergency;</td>
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<td>- to create more places;</td>
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<td>- etc.</td>
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The indicators made it possible to assess regularly whether the objectives of the programme were being met, and to assist the political level in making any modifications. One of the main difficulties lay in correctly defining the actions and in the identification of the most appropriate indicators. The programme would be followed up by a committee, with annual analysis of its performance over five years and modified if necessary.

The exercise demonstrated that, if an evaluation component is not developed at the beginning of the project, it is always difficult to carry out the evaluation. For all new programmes, evaluation components must be defined at the project planning stage, and it is important to establish clear stages in a programme.

In subsequent discussion, it was pointed out that that the indicators used in the ISARE project had been for experimental purposes only, and could not be used to make comparisons; details were available in the project’s report.
Key elements in managing the evaluation process include:

- the need to include quantifiable measures from the beginning;
- the need to target reports to politicians that aim at change, using language and content that meet their expectations;
- the importance of multi-level and multidimensional evaluation of complex programmes;
- recognition that practice will reflect local culture and that comparative evaluation needs to allow for this.

**Session 2: Regional experiences in evaluation**

Four member regions presented further examples of evaluation.


Mr Manuel Escolano, Director General of Public Health in the Regional Ministry of Health of Valencia pointed out that there was a need to get the best value and greatest efficiency in the health systems across Valencia, and to this end the region had been developing a public health management information system – SISGEREN-SP (*Sistema de Información Gerencial de Salud Pública*).

General characteristics of the system had been developed over two years to be implemented in 2005. In the public health area there is much information and a wide variety of organizations dealing with issues such as health promotion, food safety and epidemiology. The aim was to build an integrated approach, by creating a management information system that could extract data from other systems and make it available to be analyzed, evaluate and used in a smart and effective way. The result would be information that was easier to use and lead to ways to use them better.

The objective of the project was to use the information contained in the feeder systems for detailed tracking of each project, real-time evaluation and appreciation of the situation; analysis and decision-support; resource planning and control; support for training and investigations; and to meet legal requirements.

The product would be dynamic, in that the data retrieved would depend on the question posed interactively; responsive, as the user could generate new indicators according to need; and helpful to managers through synthesizing large volumes of data, allowing graphical analysis and supporting decision-making at every responsibility level. Data would be drawn from the various sources, cleansed and transformed, and then kept in a data warehouse for use through other user applications or via ad hoc enquiries.

The system would offer the user the analytical capacity to identify the following:

- the nature and scale of health problems and the factors that underlay them;
- the activity undertaken within programmes, in terms of quality, quantity and characteristics;
- the effectiveness and efficiency of programmes;
• the effectiveness and efficiency of the resources available, and their use at any moment; and
• population groups suitable for inclusion in health programmes.

It would support monitoring in these areas.

The indicators would draw on data from several services – those dealing with issues such as vaccinations and lifestyle; epidemiological data such as that on tuberculosis and outbreaks; food safety; workplace safety; the AIDS service and the child and women’s health service. The data from these sources could be used in many ways, and the user could drill down to greater detail or combine elements to give a sharper picture for a particular purpose. Data could be shown graphically or exported to other applications such as Excel and Word.

**Catalonia: Evaluation of the Catalanian Health Plan**

Dr Ricard Tresserras, Deputy Director for Health Planning in the Department of Health of Catalonia, gave the presentation on the Catalonia Health Plan which is very similar in principle to that demonstrated for Valencia. The cycle which followed in Catalonia were: baseline analysis; prioritization; definition of target and intervention; activities under the Plan; and finally, evaluation.

Most of the Health Plans developed in Spain followed the recommendations of the strategy of the WHO Regional Office for Europe’s “Health For All in the Year 2000”. The Health Plan for Catalonia established targets for the year 2000 related to the health problems that were considered priorities according to the available epidemiological information.

The targets had time limits and quantitative levels to be achieved. There were three types of targets:

a) general health targets – such as reducing stroke mortality by a percentage by a defined date;

b) risk reduction targets – such as increasing hypertension control by a percentage by a defined date; and

c) operational targets – such as measuring blood pressure for a certain group by a defined date.

In order to evaluate the achievement of the targets established in Catalonia for the year 2000, a systematic study of all general health and risk reduction target was carried out.

Evaluation was multidimensional. Two main sources of information were used. One was the routine information systems like mortality data, hospital discharge data or compulsory disease notification, and the other drew on specific epidemiological studies such as the Catalan Health Survey with physical health examinations, a nutritional survey, a serological survey, an audit of primary health care records and a survey of smoking among health professionals.

The result shows that five of the 111 established targets were not evaluated because of difficulties in its formulation or of the cost to obtain the proper indicator. Another five remained to be evaluated through the Catalan Nutrition Survey that should be carried out later. Therefore, 101 targets were finally evaluated, and of these, 69 (68.3%) were achieved, eight (7.9%) were
achieved only partially. More that 50% of the expected change was registered, and 24 (23.8%) were not achieved.

The evaluation of the targets of the Health Plan for Catalonia for the year 2000 was possible due to information available through already existing sources of health information and also to “ad hoc” epidemiological studies that were carried out. The results indicate that most of the targets were achieved. The targets related to lifestyles were those with the lowest degree of achievement.

The benefits of a health plan like this include:

- providing a clear framework for health policy
- involving health professionals
- promoting dissemination of objectives and interventions
- providing political accountability
- supporting service contracting and creating a culture of evaluation.

A next step would be to link the Plan more closely with service planning.

**South Tyrol: Diabetes – the need for epidemiological studies in evaluating health impact**

Dr Peter Kreidl from the Epidemiological Observatory in Bolzano, South Tyrol, presented on the need for epidemiological studies as a basis for the evaluation of the impact of programmes, taking the example of diabetes in South Tyrol. The estimated number of diabetics in Italy is more than 1.7 million, and is likely to double by 2025. Diabetes is the most common cause of blindness in persons aged 20–70 years, and is the third most common cause of chronic renal failure in Italy. It will increase the mortality due to cardiovascular complications by 30%, and the per capita cost of diabetics is three times the cost of others, with 60% of the cost due to hospital admissions because of complications.

Two studies aimed to identify the size of the diabetes problem in South Tyrol and the areas where primary, secondary and tertiary preventive interventions might improve outcomes, reduce risk factors and improve quality of care. The ARGENTO study used standardized interviews and measures of blood pressure, weight, height and fasting blood glucose to levels to survey a cluster sample of 210 people in the region aged over 64. The QUADRI study used a standardized questionnaire to look at 200 randomly selected people aged 18–64 years who do not pay fees for medical visits due to diabetes. The questions related to customer satisfaction, prevalence of risk factors and complications, information status, and behaviour.

Results were as follows. The estimated prevalence in the region was 10% for females and 11% for males aged over 64 years. In addition, 5% of females and 5% of males showed blood glucose levels over 125 mg%. In total, among the QUADRI sample of diabetics aged 18–64 years, 26% suffered complications, with retinopathy (16%) and cardiac problems (11%) the most common. Moreover, 61% were reported as having hypertension, but nearly a quarter reported receiving no treatment, and 45% reported as having hypercholesterolemia, of whom half said they had no treatment. Nearly half of the diabetics were overweight and 25% were obese. More than a third had an additional risk factor to their diabetes and nearly a third reported more than one. A third
of diabetic men and a fifth of the women were smokers. Nine out of ten had a good physician-patient relationship.

Slightly more than half seemed to know about HbA1c, while only 42% had had an HbA1c check in the previous four months as recommended. One quarter in diabetic treatment claimed not to know how to handle a hypoglycaemic crisis. Half were aware of the need to check their feet but only 5% of all checked their feet on a daily basis. Personal checking of blood glucose levels was 97% among insulin-dependent diabetics.

In concluding, there were gaps between the scale of the problem and the levels of control, what people need to know and what they do know, and what they know and what they do. The high percentage of potential diabetics without a confirmed diagnosis suggested that more examinations and testing were needed. Many diabetics knew how they should behave, but did not follow advice. Information and education need to be improved. The findings would be used to develop targeted programmes in the region.

**Västra Götaland: The use of health economy in evaluation of disease prevention – a case study from the Västra Götaland region**

Dr Göran Henriksson, the focal point for Västra Götaland, presented on the use of health economics in evaluation of the impact of a programme on the prevention of hip fractures in Lidköping, a ‘safe community’ in his region. The purpose of the study was to explore the extent to which a community programme contributed to health gain and to identify resource issues. The hypothesis was that it might strengthen the arguments for public health interventions. The example chosen related to hip fracture reduction: hip fractures decreased, but what was the relative value of the programme?

Data sources used in the process included:

- **document analysis** on the process of the prevention programme;
- **interviews** with key informants;
- **estimated costs** – for different sectors involved; the amount of working time spent; and costs for treatment and rehabilitation of hip fractures;
- **epidemiological data** – relating to he incidence of hip fractures, and age and sex structure;
- **a literature review** of health economic studies of prevention, treatment and rehabilitation of hip fractures.

The project first estimated the health gain, and secondly the costs for the programme minus the costs for the preventive programme. These data founded a cost-utility analysis which calculated the cost per QALY (Quality Adjusted Life Years (QALYs), as proxy for health gain) for the Lidköping community model and for alternatives, including pharmacological treatment against osteoporosis using Tibolone. The result was an estimate that, if the Lidköping model had been adopted across the region there would be a reduction of costs for treatment and rehabilitation of hip fractures of over 17 million euros and a net health gain of over 2000 QALYs, each year. The cost per QALY using the Lidköping model was a cost reduction of 7600 euros per QALY whereas the corresponding cost reduction from the pharmacological treatment against osteoporosis using Tibolone was 330 euros.

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5 [http://www.phs.ki.se/csp/safecom/lidkoping2.htm](http://www.phs.ki.se/csp/safecom/lidkoping2.htm)
In conclusion, broad community programmes can be very cost effective. Investment should be toward the creation of a better knowledge base for health economic analyses within public health programmes.

Planning and evaluation are complementary, and benefit from

- a clear understanding of the epidemiological background;
- good data available when it is wanted, ideally in real time;
- clarity about objective;
- clarity about contributions;
- an application of health economic techniques to demonstrate the comparative benefit of alternatives;

and can support

- wider engagement of important stakeholders;
- better collaboration;
- a culture of improvement.

Session 3: Working groups on effective evaluation strategies

Three groups were formed to discuss particular aspects of the application of evaluation to health issues. The topics covered were health services, public engagement and health equality.

a. Health services

This group was chaired by the focal point representative from the Northern Region of Israel, Dr Sonia Habib. The topic was chosen because evaluation of health services is too often overlooked. It is frequently ignored since it is not always seen as directly productive, even though it is the only way to learn from the successes and failures of the past and thereby improve policies and procedures for the future.

The role of health information is closely associated with the planning and evaluation of health services. Health information is used widely for the monitoring and evaluation of health services at the national level. However, because information may not be as complete or available at the regional level, it may be difficult to use as an evaluation tool.

Ms Machteld Wauters, the focal point from the Flemish Community, presented feedback. From the group there were five examples of evaluation in practice. The first was from Northern Israel, where it was discovered that cases of thalassaemia were occurring despite the fact that a screening programme had been running for many years. An evaluation of the programme revealed that only 71% of the target population was actually being screened. Action was initiated to correct this, with an intervention to increase staff awareness. After two years the success rate was increased to 97%.

The second example involved the use of the European Fund for Quality Management model to improving communication with clients in the field of environmental health.

The third was a sight examination administered to schoolchildren. The test was well established but the validity had not been evaluated. When this was done, it was discovered that validity was
80% but reliability was weak, because of differences in the nurses’ behaviour, which was corrected through training.

The fourth example came from Ústí where work is in progress to evaluate the efficacy of early vaccination to prevent the development of allergy beyond the early phase.

The last example was from the Russian Federation, where evaluation was performed using a questionnaire. This information process was aimed to change the attitudes of children in order to reduce drug use, which was linked to HIV incidence. The information process was found to be effective, with the result that drug use has actually decreased.

Catalonia added a good example of evaluation on the topic of mammography.

b. Public Engagement

This group was chaired by the focal point from North West England, Mr Peter Flynn. Public engagement is important in decision-making processes, because it gives legitimacy to policy-making, facilitates implementation, and increases the success of programmes.

Public engagement is not easy to achieve, especially when the population needs are very diverse. Educating and informing the population is an important component of public engagement. Mass media such as television, radio, workshops and print campaigns have proved to be effective for raising public awareness and informing the wider public. In addition, surveys, conferences, involvement of community leaders have been employed to inform and involve the public, providing important input to policy-makers. Public engagement is essential since policies which people are informed about, and which are accepted by the public, are more likely to be sustainable and effective.

Dr Jacek Czapla of Upper Silesia reported back from this group. The group had identified three categories of public engagement:

- people engaging with their own health and with health promotion
- engagement in health policies and programmes
- engagement in health and social service delivery.

The group discussion was on three issues. The first related to sexual health in England, where after some years the strong message that had once been communicated to younger people seemed to have got lost, and the effectiveness was much reduced. Evaluation found that there was poor education in schools, that there was resistance in religious schools, and that information campaigns were having no effect.

The second related to patients’ rights, and information about the costs of and need for treatment. There are different communication channels for patients’ rights and different ways of giving information on treatment. One approach was to develop ‘expert patients’, giving specially designed education for patients with particular conditions.

The third area was on how to establish a system for influencing policies and programmes. In some countries authorities set priorities together with communities.
The group formulated three conclusions. The first was that the medical professional cannot act alone, but must involve the particular target group, first defining the subject of the involvement and the reason for it. Second, as poor evaluation results in poor evidence, there is a need for more and better investigations, with good techniques used well. The third was that involvement policies need to engage the whole community, address particular at-risk groups and span across the whole health care system.

c. Health equality

This group was chaired by the focal point from Sicily, Dr Pina Frazzica. Equity is a particularly difficult subject to evaluate because it can be defined in a number of different ways, even for the same situation. Equity implies “that everyone should have a fair opportunity to attain his or her full health potential and, more pragmatically, that no one would be disadvantaged from achieving this potential”. Due to differences in socio-economic conditions, spending the same amount of money in different areas can have different results.

The feedback was presented by Dr Christopher Riley of Wales. After discussing two cases (a study in England which looked at unequal access to cardiac surgery services in a geographical area, and a special programme in Wales which provided funds to try to reduce inequality in health and which was being evaluated), the group selected five examples to feedback. The first two related to the evaluation of projects to improve Roma health in Hungary. A special centre was provided as a local place for Roma to receive first aid and health promotion and access information via computers. The second project was a Roma pregnancy programme where advice and support was provided. The messages that emerged were that it was essential to convince the local population and politicians that this is important and that it can have an impact, and that the tools and methods selected to carry out the evaluation must match local culture and that there must be greater use of qualitative methods.

The third and fourth examples came from Sweden. One was related to child health care and mother health care in Sweden. Under the Swedish system, all groups in society are treated in the same way and are all offered full equity of access. Long experience and results show that the programme has been every effective in reducing health inequalities across society. The other example came from northern Sweden, where an initiative aimed to reduce heart disease. It achieved its objective, reducing occurrence in all social classes. The lessons from this study were that it is valuable to build evaluation in from the beginning, and that it is important to have close collaboration between the local community, the municipality and the university.

The final example came from Sicily where a successful quality initiative had improved quality of access to all geographical areas across the region. The lessons from this were the importance of planning in advance and selecting a small number of very good measures.

In concluding, the group identified some observations. The first was that they had some difficulty in thinking of examples, which suggested that this might be an area that needed more work. One source which was mentioned was a report from the Centre for Review and Dissemination in the United Kingdom. A point made in discussion was that there must be more use of not only averages but of distribution measures, which analyzed differences within populations. It would be important to involve politicians who could champion greater interest in inequalities. A final suggestion was that this would be a good topic for a conference.

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In response to how these measures were selected, Sicily responded that they were identified by the working group, and that it helped to have very clear, measurable objectives from the start. Västra Götaland added that in the case of inequalities there too were some good measurement tools – such as the Gini Coefficient and a number of dissimilarity indicators. North West England observed that there was little evidence that public health policy had had a great impact, despite efforts over decades, and this was due to the lack of good evaluation. This must be addressed through ensuring that there is a strong public health research and development strategy alongside for clinical services.

The case studies confirmed that

- evaluation of health services is both possible and of enormous benefit in ensuring resources are used to most benefit;
- evaluations involving the public must be well designed and targeted;
- evaluations relating to inequalities need to work with the broad community and use appropriate tools and measure;

and that there is a huge value in conducting such studies

Closure

The General Director of the Valencian School of Health Studies (EVES), Mr Rafael Peset Pérez, thanked the participants for their contributions to the conference. It had been an honour for the region to host those who had attended and taken part in making possible and successful this event, which had aimed to promote health. Appreciation was also expressed to Dr Carmen Sanchis Piñol on behalf of the Valencian Minister of Health. The conference reflected the conviction of the many people who attended that they must work together to improve health and well-being across Europe, both ‘old’ and ‘new’.

Excellent training could not exist without excellent research, and therefore the Valencian School of Health Studies need to be in contact with the best ideas and most relevant policies in the region and in Europe. Daily experience of working enables the monitoring of strengths, weakness, opportunities and threats, contributing to progress.

The experience of the conference, learning of plans and tools from others, helps everyone towards their goals, which must now be understood in the context of the momentous changes caused by globalization. New communication technologies could make it easier to eliminate barriers between regions, but all had to realize that it would not be easy to overcome political and legal obstacles, which might slow progress. The network was congratulated on its programme of projects, and that the region of Valencia would work on the policy sharing and investment in health projects.

The Minister of Health of Valencia was fully behind the work of the Network and of the Valencian School for Health Studies, and wished the Network every success with the WHO in taking forward its work and establishing solidarity across Europe.
Annex 1

AGENDA

1. Registration

2. Opening session
   Welcome by Valencia
   Welcome by the RHN Secretariat, WHO Regional Office for Europe
   Adoption of the Programme, nomination of Chair and Rapporteur

3. Setting the scene
   Methodology of evaluation
   (a) Evaluation of the Valencian Health Plan;
   (b) Benchmarking regional health policies and reports – experiences from European projects;
   (c) Two-part presentation (a) Health Indicators in the European Regions – ISARE (b) Evaluation of a social and socio-medical policy for the aging population at the subnational level in France.

4. Regional experiences in evaluation
   (a) Valencia
   (b) Catalonia
   (c) South Tyrol
   (d) Västra Götaland

5. Parallel working groups

6. Presentations from working groups and discussion

7. Closure of the meeting (17.30 hours)
Annex 2

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