Committee of Senior Representatives (CSR)
Twentieth Meeting
Helsinki-Vantaa, Finland
19-20 April 2012

Northern Dimension Partnership in Public Health and Social Well-being
www.ndphs.org

Reference	CSR 20/6.3/1
Title	Proposed targets and indicators for the Priority Area 12, health sub-area of the EUSBSR Action Plan
Submitted by	Secretariat
Summary / Note	This document contains a consolidated proposal regarding the targets and indicators for the Priority Area 12, health sub-area of the EUSBSR Action Plan consistent with the provisions in the NDPHS Work Plan for 2012. It is based on the contributions received by the Secretariat from the respective Expert and Task Groups.
Requested action	For decision

1. Introduction

The NDPHS Work Plan for 2012 stipulates, inter alia, the following: "(2.2) Develop targets and indicators (1-2 per each priority action in the EUSBSR Action Plan and 1-2 for the Strategy general level). These targets and indicators shall be developed by the Expert Groups in coordination and cooperation with the NDPHS Secretariat and be submitted to the spring CSR meeting for approval for subsequent presentation to the European Commission. They shall be in full coherence with and complement the NDPHS Operational Targets and Indicators."

The EUSBSR targets (both at the strategy level and those for each Priority Area) are supposed to strengthen the monitoring of the EUSBSR and provide a basis for a comprehensive evaluation system aimed at the Strategy becoming more operational and result oriented. In addition, **clearly set indicators and targets would support alignment of funding to the actions and Flagship Projects within the EUSBSR, especially in the context of planning the EU Cohesion Policy 2014-2020**.

Although the health-related EUSBSR targets and indicators are supposed to be in full coherence with and complement the NDPHS Operational Targets and Indicators, they will be of a different nature as compared to the NDPHS' process/coordination indicators, which describe what processes will be put in place and the outcomes thereof, but do not focus on impacts and quantifiable results. The EUSBSR indicators, on the other hand, put emphasis on quantified results, the impact of the EUSBSR and the positive changes brought by it.

2. Proposed EUSBSR targets and indicators and further steps

Consistent with the above provisions in the NDPHS Work Plan for 2012, the Secretariat, on the basis of the contributions received from the NDPHS Expert and Task Groups, has prepared a consolidated proposal regarding the EUSBSR targets and indicators (cf. Annex to this document).

The CSR is invited to consider the proposed targets and indicators for the Priority Area 12, health sub-area of the EUSBSR Action Plan and approve them for submission to the European Commission, as appropriate.

Annex

Proposed targets and indicators for the Priority Area 12, health sub-area of the EUSBSR Action Plan

Expert/Task Group	**Contribution to the NDPHS Strategy** *List the number(s) of the NDPHS Strategy Goal(s) (if relevant)*	**Baseline Value/Situation and the information source** *Describe a value of indicator before intervention, the current (or in year X) state of play – can be expressed as a number or be a description of situation.* *Specify the source of information for numerical values, if available.*	**Target Value/Situation** *Describe the intended value (quantified or a desired development trend) of indicator after intervention (in year X).*	**Proposed Indicator Name and Description** *Indicator: a reflection of an objective that captures what we plan to achieve/change/influence/facilitate – a variable that provides quantitative or qualitative information on some aspects of our objective – measurement unit necessary.* *Distinguish between: (i) cooperation dimension indicators, which capture improvements in the way of cooperation and (ii) policy dimension indicators, which capture the changes and improvements resulting from (i).*
ASA EG	Goals 6 and 7	Harmful alcohol use affects public health extensively and it is considered to be one of the main risk factors for poor health. Due to its contribution to the global	**By year 2020 strengthened coordination and policy development between the ND and BSR**	**Indicator 1.1: Policy recommendations for the NDPHS Partner Countries to reduce the harmful use of alcohol have been developed** (cooperation dimension).

		burden of disease harmful alcohol consumption is listed as the third leading risk factor for premature deaths and disabilities. Reduction of harmful alcohol consumption is a good opportunity to improve health and social well-being.	**Countries in order to disseminate the knowledge base on the size and determinants of alcohol related harm and on effective interventions to reduce and prevent that harm has been achieved**.	Taking into account that many alcohol policy issues cross the ND and BSR country borders, sound actions collaboratively implemented within those countries will bring added value. The aim of document will be to propose a range of recommendations for Partner Country actions to be considered for the implementation and adjusted, as appropriate at the national level, taking into account national circumstances.
		Recorded adult per capita consumption has increased in most of the ND area countries over the period of 2000–2009 (WHO, 2011). Bigger increase of consumption has been reported in Estonia, Lithuania and Poland. Consumption has stayed quite stable in the Nordic countries. Alcohol policies still do not reflect the gravity of the health, social and economic harm resulting from the harmful use of alcohol; they fail to be properly integrated within	**Reliable alcohol policy has been developed by 2020**, with clear definition of alcohol-related terms, identical methods to measure alcohol consumption, and good monitoring in order to gain information on levels and examples of alcohol consumption.	**Indicator 1.2: Number of countries that have developed a written national multisectoral policy on alcohol** (policy dimension). A written national policy on alcohol in the ND and BSR countries is in place, which is multisectoral in nature (i.e. an alcohol policy which involves and is represented by multiple sectors such as the health sector, the social sector, the justice sector, education, employment, law enforcement, etc).

		overall health, social and development policies; and they fail to provide adequate capacity to ensure policy coherence and "joined–up" action between different government departments and sectors and at all levels of jurisdiction.	**By year 2020 alcohol policy measures have been integrated into all relevant actions that promote well-being and healthy lifestyles and that reduce the burden of NCD and communicable diseases.**	**Indicator 1.3:Number of countries that have developed plans and programmes for preventing public-health problems caused by harmful use of alcohol (policy dimension)**.
HIV/AIDS&AIEG	Goal 3	Most countries provide separate social and health care services for HIV-infected individuals in the ND area. A big amount of HIV-infected people belong to vulnerable groups as drug users, sex workers, migrants, men having sex with men etc. These groups are very difficult to reach by traditional separate services.	**Several countries in the region will have in place programmes on integration of health and social services for people living with HIV/AIDS by 2020.**	**Indicator 2.1: Policy recommendations aimed at integration of health and social services have been developed and implemented through international programmes.** **Indicator 2.2: Number of cooperation programmes focusing on strengthening the integration and capacity of social and health care systems.** **Indicator 2.3: Number of countries that have integrated social and health care services for people living with HIV/AIDS.**

NCD EG	Goal 12	By the end of 2012 a regional Thematic Paper on NCDs outlining the key problems in NCDs in ND area will provide the baseline data. (draft rev. 4 to be submitted to CSR-20 19.04.2012) Annual updates 2013-2014 Source: • WHO HFA data-base • OECD database • National vital statistics (for PYLL calculations)	**10% reduction in premature avoidable mortality (PYLL) in NDP countries' populations.** **10% reduction in the DIFFERENCE in premature avoidable mortality (PYLL) in NDP countries' populations.**	The potential years of life lost (PYLL) rate describes the number of potential years of life lost due to premature death in a population. From a social point of view, this is equal to loss of human capital. The rate is calculated on the basis of the difference between the age at death and the expected length of life, and it is determined by the cause of death according to the ICD-10. The method reviews the time of death in relation to pre-defined life expectancy. The rate is age-standardized and expressed as a sum of all deaths per 100,000 person- years. The PYLL rate provides comparable information about the wellbeing of a population concerning all death causes. It provides supplementary information for planning and decision-making for health policies. For more information see NDPHS Thematic Report 2012.

PPHS EG	Goal 5	Health inequalities exist when comparing different population groups in the BSR. Increasing prevalence of diseases is a burden for the society due to increasing health care and social care costs and decreasing productivity. Scientific evidence exists that the primary health care (PHC) plays an important role in addressing inequalities. In the BSR there exist barriers that the PHC could better address e.g. health needs of population vulnerable groups such as migrants, ex-prisoners, unemployed etc. (we could group barriers: (1) related to limited accessibility to services; (2) lack of appropriate competences of PHC professionals (nurses!); (3) lack of cooperation/teamwork with other sectors etc. **Proposed indicators: Increased accessibility to high quality**	Should be specified. 10% increase in accesibility to PHC for vulnerable groups such as migrants, ex-prisoners, unemployed.	Cooperation: based on the Strategy for Professional development of Primary health care doctors and nurses (to be developed by Imprim project until end of 2013), contry specific indicators should be developed on how/when to succeed accessibility to high quality primary health care doctors and nurses. Special attention should be devoted to vulnerable population groups.

		primary health care professionals/services: **(4.1) number of qualified (after special training in residency) family doctors per 1000 population** **(4.2) number of qualified (after special training) primary health care nurses per 1000 inhabitants** **(4.3) rate of visits primary health care doctors/secondary health care doctors** **(values should be specified**)		
OSH TG	Goal 10 (the EUSBSR targets and indicators proposed herein partly belong to and complement the Goal 10)	Great variations in working conditions in the health of the workers, and variation in access to preventive and health promotive occupational health services in the BSR and ND countries are a root cause for major inequities in health within and between countries. The potential	**By the end of 2013 a regional policy document outlining the key principles, policy options and governance tools for prevention and control of NCDs through workplace**	**Indicator 5.1. A regional policy document on Healthy lifestyles in healthy workplaces adopted by the 10th NDPHS Partnership Annual Conference in 2013** (cooperation dimension). The policy document developed through a joint project involving countries from the BSR and beyond, will

		of workplace as an effective arena for health promotion activities for adult citizens has not been fully exploited.	**health promotion programmes is in place.**	provide policy-makers with the key principles, policy options and governance tools for prevention and control of NCDs through workplace health promotion programmes. This guidance document addresses cardiovascular disorders relating to diet and physical activities, psychosocial risks relating to work demand and control, and occupational cancers through controlling cancer-causing agents (e.g., asbestos, benzene, ionizing radiation, shift work). The importance of multi-sectoral coordination with the occupational health and safety systems is elaborated
		Baseline in 2012: No ND/BSR country has a coherent national policy and framework for prevention and control of NCDs for all workers through workplace health promotion programmes. The workplace health promotion programmes are voluntarily introduced	**By 2017 all BSR countries, Norway and Russia have developed and implemented tools for prevention and control of NCDs through workplace health**	**Indicator 5.2. The number of the countries in the BSR and beyond having used the recommendations contained in the policy document and having integrated the proposed recommendations in their national strategies, policies, actions and activities by 2017** (policy dimension).

		to large companies in the BSR and ND countries. However, such programmes do not exist in most SME's and informal sectors, contributing to the health inequality related to the prevention and control of NCD at the workplace setting.	**promotion programmes**.	