

maternal health outcomes in the countries under investigation. Governments should aim to overcome the general social and economic problem of informality, improve the availability, skills and knowledge of medical staff and ensure vulnerable population groups have access to adequate maternal care.

## 4.H. Data, forecasting, evaluation: producing and using evidence

### Published Mortality Datasets – is Perfection the Enemy of Credibility?

Michael Rigby

M Rigby, S Deshpande, M Blair  
Imperial College London, London, UK  
Contact: m.rigby@imperial.ac.uk

#### Issue:

It is a core principle that health policy decisions, and appraisal of alternative approaches to service delivery, should be evidence based.

#### Description:

As population-wide measures of wellness, morbidity or functioning are scarce, mortality presents itself as a credible condition-orientated outcome measure, and one easily understood by lay policy makers as well as by professionals. However, the variation between the data published by two established sources appears to undermine the credibility of the principle.

#### Results:

The Models of Child Health Appraised (MOCHA) Project has sought to be innovative but credible in using mortality outcome measures. However, in practice there are two challenges. One is that Eurostat classifies causes of death by the 86 causes of the 'European shortlist', based on ICD10. Global Burden of Disease (GBD) records them using a self-specified 'cause hierarchy' separating causes into 4 levels.

Second, and more profoundly challenging, are the significant differences in resultant rates, and thus ranking of rates, between countries using the two sources, even when selecting apparently common cause definitions. For example, in 2015, for 20-24 year olds, GBD asthma mortality reported Finland ranking as the 8th lowest rate (0.06/100,000), but it was 29th in Eurostat (0.29/100,000). Similarly, GBD ranked neoplasm mortality in Croatia as 27th (5.80/100,000), but it was 7th in Eurostat (2.86/100,000).

#### Lessons:

Published data source conflicts undermine credibility of using basic data. This further challenges any use of deeper derivations.

With such variation on reporting of death by cause, and resultant differing results, production of credible conclusions is severely jeopardised. There is a need for rapprochement between the data analysts to minimise differences and give clarity to value adding calculations, if the utility of public health data is not to be severely compromised, especially where politicians are naturally sceptical.

#### Key messages:

- Differences between major mortality databases undermine their credibility.
- Reconciliation is needed if evidenced based policy making is not to be compromised.

### Essential health benefits in Italy: a dream came true after sixteen years. How will it be evaluated?

Alessandra Sinopoli

A Sinopoli<sup>1</sup>, D Coclite<sup>2</sup>, A Napoletano<sup>2</sup>, G Graziano<sup>2</sup>, A.J Fauci<sup>2</sup>, A Mazzola<sup>2</sup>, P Iannone<sup>2</sup>

<sup>1</sup>Department of Public Health and Infectious Diseases, Sapienza University of Rome, Rome, Italy

#### Key messages:

- This cross-country study of Bulgaria, Romania, Latvia and Moldova identifies barriers to accessing adequate maternal care.
- Women's experience is important for a comprehensive analysis of the provision of maternal care.

<sup>2</sup>Istituto Superiore di Sanità, Rome, Italy  
Contact: alessandra.sinopoli@uniroma1.it

#### Issue:

After 16 years of deadlock, the Prime Ministerial Decree (DPCM) on 12th January 2017 defined the new essential health benefits basket, so-called Essential Levels of Care – LEAs in Italy. Two agreements between the Ministry of Health/Directorate General of Planning and the Istituto Superiore di Sanità (ISS) were signed to support the Ministry of Health in the updating process for benefits and services. Particularly, the National Centre for Clinical Excellence, Quality and Safety of Care (CNEC) developed a framework to evaluate the inclusion of additional health benefits into the Italian LEAs.

#### Description of the problem:

In Italy, the central government has the duty to set the LEAs which must be guaranteed to all the residents, while the regions are responsible for the organization, delivery and planning of health services. Defining benefits and services to be included into LEAs is challenging for a large variation in people's health status across the regions. What is the decision making process to revise the LEAs? CNEC has set up a systematic and transparent methodological framework which takes into account various domains: consistency with the inspiring principles of the Italian NHS, disease burden, clinical effectiveness, risk/benefits, organisational appropriateness, recourses needed, feasibility, equity, ethical issues, costs, acceptability. This model has been calibrated to international standards recognized by scientific consensus (DECIDE project).

#### Results:

The framework was applied to evaluate the inclusion of additional health benefits for rheumatic diseases and eating disorders. Each health benefit is classified in "appropriate", "inappropriate", "suitable after modifications" and "to be reviewed" at final judgment.

#### Lessons:

International comparison is a powerful instrument for improvement, but there is a need for consistent costing rules to facilitate this process, as well as a European classification of health services to describe differences.

#### Key messages:

- Regions are responsible for ensuring the appropriate provision of LEAs to guarantee the rational use of resources at different levels of care.
- LEAs inclusion criteria based on a systematic approach.

### Competence demands for future health promotion

Kaija Matinheikki

K Matinheikki<sup>1</sup>, A Liinamo<sup>1</sup>, K Märk<sup>2</sup>

<sup>1</sup>Metropolia University of Applied Sciences, Helsinki, Finland

<sup>2</sup>Tallinn University, Haapsalu, Estonia

Contact: kaija.matinheikki-kokko@metropolia.fi

Qualified and multidisciplinary workforce is a prerequisite for sustainable health promotion. Health Promotion (HP) competences demanded in the future were studied in Estonia and Finland as part of the Health Promotion Programme project (HPP 2016-2019) funded by the European Regional Development Fund through Central Baltic Programme.

An online questionnaire was created based on the HP specialist's focus group interviews and other evidence based knowledge classified into nine domains of competence including 77 competence statements. Respondents, 588 from Finland and 249 from Estonia, represented professionals working in public sector, health enterprises, higher education institutions and NGOs. The internal consistencies were measured indicating highest reliability of the scales for nine competence domains (Cronbach Alpha from .787 to .912).

In both countries Enable change, Comprehensive knowledge base and Communication for health promotion were anticipated most essential competence domains in the future. "The competence to strengthen citizens' ability to take responsibility for their own health and well-being" was estimated as the top one sub-competence according to the Finnish as well as the Estonian respondents. Competence to strengthen cooperation across different sectors was also highlighted as essential especially by the Finnish respondents. The Estonian respondents emphasized the competences for advocacy and needs assessment as essential for Estonian HP in the future.

The survey results are utilized in designing new educational programs for professional Higher Education (10 programs) as well as for Vocational Education and Training (6 ones). The piloting of these new HP programs starts in Autumn 2018 in Estonia and in Finland.

**Key messages:**

- On the basis of the HPP research findings, concrete proposals will be addressed for integrating the findings into day-to-day practices in HP education and professional field.
- Results considered locally or globally critical to the future health promotion will be discussed.

**Evidence-Informed Health Policy (EIHP): implementation strategies for Kazakhstan**

Vitaliy Koikov

V Koikov, A Iskakova, A Akanov, A Abduazhitova, D Otargaliev, A Aubakirova  
Republican Center For Health Development, Astana, Kazakhstan  
Contact: vitaliy.koikov@gmail.com

**Problem:**

Creation of an effective health system is one of the primary goals in the Strategy of Kazakhstan development until 2050. Despite the measures taken in recent years (implementation of State programs for health development, joint project with the World Bank "Transfer of technology and institutional reform in the health system"), there is still no systematic and institutionalized approach to the EIHP. EIHP implementation can accelerate the realization of reforms, avoid common mistakes and increase the likelihood of long-term success.

**Description of the problem:**

Results of the conducted situational analysis (SA) point to a discrepancy between the declared political support of the EIHP and the actual scale of the EIHP spread, an insufficient integration of the health information systems, an insufficient awareness and experience of policy-makers in the use of evidence.

**Results:**

Taking into account the results of SA, we formulated the following implementation strategies:

- raising awareness of all stakeholders (researchers and policy makers) about the importance and necessity of using the best evidences;
- improving the practice of obtaining, adapting and applying these evidences;
- implementation of an effective mechanisms for communication between all stakeholders and ensuring their access to actual health data;
- institutionalization of the knowledge translation platform (KTP);
- formation of a country team of leaders who will support and promote all the above-mentioned activities and initiatives, actively integrating Kazakhstan into the global EIHP network.

**Lessons:**

At the first stage of implementing these strategies, we approved an EIHP development strategy, launched a series of webinars for stakeholders, defined the Republican Center for Health Development as the place for institutionalization of KTP and introduced the number of policy briefs as KPI of its activities. This allowed to expand understanding and create conditions for the use of evidence by policy makers.

**Key messages:**

- The EIHP implementation helps to increase the validity and transparency of decisions taken in the field of health system governance.
- EIHP helps to improve the effectiveness of health care.

**Care coordination across levels in the Catalan health system: results of the COORDENA.CAT survey**

M Luisa Vázquez Navarrete

A Romero<sup>1</sup>, I Vargas<sup>1</sup>, E Sánchez<sup>2</sup>, F Cots<sup>3</sup>, P Plaja<sup>4</sup>, À Vecilla<sup>5</sup>, I Ramon<sup>6</sup>, E Medarde<sup>7</sup>, M Banqué<sup>8</sup>, ML Vázquez<sup>1</sup>

<sup>1</sup>Consortium for Health Care and Social Services of Catalonia, Barcelona, Spain

<sup>2</sup>Serveis de Salut Integrats del Baix Empordà, Palamós, Spain

<sup>3</sup>Parc de Salut Mar, Barcelona, Spain

<sup>4</sup>Fundació Salut Empordà, Figueras, Spain

<sup>5</sup>Badalona Serveis Assistencials, Badalona, Spain

<sup>6</sup>Consorci Hospitalari de Vic, Vic, Spain

<sup>7</sup>Consorci Sanitari de Terrassa, Terrassa, Spain

<sup>8</sup>Consorci Sanitari de l'Anoia, Anoia, Spain

Contact: mlvazquez@consorci.org

**Background:**

Clinical coordination across healthcare levels is currently health policy priority. Despite its relevance, research on the subject is scarce. The objective is to analyze the experiences and perception of clinical coordination across care levels of primary care (PC) and secondary care (SC) doctors of the Catalan health system.

**Methods:**

Cross-sectional study, based on a survey to PC and SC doctors of the Catalan healthcare system using the COORDENA-CAT questionnaire on-line (October to December 2017). Final sample: 3282 doctors (20.3% of invited). Descriptive analysis of the experience in information coordination (transfer and use of clinical information), clinical management coordination (care coherence, patient follow-up, accessibility) and perception of coordination across care levels in the network.

**Results:**

Respondents were mostly SC doctors (63.2%), women (57.5%), 47 years in average and born in Spain (85.9%). A majority reported sharing clinical information between levels (62.2%) and using it for patient care (79.7%). They report high levels of clinical management coordination: a majority usually agrees with the treatment prescribed by doctors of the other level (75%), considers PC doctors' referrals appropriate (81.4%); and that SC doctors refer back when necessary (79.9%). Regarding accessibility, however, 73.2% reported long waiting time for a visit with SC doctor in regular referrals, but only 46.9% for urgent referral. Some differences in experience between PC and SC doctors were identified. The majority (62.3%), however, perceive that care is not coordinated across levels in their networks.

**Conclusions:**

Despite generally experiencing clinical information and clinical management coordination, doctors generally perceived that coordination of care across levels in their healthcare networks was limited. Associated factors to this perception need to be explored.

**Key messages:**

- This study measures clinical coordination across care levels in healthcare networks of a national health system from doctors' viewpoint. It reveals progress and areas for improvements and research.
- Further research is needed about associated factors of care coordination in Catalan health system.