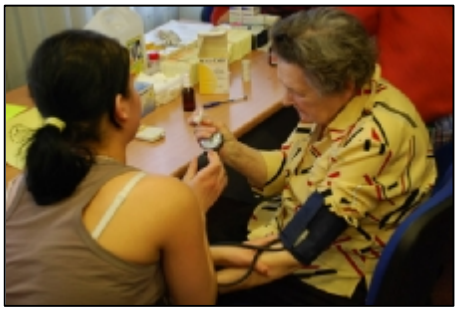
URBAN HEALTH PLAN MANUAL

methodical material

Work Group for Health Plans and Policies of the Ministry of Health





Contents:

MINISTERSTVO ZDRAVOTNICTVÍ ČESKÉ REPUBLIKY

WORLD HEALTH ORGANIZATION EUROPE

ZDRAVÁ MĚSTA, OBCE, REGIONY ČESKÉ REPUBLIKY

The material has been created within the framework of Work Group for Health Plans and Policies of the Ministry of Health.
Processing of the material was financially supported by World Health Organization in the Biennial Collaboration Agreement project.
Pilot procedure of Health Plan creation has been methodically supervised and pilot-tested in the environment of Healthy Cities of the Czech Republic (HCCZ).

1. INTRODUCTION TO THE SUBJECT

1.1. What Urban Health Plan Is and Why City Needs It

Strategic health support

Strategic health support is an integral part of long-term progress of every systematically developing city.

An established and well functioning system of strategic planning and management is a prerequisite for successful progress in this area. The moment of when stabilisation of this system has been achieved is a turning point in the city's preparedness for implementation of planning for health.

Satisfactory results in the long-term improvement of inhabitants' health can be achieved by no other than strategic progress. For this reason it is important that cities prepared their specialised plan of progress (Urban Health Plan) within the framework of which the specific objectives and activities focused on health support would be specified. The Urban Heath Plan would be also connected to annual distribution of finances from city budget or from external resources.

**Health Plan is an important part of strategic city documentation.
Its objective is to set up the basic systematic framework within the area of inhabitants' health support.**

International and local connections

Health Plan is based on Health 21 – an umbrella document of World Health Organisation. It elaborates this document according to local conditions and on the basis of expert analysis. In optimum case the Health Plan is also based on the city activities already under way - in particular on the community Plan of Health and Quality of Life etc.

Basic steps

The process of creation and consequent implementation of Health Plan altogether contains the following basic steps (an in-depth elaboration of individual steps is a part of the following text):

A. ANALYSIS, SETTING OF PRIORITIES
>> health condition analysis or Health Profile (using health indicators and others)
>> team interpretation of analysis
>> setting of priority targets (according to Health 21 targets)

B. PROGRAMME PART
>> team elaboration of priorities using standard managerial methods (e.g. LF), including indicators
>> formulation of measures, projects, activities and tools (regulations, ...)

C. REALISATION
>> organisational provision (guarantors for individual targets)
>> management cycle (evaluation, updating)
>> projects, activities
>> monitoring of indicators

1.2. The Connection between Health Plan and Other Strategic City Documentation

From the point of view of strategic city documentation, the Health Plan serves as expert concept. It is created in cooperation of city representatives with specialised partners.

Health Plan is based on expert analytical data (health condition analysis prepared using health indicators) that provide a comprehensive overview of population's health condition in a given area.

The following facts are also taken into consideration in the process of Health Plan formulation:

- **objectives of international document Health 21 and their projection into the region that the given city is situated in,**
- **outputs of community planning that represent the public demands.**

In the final phase, the existing Health Plan is connected with strategic urban plan and its budget.

1.3. The Main Actors within the Health Plan Creation Framework

The following subjects are the main collaborators in Health Plan creation process:

Local government and partners

(knowledge of local conditions and connections)

- ***City representatives*** **(e.g. Healthy City coordinator, worker in the field of medical care, councillor for the healthcare area and others)**
- ***City partners*** **(representatives of organisations that deal with health support – e.g. local NNO, medical schools and others)**

Professional institutions

(knowledge of specialised medical issues, data monitoring and evaluation)

- ***Regional workplaces of National Institute of Public Health***
- ***(if possible, the Regional Hygiene Station or regional workplace of Institute of Medical Information and Statistics may be invited)***

Representatives of the above stated organisations will form a local expert work team that consequently participates in Health Plan creation. The role of specialised partner in this process is significant in particular at the beginning of document creation, the focus of work consequently rather shifts to representatives of the city and its partner organisations.

The regional workplace of National Institute of Public Health is the principal professional partner, as it provides the city with a processing of inhabitants' health condition analysis – which is a necessary basis for consequent Health Plan processing. Work on this input document is financially covered from the part of city.

The local expert workgroup has its importance not only within the own Health Plan creation as such, but also consequently within the framework of its implementation and continuous assessment.

2. HEALTH CONDITION INDICATORS

2.1. Input Information for Health Plan

The set of health condition indicators serves as input information for Health Plan analytical data. The set has been designed in collaboration with MoH Workgroup for Health Plans and has been widely discussed with representatives of specialised institutions, in particular those from the ranks of RHS and HI.

The aim of the set of indicators is to provide the cities with input data on health condition of population in their area (or in the region area) in several basic areas:

- **Life expectancy**
- **Mortality**
- **Morbidity**
- **Reproduction health and health of the youngest children**

The set is divided into two sections – obligatory and optional indicators (the optional section includes in particular those indicators that are not directly influenced by the cities, but can be observed on the level of districts/regions). The indicators have been composed not only with respect to maximum transparency and comprehensibility, but in the first place also with respect to availability of data.

2.2. Data Resources and Processing

What Is To Be Ensured by the City and Experts?

The basic data for health condition indicators processing are possessed by Institute of Health Information and Statistics (IHIS) that cooperates with other specialised partners (Czech Statistic Office in particular). IHIS gathers and annually updates the data in the basic set of health condition indicators on the level of all MEA's.

Data processing

The Healthy Cities of the Czech Republic (hereinafter referred to only as HCCZ) offer the DataPlan information system environment for health indicators. The environment enables clear sorting of data, its interpretation, evaluation of their development in time and last but not least their comparison with results of other cities. A concrete example of health indicators' processing and benchmarking can be found on: www.dataplan.info/indikatory/zdravi.

Ukázka práce s daty v prostředí DataPlánu

2. Úmrtnost

2.1.1. Úmrtnost celková

Počet zemřelých na 100 000 evropské standardní populace (Data pro MĚSTO)

Jednotka: [počet]

Municipalita	2003	2004	2005	2006	2007	2008	2009	2010	2015
Chrudim	751,1	791,3	813,8						
Litoměřice	891,7	853,1	840,6						
Ústí nad Labem	981,5	916,9	886,5						
Vsetín	775,6	776,0	870,3						

2.3. Health Condition Indicators – Overview

The Basic Set (Obligatory Indicators)

Area / Criterion / Indicator	Measuring Frequency	Data availability	Data Source
1. LIFE EXPECTANCY			
1.1. Life expectancy Life expectancy at birth – males, females	5 years	MEA	CSO IHIS
2. MORTALITY RATE			
2.1. Mortality rate - total (standardized – per European standard population) 2.1.1. Mortality rate - total	1 year	MEA	IHIS
2.2. Mortality rate by causes (standardized – per European standard population) 2.2.1. Diseases of the circulatory system 2.2.2. Tumours 2.2.3. Injuries and poisoning 2.2.4. Intentional self-harm	1 year	MEA	IHIS
3. MORBIDITY			
3.1. Hospitalization in hospitals (standardized – per European standard population) 3.1.1. Total number of in-patients Total number of cases of hospitalization 3.1.2. Diseases of the circulatory system 3.1.3. Tumours 3.1.4. Injury and poisoning	1 year	MEA	IHIS
3.2. Incidence of tumours 3.2.1. Incidence of malignant tumours and tumours in situ without dg. C 44 (standardized – per European standard population)	1 year	MEA	IHIS
3.3. Incidence of selected infectious diseases 3.3.1. Infections with sexual mode of transmission 3.3.1.1. Syphilis 3.3.1.2. Gonoccocal infection 3.3.2. Tuberculosis 3.3.3. Acute diarrhoeal diseases (salmonella infections, Campylobacter enteritis 3.3.4. Viral hepatitis (A,B,C)	1 year	MEA	RHS, NIPH

** Selected data above a specific size can be also processed for a city level (over 50 thousand of inhabitants)*

==

ABBREVIATIONS USED:
CSO – Czech Statistical Office
IHIS - Institute of Health Information and Statistics
NIPH – National Institute of Public Health
RHS - Regional Hygienic Station
CSSA - Czech Social Security Administration
MEA – municipality with extended authority of 3rd degree

Additional Set (Optional Indicators)

Area / Criterion / Indicator	Measure frequency	Data availability	Data source
2. MORTALITY RATE			
2.3. Mortality rate of the youngest children 2.3.1. Neonatal mortality rate 2.3.2. Infant mortality rate (children up to 1 year of age)	1 year - District 5 year moving average - Town	MEA	IHIS
3. MORBIDITY			
3.2. Incidence of tumours 3.2.1 Standardized incidence of malignant neoplasm of colon (C18) 3.2.2. Standardized incidence of *MN of rectosigmoid junction, MN of rectum MN of anus and anal canal* (C19-21) 3.2.3. Standardized incidence of *MN of trachea, bronchus and lung* (C33-34) 3.2.4. Standardized incidence of MN *Malignant melanoma of skin* (C43) 3.2.5. Standardized incidence of *MN of breast* (C50) 3.2.6. Standardized incidence of *MN of cervix uteri* (C53) 3.2.7. Standardized incidence of *MN of corpus uteri* (C54) 3.2.8. Standardized incidence of *MN of ovary and other and unspecified female* genital organs (C56-57) 3.2.9. Standardized incidence of *MN of prostate* (C61)	1 year	MEA	IHIS
3.3. Allergic diseases 3.3.1. Number of treated patients in allergology facilities per 100 000 inhabitants	1 year	MEA (by the seat of establishment)	IHIS
3.4. Diabetes mellitus 3.4.1. Number of diabetics under treatment per 100 thousand inhabitants	1 year	MEA (by the seat of establishment)	IHIS
3.5. Incapacity for work (IFW) 3.5.1 Number of notified cases of IFW per 100 thousand of sickness insured 3.5.2 Mean percentage of IFW	1 year	MEA (by the employers' seat)	CSSA
4. REPLACEMENT HEALTH AND HEALTH OF THE YOUNGEST CHILDREN			
4.1. Spontaneous abortions per 1 000 women at fertile age **4.2. Live births with congenital malformation diagnosed within the 1st year of live per 10 thousand live births *)** **4.3. Proportion of live births with low birth weight (below 2 500g)**	1 year - District 5 year moving average - Town	MEA	IHIS

****) classified by the year of the child´s births***

NOTE:
Filling of additional indicators on the level of cities and towns is not obligatory, it is optional.
Filling of all indicators on the level of regions is obligatory – except of indicator No. 4, it is optional

Thematic Sets of Indicators – Health Condition of Seniors etc.

The basic set of Health Indicators can be also successfully used for monitoring of other significant areas, in particular with respect to target groups. This procedure gave rise to a set of indicators of seniors' health condition, whose objective is to provide the city with information necessary for systematic approach in the field of healthy ageing (for more information see a separate chapter of the manual).

Possibilities for Health and Healthy Lifestyle

In addition to recommended Health Indicators, the cities are also recommended to monitor their own indicators *of possibilities for health and healthy lifestyle*. These are the indicators that can be directly and actively influenced by the cities themselves. This area has not been specified by any previously defined indicators – in this field the cities can determine their own indicators that reflect their conditions and needs (for instance the following areas are recommended for monitoring: possibilities for sports, eating, non-smoking, education etc.).

3. HEALTH PLAN WORK PROCEDURE

The procedure of Health Plan creation has been tested in four pilot cities of middle to greater size from various CZ regions (Chrudim, Litoměřice, Ústí nad Labem, Vsetín).

The experience from these pilots is reflected in this methodical "*Urban Health Plan Manual*", whose objective is to provide other interested parties with a clear and comprehensive manual for processing of their own Health Plan (incl. an example of processing its particular area – health of seniors).

3.1. Preparatory Phase

Management Discussion

Commencement of work on Health Plan should be preceded by discussing it with city management, which is necessary for further steps. We recommend a review of document processing at least on the level of City Council.

Owing to this step, not only the formal "political approval" with processing of this specialised concept will be obtained (a support for further document-related work activities), but the city management will be also practically familiarised with basic connections (what a Health Plan is, its contributions to the city, the steps for its processing etc.).

Commencement of Cooperation with Specialised Partner

The next step for discussing of works on the document at the City Council is the conclusion of agreement with Regional Workplace of National Institute of Public Health on processing of health condition analysis (see Chapter 3.2. analytical phase).

Local Expert Work Team

In the interim of work on the analysis it is recommended to select the members of local expert work team comprised of representatives of the city, its partners and specialised institutions (see chapter 1.3 for more details). It is recommended that the team is established as an official city work body for health affairs (e.g. a work group of an existing council committee).

It is also important to appoint a work team coordinator who arranges meetings, records their outputs and supervises fulfilment of established objectives (it is recommended that the team is coordinated by city representative – in case of Healthy Cities e.g. by HCP or LA21 coordinator).

3.2. Analytical Phase

Health condition analysis

Health condition analysis is an essential groundwork for creation of City Health Plan and its processing represents the first step within the framework of work on this document. Health condition analysis requires collaboration of the city with specialised partner – regional workplace of National Institute of Public Health. The work on analysis from the part of NIPH is subject to payment.

Health condition analysis should be repeated in a 2 - 3-year cycle.

The analytical works include …

- **ensurance of a set of health condition indicators and other required information (Health Condition Indicators – to be supplied by IHIS/NIPH and HCZZ – Chapter 2.3.)**
- **interpretation of results of a set of health condition indicators (a brief text of up to 10 pages in length - to be processed by regional workplace of NIPH)**

Health Profile

Health Profile is an "extended version" of health condition analysis. It is a communication tool – a summary material that brings a view on health in the city.

Health Profile, however, is not a necessary precondition for processing of Urban Health Plan – the Health Condition Analysis serves as the basis in this case.

The recommended structure of Urban Health Profile is as follows:

1. **health condition analysis (using a recommended set of indicators)**
2. **community/action health plan**
3. **sociological research, survey**
4. **demographic data**
5. **analysis of conditions for health**

The processing of Health Profile is a more financially demanding step if compared to the analysis (the budget must not only take into account the analysis as such but also the sociological research etc.).

3.3. Programme Phase

The processing of health condition analysis (or that of Health Profile) is followed by a programme part, within the framework of which the Health Plan is elaborated by standard managerial methods used within the framework of established work team (e.g. using the Logical Framework Method).

Creation of Health Plan Basic Structure

Within the framework of preparation of Health Plan formulation it is recommended that the local team meets at least at 2-3 independent meetings:

1. **meeting – information about common objective of work, introduction of health condition analysis outputs, team interpretation of Health Plan priority objectives.**
   (before the team meeting it is recommended to familiarise its members in writing with health condition analysis text)
2. **meeting – team elaboration of basic Health Plan structure**
3. **meeting (if necessary) – completion of basic Health Plan structure.**

The formulated priorities, arising on the team work basis, are based on:

- **analysis of results in given city**
- **Health 21 objectives**
- **regional Health Policy (or Health 21 on the regional level – if processed)**

The processed Health Plan draft has the following hierarchical structure (there is a model example shown to each level):

priority	**>> 1. Healthy lifestyle**
objective	**>> 1.1. Healthy behaviour in diet will be actively supported**
group of activities	**>> 1.1.1. Programmes for proper diet for schools**
activity (topic)	**>> 1.1.1.1. Lectures on the subject of obesity for basic schools**

An example of Health Plan structure elaboration.

Priorita 1: Zdraví mladých			
Cíle:	1.1.	Bude aktivně podporováno nekouření mladých	
	Skupiny aktivit:	1.1.1.	*vytvářet nekuřácké prostředí ve společném stravování*
		Aktivity	-
		1.1.2.	*zaměřit se na edukaci dětí a mládeže v prevenci kouření*
		Aktivity	My nechceme kouřit ani pasivně
			Normální je nekouřit
			Kouření a já
		1.1.3.	*realizovat preventivní programy - kouření, alkohol, drogy*
	1.2.	Bude řešena problematika "mládež a výživa"	
	Skupiny aktivit:	1.2.1.	*realizovat programy a aktivity k tématu výživy mládeže*
		Aktivity	přednášky na ZŠ a SŠ na téma výživa, pohyb, kouření
			činnost poraden
	1.3.	Bude omezena četnost úrazů u dětí	
	Skupiny aktivit:	1.3.1.	*realizovat programy protiúrazové prevence*
		Aktivity	bezpečná cesta do školy
			edukace rodičů - prevence úrazů
			seznámení rodičů, pedagogů, dětí a mládeže s nejčastejšími úrazy, jak jim lze zabránit
			první pomoc

Management Discussion

As soon as the Health Plan is processed in the above shown basic structure, it is recommended to submit it for repeated review by city management. In this phase it should involve a review on the level of Municipal Council (a resolution on document existence – the Municipal Council acknowledges).

The structure of Health Plan including health condition analysis is submitted for review to the Municipal Council. The connections of both documents and their effect for the city are a part of summary explanatory report – see the following example.

Explanatory Report – an example of wording

The City of …….prepared in the course of year .... in cooperation with specialised medical institutions (in particular with NIPH) a proposal of Urban Health Plan, which is submitted to the Municipal Council for discussion.

The document has been prepared under methodical guidance of Healthy Cities of the Czech Republic (HCCZ) in accordance with recommendations of expert Workgroup of the Ministry of Health for Health Plans. All materials and data for Health Plan (health condition analysis, health indicators, the environment of DataPlan information system etc.) have been provided to the city as a member of HCCZ at a reduced price of CZK ……. . Owing to this activity, the City of ……has ranked among the group of pilot cities in the CR that have this type of document available.

Basic Information

Health Plan represents an important part of strategic city documentation. It is a specialised document (concept), whose objective is to set up the basic systematic framework within the area of inhabitants' health support.

Health Plan is based on Health 21 – an international document of World Health Organisation, which it elaborates on the basis of specialised analysis according to local conditions. Expert Health Plan is also based on the city activities already under way (in particular on the community Plan of Health and Quality of Life etc.) and is an important part on the way to advanced "Healthy City".

Last but not least, an important impulse for formulation of Health Plan is the fact that the existence of this document will be taken into account in the process of gaining external financial resources (in particular those under management of the Ministry of Health).

Urban Health Plan

Formulation of Health Plan is preceded by Health Condition Analysis, which is an integral part of the document. This analysis focused on examination of health condition of inhabitants in the area of city or in the nearby region from the point of view of basic aspects (life expectancy, morbidity, mortality). The analysis utilised so called health indicators recommended by the Ministry of Health, for which the data were provided by specialised national institutions (NIPH, IHIS).
On the basis of outputs of this analysis, the Urban Health Plan has been elaborated in the following structure:

- *Priorities* (with respect to priorities of Health 21 determined on the level of …….region)
- *Objectives*
- *Groups of activities (measures)*

After the Health Plan approval by the Municipal Council there are prepared successive steps that would primarily consist of elaboration of partial activities, determination of indicators for their evaluation and selection of responsible realisers. These successive steps will be taking place in cooperation with health care institutions and other specialised partners of the city in the health support area.

City management will be regularly informed about the progress and continuous results. A regular evaluation report will be submitted to the Municipal Council for review once a year.

Attachments:

- Health Plan structure
- health condition analysis (or Health Profile)

3.4. Realisation Phase

After the basic structure of Health Plan is discussed by the Municipal Council, we may proceed to the so called realisation phase of work.

Successful Health Plan implementation requires the following specification for each objective:

- **responsible realiser (or cooperating subjects)**
- **indicators (for evaluation of objective fulfilment success)**

The proposals of realisers and indicators are determined by mutual agreement of work team. These proposals can be a part of documents to be discussed by the city management, however, it is not necessary.

A systematic connection with city budget and related financial support of concrete activities are naturally a precondition for successful Health Plan implementation.

This step can be yet again addressed using the DataPlan HCCZ that enables work with information on various levels (connection of individual strategic documents and concepts, monitoring of indicators, monitoring of financial expenses etc.) in the area of strategic planning and management.

The cycle of continuous evaluation of plan objectives on the basis of determined indicators makes a basic part of Health Plan implementation. City management is continuously informed about Health Plan fulfilment through annual evaluation reports.

4. INFORMATION, EXPERIENCE, INSPIRATION ...

Best Practice

In the current CZ environment in field of health support on the local and regional levels there is a number of inspiring activities and example solutions, starting from particular events and events (Health Days, Injury Free Days etc.) up to systematic solutions on the level of planning for health.

The cities interested in being active in this area thus may take advantage of tried and tested solutions and in the good sense of the word "copy" the procedure that had already been created and tested somewhere else.

For instance the internet Database BestPractice is based on this principle of sharing best practice (see www.dobrapraxe.cz). Here you can find a number of innovative solutions and examples not only from the field of health support. The database gathers primarily the experience and activities from the environment of Healthy Cities, Municipalities and Regions, who approach health support in the long run and systematically under the methodical guidance of HCCZ and who also as a standard utilise the "network" environment as a platform to be used precisely for sharing of information, procedures and ideas.

Contact for More Information:

Processing of the material was financially supported by World Health Organization in the Biennial Collaboration Agreement project.

Formulation of manual for Urban Health Plan has been coordinated by expert Workgroup of the Ministry of Health for Health Care and Health Plans and Policies.

Representatives of the following institutions are among the members of this MH Workgroup:

- **Ministry of Health (MH)**
- **National Institute of Public Health (NIPH)**
- **Czech branch of the World Health Organisation (WHO CZ)**
- **CZ Healthy Cities (HCCZ)**
- **Institute of Health Information and Statistics (IHIS)**
- **Regional Hygiene Station in Liberec (RHS)**

Pilot procedure of Health Plan creation has been methodically supervised by the Healthy Cities of the Czech Republic and tested in the environment of its member cities:

- **Healthy City of Chrudim**
- **Healthy City of Litoměřice**
- **Healthy City of Ústí nad Labem**
- **Healthy City of Vsetín**

In the course of 2007, the specialised methodical procedure described in this manual has been also put to pilot testing on the regional level – specifically in the Healthy Region Vysočina. The output of this testing is represented by Regional Health Policy: "Programme Health 21 for the Region Vysočina". Partial experience of Liberecký Region and that of other regions that have health policies available have been also used during document formulation. A separate methodical manual will be processed for detailed procedure of regional Health Policy creation.

Contacts for Further Information:

MH Workgroup:
MUDr. Lidmila Hamplová
koordinátor pracovní skupiny
E: Lidmila.Hamplova@mzcr.cz

Healthy Cities of the Czech republic:
Ing. Petr Švec
association director
E: praha@nszm.cz
W: www.zdravamesta.cz

National Institute of Public Health:
MUDr. Miloslav Kodl
E: mkodl@szu.cz

THEMATIC APPENDICES

• SENIOR'S HEALTH SUPPORT (Healthy Ageing)

Last but not least, the emphasis on important target groups in the city is a part systematic health support. Seniors who comprise a significant part of population are one of these groups.

A city or municipality has a number of options how to support health and improve the quality of seniors' life in its area. Systematic approach of local government office is important in the areas such as support of seniors' active way of life, provision of possibilities for ageing in home family environment, safety of seniors, availability of all services for seniors and creating of generally favourable environment for seniors. The basic condition for successful approach to this issue is the implementation of this topic into the conceptual city documents (e.g. community development plan, community plan of social services or in ideal case Urban Health Plan) and its subsequent realisation and continuous evaluation.

Healthy and active ageing can be briefly described and practically dealt with through the following thematic areas:

Life in Home Environment

With respect to the quality of seniors' life and also to the often very limited capacity of services provided within the framework of residential care, the life of seniors in home environment is an ideal solution that should be supported by the city using suitable means. Homecare can successfully use the natural social networks and natural social environment. In the family environment it is possible to ensure both the medical service as well as nursing service, social and other services. In the event that circumstances do not allow that one spends old age in home environment, he/she should be allowed to dwell within the framework of so called sheltered housing at least in the same municipality. The Declaration of Human Rights enshrines the human right for place of stay – it is this right which is most often disputed in the particular case of seniors.

Active Ageing

Healthy lifestyle, healthy diet and sufficient physical and psychical activity are important parts of healthy and active ageing Cities and municipalities have a number of tried and tested possibilities in this area that can be successfully used. It is recommended to allow seniors to work as long as possible, be it in a different form than in regular employment (involvement of seniors as volunteers within the framework of community activities in municipality, support of seniors' employment by local entrepreneurs etc.). Education for seniors (University of Third Age, retraining courses for seniors, courses of PC use etc.) is also a time-proven tool. Seniors can also help each other within the framework of interest associations, by involvement in inter-generation programmes in whole communities. Las but not least, the offer of possibilities for physical and social activities is also important (exercise for seniors, seniors' club, Walk of All Generations Campaign etc.).

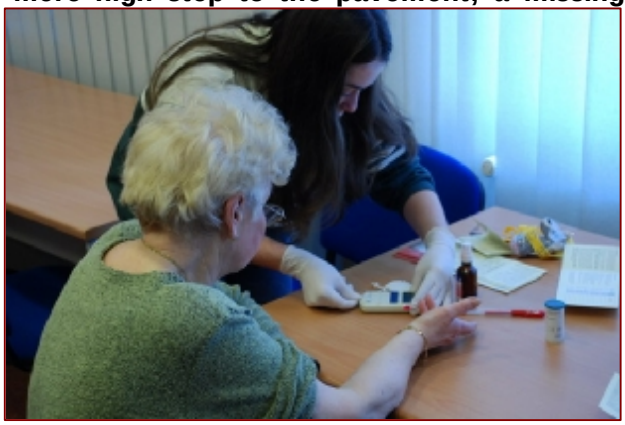
Seniors' Safety

According to various researches, safety represents one of the most important seniors' needs that the city should be able to satisfy. The feeling of safety not only involves the protection

against criminal elements but also the safety during stay in public areas and in road traffic. Seniors must overcome various barriers and are exposed to unnecessary risk of injury. In the event that there is a medical and social facility with continuous operation in the municipality, an emergency line may be offered to seniors. Municipality may ensure a well functioning communication of seniors .e.g. with the police as well as with other elements of municipal emergency system. In case of problems, seniors can have a pharmacy available as well as for instance a municipal police officer.

Favourable Environment for Seniors

Favourable environment for seniors is where they feel well both from the physical and moral point of view. A favourable physical environment can be called barrier-free environment. For a senior, a barrier in the city can be often mere high step to the pavement, a missing escalator or bench in a shopping centre or too deep shopping basket. The city should set an example in particular at offices and other public spaces which it can influence the most. It is also necessary to influence the local entrepreneurs, establishments and carriers so that they target their services on seniors. By all means, municipality should prevent discrimination of seniors in provision of services.



Availability of Services to Seniors

The availability of medical and social services to seniors is vital. Municipalities should make sure that general practitioners visit the seniors where needed. It is also necessary to ensure the functioning of nursing services in all areas. Pharmacy can be more responsive and create health supporting programmes for seniors, pharmacists can serve as seniors' advisers. In the field of catering it is possible to motivate entrepreneurs in the municipality to offer possibilities to seniors of how to use their services instead of leave them dependant on delivery of meals from nursing service. Cities can also consider establishing of community nurse in the period when all geriatric nurses had been abolished without compensation. City can also establish a Seniors' Council that listens to seniors and responds to their needs.

INDICATORS OF HEALTHY AND ACTIVE AGEING

Successful municipal progress in the field of systematic support of healthy ageing can be evaluated using thematically focused indicators. There are two sets of these indicators available, as prepared by the specialised Workgroup for Health Plans and Policies of the CZ Ministry of Health:

<u>Basic Set</u> – Indicators of Seniors Health Condition – this is based on the basic set of health condition indicators stated in Chapter 2.3 and includes the data available o the national level from Czech Statistical Office and Institute of Health Information and Statistics.

<u>Additional Set</u> – Healthy Ageing – Communication Models and Indicators that serve as voluntary solutions for extension of the basic set and include topics that express the generally favourable environment for seniors.

ABBREVIATIONS USED IN CHARTS:
CSO – Czech Statistical Office
IHIS - Institute of Health Information and Statistics
NIPH – National Institute of Public Health
RHS - Regional Hygienic Station
CSSA - Czech Social Security Administration
MEA – municipality with extended authority of 3rd degree
CTR – Centre of Traffic Research
MWSA – Ministry of Work and Social Affairs
RO – Regional Office

BASIC SET OF SENIORS' HEALTH CONDITION INDICATORS

Area / Measure / Indicator	Measuring frequency	Data availability	Data source	Note
1. LIFE EXPECTANCY				
1.1. Life expectancy 1.1.1. Life expectancy at age 65+ – males, females 1.1.2. Life expectancy at age 80+ – males, females	5 years	MEA	CSO, IHIS	The data will be a part of "DPS – MEA", which is to be processed until the 2003
2. MORTALITY				
2.1. Overall mortality 2.1.1. Overall mortality	1 year	MEA	IHIS	The data will be structured according to the following classification: Males, females: - absolutely (65+, 80+) - per 100 000 inhabitants (65+, 80+) - standardised mortality
2.2 Mortality by causes 2.2.1. Diseases of the circulatory system *2.2.1.1 Brain vascular diseases* 2.2.2. Tumours 2.2.3. Injuries (accidents) and poisonings 2.2.4. Deliberate self-harm (suicides)	1 year	MEA	IHIS	
3. MORBIDITY				
3.1. Hospitalisations in hospitals 3.1.1. Number of hospitalisations overall 3.1.2. Diseases of the circulatory system *3.1.2.1 Brain vascular diseases* 3.1.3. Tumours 3.1.4. Injuries (accidents) and poisonings	1 year	MEA	IHIS	The data will be structured according to the following classification: Males, females: - absolutely (65+, 80+) - per 100 000 inhabitants (65+, 80+) - standardised hospitalisation or incidence
3.2. Incidence of tumours 3.2.1. Incidence of malignant tumours and tumours in situ without dg. C44	1 year	MEA	IHIS	
3.3. Incidence of selected infectious diseases – acute diarrhoeal diseases 3.3.1. Salmonellosis 3.3.2. Campylobacter enteritis	1 year	MEA	NIPH	The data will be classified: - absolutely (65+, 80+) - per 100 000 inhabitants (65+, 80+)
3.4. Patients aged 65 and older dispensarised due to selected diseases, kept in the records of general practitioner for adults 3.4.1. Hypertension diseases 3.4.2. Ischemic heart disease 3.4.3. Brain vascular disease	1 year	MEA	IHIS	
3.5. Treated diabetics Diabetes mellitus	1 year	MEA	IHIS	The data for diabetes mellitus are available in age group 65+ since the 2007. The indicator states the number of diabetics treated as to 31.12. of a given year.
3.6. Dementia Organic mental disorders including symptomatic (MKN 10 – dg. F00-F09)	1 year	MEA	IHIS	The data are available for age group 20+. The indicator states the number of first examinations at ambulant psychiatric departments/workplaces in a given period.
4. HEALTH SERVICES				
4.1. Agencies of home health care and general practitioners 4.1.1. Number of home health care agencies (HHCA) 4.1.2. Number of workers in HHC 4.1.3. Continuous availability of HHC 4.1.4. Region-wide availability of HHC 4.1.5. Number of general practitioners for adults	1 year	MEA	IHIS	The indicator 4.1.4 presumes that at least one HHC agency within MEA provides care for the whole region

HEALTHY AGEING – COMMUNICATION MODELS AND INDICATORS

COMMUNICATION MODEL	INDICATOR PROPOSAL	Data Source	Notes
1. BASIC INFORMATION, DEMOGRAPHY	Number of seniors (65+, 80+)	CSO	
	Life expectancy (65+, 80+)	CSO	see indicators 1.1.1 and 1.1.2 (*the basic set of health condition indicators*)
	Age index	CSO	
2. LIFE AT HOME AND IN FAMILY *(homecare, sheltered housing, aids for self-reliant and independent life at home and in a community)*	Family – ageing in a shared household	CSO	according to census, last available data on household sharing come from 2001
	Sheltered housing	MEA	
3. ACTIVE OLD AGE *(social, hobby and physical activities, work opportunities, education, care for mental health)*	Events and activities for seniors (education, social events etc.)	MEA, municipality, munic. funded institution	the number of events per year can be measured
	Unemployed by age – 50 +	Employment Bureau	
	Retraining programmes – 50 +	Employment Bureau	
4. SENIORS' SAFETY *(violence prevention, injury prevention, safe transport)*	Crime on seniors	Police – department of offences	
	Seniors' injuries	IHIS	see indicators 2.2.3 and 3.1.4 (*the basic set of seniors' health condition indicators*)
	Number of seniors' injuries in traffic	CTR	
5. FAVOURABLE ENVIRONMENT FOR SENIORS *(A. Physical environment – mobility, barrier-free, availability) (B. Social environment – communication, inter-generation problems, seniors' councils)*	Seniors' councils – advisory body for city development	Municipality	
	Availability of seniors' engagement in municipal life – a system of discounts on fares and admission fees to social, cultural, sports and education events	Municipality	
	Community centre for seniors	Municipality	
	Barrier-free public transport – the share of PT performance equipped with barrier-free vehicles of the total PT performance per calendar year – in person-kilometres	Municipality	see indicators of sustainable transport
6. AVAILABILITY OF SERVICES FOR SENIORS, HEALTH AND SOCIAL SERVICES *(services, facilities, financial affordability, network of organisations with services for seniors)*	Contribution for care – Number of people aged 65 + with contribution for care	MEA, MWSA	
	Nursing service – the number of persons the service is provided to	RO registers	
	Other social services for seniors	RO registers	
	Number of home health care agencies (HHCA) - Number of workers in HHC - Continuous availability of HHC - Region-wide availability of HHC	IHIS	see indicators 4.1.1 – 4.1.5 (*the basic set of seniors' health condition indicators*)
	Number of general practitioners for adults within MEA	IHIS	
	Housing with services – Houses with nursing service, flats for seniors	MEA	
7. SYSTEM *(syst. support of healthy ageing from the part of city/region/state)*	Urban/Regional Health Plan also including the issue of seniors	Municipality	

INDICATORS OF HEALTHY AGEING IN THE WORLD

The World Health Organisation (WHO) formulated in the 2008 within the framework of WHO European Healthy Cities Subnetwork on Healthy Ageing a manual for processing of *Healthy Ageing Profiles – guidance for producing local health profiles of older people* that also contains a list of recommended indicators. This set of WHO indicators monitors 3 basic areas – Population Profile, Access to Health and Social Services and Socio-Economical Image: weaknesses and strengths – and it is a universal summary of indicators that can be monitored in the area of seniors' life on the local level.

The sets of indicators prepared for the Czech form of Urban Health Plan Manual are based on WHO recommendations and are inspired in indicators proposed. The final composition of the set of indicators, however, at the same time reflected the local conditions of the Czech Republic. Particular emphasis was put on the possibility to use for seniors' systematic health support the data available for the local/regional level, processed and regularly updated by specialised institutions such as IHIS or CSO. The primary data on seniors' health condition are in this respect in particular provided by the basic set of indicators. The additional set that also contains communication model of the healthy old age topic and that in general deals with environment favourable for seniors, rather approximates, due to its focus, the list of indicators formulated by WHO.

Section A	**Population profile**
1	Population structure
2	Small-area residence
3	Life expectancy
4	Population dynamics
5	Dependency ratio
6	Single household status
7	Mortality by cause, age and sex
8	Morbidity
9	Mental health
10	Functional impairment
11	Behaviour
Section B	**Access to health and social support services**
12	Values
13	City delivery and social support system
14	Health and social care responsibility
Section C	**The socioeconomic portrait: vulnerabilities and strengths**
C1	*Employment, income and social position*
15	Economic status
16	Income
17	Education
C2	*Housing and environment*
18	Housing ownership
19	Safety and security at home and in the neighbourhood
20	Access to transport
C3	*Participation and empowerment*
21	Participation in decision-making
22	Influence in the community

Source: Healthy ageing profiles, WHO, 2008