Health targets: navigating in health policy

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Chapter 1

Introduction

1.1 Background

Since the introduction of 'management by objectives' by Peter Drucker in 1954,[1] targets have been used to structure and rationalise policy issues by focusing on outcome, strategy, productivity, marketing and innovation.[1] Targets are also frequently used in the health policy sector. In the second half of the twentieth century, when universal access to health care became a policy goal in most Western European countries, targets in the health sector related to improvements in productivity and focused on the structure and organisation of the health system. It was an era of growth and there was a clear need for policy measures to ensure a good geographical spread of services and a system of quality assurance for this rapidly-expanding field. The expansion of the system reached its zenith in the late 1970s. The emphasis of policy shifted from the establishment of infrastructures to containing costs and improving the efficiency of health service delivery. There was subsequently a shift from productivity targets to strategy targets, with the latter aiming to improve the effectiveness and efficiency of health service delivery. These targets were increasingly phrased in terms of containing overall expenditure by controlling supply, for instance through capped budgets for hospitals or by fixing the number of hospital beds. These kinds of productivity and strategy targets still exist.[2]

Outcome-related targets are called health targets. This type of target does not focus on the structure and organisation of the health system or the effectiveness and efficiency of health service delivery, but on the health status of the population. There has been widespread awareness of health targets since the beginning of the 1980s. They draw attention to the fact that all the investments of time and money in health policy and in collateral areas are ultimately legitimised by the fact that they either contribute to maintaining or improving the health status of the population.[2] The use of health targets – as a tool in developing health policies – has been promoted through the Health for All by the Year 2000 campaign of the World Health Organisation (WHO).[3] The aim of this campaign was to ensure that all citizens of the world attain a level of health by the year 2000 that will permit them to live socially and economically productive lives. In 1984, all the countries of the European region adopted 38 health targets.[4,5]

The first two WHO health targets were intended to reduce the differences in health between groups and enhance the quality of life. The following ten health targets focused on the outcome in terms of mortality and morbidity (i.e. reduction in chronic diseases, infectious diseases, cardiovascular diseases, cancer, accidents, mental disorders and suicide) and on improving the health of specific groups (handicapped, elderly, children and women). In addition, there were health targets relating to health determinants. Some of them related to the public health sector, examples being the targets for the promotion of healthy lifestyles. Other risk-related health targets were intended to achieve a healthy environment and required action from sectors other than the health sector. A third sub-group of the determinant-related health targets were the targets that focused on appropriate care. The final group of WHO health targets were more conditional in nature and called attention to the need to develop country-specific Health for All policies.[4,5] With this set of health targets, WHO European Region linked up with health policy developments in Canada[6] and the US.[7]

To monitor progress, WHO European Region proposed a large number of indicators. Each European country was supposed to elaborate these targets in its own way. Following this WHO initiative, there were discussions in almost all European countries about how to improve health policy.[5] In 1996, the 38 health targets of WHO Europe were evaluated using Dutch data.[8] Although the Health for All by the Year 2000 strategy of WHO was an important initiative, the results of the analysis showed a sobering picture. It was expected that ten targets would be achieved partially in the year 2000. For almost half of the 38 targets - namely those for appropriate care and the development of national Health for All policies - no conclusion about achievement in the year 2000 could be drawn because these targets had hardly been made operational by WHO, if at all. Looking back, the 38 targets were too ambitious and too specific for general use, in particular the targets about reductions in mortality and morbidity. The targets were based too much on political desirability and not enough on scientific (especially epidemiological) considerations.[8]

Although the results of the study were not so positive for the health targets of WHO, the efforts to set health targets in the Netherlands looked promising.[8] As stated above, the setting of targets is a way to structure and rationalise policy issues. Health targets therefore express the planned changes in population health explicitly. At the same time, they provide a logical measure for the subsequent

evaluation of the chosen policy. However, the very limited attainment of the Health for All by the Year 2000 targets in the Netherlands begs the question of whether setting health targets is a useful tool in health policy.

The difficulty with health targets is that they cover a very complex field. As Lalonde[6] pointed out, this complexity results from the numerous determinants that affect the health status of the population. Our limited understanding of the causal web and the long lag times also make the health policy field a complicated one.[2] In addition, many actors are involved. Although it is usually central government that sets the health targets, other organisations or even ministries other than the Ministry of Health are often the ones who have to take the action necessary to achieve the change in the stated health determinants. In this way, health targets differ from the planning and financial targets, because there the Ministry of Health is often directly responsible for the allocation of resources necessary to achieve targets.[2]

1.2 Aim and research questions

The mechanisms described above mean that the setting of health targets is often approached with mixed feelings. An overview of the usefulness of health targets as a tool in health policy was missing. The aim of the studies described in this thesis is therefore to gain insight into the practice and potential of the health target approach.

First of all, it is necessary to look back at how health target setting as a tool in health policy developed. Here, the following questions were addressed:

1 To what extent are health targets accepted as a tool in health policy in European countries?
2 What benefits, drawbacks and necessary conditions were encountered with health target setting?

Secondly, it is necessary to look forward to how health target setting can help to face future challenges in health policy. In this area, the following questions can be asked:

3 How can the health target approach be used in health policy development?
4 How can supranational health policy contribute to the achievement of health targets?
5 How can intersectoral health policy contribute to the achievement of health targets?
6 How can health care policy contribute to the achievement of health targets?

1.3 Methods

This paragraph will give a rough outline of the methods used. A more detailed description will be given in the subsequent chapters. The first two questions addressed by this thesis have a retrospective character. The answers to those questions are based on two previous studies[8,9] and on an additional literature search on health policy, health targets and management by objectives. The aim of the first study[8] was to analyse progress made in the Netherlands towards the achievement of the Health for All targets of WHO Europe by the year 2000. All 38 targets were covered in this study, but the main focus was on the health outcome targets, which were mainly focused on morbidity and mortality. The other targets were analysed in less detail. The data used for the evaluation was obtained from secondary data sources. For supplementary data and validation of these results, additional sources were used. If sufficient quantitative information was available, the trend was extrapolated to determine whether developments with respect to the target were in the intended direction and/or whether it appeared likely that the target would be achieved by the year 2000.

The aim of the second study[9] was to review available knowledge of, and experience with, the practical use of health targets in Europe, in particular their use for priority setting in health policy development. An analysis was also conducted in order to determine whether health policy making in European countries was influenced by WHO's Health for All initiative. The study consisted of a literature review on health target and priority setting and an inventory of the actual situation in terms of setting health targets and priorities in eighteen European countries. The inventory included the collection of relevant material and consultation of local experts. For the Czech Republic, Finland, Hungary, Italy, Portugal, Poland, Spain and Romania the information was collected by collaborating institutes in the countries involved. Austria, Denmark, France,

Germany, Ireland, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom were covered by the authors. All collaborating institutes received similar instructions on questions to be addressed and the format of the report. With very slight differences, they all followed the same approach to collecting materials. In addition to literature searches, the health policy section and the documentation centres of the Ministries of Health, embassies and a variety of scientists and other health policy experts were asked for relevant policy documents, reports and other publications. To gather expert opinion about developments in a country, questionnaires were sent to at least two experts per country. Finally, the country reviews were sent to the Ministries of Health in each country in order to give them the opportunity to check the review before publication.

These two studies and the additional literature search on health policy, health targets and management by objectives also provided the empirical basis for addressing the third question of this thesis.

The study of the new global Health for All strategy[10] provided the answer to the fourth question. The aim of this study was to round off the internal debate at WHO Headquarters about the new global Health for All strategy. During a visit to WHO in Geneva, face-to-face interviews were conducted with about thirty staff members using a semi-structured questionnaire on the proposed new global health targets. The respondents formed a reasonable cross-section of WHO staff. These interviews yielded a great deal of oral and written material. A literature search provided additional information. The criteria for judging the total framework were taken from a range of fields such as public health, organisational science, management, and communications. In order to assess the individual targets, criteria were used relating to the target type, the target group, the target conditions, the relevance of the proposed indicators, the demographic and epidemiological trends, and the relevance and attainability for WHO member states. The presentations of the preliminary results at a meeting with the programme managers and at a yechnical seminar at WHO headquarters, as well as at several meetings with the policy action coordination unit, produced feedback from WHO staff.

The aim of the fifth question was to analyse the possibilities of achieving health gain through intersectoral policy.[11] The analysis was based on a literature review. First of all, an inventory was made of policy fields that could possibly influence the health status of a population. In addition, attention was given to health determinants in relation to socio-economic health inequalities. Secondly, an inventory was made of factors that influence the feasibility of intersectoral policy. Thirdly, four policy fields were analysed in terms of the feasibility factors which had been identified. These policy fields are education, safety, agriculture and urban areas. A literature review was conducted for each policy field. Finally, overall conclusions were generated and the relationship with health target setting was discussed.

The answer to the last question about the contribution of health care to the achievement of health targets is based on the information gathered in all studies mentioned, especially in the review study in which we compared eighteen European countries.[9] This study analysed the differences and similarities between public health and health care at the national level. An additional literature search was conducted for an analysis of differences and similarities in actual practice. This literature search included an analysis of articles and grey literature relating to evidence-based medicine and clinical guidelines, and of articles and grey literature relating to screening, vaccination and health promotion programmes.

1.4 Outline of the thesis

Answering the research questions results in an overview of health target setting in health policy. Although it is hard to measure the direct contribution of setting health targets to the improvement of the health status of a population, this thesis provides justification for the usefulness of health targets as a tool for structuring health policy and making it more effective. Following the research questions, chapter 2 contains the results of the review carried out in eighteen European countries. It presents the use of health targets in eighteen European countries and stresses differences and similarities. The lessons learned from several health target approaches are described in chapter 3. This chapter summarises the benefits, drawbacks and conditions for application. Chapter 4 presents more practical guidelines for application.

Chapters 3 and 4 are of a general and theoretical nature and they fit in with the rational approach introduced by Simon in 1947.[12] In this approach, policy is structured in purely logical-strategic terms, i.e. as a series of sequential steps worked out to attain a given aim. However, the practice of policy development is obstinate. One can also argue that only small adjustments are possible, based on value judgements and strategic coalitions with a view to the empowerment of the specific positions of parties involved. This is called the incremental approach and was introduced by Lindblom in 1959.[13] De Leeuw stated that a combination of both approaches, known as the mixed-scanning approach - presented by Etzioni in 1967[14]- will be the best theoretical framework.[15] This approach makes use of fundamental decisions, based on the rational reflection of available knowledge, and of incremental changes based on value judgements and reflection on power structures.[15,16]

The final chapters of this thesis will therefore focus on actors involved in the policy making process. The supranational level is highlighted first by discussing the new global Health for All policy (Chapter 5). Since not all determinants that influence the health status of the population are under the direct responsibility of the Ministry of Health, intersectoral policy is necessary to achieve the health targets set. However, before developing intersectoral policy, it is wise to analyse the feasibility of potential intersectoral policy fields (chapter 6). Although other policy fields play an important role in achieving health targets, the health sector itself also plays an important role. Both public health professionals and health care professionals should be involved. Chapter 7 shows that it seems that both actors develop their policies independently. Combining the efforts of both sectors may lead to an integrated health policy. The final chapter (Chapter 8) discusses all the findings described in this thesis.

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