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Health targets: navigating in health policy

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Chapter 3

Targets as a tool in health policy

Part I: Lessons learned

1.1 Historical overview

The use of targets in health policy is inspired by the management-by-objectives (MBO) approach used in the business world. The term management-by-objectives was first introduced in 1954 by Drucker in his book *The practice of management*.¹ The term refers to the use of directed efforts to identify the individual departments or units necessary to achieve common goals. The underlying assumption is that it is possible to specify common goals, which are then explicitly identified in targets. The MBO process starts with the identification of the overall goals of the organization, followed by the identification of the specific objectives for each department. In the next phase, the objectives are broken down into specific targets. The final step is to monitor and evaluate the progress towards the targets, which

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Abstract

This article reviews the start of the use of targets as a tool in health policy, summarises the fruitful uses and frequently-heard objections, and proposes some conditions for successful health target setting. Targets as tool in health policy are based on the management by objectives approach (1954). The use in health policy was possible due to advances in the use of epidemiology for public health purposes. It provisionally ends with the new health targets adopted by WHO in 1998. The setting and monitoring of health targets is one way in which a government can provide leadership, guidance and strategic direction for the health sector. These benefits, and others, will also be reviewed. Drawbacks - such as political accountability and the limited malleability of society - will also be discussed. To overcome most of the objections, the article ends with some SMART conditions for successful health target setting: Specific, Measurable, Achievable, Realistic and Time-bound. When SMART conditions are met, political will and daring are the recipe for a successful health target approach.

3.1 Introduction

In May 1998, the WHO in Geneva adopted ten new global health targets called Health for All in the 21st century.¹ The European region of WHO followed in September 1998 with its Health 21: 21 targets for the 21st century.² In the same year, the United States presented their national draft Healthy People 2010 objectives.³ These new target documents are the successors to Health for All by the year 2000^{4,5} and Healthy people 2000.^{6,7} In Australia, New Zealand, the United Kingdom and other countries, targets have been adopted in health policy.⁸⁻¹⁴ Why health targets? And – because all approaches differ in the way the targets were established – how should health targets be used? This paper reviews the groundwork for the successful application of targets as a tool in health policy.

Before looking forward, we do well to look backward for guidance. Part I of this article will therefore review the start of the use of targets as a tool in health policy, summarise the fruitful uses and frequently-heard objections, and will finally propose some conditions for successful health target setting. In part II of this paper,¹⁵ we give more guidelines for the application of health targets as a tool in health policy by posing questions related to the policy cycle.

3.2 Historical overview

The use of targets in health policy is inspired by the management by objectives approach used in the business world. The term management by objectives was first introduced in 1954 by Drucker in his book *The practice of management*.¹⁶ The term refers to a set of directed efforts to identify the individual steps and targets necessary to achieve common goals. The underlying assumption is that it is possible to specify common goals, which, when explicitly identified in targets, will yield more focused and efficient efforts. Management by objectives can be seen as a cyclic process, which starts with the definition of strategic goals, followed by background documentation and the identification of objectives. In the next phase the objectives should be implemented and monitored. The evaluation should give information for the redefinition of the objectives, which again should be implemented and so on.¹⁶

The pioneer of management by objectives for health was McGinnis. He established and guided the process of the Objectives for the Nation⁶ in the United States. McGinnis distinguished several types of objectives applicable to the health policy field. His comparisons of the various types of objectives from the business and health fields are listed in table 1.¹⁷ By bringing the management by objectives approach to the health sector, an important idea was born: health systems could be evaluated in terms of output: population health gains, or, put more simply, healthier people. After Objectives for the Nation⁶ in 1980, Healthy People 2000⁷ appeared in 1990 and a draft of Healthy People 2010³ in 1998. National health objectives therefore appear to be able to survive changes in government, provided they are based on good technical support and that they build strong coalitions for action outside government.^{18,19}

Table 1 Application of the Management by Objectives concept

Objective bases	Business applications	Health applications
Outcome	Profits	Morbidity and mortality reduction
Strategy	Product type and mix	Risk factors
Productivity	Labour/capital mix	Scope of services
Marketing	Client attitudes and awareness	Public/professional attitudes and awareness
Innovation	Product improvement	Surveillance, evaluation and research

The use of health targets at the beginning of the 1980s was also possible due to advances in the use of epidemiology for public health purposes. Since the identification of tobacco smoking as the principal cause of lung cancer in the early 1950s, other major risk factors for non-communicable diseases became known. The evidence epidemiologists generated relating to the contribution of risk factors to health problems and their magnitude was impressive. Later, epidemiologists began to explore the subtleties of confounding, misclassification, survivorship, and other such issues. The results of experimental and observational studies led to evidence-based preventive interventions and increased the direct impact of epidemiology on policy decisions. Nowadays, epidemiology remains the basic science of public health, because it continues to provide an improved understanding of the causes of disease, disability and death. This

makes it theoretically possible to identify populations at risk and to try to improve the health of these populations and prevent disease.²⁰⁻²³

The combination of these developments in epidemiology, the American approach to setting health objectives for the nation and the Lalonde health field concept²⁴ – which emphasised the interaction between life style, environment, human biology, and health services – contributed to the production by the European Region of the WHO of 38 targets as a specification of the global Health for All strategy.¹⁸ These targets were endorsed in 1984⁵ and motivated policymakers to think rationally about health policy, the use of targets as a tool to improve health policy, and the methods and structures required to bring about significant improvements in population health.¹⁹ And with success, because since then a number of governments have adopted targets in their health policy – in and outside Europe.⁸⁻¹⁴

With the use of targets, the need to monitor and evaluate consistent activities also increased. More specific epidemiological data on various health problems and on various population groups was collected. This monitoring of health gains initiated country-specific and international comparative activities in epidemiological research and surveillance. The development of the European Health for All database is just one of the initiatives taken. The possibilities opened up by epidemiological research and surveillance made it possible to base health policy decisions on scientific facts rather than on untested expert opinions.²⁰⁻²³

As mentioned in the introduction, 1998 was the year which saw the presentation of new health target approaches for the first decades of the new millennium.¹⁻³ These new policies of WHO and some governments are a good stimulus for the further development of targets as a tool in health policy. The examples mentioned below will show that health targets may contribute to the development of a more rational health policy.

3.3 Fruitful use of health targets

Health targets are used by governments in several countries, including the USA, Australia, and the United Kingdom. The use of health targets by these

governments and by WHO will be taken as examples in this article, because a large body of English literature is available about these strategies. The strategies of the USA, Australia and the United Kingdom illustrate that health targets can help to rationalise health policy, although these countries have very different cultural-historical and political-administrative backgrounds. By comparison with the United Kingdom, the USA and Australia are relatively young nations. The USA and Australia differ in their political system. The USA has a two-party system, while in Australia several parties form the coalition government. The policies in Australia are therefore based more on consensus. Within WHO, all Member States have to agree with the policy, so here consensus plays an even more important role. Another factor that illustrates the differences between countries is the way in which the health targets are used. Many governments resemble WHO in giving their targets a more inspirational role, while the objectives of the USA have a more managerial and practical character.

Table 2 Benefits

Policy development phase	Benefit
Formulating targets	<ul style="list-style-type: none"> Gives insight in the health of the population Reveals gaps in knowledge Gives insight into consequences of alternative strategies Supports the priority setting process Increases the transparency of health policy Ensures consistency among several health programmes Shows up deficiencies in the health policy Stimulates debate
Implementing targets	<ul style="list-style-type: none"> Inspires and motivates partners to take action Improves commitment Fosters accountability Guides the allocation of resources
Monitoring and evaluation of targets	<ul style="list-style-type: none"> Supplies concrete milestones for evaluation and adjustments Provides opportunities to test the feasibility of the targets Provides opportunities to take actions to correct deviations Exposes data needs and discrepancies

The direct contribution of health policy to the improvement of the health status of a population is hard to measure and cannot be distinguished from the effects of other societal processes. The same applies to the setting and application of health targets. However, there are clear arguments that indicate that target setting helps to develop a more rational and transparent health policy (table 2). Firstly, during the process of health target setting, all aspects of population health are analysed and put into perspective. This facilitates the understanding of what is needed and what is possible and focuses the attention on groups that deserve higher priority.^{25,26} This element can be illustrated by reference to the first USA health objectives. When they were set, a wide range of possible systems was drawn upon to provide data. They included: (a) data systems based on records, such as those in the US Vital Statistics System; (b) population-based surveys, such as those periodically undertaken by various health agencies to determine the prevalence of various health habits; (c) surveillance and monitoring systems, such as those established to monitor infectious disease prevalence; and (d) regulatory reporting systems established to monitor compliance with statutes or regulations.²⁵

Health targets give the policy focus and increase recognisability. They also ensure consistency among disparate health programmes and show up underexposed areas in health policy.²⁶ The first health targets of the WHO regional office for Europe, for instance, were based on the health field concept of Lalonde and distinguished five groups of targets. Another example is the division into three major categories of the Australian targets of 1988. These three categories were: population groups, major causes of sickness and death, and risk factors.^{8,9}

The target setting process stimulates debate. Target setting can also provide a common language for communications relating to programmes and priorities. It helps to build awareness of, and support for, health programmes among policymakers, field workers and the public. In turn, this can make existing implementation systems more efficient.^{18,26} Such a commitment is also needed to survive changes in government. In the USA and Australia, the health targets are developed through a process of consultation. The targets therefore do not reflect the views of just one organisation, but are rather the product of a national process.^{8,27}

Health targets improve management, because the targets can help clarify whether or not a policy is realistic in terms of strategies, timetables, and resource allocation (manpower, equipment, supplies, facilities, etc.).^{17,26,28} Used in this way, targets can also improve short- and long-term planning, examples being the WHO targets regarding eradication of communicable diseases, like polio. Targets were set to improve polio vaccination. After development and introduction, the programme is now in full operation and will soon enter into the final phase of post-vaccination surveillance.¹

Health targets provide benchmarks for the measurement of progress and the extension of accountability. Defining measurements makes it possible to organise feedback and establish systematic reviews and revisions of targets, priorities and the allocation of resources. It also facilitates the evaluation of the impact of health gain activities.¹⁷⁻²⁹ A number of examples can be listed here, such as the work of the Central Health Monitoring Unit at the department of Health and the National Audit Office in the UK. Such measurements increase our understanding of changes in population health and changes in environment, thereby providing support, in the past, for the revision of the Health for All targets,^{1,2} of Healthy People in the USA,^{3,7} of the Health of the Nation approach in the UK¹³ and of the target approach in Australia.⁹

Finally, health targets expose data requirements and discrepancies. When the first objectives in the USA were published, the data sources then available were listed for each of the areas and for some of the objectives no baseline data could be found. Such a systematic approach to the health information system contributed greatly to the improvement of data systems and the dissemination of public health information.^{23,30}

3.4 Objections

Notwithstanding the above arguments, the use of health targets has frequently been the subject of criticism. These criticisms are listed in table 3. Some of the constraints cannot be dealt with. Take for instance the limited malleability of society. One must accept that action taken by government has a limited impact on population health.²⁵ A government can discourage smoking, for example, by increasing the tax on tobacco, by warning in mass-media campaigns against the

health effects, by banning smoking advertising, by creating smoke-free public buildings, etc. However, all this may never result in the complete elimination of tobacco-smoking. Other unhealthy behaviour, like drinking, will also be hard to reduce by means of government action. Furthermore, our understanding of the causal web in non-communicable diseases is still limited, and this means that we may not be able to control all the variables that will determine the occurrence of disease in a population. Thirdly, many non-communicable diseases have long latency periods and risk factors with a very long lag time. The timeframe of interventions may therefore be much longer than those of policy periods.

Table 3 Drawbacks

Policy development phase	Drawback
Formulating targets	<ul style="list-style-type: none"> Makes it impossible to maintain that there is no rationing Increases political accountability Assumes a malleable society Oversimplifies the policy field Risk of setting easily measurable targets Neglects other important or new issues
Implementing targets	<ul style="list-style-type: none"> Frustrates when there are too many and too ambitious targets The technical and planning process could be seen as an end in itself Resource allocation could become inflexible
Monitoring and evaluation of targets	<ul style="list-style-type: none"> Attention could be given to measurable issues only Additional data and research could be needed

However, other objections are directed at the health system in a country. The effect of these objections on the potential for the successful use of health targets depends on how severe they are and what value is attached to them. They must therefore receive attention in an attempt to minimise their effect. Firstly, some political objections will be discussed, because explicit target setting makes it impossible to maintain the façade that there is no priority setting in health policy.³¹ Furthermore, health targets could be seen as political promises and commitments. If targets cannot be achieved, some politicians may fear that their position will be undermined if they claim that their policy will result in the

achievement of the targets. Politicians become more vulnerable when they have to depend on other ministries and organisations to share the selected targets and divert energy and financial resources. This, for instance, happened in the Netherlands in the beginning of the nineties. The then Secretary of State for Health believed that it was not desirable to establish quantitative health targets because of the political accountability and the implied responsibility if the targets were not met. The Dutch Draft Target Document³² was therefore never endorsed. In addition, politicians prefer targets that are attainable in the short term – say one or two years – which can compete with more effective long-term plans.²⁸ The most important drawback may therefore be the lack of political commitment.

Other drawbacks are of a methodological nature. A first methodological problem is that a health policy based on targets can lead to an oversimplification of the policy field. Many of the most important diseases have several risk factors and some risk factors affect several diseases. These interdependencies of both risk factors and diseases make it quite difficult to quantify health targets. This can lead to an inclination to set targets for the easily measurable and controllable diseases or health problems.^{29,33} This in turn can lead to the danger of unwanted side effects for non-target diseases or health problems. An example might be less attention for complicated or new issues such as mental health problems and the occurrence of BSE and CJD. A health policy based on too many targets, or targets that are defined too generally and ambiguously, or targets that are too ambitious also frustrates the policy process and draws usefulness into question.^{28,29} An example here are the 38 targets of the WHO's Regional Office for Europe and the inachievability of these targets simultaneously due to intervening developments like substitute mortality and morbidity.³⁴

There is also the danger that some people will see the setting of targets as an end in itself, which can divert the attention from the activities required to achieve them.^{18,29} This can also lead to an inflexible system for the allocation of resources. In the case of the development or improvement of the health information system, subgroup comparison – with subdivisions into, for instance, age, sex, or socio-economic status – should only be carried out when there is evidence that there are inequities between the subgroups. There should be a clear balancing between investments in monitoring and the relevant health gain. Otherwise work and money will fail to produce returns. With vaccination programmes, for

example, the monitoring system should be able to detect herd immunity. On the other hand, the extra amount of work for the fieldworkers should be limited, because this will weigh on the budget and may therefore compete with the total number of vaccinated people.³⁵

The monitoring and evaluation of the targets can result in an excessive focus on items that are measurable but of lesser importance than other issues.²⁹ Additional data and research could also be needed to measure progress in more difficult policy areas such as the increased interest in the quality of care.

A final objection is that national health targets may result in an imbalance in local priorities. Local circumstances may suggest different priorities than those set as national targets and there is, therefore, a real danger that the pursuit of targets may neither maximise health gains nor use resources in the most cost-effective manner.³⁶

3.5 Discussion

Balancing benefits and drawbacks, we conclude that target setting can be a worthwhile tool in health policy. In a structured process, health targets can make explicit the priorities that are inevitable in health policy. It also generates a system for monitoring the pursuit of the selected direction. Evidently, the use of health targets has a greater impact if one can successfully deal with the drawbacks which have been identified. Setting targets is therefore subject to a number of methodological and political conditions. These conditions are listed below.^{18,26,29,33,34,37–39} A more practical elaboration will be given in the next article.

The methodological conditions can be summarised in the acronym SMART: Specific, Measurable, Achievable, Realistic and Time-bound. To improve the acceptance of health targets, they should in the first place be specific and measurable: clear, easily appraised and understood by a wide audience (public, politicians, policymakers, administrators and professionals). Due to the limited direct influence of the actions taken by the government on the health status of a population, targets should mainly focus on health determinants. Targets with the best prospects are probably those that are based on structural interventions and less on interventions directed at behavioural change.^{18,26,29,33,34,37–39}

Since the targets concern desirable situations at some time in the future, another methodological requirement – alongside appropriate knowledge about the current situation – is that they should be based on a strategic vision for future health policy. They need to be focused on the achievement of tangible results combined with political desirability. The achievability of these results depends on the soundest evidence available: it therefore requires ample epidemiological understanding, knowledge about the effectiveness of candidate interventions, and an approach which allows for a lag time between intervention and effect. There should also be an understanding of existing policies relating to the relevant areas and also some awareness of the other targets and programmes with which a target can interlock. Targets that are set too high result in non-achievement, and cause frustration or foster complacency. Targets set too low provide no challenge and will lapse into formalities. So targets should be realistic: they should provide some challenge, but they should also be attainable. To increase credibility, it is better to be selective and to choose a limited number of targets rather than to be comprehensive. A set of targets which tries to tackle too much is almost bound to produce fragmented and loosely integrated strategies. A few key issues focus attention and discussion, direct participation and attenuate the forces of fragmentation. They also keep the system flexible when new issues come up.^{18,26,29,33,34,37–39}

Adequate time and sufficient resources should be made available for the process of target setting, implementation, and evaluation and feedback. Commitment to supporting the process of setting health targets requires not only consensus, but also a considerable amount of will at a variety of levels. This requires communication and co-ordination and a balanced monitoring process through a mixture of process and outcome measures. These measures could describe the levels of health, the appropriate determinants of health and the levels of relevant service provision. The measures should be timely and quantifiable in one way or another, and they need to be sensitive enough to detect changes. Within the health information system, a good balance between what is needed and what can be achieved for a given amount of money should be found.^{18,26,29,33,34,37–39}

In addition to these SMART conditions, there is one political prerequisite which should be satisfied before starting a target approach. This is political will and daring. Without political commitment and the will to execute a health target approach, a policy will be doomed to fail.

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