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Health targets: navigating in health policy

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Chapter 4

Targets as a tool in health policy Part II: Guidelines for application

Figure 1 The health-policy development cycle



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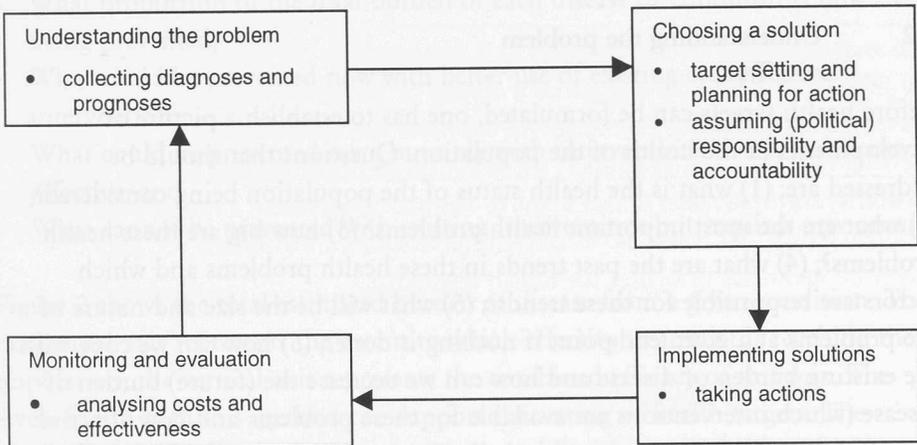
Abstract

The use of health targets as a tool in health policy is receiving more attention. Beyond political will and daring, there awaits the challenge of the fruitful use of health targets. This means an adequate response to the complexity of population health in a target structure that is transparent, controllable, and adaptable in changing circumstances. In this article, we will review the health policy development cycle in relation to health target setting. First, there should be understanding of the problem, and a clear picture of the health status of the population. Then a solution can be chosen. This part is not restricted to the technical side of the solution, i.e. the target setting and action planning. It also has a political side in which responsibility is taken for the choices made. In the next step, the chosen solutions are implemented by government and stakeholders. This will be followed by a monitoring and evaluation phase, which will in turn provide us with an insight into the health status of the population. At every step of the health policy cycle, questions which should be addressed when using health targets in health policy will be discussed.

4.1 Introduction

In the previous article,¹ we presented a historical overview of health targets as a tool in setting health policy. In that article, the fruitful uses, drawbacks and conditions were described. One of the conclusions was that the setting and monitoring of health targets is one way in which a government may provide leadership, guidance and strategic direction for the health sector. The use of health targets as a tool in health policy is receiving more attention. This is not surprising, since health targets help to rationalise health policy and make governments and organisations accountable for their activities. When setting health targets, the relationship between the content of the policy and the responsibility of government and stakeholders can be specified. This may however put them in a vulnerable position. So beyond political will and daring, there awaits the challenge of the fruitful use of health targets. This involves an adequate response to the complexity of population health in a target structure that is transparent, controllable, and adaptable in changing circumstances.

Figure 1 The health policy development cycle



Reduced to its basics, health policy development can be depicted as a four-step, problem-solving process (figure 1). Before a health policy can be developed, there should be understanding of the problem, and a clear picture of the health status of the population. Then a solution can be chosen. This part is not restricted to the technical side of the solution, i.e. the target setting and action planning. It

also has a political side in which responsibility is taken for the choices made. In the next step, the chosen solutions are implemented by government and stakeholders. This will be followed by a monitoring and evaluation phase, which will in turn provide us with an insight into the health status of the population. The cyclic process emphasises that there is no final end-point. One of the implications of the policy cycle is the assumption that, in principle, the elements of the cycle may change over time; new or different problems will require new or different solutions. This in turn may require organising or financing activities in public health differently.

In this article, we review the health policy development cycle in relation to health target setting. We will give a more practical elaboration and some guidelines for application of health targets as a tool in health policy. The aim of this article is to provide ideas that can serve as a handle when developing a health policy with health targets. At every step of the health policy cycle, questions will be discussed that should be addressed. The answers to these questions should be taken into account in the health targets and the health policy document.

4.2 Understanding the problem

Before health targets can be formulated, one has to establish a picture of developments in the health of the population. Questions that should be addressed are: (1) what is the health status of the population being considered?; (2) what are the most important health problems? (3) how big are these health problems?; (4) what are the past trends in these health problems and which factors are responsible for these trends?; (5) what will be the size and nature of the problems at a given end-point if nothing is done?; (6) how can we cope with the existing burden of disease and how can we decrease the (future) burden of disease (which interventions are available for these problems and how effective and efficient will these interventions be)?; (7) what will be the situation at a given end-point if interventions are implemented?

Epidemiological and demographic insights into the health of the population are the starting points for the setting of health targets. The areas chosen could be a major cause of premature death or avoidable ill health or disability, either in the population of the nation as a whole, or among specific groups of people or in

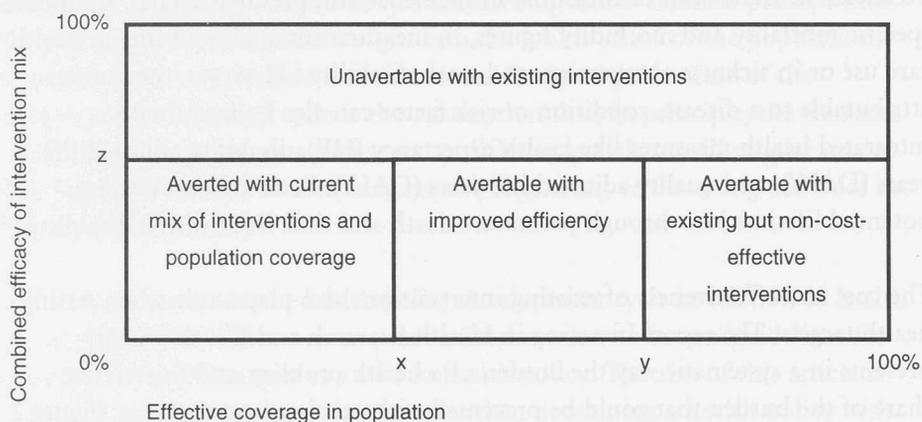
specific geographic areas. The epidemiological and demographic insights not only imply the present health status but also an understanding of trends in past decades. The trends can be measured in incidence and prevalence rates, in disease-specific mortality and morbidity figures, in measures on quality of life, in health care use or in sickness absenteeism and work disability.² However, the burden attributable to a disease, condition or risk factor can also be measured in integrated health measures like health expectancy (HE), disability adjusted life years (DALY), and quality adjusted life years (QALY). Such measures express potential lifetime lost through premature death and time lived with a disability.³⁻⁵

The cost and effectiveness of existing interventions also play a role when setting health targets. The report *Investing in Health Research and Development*⁶ presents in a systematic way the burden of a health problem and the relative share of the burden that could be prevented with existing interventions. Figure 2 shows the analytical approach applied in this report. Using data on the available cost-effective interventions, and consulting the judgement of field experts on the proportion of the population receiving effective interventions, it is possible to estimate:

- What proportion of the total burden of each disease or condition is now being prevented;
- What could be prevented now with better use of existing cost-effective interventions;
- What could be prevented now, but only with interventions that are not cost-effective; and
- What cannot be prevented with existing interventions but requires new ones.

Figure 2 shows the total estimated burden of disease from a given condition. The horizontal axis represents the extent to which effective treatment is reaching the population, the vertical axis represents the combined efficacy of this mix. The levels found with this method can support the setting of health targets. The categories of evidence for both resource use and health outcome, as well as the generalisability of those data, also determine recommendations for cost-effectiveness studies.⁷

Figure 2 Relative shares of the burden that can and cannot be prevented with existing interventions



x = population coverage with current mix of interventions

y = maximum achievable coverage with a mix of available cost-effective interventions

z = combined efficacy of a mix of all available interventions

The analysis of the epidemiological and demographic trends and the analysis of the relative shares of the burden of a disease or condition that could be prevented with existing interventions, supports the identification of the most pressing needs, as well as guiding the selection of priorities and thereby the feasibility of the targets. It also helps to identify areas where a major health problem exists, but where no effective interventions are available yet, and therefore identifies priorities for health research.

4.3 Choosing a solution

In the next step of the health policy cycle, solutions will be chosen and choices will be made, i.e. targets and action programmes will be formulated and political responsibility is taken. In this phase, the following questions should be considered: (1) how will the health policy priorities be selected?; (2) which stakeholders should be involved in the process?; (3) what kind of targets will be set and which steps should be taken? (4) which requirements should the targets meet?; (5) who will be responsible for the choices made?; (6) which actions are

necessary to achieve the targets?; (7) who will be responsible for those actions?; (8) how will progress towards the targets be measured?; (9) what will be regarded as a success?; (10) what is the consequence if a target is not achieved?

When setting health targets, one must also be aware of the type of use of targets and of the developmental steps taken (see figure 3). Three types of use can be distinguished: inspirational use on the political level, managerial use on the policy level and technical use on the practice level. The setting of targets is a step-by-step approach with increasing specificity. It starts with (1) principles and values and is followed by (2) goals, (3) objectives, (4) qualitative targets, (5) quantitative targets and ends with the development of (6) indicators and a monitoring system.

Figure 3 Three uses of health targets in different steps of development

Steps in development	Inspirational use (political level)	Managerial use (policy level)	Technical use (practice level)
Step 1. Principles and values	■ ■ ■ ■ ■		
Step 2. Goals	■ ■ ■ ■ ■	■ ■ ■ ■ ■	
Step 3. Objectives	■ ■ ■ ■ ■	■ ■ ■ ■ ■	□ □ □ □ □
Step 4. Qualitative targets	□ □ □ □ □	■ ■ ■ ■ ■	■ ■ ■ ■ ■
Step 5. Quantitative targets	□ □ □ □ □	□ □ □ □ □	■ ■ ■ ■ ■
Step 6. Indicators		□ □ □ □ □	■ ■ ■ ■ ■

■ ■ ■ Obligatory step □ □ □ Optional step

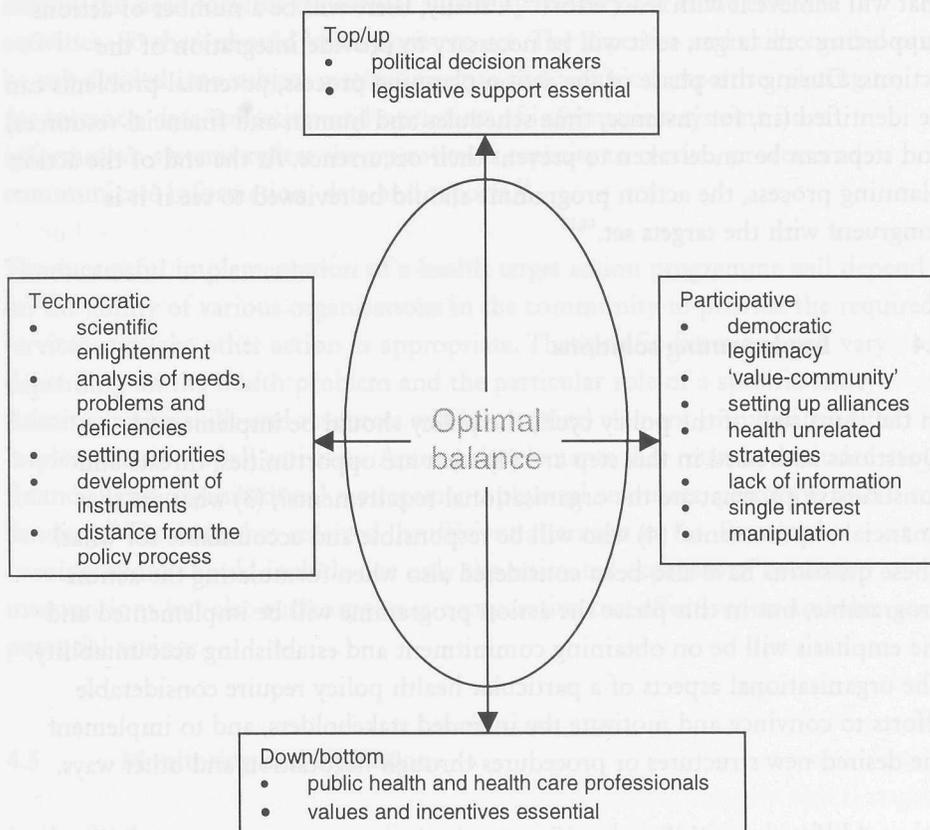
These steps should have a logical and meaningful relationship with each other and with the types of use of health targets. Targets with a more inspirational use are focused on steps 1 to 3 in the target development process. The responsibility and accountability for this kind of targets lies with the government. Managerial targets include the developmental steps 2 to 4 but could also cover step 5 and 6. At this level, policymakers – and in the end the Minister of Health – are responsible and accountable for the chosen targets. The use of health targets as a technical tool is assumed to correspond to the practice level and suggests the concrete deployment of programmes by stakeholders. This use of health targets

includes developmental steps 4 to 6, and possibly step 3. Responsibility and accountability are located with the stakeholders involved.⁸

The selection of health policy priorities and the setting of health targets rely on a social and political compromise. Figure 4 shows four poles between which such a compromise can be established.⁹ The poles of the horizontal axis represent the process of defining health targets. These have been termed 'technocratic' and 'participative'. A 'technocratic' selection of health targets has the merits of scientific rigour and transparency. It not only makes the decisions explicit, but the objectives upon which these decisions are based are also made clear. On the other hand, it is distanced from the political process and lacks political legitimacy.^{9,10} By contrast, the 'participative' selection of health targets has the advantage of democratic legitimacy, it can draw on common values and it is able to set up political alliances which will support the process of defining and implementing a programme.^{9,10} However, the results of the 'participative' process depend on the selection of people involved. The more people are invited to participate in the selection of the health priorities, the more they will expect to see their proposals appear in the action programme, and the greater the danger of fragmentation, confusion, and, at a later stage, disappointment and disillusionment as expectations cannot be met.¹¹ The vertical axis signifies the relation between the policymakers and those who are responsible for implementing, executing and running the action programme. In a top-down strategy, policymakers select the health policy priorities and the action programme is carried out on their behalf. In a bottom-up strategy, those working in the health field or the community initiate the selection of health policy priorities. The interaction between the two poles on the vertical axis is crucial for success in the implementation of a health target action programme. An optimal balance in terms of managing the tension between the poles is to arrange a compromise and build a political alliance as indicated by the oval.⁹

The targets themselves should also meet certain requirements. These SMART conditions (Specific, Measurable, Achievable, Realistic and Time-bound) were already listed in the first part of this article.¹ Prior to widespread implementation, attention should also be paid to evaluation. So how progress will be measured and what will be considered to be a success should already be defined when targets are set. Finally, the consequences of not achieving a target should also be explored.

Figure 4 Political co-ordinates of defining and implementing health target policies



Activities should be directed toward the achievement of the targets. The action programme is concerned with what functions, tasks, and activities have to be carried out, and what is the best way to do this. In addition, it is necessary to determine when things have to be done, who is going to do them and who is accountable for them.¹² So in an action programme, priorities could be assigned to the targets, and financial and organisational resources should be put into a time frame. Roles, authority and the responsibility of organisations should also be taken into account. Theoretically, the action planning process will start by identifying all the possible ways or means by which the target might be reached. It will then proceed to the determination of the likely consequences of each

alternative. Finally, the selection takes place of the alternative (or alternatives) that is most likely to achieve the target, that will come closest to achieving it or that will achieve it with least effort.¹³ Usually, there will be a number of actions supporting one target, so it will be necessary to provide integration of the actions. During this phase of the action planning process, potential problems can be identified (in, for instance, time schedules and human and financial resources) and steps can be undertaken to prevent their occurrence. At the end of the action planning process, the action programme should be reviewed to see if it is congruent with the targets set.^{14,15}

4.4 Implementing solutions

In the third step of the policy cycle, the policy should be implemented. Questions addressed in this step are: (1) what are opportunities, threats and constraints?; (2) what are the organisational requirements?; (3) what are the financial requirements? (4) who will be responsible and accountable for what? These questions have also been considered also when formulating the action programme, but in this phase the action programme will be implemented and the emphasis will be on obtaining commitment and establishing accountability. The organisational aspects of a particular health policy require considerable efforts to convince and motivate the intended stakeholders, and to implement the desired new structures or procedures through negotiation and other ways.

To establish accountability, specific organisations must accept responsibility for undertaking activities that are expected to contribute to the achievement of targeted outcomes. When every participating organisation accepts accountability for their part of the process, the Minister of Health and the government can accept the overall accountability.

To implement such an action programme, arrangements are required for leadership, community empowerment, authority to act, expertise and skills, information systems, implementation resources, administrative skills and resources and funding.¹⁶ Leadership is critical to initiate and sustain the process, particularly in reaching agreement among stakeholders regarding areas of accountable performance. Community empowerment complements leadership and encompasses the ability to establish and maintain a community perspective

on health targets and activities and to establish an environment in which many stakeholders can work together. Even though much depends on co-operative efforts, the need remains for formal authority to carry out some essential activities. So there should be authority to act. The expertise and skills needed can be sub-divided into subject matter expertise and technical expertise relating to, for instance, data collection and operation of information systems since information systems reflect the operational capacity to receive, process and communicate information, data and reports.¹⁶

The successful implementation of a health target action programme will depend on the ability of various organisations in the community to provide the required services and take other action as appropriate. The specific functions will vary depending on the health problem and the particular role of a specific entity. Administrative skills and resources will be a critical element in supporting the implementation of all activities. Among the elements that must be included are financial and organisational management, physical resources, personnel and funding.¹⁶ The latter has received insufficient attention so far. Financial considerations should include not only the estimated expenses of concrete interventions but also such aspects as comparative cost-effectiveness and the potential savings.

4.5 Monitoring and evaluation

In the final step, questions regarding monitoring and evaluation should be answered: (1) how to measure progress in outcomes (see also the question addressed in policy formulation phase?); (2) how to measure performance? (3) was the policy effective?; (4) was the policy efficient?; (5) which lessons can be learned (technical, organisational, financial, etc.); (6) is additional action needed to achieve the initial target? The aim here is to establish whether the targets have been met, whether the process of target setting has succeeded and whether additional action should be taken.

The indicators chosen depend on the aim of monitoring and evaluation. When monitoring progress in outcomes, the same indicators can be used as mentioned in the section 'understanding the problem', i.e. the incidence and prevalence of specific diseases and conditions, the subjective self-assessment of the state of

health, the use of health care facilities, the economic consequences of morbidity and mortality and the prevalence of health, morbidity and mortality, etc.² In addition to health outcome figures, performance figures are needed to monitor whether the action programme is being implemented as intended. Such process measures must apply to specific organisations that have accepted responsibility for some aspect(s) of the action programme. Since health priorities have many dimensions and can be addressed by various sectors, sets of indicators will be needed to assess performance.¹⁶

Although both types of indicators serve another aim, they are both important in this step of the health policy cycle. All indicators must be useful, clear, reliable, valid, objective, specific, sensitive to changes (in health status or performance) and available in good time at reasonable cost. The information provided by the selected outcome and process indicators should be reviewed regularly and used to inform further action.¹⁷ As current targets are achieved and new ones adopted, the health policy cycle supports the initiation of new activities and selection of new indicators.

4.6 Discussion

Setting health targets is a cyclic process, so with monitoring the first step is already taken to understand the problem, which in turn, etc. Setting health targets is also a way of rationalising health policy. Although the choice of the selected health targets is a more political one, health targets can be used as a tool to make the health policy consistent and coherent. When the health targets are based on available knowledge, one can also speak of evidence-based policy.

This brings us to the resemblance between evidence-based policy and evidence-based medicine. In evidence-based medicine, the 'understanding of the problem' also takes place by systematic analysis of relevant literature. An overview of these systematic reviews is available at The Cochrane Library.¹⁸ The 'choosing a solution' phase of evidence-based medicine can be found in the development of clinical guidelines such as the setting of health targets in evidence-based policy. In both evidence-based medicine and evidence-based policy, the commitment of stakeholders is very important when 'implementing solutions'. The same applies to monitoring and evaluation.

Evidence-based policy and the setting of health targets is, like evidence-based medicine, a complex task. Expertise of many kinds, and essentially from all of the public health disciplines, is often required. Moreover, acceptance of the targets as a basis for action by the various parties that may contribute to their attainment depends upon the extent to which these parties view them as sensible. Involvement of this entire framework in the formulation of targets enhances the likelihood that every necessary element will join in the mobilisation toward achieving them. It is important to stress that the intent of setting targets is not to predict what would happen if present trends continue, but to indicate what could be achieved with proper mobilisation of resources.¹⁹

As the pioneer of management by objectives, Peter Drucker, wrote in 1954: targets are not a railroad timetable. They can be compared to the compass bearing by which a ship navigates. The compass bearing itself is firm, pointing in a straight line toward the desired port. But in actual navigation the ship will veer off its course for many miles to avoid a storm. She will slow down to a walk in a fog and heave to altogether in a hurricane. She may even change destination in mid-ocean and set a new compass bearing toward a new port – perhaps because war has broken out, perhaps only because her cargo has been sold in mid-passage. Still, four fifths of all voyages end in the intended port at the originally scheduled time. And without a compass bearing, the ship would neither be able to find the port nor be able to estimate the time it will take to get there.²⁰

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