



UvA-DARE (Digital Academic Repository)

Health targets: navigating in health policy

van Herten, L.M.

Publication date
2001

[Link to publication](#)

Citation for published version (APA):

van Herten, L. M. (2001). *Health targets: navigating in health policy*. [Thesis, fully internal, Universiteit van Amsterdam].

General rights

It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations

If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: <https://uba.uva.nl/en/contact>, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

Chapter 5

New global Health for All targets

Global health targets are the most concrete end points to be pursued. They can be divided into three subgroups (see box 1) and are health outcomes, health determinants and health systems. All member states are supposed to set their own targets within this framework, based on their specific needs and priorities.

Box 1 Global health targets

Health outcomes

Target 1 Health equity indicators remain

By 2025, health equity indicators will be used within and between countries and health systems promoting and monitoring equity in health. Health equity will be considered to be a measure of child growth.

Target 2 Fetal, neonatal, infant and child mortality rates to be halved

By 2025, the targets agreed at WOT will be achieved: a 50% reduction in 100,000 live births, under-five or child mortality rates and life expectancy (LE > 70 years) will be met.

Target 3 Reduce global burden of disease and disability

By 2025, the world-wide burden of disease will be substantially decreased. This will be achieved by the implementation of several intersectoral programmes aimed at preventing the current trends of increasing morbidity and disability caused by non-communicable diseases, infectious, maternal, mental disorders and injuries, trauma.

Target 4 Eradicate and eliminate specific diseases

Polio will be eradicated by 2025. Leprosy elimination will be completed by the year 2020. The transmission of Chagas disease will be interrupted by 2010. Leprosy will be eliminated by 2010 and tuberculosis will be eliminated by 2025. In addition, vitamin A and

LM. van Herten & H.P.A. van de Water

British Medical Journal 1999; 319:700-703. Reprinted with permission.

Abstract

- The renewal of the Health for All strategy represents a further call for social justice.
- Ten new global health targets reflect most health problems in the world.
- Although the four targets for health outcome are the most concrete and measurable ones, they will be hard to achieve.
- The remaining six targets, dealing with the determinants of health and health policies, need further elaboration.
- Global targets are of questionable use to individual member states.

5.1 Introduction

In May 1998, the World Health Organisation adopted a resolution in support of the new global Health for All policy.¹ The new policy, Health for All in the 21st century,² succeeds the Health for All by the year 2000 strategy launched in 1977.³ The renewal of Health for All, concurrent with the 50th anniversary of the WHO and the appointment of a new director general, offers a unique opportunity for the organisation to re-establish its purpose. In the new policy, the world-wide call for social justice is elaborated in key values, goals, objectives, and targets. The ten global health targets are the most concrete end points to be pursued. They can be divided into three subgroups (see box 1) four health outcome targets, two targets on determinants of health, and four targets on health policies and sustainable health systems. All member states are supposed to set their own targets within this framework, based on their specific needs and priorities.

Box 1 Global health targets

Health outcome

Target 1 Health equity: childhood stunting

By 2005, health equity indices will be used within and between countries as a basis for promoting and monitoring equity in health. Initially, equity will be assessed on the basis of a measure of child growth.

Target 2 Survival: maternal mortality rates, child mortality rates, life expectancy

By 2020, the targets agreed at world conferences for maternal mortality rates (MMR; < 100/100000 live births), under-five or child mortality rates (CMR; < 45/1000 live births), and life expectancy (LE; > 70 years) will be met.

Target 3 Reverse global trends of five major pandemics

By 2020, the world-wide burden of disease will be substantially decreased. This will be achieved by the implementation of sound disease-control programmes aimed at reversing the current trends of increasing incidence and disability caused by tuberculosis, HIV/AIDS, malaria, tobacco-related diseases and violence/trauma.

Target 4 Eradicate and eliminate certain diseases

Measles will be eradicated by 2020. Lymphatic filariasis will be eliminated by the year 2020. The transmission of Chagas disease will be interrupted by 2010. Leprosy will be eliminated by 2010 and trachoma will be eliminated by 2020. In addition, vitamin A and iodine deficiencies will be eliminated before 2020.

*Box 1 Global health targets (continued)***Determinants of health***Target 5 Improve access to water, sanitation, food and shelter*

By 2020, all countries, through intersectoral action, will have made major progress in making available safe drinking-water, adequate sanitation, food and shelter in sufficient quantity and quality and towards the management of risks to health from major environment determinants, including chemical, biological and physical agents.

Target 6 Measures to promote help

By 2020, all countries will have introduced, and be actively managing and monitoring, strategies that strengthen health-enhancing lifestyles and weaken health-damaging ones, through a combination of regulatory, economic, educational, organisational and community-based programmes.

Health policies and sustainable health systems*Target 7 Develop, implement and monitor national Health for All policies*

By 2005, all Member States will have operational mechanisms for developing, implementing and monitoring policies that are consistent with this Health for All policy.

Target 8 Improve access to comprehensive essential health care

By 2010, all people will have access throughout their lives to comprehensive, essential quality health care, supported by essential public health functions.

Target 9 Implement global and national health information and surveillance systems

By 2010, appropriate global and national health information, surveillance and alert systems will be established.

Target 10 Support research for health

By 2010, research policies and institutional mechanisms will be operational at global, regional and country levels.

Presenting the new policy at the World Health Assembly was the first step in the renewal of the Health for All movement. The development of indicators for some of the targets and the promotion of the Health for All policy in all member states formed the next steps in the process.⁴ There are two main aims behind the Health for All in the 21st century programme. Firstly, the WHO wants to develop a shared vision by listing the ten most important health issues. Secondly, the organisation wants to formulate ten targets to motivate all member states to take action and to set priorities for resource allocation. To fulfil these aims the WHO sought to include in the new targets components that were inspirational and achievable.

5.2 Methods

In our review of the new policy,⁵ we considered how the ten new targets could be measured and attained, and their relevance. Measurability assumes unambiguous clarity, the use of quantitative elements, and the availability of indicators. We analysed the proposed indicators in relation to clarity and whether they could be measured, and assessed the indicators proposed for a given target, insofar as they had been developed. Attainability was analysed against a background of epidemiological and demographic trends. Relevance was considered in two parts – the global importance of the target and its usefulness for individual member states. The analysis was carried out by the authors separately, and, after consultation, the results were discussed with WHO staff.

5.3 Measurability

The table lists the results of our analyses for each target. It seems that most of the health outcome targets had been clearly (univocally) formulated. However, the other targets contain elements that are more difficult to interpret and measure – for example, they include terms such as ‘substantially’, ‘major progress’, and ‘sufficient quantity and quality’. Quantitative outcomes have been given for three targets only; outcomes for other targets are qualitative. All targets have a clear deadline, except for part of target 1, which relates to the promotion of equity in health. We found that the clarity of the indicators was reasonable to good for part of target 1 (childhood stunting), target 2 (survival), target 4 (elimination of diseases), and target 5 (water, sanitation, food, and shelter) only. Of these four targets, only the indicators for target 5 did not include quantitative elements. For the remaining six targets, indicators were not given or were described poorly.

Table 1 Overview of results of the analysis of target characteristics, appropriateness of indicators, and overall results on relevance and attainability of the ten global Health for All targets

nr	Target	Target characteristics			Indicator characteristics			Attainability	Relevance	
		Clear	Quantitative	Time-bound	Clear	Quantitative	Total set			Better needed
1	Equity in health	Yes	No	----	not given			Unclear	Yes	Yes
	Equity indices	Yes	No	05	not given			Yes	Yes	Yes
	Stunting	Yes	Yes	20	Yes	?	Yes	?	?	?
2	MMR, CMR, LE	Yes	Yes	20	Yes	Yes	No	?	Yes	?
3	Five major pandemics	?	No	20	not well described			Unclear	Yes	?
4	Elimination diseases	Yes	Yes	10; 20	Yes	?	yes	?	Yes	Yes
5	Water, sanitation, food and shelter	?	No	20	?	?	yes	Unclear	Yes	?
6	Health promotion	?	No	20	not well described			Unclear	Yes	?
7	HFA policies	?	No	05	not well described			Unclear	?	?
8	Essential health care	No	No	10	not given			Unclear	Yes	?
9	Alert systems	Yes	No	10	not given			Yes	Yes	Yes
	Surveillance systems	?	No	10	not given			?	yes	Yes
	Health information systems	?	No	10	not given			Unclear	Yes	Yes
10	Research	No	No	10	not given			Unclear	Yes	?

? questionable

5.4 Attainability

The table also shows the results of demographic and epidemiological analysis showing how attainable the targets are.⁶⁻¹³ Information about available interventions, the use of equity indices, and alerting, surveillance, and health information systems was found in health policy documents.¹³⁻¹⁸ Whether some targets are achievable is uncertain because there is no clear, quantitative statement of what will be considered as success in the given end year. These targets must be made more specific.

Judging the global attainability of the targets is difficult because of large differences in epidemiological and demographic trends between member states. This can be illustrated by the differences in maternal and child mortality and life expectancy. Another example is childhood stunting, a target more relevant for the developing world than for developed countries.^{19,20} Cigarette smoking is yet another example – it is the major cause of preventable mortality in developed countries, but is also becoming important for developing countries, where tobacco consumption is increasing steadily.²¹ With regard to communicable diseases, more people will be at risk because of ‘globalisation’ and increasing mobility.

Cost is another determinant of attainability. Take, for example, target 3. The cost of smoking prevention – financial measures to discourage tobacco consumption, the banning of tobacco advertising, health warnings on tobacco product packaging, and programmes of health promotion and education – could be relatively low.²¹ But reversing the current trends in tuberculosis would cost much more. The use of directly observed treatment short course regimens to avert further contamination and prevent multidrug resistant tuberculosis is acknowledged in tuberculosis control programmes. In urban areas, directly observed treatment short course regimens can be provided on a daily or alternate day outpatient basis, but in rural areas patients would probably have to be admitted to hospital or clinic for treatment. Including all patients with tuberculosis in directly observed treatment short course regimens would more than double the number of patients being treated, which would lead to logistical and financial problems, especially in sub-Saharan Africa.²²

For most targets, global epidemiological and financial constraints demand enormous additional amounts of political will, financial resources, and organisational effort. The creation of political will and impetus is a formidable challenge for the WHO and its new director general.

5.5 Relevance

At the global level, most targets are relevant in achieving Health for All (table 1). However, in target 1, for example, the relevance of childhood stunting is questionable for the developed world. Target 7 is only relevant globally when it is perceived as a stimulus for member states to develop health policies systematically. In our view, the new policy lacks targets related to the social environment and mental health issues. These major issues in global health have been omitted without argument.

The relevance of the targets for the member states varies in relation to epidemiological patterns and resources. For some member states, for instance, target 2 is set too high and is therefore potentially demotivating. For more developed countries, the relevance of this target is also questionable since it has already been wholly or partly met. The same applies to other epidemiological targets, and rates that are specific to region and to country are therefore needed. The elaboration of the targets also affects their relevance. For example, targets 5 and 6 are open to interpretation. Furthermore, the formulation of target 7 allows any country to state that it has a policy consistent with Health for All. The same applies to targets 8 and 10.

Thus, the ten targets are reasonably relevant globally, but represent an uneasy mixture of unequal entities. Some, for instance, are more specific than others. Some targets (such as target 10) focus on just one issue, while others (such as target 4) consider several different ones. Given these differences, it is impossible to compare the importance of the targets. It is therefore wise to measure progress in achieving the targets individually for the targets or their components.

5.6 Health for All in the 21st century?

The WHO has two aims with the new global Health for All policy. Firstly, the policy is a world-wide call for social justice. The WHO seems to succeed in the difficult task of drawing attention to the most important health issues. Just like the Health for All by the year 2000 strategy,^{23,24} the new global health targets could give a new impetus to the development of health policies in member states in the decades to come. It will again put public health on the policy agenda. Secondly, the new policy aims to motivate member states to take action and to set priorities for resource allocation. Much work still needs to be done to achieve this. To be useful in health policy at this level, all the targets need to be elaborated further and clear, practical statements must be made on their operation – especially the four targets on health policy and sustainable health systems. The WHO should stimulate the discussion of these important targets, but it should also be careful about being too prescriptive about health systems since this could be counterproductive.

In addition, more attention should be given to the usefulness of the targets in member states. One way of doing this is to rank the countries by target and to divide them into three groups. A specific level could be set for each group. For example, for target 2, three such groups could be distinguished as follows:

- Countries that have already achieved this target
- Countries for which the global target is achievable and challenging
- Countries that find the global target hard to achieve and therefore ‘demotivating’.

The first group needs stricter target levels, and the third group less stringent ones. If a breakdown of this kind is made for each target, some countries may be classified in different groups for different targets. In this way, the targets will provide an insight into the health status of the population and could be useful for policymakers in member states in encouraging action and allocating their resources.

Acknowledgement

This study was commissioned by Policy Action Co-ordination at the WHO and supported by an unrestricted educational grant from Merck & Co Inc, New Jersey, USA. We thank Dr J. Visschedijk and Professor L. J. Gunning-Schepers and other referees of this article for their helpful comments.

References

- 1 World Health Assembly. Resolution WHA51.7. In: Health for all policy for the twenty-first century. Geneva: World Health Organisation, 1998.
- 2 World Health Association. Health for all in the 21st century. Geneva: World Health Organisation, 1998.
- 3 World Health Association. Global strategy for health for all by the year 2000. In: Geneva: World Health Organisation, Health for all series, no 3, 1981.
- 4 Visschedijk J, Siméant S. Targets for health for all in the 21st century. *World Health Statistics Quarterly*, 1998; 51: 56-67.
- 5 Water HPA van de, Herten LM van. Never change a winning team? Review of WHO's new global policy: health for all in the 21st century. Leiden: TNO Prevention and Health, 1999.
- 6 WHO, World Health Organisation. World health report 1995: bridging the gaps. Geneva: World Health Organisation, 1995.
- 7 WHO, World Health Organisation. World health report 1996: fighting disease, fostering development. Geneva: World Health Organisation, 1996.
- 8 WHO, World Health Organisation. World health report 1997: conquering suffering, enriching humanity. Geneva: World Health Organisation, 1997.
- 9 Murray CJL, Lopez AD (eds). The global burden of disease. Boston: Harvard University Press, 1996.
- 10 United Nations. The world population prospects. New York: UN, 1998.
- 11 United Nations Development Programme. Human development report 1997. New York: Oxford University Press, 1997.
- 12 World Bank. Poverty reduction and the World Bank: progress and challenges in the 1990s. New York: World Bank, 1996.
- 13 WHO, World Health Organisation. Third evaluation of health for all by the year 2000. Geneva: World Health Organisation, 1999.

- 14 Ad Hoc Committee on Health Research Relating to Future Intervention Options. Investing in health research and development. Geneva: World Health Organisation, Document TDR/Gen/96.1, 1996.
- 15 Taylor CE. Surveillance for equity in primary health care: policy implications from international experience. *International Journal of Epidemiology*, 1992; 21: 1043-9.
- 16 Frerichs RR. Epidemiologic surveillance in developing countries. *Annual Review of Public Health*, 1991; 12: 257-80.
- 17 WHO, World Health Organisation. Health for all renewal building sustainable health systems: from policy to action. Report of meeting on 17-19 November 1997 in Helsinki, Finland. Geneva: World Health Organisation, 1998.
- 18 WHO, World Health Organisation. EMC annual report 1996. Geneva: World Health Organisation, 1996.
- 19 WHO, World Health Organisation. Physical status: the use and interpretation of anthropometry of a WHO expert committee. Geneva: World Health Organisation, technical report series No 834, 1995.
- 20 WHO, World Health Organisation. Global database on child growth and malnutrition. Geneva: World Health Organisation, 1997.
- 21 WHO, World Health Organisation. Tobacco or health: a global status report. Geneva: World Health Organisation, 1997.
- 22 Erkens C. Cost-effectiveness of 'short course chemotherapy' in smear-negative tuberculosis. Utrecht: Netherlands School of Public Health, 1996.
- 23 Water HPA van de, Herten LM van. Bull's eye or achilles' heel: WHO's European health for all targets evaluated in the Netherlands. Leiden: TNO Prevention and Health, 1996.
- 24 Water HPA van de, Herten LM van. Health policies on target? Review of health target and priority setting in 18 European countries. Leiden: TNO Prevention and Health, 1998.

