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### Health targets: navigating in health policy

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# Chapter 7

## Health policy and practice

### Box 1 Some examples of health target setting

- The UK's 1999 strategy 'Our Healthier Nation' and its predecessor 'Health of the Nation' are one of the most developed health target approaches in Europe. These strategies aim to improve health by using a limited number of quantitative health targets. The new policy is based on increasing effectiveness. In the target period of the year 2010 have been set for four areas: heart disease and stroke, accidents, injuries and mental health.
- Since 1989, nearly all regions of Spain have approved regional health plans. These plans have similar sets of health targets, although practical approaches may differ. In 1997, the Ministry of Health issued a Health Plan, which represents a step forward in the harmonisation of the regional policies.
- In Sweden, health promotion and disease prevention are primarily coordinated with a number of national and regional targets. Most of the health plans and programmes drawn up by the County Councils refer to WHO's Health World and the health target model. In line with the WHO monitoring scheme, the National Board of Health and Welfare issues a Public Health Report every three years.
- In the Netherlands, the setting of quantitative health targets was adopted in 1992. The secretary of State on Health took a less specific approach: the Dutch government stated six general goals in their most recent policy paper. These goals are: improvement of health by life expectancy, prevention of premature mortality, the improvement of the quality of life.

**Abstract**

The drive to achieve health gain and the increasing use of scientific evidence are important developments in the health sector. On the national level, data on efficacy, effectiveness and cost-effectiveness are used to set priorities. At this level the public health and the health care sector both address the population as a whole. However, in actual practice, the approaches in the public health and health care sectors have traditionally differed. This paper explores the different traditions in using evidence on efficacy, effectiveness and cost-effectiveness. The public health and health care sectors could profit from each other's experience. In the public health sector, efficacy should not be replaced by effectiveness. In the health care sector, more attention could be paid to heterogeneity within populations and to organisational circumstances affecting effectiveness. Finally, both sectors will need to combine outcome measures with cost measures.

## 7.1 Introduction

In June 2000, the World Health Organisation (WHO) presented its World Health Report 2000. In that report, it calls for attention to be paid to the performance of health systems in terms of health status, responsiveness of the system and fairness of finance.<sup>1</sup> With this report, WHO shifted its attention from public health targets towards health services. Outcome studies have been used traditionally to analyse the extent to which health services contribute to the health status of the population. Quantitative data is needed on (1) the nature and extent of the health problem and the inequalities between sub-populations and (2) on the efficacy and effectiveness of interventions.<sup>2</sup> The scarcity of resources in the health sector mean that the cost-effectiveness of interventions increasingly play a role in policy.

### *Box 1 Some examples of health target setting*

- The UK's 1998 strategy 'Our Healthier Nation' and its predecessor 'Health of the Nation' are one of the most developed health target approaches in Europe. These strategies aim to improve health by using a limited number of quantitative health targets. The new policy is based on increasing effectiveness. In this strategy, targets for the year 2010 have been set for four areas: heart disease and stroke, accidents, cancer and mental health.
- Since 1989, nearly all regions of Spain have approved regional health plans. These plans have similar sets of health targets, although practical approaches may differ. In 1995, the Ministry of Health issued a Health Plan, which represents a step forward in the harmonisation of the regional policies.
- In Sweden, health promotion and disease prevention are priority areas associated with a number of national and regional targets. Most of the health plans and programmes drawn up by the County Councils referred to WHO's Health for All and were based on the target model. In line with the WHO monitoring scheme, the National Board of Health and Welfare issues a Public Health Report every three years.
- In the Netherlands, the setting of quantitative health targets was rejected in 1992 by the Secretary of State on Health. As a less specific approach, the Dutch government stated three general goals in their most recent policy paper. These goals are the extension of healthy life expectancy, prevention of premature mortality and the improvement of the quality of life.

There are however differences in how this data is used on the national level and in practice. On the national level, the data is used to set priorities. In public health, these priorities are often made explicit by health targets (see box 1).<sup>3</sup> In the health care sector, governments are increasingly turning to priority-setting methods in order to justify allocation decisions (see box 2).<sup>3,4</sup> Although there are many differences, the discussions in the public health and health care sectors on the national level are similar in that they address the population as a whole. They often focus on average health outcomes.

*Box 2 Some examples of priority-setting methods*

- In Finland, the 1995 report 'From values to choices' presents ethical, economic and administrative issues related to making choices, but it does not offer prioritisation lists for individuals or groups.
- In the Netherlands, the 1991 Dunning report recommend four criteria (sieves) for including health care interventions in basis insurance package: Is the intervention necessary from the community point of view? Has proof been given that it is effective? Is it efficient? and Can it be left to individual responsibility? This advice was discussed thoroughly in the health care sector, but never put into use in the practical sense.
- In Norway, the 1987 Lønning report identified five levels of urgency. The second report in 1997 took into account the severity of diseases as well as the effectiveness (including the cost-effectiveness) of interventions. Four groups of services were defined: basic health services, supplementary health services, health services of low priority and services that do not belong within the health services financed by the government.
- The Swedish Parliamentary Priorities Commission issued its final report in 1995. This report presented a way of thinking about priority setting to assist those responsible for taking decisions, both on the policy and on the clinical level. As a basis for priority setting the commission laid down three principles: human dignity, solidarity and efficiency.

However, in actual practice, the differences between the public health and health care sectors will be greater than at the national level. In the health care sector, clinical guidelines provide patient averages which have to be translated to the individual (see box 3).<sup>5-7</sup> And although the tradition of using population averages is accepted for many prevention programmes (see box 4), such as vaccination and screening, health promotion programmes are increasingly being adapted to specific population subgroups and different settings.<sup>8-10</sup>

*Box 3 Some examples of clinical guidelines*

- In the UK, professional bodies, encouraged by the National Health Service, are producing guidelines to be used by providers in order to improve care and by purchasers to guide contracting and commissioning decisions. The NHS is now using an appraisal instrument to determine which guidelines to recommend to health authorities.
- In the Netherlands, the Dutch College of General Practitioners has produced guidelines since 1987, issuing more than 70 guidelines at a rate of 8-10 topics per year. A rigorous procedure involves an analysis of the scientific literature, combined with consensus discussions among general practitioners and content experts.
- In Finland, national and local bodies have issued more than 700 guidelines since 1989. A programme for evidence-based guideline development has been launched recently.
- In Spain, the Catalan Agency for Health Technology Assessment has started preparing guidelines and teaching methods for guideline development.

*Box 4 Some examples of prevention programmes*

- In 1953, the Netherlands started a National Immunisation Programme. All children may be vaccinated free of charge at the age of 3,4,5 and 11 months (DTP-Polio and Hib), 14 months (MMR), 4 years (DT-Polio) and 9 years (DT-Polio and MMR). Although there is no legal obligation or requirement to be immunised, the coverage has been over 90%.
- In 1995, the European Parliament recommended population-based mammography screening for all women aged 50-69 years. However, each Member State sets its own target age group for screening as it sees appropriate.
- In 1985, the Heartbeat Wales programme on behavioural risks for cardiovascular disease was started. The programme used a range of established health promotion methods directed towards both changing health behaviour in individuals and achieving environmental, organisational and policy changes that support healthy choices.

The public health and health care sector, both at the national level and in practice, use health outcome results from research (see figure 1). It is, however, often unclear how evidence on efficacy, effectiveness and cost-effectiveness of interventions is used. This paper explores the different traditions in using this evidence at the national level and in practice, both in health care and public

health, and looks where the two sectors could profit from each other's experience.

*Figure 1 Four fields of health policy*

	Population	Individual/Community
Health care	Priority-setting methods	Clinical guidelines
Public health	Health targets	Protocols for preventive activities

## 7.2 Efficacy

The overall aims of public health are health protection, disease prevention and health promotion. To ensure that there will be no harm to individuals, this sector has a strong tradition of using scientific research. The criteria of Wilson and Jungner<sup>11</sup> stress that there should always be clear evidence on several aspects before introducing prevention programmes such as screening. In general, population data is used as a basis for interventions for the population. Traditionally, the public health sector has used this data to develop protocols for preventive intervention, underpinned by the results of scientific research on efficacy.

The health care sector, by contrast, traditionally focuses on the health status of the individual patient.<sup>12</sup> Scientific research at the (patient) population level has to be translated into treatment decisions at the individual level which are increasingly based on scientific fact rather than on expert opinion. The aim of the clinical guidelines and evidence-based medicine is to improve the quality of medical care, to reduce interdoctor variability and to close the gap between what physicians do and what scientific evidence supports.<sup>6,13-16</sup> Most clinical guidelines are based on reviews of the efficacy of interventions in a homogeneous study population which may not have the same characteristics as an individual patient. The attempt to standardise care potentially ignores the heterogeneity of patients and the complexity of medical decisions.<sup>12,17</sup> This is the inherent tension in the acceptance of evidence-based medicine by individual physicians. It is therefore increasingly stressed that guidelines are primarily intended as recommendations and that it is the art of medicine to interpret these recommendations in the light of the specific characteristics of each individual patient.<sup>6,15,18</sup>

### 7.3 Effectiveness

Since many vaccination and screening programmes have a long tradition of working in accordance with strict protocols, the difference between efficacy and effectiveness is often minimal in these public health programmes. However, a major difference is found in health promotion where increasingly community-based and tailor-made interventions try to adapt to the specifics of the subpopulation and of the setting.<sup>12,19-21</sup> Supporters have even argued that efficacy trials are a waste of time since every community is different.<sup>22</sup> An argument reminiscent of medicine before the era of clinical guidelines. However, although it is hard to develop efficacy trials in public health settings, they are needed to prove that interventions will, in principle, have a positive effect on the health status of individuals or subpopulations. Effectiveness trials, on the other hand, will help clarify what specific circumstances determine success in a particular setting. Although process evaluation has to be part of such trials, outcome still ultimately determines success.

In the health care sector, effectiveness studies which include variation of individual characteristics in patient populations or the organisational settings are rare.<sup>16,23</sup> It is often assumed that the same expertise is present in everyday practice as in the trial. Most of us know this is not the case, but research funding for studying the two variables is scarce. Although some organisational circumstances are difficult to change (like budget constraints, waiting lists and limited personnel), the importance of such circumstantial conditions is often ignored when efficacy trials are used to set priorities at a national level. To a certain extent, this also applies to public health targets. To reap the full benefits of evidence-based medicine and evidence-based public health, more attention needs to be paid to this area in order to ensure that the critical success factors are also in place.<sup>24,25</sup>

### 7.4 Cost-effectiveness

On the national level, the main issue in discussions of health policy is the allocation of available resources against the background of increasing demand and expanding technical possibilities. Analysing the cost-effectiveness of interventions is mostly seen as a first step in discussions of the value of

interventions. This discipline needs further elaboration in both sectors. Difficulties relate to cost measures and effect measures.<sup>26-29</sup> Alongside discussions about incorporating direct and indirect costs or the measures used for health benefits, there is continuing debate about discounting. The latter is especially important for the public health sector, where short-term costs are often related to long-term benefits.<sup>30,31</sup> In the health care sector, the tension between practice and the national level is more apparent. Incorporating cost-effectiveness in the evidence-based guidelines is often equated with cost-cutting policies.<sup>32</sup> The use of cost-effectiveness rather than quality arguments has made priority-setting by governments somewhat suspect with the medical profession.<sup>33</sup>

## 7.5 Conclusions: items for the research agenda

The drive to achieve health gain and the increasing use of scientific evidence are important developments in the health sector. We have seen here that the public health and health care sectors have similar experiences even though the approaches have traditionally differed. Health care started at the individual level and went on to use research to set priorities at a population level. Public health, on the other hand, started with average population measures and only recently refined them for specific subpopulations. Where health care has traditionally concentrated on efficacy and has little experience with effectiveness, health promotion seems almost to have thrown efficacy overboard and sometimes seems to equate effectiveness with process evaluation. In addition, both sectors have difficulty in using cost-effectiveness data.

Both sectors could learn from each other's experience, possibly in joint research. It is important to make distinctions between efficacy and effectiveness. The efficacy of interventions should always be clear. Outcome research on efficacy in public health should be strengthened, since the interest in effectiveness studies sometimes appears to have replaced efficacy trials.

On the other hand, the effectiveness of interventions depends on individual characteristics and on organisational circumstances. The public health sector shows that there is much to gain for the health care sector in translating efficacy results into effectiveness outcomes. Research on the consequences of patient

heterogeneity and organisational circumstances could optimise the health outcome of medical interventions.

Finally, both sectors will need to combine outcome measures with cost measures if evidence is to be used to allocate resources at a population level. This means that societies must optimise cost-effectiveness by choosing the 'right' mix of medical and non-medical services and by producing them at minimum cost. Much could be gained at a national level if composite health measures such as DALYs and QALYs could be developed along similar lines in public health and health care policy.

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