

SETTING
HEALTH
TARGETS
FOR HONG KONG

The Institute for Health Policy and Systems Research (IHPSR) has recently completed a study on health targets. Specifically, the study assessed the need for introducing health targets in Hong Kong as a policy initiative and proposed practical strategies on moving forward on this topic. The study was supported by a grant from Merck Foundation.

The concept of health targets is not new. Health targets are proven to be useful indicators to policy makers, healthcare industry practitioners as well as the general public in many developed countries. The end result of having these indicators has facilitated better planning and allocation of resources to both improve people's health and promote the overall well-being of the community. In Hong Kong, health targets have not been formally adopted in policy-making nor received the attention it deserves. In light of the pending healthcare financing reform, the need and utility of health targets as a policy initiative are worthwhile concerns and subjects of study.

The approach of this study consists of literature review, study tours to the United Kingdom and Germany, and focus group interviews. In addition, a conference with overseas speakers and learned scholars from the World Health Organization's Western Pacific Regional Office, Singapore and Thailand as well as prominent local experts and researchers were held to share the international experience and examine local issues in implementing health targets as a policy initiative.

This document presents key results and findings of the study as well as proceedings of the conference. It is intended that the information contained herein will help to enrich the knowledge base of health targets in Hong Kong and to trigger similar initiatives in other countries within the region. As a follow-up to this study, IHPSR has formalized plans to collaborate with relevant organizations and agencies to study in practice the effects of health targets in enhancing health of the community. Longer-term initiative is also in place to establish a research foundation to study the effects of health targets on improving health and the healthcare system's performance.

We welcome comments, suggestions and views on the concept of health targets and its relevance to further enhancing people's health and to developing and sustaining a world-class healthcare system in Hong Kong.

For more information, please write to: ihpsr@hongkong.com

The Institute for Health Policy and Systems Research

“The Need for and Feasibility of Health Targets
as a Policy Initiative in Hong Kong’s Healthcare Reform”

A Focus Group Discussion on Health Targets, 23 January 2002

The Institute for Health Policy and Systems Research conducted a focus group meeting on 23 January 2002 with a group of selected health care practitioners and stakeholders to discuss the following topics:

- How will the concept of Health Targets benefit Hong Kong's healthcare and development?
- What targets are worth pursuing?
- What are the facilitators, barriers and inhibitors in introducing Health Targets as a policy initiative in Hong Kong?

Background

The concept and practices of Health Targets in certain developed countries and international organizations were presented as background information for participants. Health Targets are defined as specific and measurable objectives to improve health as part of a comprehensive health care strategy on a national or regional level. They can be divided into health status targets and health systems targets. Key features of these targets are that they must be quantifiable or at least measurable and that chosen areas must be one where effective interventions exist. Health Targets must be initiated at the political level. From this, policies can be formulated and then practices implemented.

The World Health Organisation (WHO) led the drive for the establishment of Health Targets by publishing the "Health for All by Year 2000" targets in the late 1970's. This was followed in 1984 by its European Regional Office which published 38 targets under five major categories:

- targets for reduction of certain diseases
- targets for lifestyles
- targets for healthy environment
- targets for health services
- targets for supported needed

Examples of Health Targets of several developed countries included:

- sixteen key areas identified in the 1991 Green Paper published by the United Kingdom
- four targets established by the Australian Health Ministry Advisory Council
- the “Healthy People 2010” which included two overriding goals and 467 specific objectives under 28 focus areas released by the U. S. Department of Health and Human Services in 2001

A major weakness of Health Targets appears to be the lack of reliable and comparable health data especially those involving morbidity and quality of life.

Benefits to Hong Kong

On whether or not Health Targets will benefit Hong Kong’s healthcare and development, all participants agree that the environment is ripe for Hong Kong to establish a set of Health Targets for its populace. Operational data and statistics are already available but are not used to measure the effectiveness of the health care system as no targets are set. A hodgepodge set of administrative policies by various governmental agencies are currently being proposed or implemented which could easily be coordinated and re-labeled as health targets. These included areas such as the anti-smoking campaign, alcoholism and drink driving, and work area safety.

The debate that leads to the establishment of the health targets for Hong Kong will increase the public’s awareness on health issues as well as the transparency of the health care system. Community ownership, commitment, and participation are essential to the success of any health targets.

A set of well defined health targets will help prioritise and shift funding to areas supported by the community. This is especially important now when the Government is attempting to limit the ever escalating costs of providing health care services to the general population. Health care providers can also base their investment decisions on these targets. Universities and researchers can direct their studies and researches in these areas. All in all, health targets will facilitate a more efficient allocation of limited resources.

Health targets, if and when implemented successfully and achieved, will provide Hong Kong with a healthier environment and will elevate Hong Kong to the ranks of one of the world's developed cities.

Targets Worth Pursuing

While no specific targets were proposed in the meeting, the group did agree that any Health Targets to be pursued must be quantifiable or at least measurable and that chosen areas must be one where effective interventions exist. In addition, it is proposed that Health Targets for Hong Kong should meet the following criteria:

- they must be financially viable and sustainable
- they should be cost effective
- they must have the support of the community
- everyone should be better off and no one is worse off
- initial targets should be few in numbers, easy to attain, and noticeable

Participants also advocate that Hong Kong should have both long-term targets for health and short-term ones for healthcare. One suggestion is to start with the top ten claims of local insurance companies. Another is the six diseases categories already identified by the Hospital Authority.

Facilitators, Barriers and Inhibitors

Health is everybody's responsibility. With a more educated and informed society, Hong Kong residents are well aware of this fact. This in itself is the biggest facilitator.

For the community as a whole, however, the setting of health targets and their implementation and achievement must be driven by the Government as well as public health experts. Employers, as the ultimate financier of most private health care, will also be an influential factor.

While health targets as a policy initiative in Hong Kong appears to be the right thing to do, there are barriers and inhibitors that must be overcome. Among these are Hong Kong's culture and its people's living habits, some of which may have to be changed and people are generally resistant to change.

There are no incentives for most stakeholders to help achieve the health targets. The Government, while an important facilitator, will also be the biggest barrier as its bureaucracy is geared towards a process orientation rather than results orientation. The Government's lack of public relations focus will also inhibit its effort, if and when it decides to set targets, to generate a consensus and commitment from the populace.

Conflict of interest among health care providers may also exist. Care must be taken that non-target areas are not neglected.

List of Participants of the Focus Group

Mr. Ronald Cameron	Consumer Council
Dr. C K Chan	Hospital Authority
Dr. W K Chan	Hong Kong General Chamber of Commerce
Mrs. Alice Chin	MSD (Hong Kong)
Prof. S P Chow	Hong Kong University Faculty of Medicine
Ms. Luzia Hung	HSBC Insurance
Dr. C H Leong	Hong Kong Academy of Medicine
Ms. Angela Lee	Dow Jones
Prof. S H Lee	Chinese University of Hong Kong Department of Community Medicine
Dr. Geoffrey Lieu	Hay Group Limited
Ms. Selina Lo	MSD (Hong Kong)
Mr. Robert Siu	The Hong Kong Association of Pharmaceutical Industry
Mr. Raymond Wong	Hospital Authority
Mr. Stephen Wong	Private Investor
Dr. Vivian Wong	Hospital Authority
Prof. Peter Yuen	Hong Kong Polytechnic University Department of Management

Implementing Health Targets as a Policy Initiative

An international conference organized by
The Institute for Health Policy and Systems Research
and supported by Merck Sharp & Dohme (Asia) Limited

The conference was held at the Hong Kong Convention and Exhibition Centre on 23 March 2002

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- Dr Geoffrey Lieu, chairperson of the conference, welcomed the attendees and commended them on their interest in the topic of health targets. The objective of the meeting was to explore the implementation of health targets as a policy initiative in Hong Kong and to hear the experiences of other countries.
 - The chairperson introduced Dr Aviva Ron, Director of Health Sector Development (Western Pacific) of the World Health Organization (WHO). Dr Ron presented the broader, WHO perspective on health targets.
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Keynote Presentation: Health Targets in Health Sector Development *Dr Aviva Ron*

To understand health targets and their potential role in the health sector, one must first analyse the trends and changes in health systems, demographics and epidemiology. Dr Ron discussed the issues that must be considered before health targets for the future can be established.

Trends affecting health targets

Demographic data shows that an ageing population is associated with decreases in mortality and fertility. The global populace is growing together with increasing globalization, mobility and urbanization. There are more single parents and more adults living alone than before.

In Asia, the ageing of the population is more rapid and the need to address this issue is consequently more urgent. In Europe, it took 100 years for the proportion of the population older than 60 years to increase from 5% to 10%. In Asia, this takes just 25 years.

Epidemiologically, Asia has a high disease burden in the categories of communicable diseases, maternal and perinatal conditions and nutritional deficiencies as well as in the categories of non-communicable conditions, neuropsychiatric disorders and injuries. Asians now experience more cardiovascular disease, diabetes, injuries and mental health problems. In the

western Pacific region, there are about 1,000 suicides per day. There are also about 1,000 daily deaths due to tuberculosis, with an average of 700 deaths in China and 80 in the Philippines per day. Millions of people are still undernourished.

For communicable diseases, at least, there is a global focus on HIV/AIDS, tuberculosis and malaria. There is also an improved understanding of the interaction between poverty and health.

Epidemiological predictions suggest that disability-adjusted life years (DALYs) due to communicable disease, maternal and perinatal conditions, and nutritional deficiencies will decrease from 49% to 22% between 1990 and 2020. Over the same period, injuries will increase from 15% to 21%, neuropsychiatric disorders from 9% to 14%, and non-communicable conditions from 27% to 43%.

Obesity is also increasing in Asia and around the world. This has an important association with diseases such as diabetes. The average body mass index of Samoans, for example, increased from 59.1 to 78.9 from 1978 to 1991. This pervasive trend reflects the impact of changing lifestyles and the move away from traditional diets on the weight and health of Asians.

There are still considerable health disparities between countries in the region. Infant mortality rates, for example, range from 3.4 and 7.0 per 1,000 live births in Japan and New Zealand, respectively, to 77 in Papua New Guinea and 101 in Laos. The maternal mortality rate also varies greatly from 5.2 and 5.7 per 100,000 live births in New Zealand and Japan, respectively, to 370 and 650 in Papua New Guinea and Laos, respectively. Countries that are in the same World Health Organization (WHO) region are not going to have the same health outcomes purely by virtue of their locality. However, the reasons for these disparities are of significant interest.

In recent years, there has been much talk of changes to the healthcare system. These changes, however, have been slow and unbalanced; changes have been effected in one area but not in another. This has led to inconsistencies with, for example, changes being made to financing but not to organization and operations.

Globalization has had a mixed impact on these changes. Skilled health professionals leave developing countries for higher incomes elsewhere. At the same time, because of communications trends and the availability of information, more people know more about healthcare options. However, many of these options remain beyond the reach of those in poorer areas.

Health systems remain under-funded, and the role of the state is still unclear. Government stewardship of the healthcare system is often weak and poorly coordinated: for example, ministers of health and relevant ministers of labour and the environment do not communicate and coordinate their activities to maximize benefits to public health. There may often be a lack of responsibility and accountability for essential public health functions. The role and use of the private sector in public health may also be poorly regulated.

National health targets

Many of these key issues are covered under the United Nations millennium development goals. These goals will focus on malaria, tuberculosis and HIV/AIDS. They also aim to reduce poverty by 50% and boost the education of children and future mothers: a higher level of maternal education is associated with lower maternal mortality ratios and infant mortality rates.

What then is the role of national health targets? Six national health targets were identified.

Health target 1:

Achieving the safe and rational use of health services, such as drugs, injections, medical equipment and blood, is a fundamental health target. The achievement of this target would mean that resources are efficiently and effectively used, with fewer inequalities within the service because wastage is minimized and resources are better distributed. It would also mean that adverse effects are reduced as unnecessary drugs and surgery would be avoided. Services would be less vulnerable to misuse and compliance would be enhanced, ultimately resulting in improvements in health outcomes.

Some examples were used to explore this health target. Safe water and good sanitation reduce morbidity. In many countries, 40% to 50% of morbidity is caused by unsafe water and poor sanitation. It is entirely feasible to achieve safe water and sanitation.

Elaborating further on the issue of safe and rational drug use, Dr Ron discussed the “sub-target” to reduce antimicrobial resistance. Antimicrobial susceptibility testing in the western Pacific region has shown that 2% to 40% of tuberculosis cases exhibit primary antimicrobial resistance to first-line agents, and 10% to 80% of malaria cases are resistant to chloroquine. In pneumonia, 90% of *Streptococcus pneumoniae* are resistant to penicillin. Ninety percent of *Shigella* infections, causing dysentery and diarrhoea, are resistant to first-line antimicrobial therapy, and the penicillin-resistance rate of gonorrhoea infections ranges from 5% to 98%. How has this situation developed?

These patterns of resistance have arisen largely because of inaccurate or incorrect diagnoses, antimicrobial therapy that has not been prompt or sustained for long enough, or because of treatment with inappropriate or substandard drugs. The cost of therapy, and inadequate hygiene and sanitation also compound this dire situation. If this pattern were to continue, there would be no effective antimicrobial therapies against some very common infections in the future. Dr Ron feels that safe and rational prescribing must be implemented immediately to ameliorate this situation, as current research initiatives alone will not solve the problem of antimicrobial resistance.

Another facet of the target to ensure safe and rational use of health services is a safe supply of blood. A sub-target of this is to ensure safe and rational transfusion services, which would aim to:

- increase voluntary blood donations
- centralize blood banks and services
- improve transfusion practices
- achieve appropriate use

This target has been reached in Hong Kong, Singapore and some other Asian countries. However, some countries in the region, such as the Philippines, have only partially achieved this goal, with some areas lagging behind the rest of the country. Many Asian countries, however, have not achieved this goal at all.

Health target 2:

Dr Ron said the second health target should aim to separate revenue-generating mechanisms from provider payment. Much of the misuse of drugs and services is due to the link between revenue and services. Providers receive payment for their services and may attempt to provide such services, even when it is not entirely necessary. An attempt should be made, therefore, to provide other incentives through education or research opportunities. This will help to shift the focus of the healthcare system away from profit making. Profits could instead be made through the provision of non-medically essential services, such as air-conditioning in hospital wards and second-opinion consultations.

Health target 3:

The third target would aim to finance personal healthcare through prepayment. This would involve the establishment of mechanisms that would identify and cater to all population sectors, allowing for contributions from those with the means to pay into the system and providing social assistance to those who cannot. It would also be crucial to establish a comprehensive benefit package with emphasis on preventative services and approaches. Preventative medicine must become an integral part of healthcare systems and should be covered by health insurance schemes.

Health target 4:

Public health care should be financed through general tax revenues. If health target 3 was implemented, this would facilitate a reduction in the burden on government to provide public healthcare. Instead, the government could intensify efforts to improve public health through:

- food and hygiene inspection and monitoring
- licensing, regulation and accreditation of all components of the public health system to ensure quality
- the promotion of a healthy lifestyle
- the education of health workers
- collaboration with academic institutions and individuals
- the study of variations in health care, providing insights into local patterns of irrational and inappropriate use of healthcare services

Health target 5:

A further health target should focus on achieving better management of health services. Deferring to the hospital directors and managers in the audience, Dr Ron mentioned that positions in healthcare administration do not always attract the best candidates. To ensure the highest calibre of administrators in these positions, avenues should be explored to:

- attract the best candidates
- focus on education and skill
- train administrators effectively
- promote professionalism and avoid political appointments
- continue to update and educate administrators through, say, the reading of journals on public health administration and management, and attendance at conferences and trade shows
- encourage and reward accountability
- maintain information systems

Forming partnerships for success

New partnerships need to be forged to broker these health targets and to ensure their success. Focusing on advocacy and lobbying, these partnerships would need to be established between government and:

1) Industry

This would facilitate the production of safer products through good standardized manufacturing processes that are uniformly applied. Product labelling with appropriate messages should be improved, and these messages could be conveyed to a larger audience through advertising.

2) Labour

Labour could be encouraged to use their bargaining power to negotiate for healthier working conditions and products. Their collective power would be a significant lobbying force for better health services.

3) Civil society

Government should work in collaboration with civil society and associations to promote education and understanding of the value of good health, and the importance of safe water and good sanitation. If the public is aware of the importance of a healthy environment, it would be more likely to demand it of their government. These groups could also be used to promote behavioural change among healthcare providers and consumers; the public should be empowered to expect good medical service and to question the service they receive. Civil groups could assist the government in supporting vulnerable populations, such as the elderly and people with special needs.

Conclusion

National healthcare systems and governments should do what they can do now. A focus on well-monitored and managed processes will lead to better use of resources and enhance the credibility of the health service. Once the credibility of the service has been established, ministers of health will feel more empowered to talk to other ministers, and the way will be open to tackle more complex issues and promote the healthful behaviour of the public.

Open Discussion

Question: I feel that many people have many different ideas about what a health target is. What is the general principle of a health target?

Dr Ron: In brief, a health target aims to achieve better health. There are global health targets, regional health targets and local health targets. At a local level, a health target aims to identify and attain better health for a given population.

Question: Could you please clarify whether the health targets you mentioned are for the entire region or for Hong Kong alone. Also, could you explain more about how these targets are developed? I feel that some of these targets are controversial and are based on a specific economic philosophy. For example, the target that personal health care should be financed through prepayment; in Hong Kong and Singapore, outpatient services are financed out of pocket.

Dr Ron: These health targets were not formulated for Hong Kong specifically, but they may be applicable in this setting. To take your example on prepayment, it was once true that when you sought help as an outpatient, you would have a fair idea of the cost involved. That is not true today, because even in the outpatient setting, patients may have to pay the cost of drugs and diagnostic test up front. After 1 or 2 instances of this happening, patients may be reluctant to seek treatment in future, leading to delays in treatment. Prepayment removes the financial factor at the time of illness when the decision is being made about seeking treatment.

Comment: I feel that it is especially important to consider cultural and racial issues when discussing the implementation of health targets.

Dr Ron: Yes, the issue of culture is very important. The WHO cannot make health targets for countries; each country has to develop its own targets, specific to their situation, culture, epidemiology, demographics and trends.

International Panel: The European and Asian Experiences

The perspective from Singapore

Dr Phua Kai Hong
Associate Professor
Department of Community, Occupational and Family Medicine
National University of Singapore
Singapore

History of healthcare policy

A National Health Plan was implemented in Singapore in 1983. The aim of the policy at the time was to encourage more personal responsibility by emphasizing disease prevention and introducing new health care financing in the form of medical savings. Prior to these reforms, the public had become dependent on practitioners for health care and on the government for financing based on the tax-based system.

The Review Committee on National Health Policies was formed in 1991 to correct some of the problems in the implementation of the health policies of Singapore. To monitor the effectiveness of new health programmes and to have measurable targets for policy-making, the committee first had to establish a baseline. To this end, the first interim report, the so-called Pink Report, was hurriedly produced by the end of 1991.

The Pink Report focused on disease prevention and health promotion, and aimed to identify priority health problems and programmes.

The main report, the so-called Blue Report, followed in 1992. It re-emphasized the need to target priority areas. The report focused on 5 disease-control programmes, which target diseases with the highest mortality. The Blue Report also made recommendations to revamp the health system, with particular attention paid to:

- medical training and specialization
- professional standards and quality of care
- changes to healthcare financing
- the implementation of cost-control measures

These initiatives eventually led to the White Paper on Affordable Health Care in 1993. This paper initiated a number of control mechanisms to reduce increasing health care costs and to focus efforts on health outcomes.

Policy now aims to encourage people to be more aware of their health, and to take on some of the responsibility, including financial, for their health. The philosophy has changed from one of dependency to joint responsibility.

Why set health targets?

Singapore's experience with its National Health Campaigns on Healthy Lifestyles has mediated its move toward health targets. The National Health Campaigns initially focused on disease, particularly cancer, ischaemic heart disease, hypertension, diabetes and mental illness, and the prevention of those diseases through healthy lifestyles. These campaigns continued without proper systems to monitor and compare their effectiveness, until a sub-committee was set up as part of the National Healthy Lifestyle Campaign of 2000. This campaign, driven by the Ministry of Health, concentrated on health targets. Considering the baseline from studies in Singapore, trends in demographics and epidemiology, and evidence from other developed countries, the sub-committee came up with realistic 10-year targets with intermediate targets for ongoing review. Instead of looking at the final outcome, they examined disease risk factors. They analysed priority indicators, such as:

- work status
- weight and diet, setting targets for weight reduction and changes in diet
- trends in cigarette smoking
- physical activity

These health risk indicators are being very effectively monitored. The responsibility for these initiatives is shared between the Ministry of Health and other partners, including companies, and voluntary and professional organizations, which all share a common objective to improve health outcomes.

What is a health target?

Health targets are specific and measurable objectives to achieve certain goals. They specify the target population, the intended intervention and the indicator by which progress will be measured. Health targets are implemented to address:

- huge variations in performance
- a lack of consistent outcomes
- the persistence of ineffective practices
- the drive for greater quality, efficiency and cost-effectiveness

Health targets are necessary because politicians have very short-term goals, whereas health system managers have longer-term ones. In the words of the famous economist John M Keynes:

“There is nothing a politician likes so little as to be well-informed because it makes decision-making so complex and difficult.”

On the other hand:

“There is nothing a manager likes so much as to be well-informed because it makes decision-making and control so simple and easy.” (K H Phua)

Data is necessary for the establishment and monitoring of health targets. Target indicators are indirect measures that enable managers to determine whether key activities are carried out as planned and have the expected effects. These indicators should provide information on the effectiveness, efficiency, equity and quality of the targets. The implementation of health targets should be viewed from a systems perspective with equal attention and effort focused on each step of the system:

Input → Process → Output → Outcome

Too often, attention is focused on the input stage, on financing and resources, and not on the other steps in the rest of the system that lead to the desired outcomes.

Conclusion

Setting health targets guides the implementation of policy and enables the evaluation of the process. Health policy objectives should be specific and their equity, efficiency, effectiveness and quality can be measured by the use of indicators.

The perspective from Thailand

Dr Suwit Wibulpolprasert
Deputy Permanent Secretary
Ministry of Public Health
The Royal Government of Thailand
Thailand

The process of establishing and striving for health targets has been in practice in Thailand since the late 1970s. The success of these health targets is measured in terms of health status and the provision of services.

Since 1982, Thailand has had its fifth 5-year National Health Development Plan, which is a medium-term scheme, including targets focusing on service coverage, and behavioural and environmental changes. In the short-term, the yearly budget also sets health targets for health development.

To have successful outcomes from health targets, both medium- and short-term strategies are necessary. Continuous monitoring and evaluation is also essential.

A new initiative from the Royal Thai Government will be introduced with the new financial year. Ministers will be required to sign a contract with the National Budget Policy Committee, stating clearly their delivery targets. The ministers will in turn require the director generals of various departments to sign contracts committing themselves to the delivery of more measurable targets, or key performance indicators. For example, the current Thai Minister of Health has been contracted to deliver universal health insurance coverage. She will in turn enter into a contract with the permanent secretary involved to achieve the key performance indicators for the delivery target. The following delivery targets have been identified for the next fiscal year:

Delivery target 1 aims to achieve health insurance coverage for all Thai people with the following key performance indicators:

- i) 100% coverage in the so-called “30-Baht Scheme”, which is 99% financed by tax and less than 1% by the patient. The patients pay 30 Baht for any treatment or consultation
- ii) 70% satisfaction
- iii) 100% coverage of hospital accreditation

Delivery target 2 will promote healthful lifestyles and behaviours. The key performance indicators are:

- i) 72% of children younger than 5 years develop appropriately
- ii) 90% of pregnant mothers receive antenatal care
- iii) 50% of the adult population engages in regular exercise

Delivery target 3 focuses on disease prevention with the main performance indicator being:

- i) a reduction in the rate of incidence of HIV/AIDS in pregnant women and new recruits to 0.5% by 2003

Monitoring health targets

Elaborating further on the monitoring systems for delivery target 3, Dr Suwit explained that to set such targets it is imperative to understand the epidemiological trends. The incidence of HIV infection in pregnant women receiving antenatal care was 1.5% in June 2000. This rate had declined to approximately 1.2% by 2001 and is predicted to be slightly less than 1.0% in 2002. A further reduction to 0.5% by 2003 is feasible, but constant monitoring of strategies is required to ensure that the goal is achieved. One main strategy is a project to achieve 100% condom use among commercial sex workers. This project has been very successful, with condom use increasing from just 25% in 1989 to 97.6% in 2000, but continued monitoring is necessary to achieve their health target.

Many factors contribute to the success or failure of health targets. A health target to reduce the incidence and mortality rates of malaria in Thailand very successfully reduced the mortality rate. However, the control of the incidence rate was less successful; when the economy weakened, the incidence increased, regardless of the efforts of health workers. The departments in charge of environmental control had less money to spray mosquito breeding areas, and the people had less money to buy mosquito nets, and the incidence of malaria increased as a result.

Other factors may impinge on the success of health targets. The “brain drain” is one such factor in Thailand. From the 1960s, many doctors started leaving Thailand to pursue their careers in other countries, leading to a drain on human resources and an inequitable urban-rural distribution of doctors. To stem this tide, a number of measures were implemented, including huge financial incentives for newly graduated doctors who accepted posts in rural areas. This strategy saw the number of doctors in rural hospitals increase from 9.3 doctors/100 beds in 1979 to 14.0 doctors/100 beds in 1989. Thereafter, however, this rate again declined to a low of 6.6 doctors/100 beds in rural hospitals by 1998. This decline was attributed not to an international “brain drain” but to a national one, as the rapid economic growth of this period saw doctors being lured away from public hospitals to new, richer private hospitals. With the economic crisis of 1997 and the bankruptcy of many private sector hospitals, the number of doctors in rural hospitals has again started to increase. Such dynamics are beyond the realm of the health sector and can profoundly affect the success of health targets.

Conclusion

The success of health targets depends on the cooperation and collaboration of many sectors. Multinational, national and even sub-national health targets are commonly initiated throughout the world. Their success and sustainability depend on strategic planning and political commitment. Social partnership and involvement are important to reduce the influence of external factors and to enlist the help of other sectors. Dr Suwit emphasized that at a governmental level, ministries need to work together to ensure the success of health targets.

The perspective from the United Kingdom

Professor SH Lee
Honorary Professor
Department of Community and Family Medicine
Chinese University of Hong Kong
Hong Kong

In July 1992, the British Government launched the Health of a Nation: a Strategy for Health in England. This publication set out 5 health target areas:

- coronary heart disease (CHD) and stroke
- cancer
- mental illness
- sexual health, including HIV/AIDS
- accidents

These targets followed the WHO principles of Health for All by the Year 2000 strategy, which emphasized equity, health promotion, community participation, multi-sectorial co-operation, primary health care and international co-operation.

The Health of the Nation strategy

These 5 key areas were composed of a number of sub-targets. By 2000, the CHD/stroke sub-targets aimed to:

- reduce CHD/stroke mortality rates by 40% in people younger than 65 years
- reduce CHD mortality rates by 30% in people aged 65 to 74 years
- reduce stroke mortality rates by 40% in people aged 65 to 74 years

The cancer sub-targets were to:

- reduce deaths due to lung cancer in men younger than 75 years by 30% and in women younger than 75 years by 15% by 2010
- reduce death rates for breast cancer in the screened population by 25% by 2000
- reduce the incidence of invasive cervical cancer by 20% by 2000
- halve the year-on-year increase in skin cancer by the year 2005

Sub-targets for mental illness aimed to:

- improve the health and social functioning of mentally ill people
- reduce the overall suicide rate by 15% by 2000
- reduce the suicide rate of severely mentally ill people by 33% by 2000

For HIV/AIDS and sexual health sub-targets, the goals were to:

- reduce conception in women younger than 16 years by 50% by 2000
- reduce the percentage of intravenous drug users sharing needles by 50% by 1997 and by a further 50% by 2000

For accidents, the sub-targets were to reduce death rates:

- by 33% among children younger than 15 years by 2005
- by 25% among people aged 15 to 24 years by 2005
- by 33% for people older than 65 years by 2005

To ensure that health targets are implemented, a number of monitoring mechanisms were put in place. The chief monitoring bodies were the Department of Health, the National Audit Office, the Cabinet Committee and local health authorities. By 1996, the National Audit Office having completed its assessment found that many of the targets had been successfully carried out.

Assessing the results

The Health of the Nation strategy aimed to improve health standards, service and protection, to increase surveillance and data collection, and to reduce risk factors. This strategy had a number of positive effects, which:

- increased the focus on outcomes
- led to the development of new professional models and protocols
- established national service frameworks
- improved performance
- increased awareness of new therapies

There was also criticism of the 1992 Health of the Nation targets. Some felt that the targets were too narrow in focus, and that they placed too little emphasis on social and environmental issues. Critics also felt that the targets failed to acknowledge the role of poverty and social deprivation. Still others pointed out the lack of suitable data and mechanisms for measuring some of the targets and that some of these targets were too easy, being nothing more than extrapolations of inherent trends.

Health targets - revised

These results and criticisms led, in 1999, to a new document, titled Our Healthier Nation, which set out new goals to improve health and reduce inequalities. More attention was given to health determinants of an individual (lifestyle and behaviour) and socio-economic nature. To effect this improvement, a “3-way deal for health” partnership was established in which responsibility is shared between the Government, the community and the individual.

The Our Healthier Nation strategy outlined 4 national health targets for 2010, including cancer, CHD and stroke, accidents and mental health. Local targets have also been implemented in which local health authorities will run local health improvement programmes.

Conclusion

Dr Lee ended his presentation with a quote from a talk given by Professor Nick Bosanquet (Professor of Health Policy, Imperial College, London) at a conference on the Prioritization of Healthcare Services:

“Target setting in the United Kingdom began very strongly with an endorsement saying that we had done better on meeting WHO standards than anybody else, but targets have now somewhat faded as the key focus of the British health system. Nevertheless, out of that experience of target setting will, I hope, come a more local agenda for improving health care, and for bending and steepening the curve so that we can achieve more effective health services that are there for the making in the next few years.”

This shows that the health target system was largely successful in Britain, but that the emphasis has shifted away from national health targets to local targets for improved health. Professor Bosanquet forecast that future health targets in Britain will be used to:

- study how to improve performance and how to use innovation particularly in partnership with key private sector providers
- encourage more joint meetings between patient and carer groups, and people in specific professions
- promote joint efforts to define targets for health improvement at the local level
- develop more common research projects on specific subjects

The perspective from Germany

Dr Geoffrey Lieu
The Institute for Health Policy and Systems Research
Hong Kong

Dr Lieu focused on the concept and implementation of and reasons for health targets in Germany.

Logically and systematically conceived, the German concept of health targets goes beyond defining health or systems performance outcomes to include the strategic aims of the health system and the targets relating to each aim. Within each target, sub-targets focus on more specific areas of target execution and the establishment of measures and instruments to determine whether the targets have been successfully implemented.

The aims of the German system are:

- disease prevention
- promotion of healthful lifestyle
- enhancement of health-related, including system, technical and knowledge, capabilities
- creation of a healthy environment

Dr Lieu used the disease prevention aim as an example. Within this aim, there are a number of targets, including:

- cardiovascular disease
- cancer
- accidents, intoxications and other injuries
- paediatric and perinatal health
- chronic respiratory diseases
- sexual health

Within the target of cancer, there are a number of sub-targets for the most at-risk age group of 45-64 years. By 2010, these sub-targets aim to:

- reduce the general cancer rate by a minimum of 25%
- reduce the lung cancer rate by a minimum of 25%
- reduce cancer-free years of life by a minimum of 20%

The sub-targets then go further, looking at strategies for how to deal with these illnesses and to reach their targets. The strategy for lung cancer, for example, is the prevention of smoking. To do this, there are a number of measures and instruments to be employed. These are:

- to encourage public discussion
- to initiate programmes for high-risk groups
- to prevent smoking in adolescents
- to encourage smoking cessation for adolescents
- to establish information group for parents

This analysis give an insight into how health targets are implemented in Germany and it also constitutes a comprehensive, in-depth definition of what a health target is.

Why have health targets?

In Germany, more than 10% of the gross national product is spent on statutory health care; only the United States enjoys a higher rate (at 13%). However, estimates have shown that the health service in Germany has only a 10% to 30% influence on the health of the population. Health targets are a means of increasing this influence, as they have a substantial impact on the health of the individual. Another reason for health targets is that the causes of disease and health are beyond the control of health services. They are unable to minimise the impact of these factors. So instead, they establish national targets for disease prevention and health promotion.

There is also a need to improve health and healthcare in Germany. The health outcomes in Germany are not proportional to the amount of money it invests in health services. Indeed, they have a:

- medium international ranking in early mortality after cardiac infarction contingent on medical care
- increased mortality after colon and breast cancer
- medium ranking in patient satisfaction compared with other European countries
- their efficiency and cost-effectiveness are not optimal
- an unsatisfactory ranking in world health reports

Patients were also demanding improvements to their health care. They demanded disclosure of treatment standards and documentation, access to advanced treatment methods and shortened waiting times for diagnoses. They also complained that general practitioners are not referring them to specialists readily. They expected transparency on doctors' experience and accounts, and the enforcement of quality controls. All these factors played a part in the development of the health target policy in Germany.

The development and implementation of health targets in Germany has fought resistance, both from the political and medical arenas, for many years. It was not until the mid-1990s that various health targets and initiatives were tried. Many of these initiatives failed for many reasons including a lack of political support, a lack of involvement of key stakeholders and a lack of expertise.

The German approach to designing health targets

Things have improved. Towards the end of 2000, the German Federal Ministry for Health asked an organisation called the Association for Social Security Policy and Research (GVG) to complete by July 2002, a proposal on how to implement health targets. Realizing that health targets complement the existing health policy, the GVG took a pragmatic approach to developing the proposal. They focused on four potential areas:

1. Disease-orientated targets
This focused on chronic back pain, breast cancer, heart disease and stroke, diabetes and depression.
2. Defined population-group targets
This included integrated programmes for people younger than 20 years that would focus on physical activity, nutrition, stress reduction and vaccination.
3. Citizen/patient orientated targets
This focused on increasing the health competence of the population and patients, to improve transparency, strengthen rights, increase knowledge and the capacity for healthcare.

4. Prevention-orientated targets

The reduction of tobacco consumption was identified as a very important target in this category.

This framework was used to develop the requirements for the fulfilment of these targets. Such requirements might include:

- the strengthening of self-help
- gender mainstreaming, to redress the existing and emerging inequalities between men and women
- Equal access
- Integration of health provision and care
- Evidence-based, disease-orientated targets

These are requirements that must be integrated into the pursuit of health target goals.

The GVG has also analysed how best to approach health targets to maximize the probability of successful outcomes. This approach considers the political decision-makers and the need for legislative support at the top. It also includes at the bottom the healthcare professionals, whose values and incentives are critical.

Two other groups are also considered: the “Technocratic” element and the “Participatory” element. The technocratic element focuses on scientific enlightenment, the analysis of needs, problems and deficiencies, the setting of priorities and the development of mechanisms. The technocratic group is essential to ensure that health targets are successfully introduced and implemented. They are distant from the policy process and not generally democratic in terms of their work.

The participatory element, on the other hand, focuses on democratic legitimacy, the value of the community, the setting-up of alliances and making sure that there is sufficient grassroots support for their work. Their strategies would be unrelated to health. They would lack information and have singular interests.

This approach suggests that all the elements must be in place for health targets to be successful.

Conclusion

By providing a focus, health targets can enhance an inter-sectorial approach to health, with different elements striving for a common goal. Health targets help address the question: how do we use the money we have to get the most cost-effective outcome?

Health targets should be introduced gradually, with 1 or 2 health targets being set at first. Interest mediation and conflict resolution skills are critical during implementation.

Open discussion

Dr Edith Lau: I would like to comment on Geoffrey Lieu's suggestion that perhaps we can only pilot 1 or 2 health targets in Hong Kong. I feel that if we only focus on 1 or 2 issues, say, cardiovascular disease, we will have to contend with pressure from the diabetes and cancer lobbies. Is it not better to develop a more comprehensive set of health targets? As a test of the implementation of health plans, I feel we can start with 1 or 2 targets, with a view of expanding to a more comprehensive implementation.

Dr Lieu: I would agree with you entirely. In fact, this is something we explored in the United Kingdom. Their caution to us was that it is better to demonstrate that something like this can actually work and to learn from the process before a full-scale implementation of health targets.

Question: In Hong Kong at present, the community enjoys cheap, if not free, health services from hospitals. In this light, how can we involve the community without much resistance or political opposition?

Dr Ron: There is a similar situation in most ex-British colonies, which have enjoyed a national health system for many years. Their public health systems are excellent at taking care of the public interest, focusing on areas like prevention and health promotion, but not so good at promoting individual responsibility for health. They now face the problem of trying to persuade people to take responsibility for their own health.

Question: What are the risks if we do not implement health targets as a policy initiative?

Dr Ron: To me, it is quite simple: politicians will set the health agenda, and the outcomes might not be as good.

Dr Lieu: Your question reminds me of a passage from Alice in Wonderland. Alice came to a junction of several roads. She asked, "Which way should I go?"

"Well, it depends on where you want to go," was the response.

"I don't know," Alice says.

"If you don't know, it doesn't matter which road you take. You should be happy wherever that road takes you."

The question I would raise is: How do you know you are getting the best out of your healthcare buck? If we do not have health targets, if we do not have objectives for the future, we should be happy wherever we end up. That's the risk.

Expert Panel: The Need for Health Targets and Implementation Issues in Hong Kong

A perspective from Hong Kong

Ms Christine Loh

Ms Loh opened the discussion with her definition and interpretation of “setting of health targets”. Firstly, the setting of health targets differs from performance pledges. Secondly, the setting of health targets is essentially a political process. And thirdly, it is essential that the political process is well informed and that all stakeholders are aware of the issues.

As Ms Loh was less familiar with health issues, she shared some of her experience in another policy area: the environment.

Pollution is an issue in Hong Kong and, from the perspective of a politician, she stressed that it is important to understand what is causing the problem. A key question to ask is whether there is sufficient scientific data and appropriate research to assist policy makers in making policy-relevant decisions. Although there is substantial research in Hong Kong from academia, government and consultants, the data are not always aimed at policy-makers.

For example, a current government pollution-related project is investigating visibility. Various factors may contribute to visibility such as fine particles, ozone or other chemicals. Controlling any of these factors may rely on a different methodology or approach, with different cost implications. It takes time to understand all the issues, the possible result of each of the control measures, how much time and money should be spent on the project, and what will be the overall benefit to the public.

It is important to question and research all the issues, because sometimes ideas are put forward by parties with vested interests, in this case potentially major polluters. Parties with different interests may prevent different sets of results and argue about the integrity of their research. This situation can

apply to environmental targets, health targets, or other processes. Therefore, the community should engage in a process that is more collaborative. When referring to a participatory process that is inclusive, what does this really mean?

There is a need to develop processes that can ultimately become a component of the political process. The political process can take considerable time, and involves a number of components including: community discussion; political compromise; interaction with the government; speaking with the Legislative Council; and workshops. Finally, legislation may be passed which will result in funding for the agreed course of action. From Ms Loh's perspective, the civic process is not well designed as it does not inform. Rather, it is seen as a "nice to do" component of the political process where people get together to talk at workshops.

It is important to build civic strength, and for individuals to be informed. The process needs to be developed for individuals, interested groups and opposition groups to come together as part of the community. Information must be current and the community must be willing to fund continuous research. Feedback, ideas and concerns should actually be addressed in the political process. Ms Loh stressed that politicians and government will not organize the process, but it is necessary for the community to organize themselves to contribute.

With regard to the environment, Ms Loh described 2 areas which she feels are grossly neglected:

1) Air quality

The air quality objectives in Hong Kong are not legally enforceable. Perhaps making air quality objectives a legal requirement would force people to comply. There is also the issue of accountability. Once environmental or health targets are set, it is necessary for someone to be accountable.

2) Noise

The average level in Hong Kong is 75 decibels, which is extremely high when you compare it to WHO targets which are in the 50s. People in Hong Kong constantly live with this level of background noise. However, there is no research on what effect this may have on the current generation, and whether this will result in hearing impairment in the future.

The progress in Hong Kong

Dr CH Leong
President
Hong Kong Academy of Medicine, and
Member of the Board
Hong Kong Hospital Authority

Dr Leong reiterated comments of earlier speakers in that healthcare reform and changes to the health system in Hong Kong are very slow to eventuate. He has been active in promoting the idea of health targets since the early 1990's, and gave his interpretation of health targets. Health targets are about health, and not about sickness. The aim is to promote health rather than reducing or curing already existing illness.

Why focus on health targets?

About 10 years ago, there was little that was positive in the way of healthcare policy in Hong Kong. People rely on hospitals for treatment, therefore promotion of primary healthcare may reduce hospitalization and reduce costs. Prevention is also better than cure, however, there is a lack of targets for preventative care.

Many disease and illnesses are preventable. Christine Loh spoke earlier about the environment. Environment and health are related: if the environment is poor, health will deteriorate. Situations such as noise and industrial injury are preventable. As medical science progresses, more diseases will be preventable or curable, therefore people should become more healthy.

Health targets are not only a medical issue, but also encompass moral and ethical issues, cultural issues, education and societal issues. Therefore, it is not only the responsibility of doctors, healthcare networks or the government, but requires participation by the entire community.

Problems in developing health targets

There are a number of issues that need to be addressed in Hong Kong in order to develop health targets. These issues will be described further but include: taking the wrong approach to health targets; “government/doctor responsibility syndrome”; the “anti-health” movements; lack of interest of politicians; policy-maker concerns; and confusing health targets with healthcare targets. Dr Leong stressed that health should be everybody’s business.

The wrong approach

Hong Kong has a history of taking the wrong approach to health. The belief in Hong Kong was that the best way to keep healthy is to have your disease cured and the only way to do this properly was in hospital. This was the underlying feeling of not only the general population, but also of the teaching hospitals at the time. Therefore, the wrong approach was to say that the best way to get healthy is to receive the best treatment at the best hospital by the best doctor. However, the point that many people did not realize is that the best way to get well is to stay well.

Government/doctor responsibility syndrome

Health is a problem of the individual. However, the population has the general opinion that they are dependent on healthcare money from the government, and that doctors are responsible for their health. This responsibility, or dependency, syndrome is evident in Hong Kong.

An example of this occurs when there is a cholera outbreak in Hong Kong. People continue to eat raw shellfish, which are a source of cholera, but insist that cholera is the problem of the government. It is the responsibility of the individual to take control of their own health.

In order to move towards a more healthy society, the two issues above need to be addressed. However, this will require a change in the culture of the population, and in the healthcare profession.

Anti-health movements

Health targets mean, by implication, prevention of behaviour that can harm health. It is often big businesses that are associated with these “health-harming agents”, e.g. tobacco companies and junk food manufacturers. For instance, the government will not increase taxes on tobacco as they believe it will lead to the sale of illegal cigarettes. However, Dr Leong questioned whether this was really the case, or due to effective lobbying of tobacco companies.

Another example is the too stringent control of products such as toys. This makes the product more expensive and as a result can make it more difficult for people to import products into the region. This can ultimately affect business, and the entire economic situation.

There is also the possibility of burden on employers due to unsafe work practices such as workers climbing scaffolding without harnesses, improper use of safety helmets and ear protection. The community needs to address these issues as they are potentially harmful to health, but there would be lobbyists resistant to changes.

Lack of interest of politicians

Politicians may be disinterested about health targets for a variety of reasons. Firstly, they can be short-sighted about long-term issues. A good result, obtained quickly, can mean votes at the next election. However, health targets are a long-term proposition, and something that generates results in 10 years’ time does not result in votes today. Implementation of health targets may even result in loss of votes. For example, trying to develop anti-smoking strategies may result in loss of votes from the tobacco industry.

Policy-makers’ concerns

Policy-makers are not concerned about health targets for a number of reasons. The results, if any, take time. Policy secretaries in Hong Kong tend to have short-term views, therefore they may think that implementing a health target now would mean that their successors will gain the benefits. In addition, the issue may be broad-ranging and therefore may involve several departments. For instance, health, education and environment may all need to act together, but the relevant departments may not see it as their responsibility.

Further, there may be strong opposition from anti-health movements. And lastly, healthcare targets (rather than health targets) may be more attractive to the policy-maker. Dr Leong sees healthcare targets more as performance pledges, for example, to reduce waiting time at an outpatient clinic to 3 hours. But in health targets, the ultimate aim may be to reduce the incidence of lung cancer by reducing smoking. However, this may not be as attractive to a policy-maker for the reasons outlined above.

Concluding remarks

Dr Leong completed his presentation by saying that Hong Kong has been living on false confidence in the health system for too long. For many years, health officials have been taking pride in long life-expectancy and low infant mortality. However, Hong Kong needs to start setting, and achieving, targets on health in order to improve their global health rating. This will require partnerships between the government, healthcare professionals and the community, and there must be a will to achieve the aim.

Lastly, Dr Leong provided some answers to questions posed in the previous session. Mr Raymond Wong asked, “What if we do not have health targets?” The answer is simple: we’re moving back to the situation where we are only curing diseases, we are not promoting health. Dr Suwit said that it is harmful to a certain extent if we’re going to have health targets. Dr Leong agrees, but if health targets are to be set by the community at large, then the priorities are there. And to Mr Michael Mak who says that the setting of health targets requires community participation, Dr Leong agrees that community participation is required, but the overall cost is minimal.

Evaluating Health Target Programmes: Preliminary Evidence

Professor Peter P Yuen
Department of Management
Hong Kong Polytechnic University
Hong Kong

Professor Yuen has recently participated in the study tour to the United Kingdom and Germany and was given the task of evaluating health target programmes from these two countries as well as from other countries. He indicated that this was not an easy task, and he presented the preliminary evidence below on the performance of various programmes.

Objectives of health targets and Implications for Hong Kong

To evaluate a programme, it is important have to look at the objectives. Earlier speakers have already mentioned the overriding objective — to have better health. Central to this is to reduce mortality and morbidity, improve quality of life, and to reduce inequity in mortality and morbidity in a particular country or territory.

Another objective of developing health targets would be to provide better and more appropriate health services.

A third objective would be to have greater transparency in health policy making. This includes greater rationality in resource allocation, priority setting and decision making based on public participation, cost effectiveness, and evidence-based medicine.

The system in Hong Kong can benefit from such type of exercise, as hospital services are delivered in a neo-monopolistic fashion by the Hospital Authority. There are not many effective mechanisms to ensure that resources are appropriately spent. As in any public sector organization, there is also a tendency to resist change. Health targets can be a way to facilitate change, and to ensure that resources are allocated in line with the wishes of the community.

Evaluation of health target programmes

This talk aims:

- 1) to determine whether the objectives of better health and better and/or more appropriate health services have been achieved through having a health target programme; and
- 2) to determine the most effective approach.

The results presented are preliminary in nature. A meta-analysis approach was taken, analysing research performed by others, as well as information collected from secondary sources on the study tour. The two key publications were:

- Wismar M, Busse R. Health Policy 2002;59:223-241.
- Van Herten L, Ven de Water HPA. European Journal of Public Health 2000;10: 11-16.

Other documents and published studies from European, North American and Australasian countries were included in the analysis.

The programmes were evaluated on the basis of :

- How many targets have these countries achieved? and
- Whether the targets have any impact
 - at the political level, i.e. politicians involvement
 - at the policy level, i.e. resource allocation decisions or legislation being influenced as a result of these targets
 - at the practice level, i.e. individual practitioners modifying their practice patterns in light of the targets

The Netherlands

A study was performed by Water and Herten in 1996 on health targets in the Netherlands set for the year 2000. The authors pointed out that not a single target was fully achieved. There were 10 targets that were partially achieved, 11 that were not achieved at all, and 17 which were inconclusive.

The United States of America

The USA has a long history of target-setting dating from the 1980's. However, in the early stages, health planning was geared more towards cost containment. Targets were set in 1990 and evaluated in 1996. The USA has more than 300. A recent review shows that 8% of targets were achieved within the stated timeframe, 40% achieved what is known as correct orientation, 8% reported no change, 18% were actually moving in the opposite direction of the targets, and there were no data for the remaining 26%.

More recent initiatives were published in 2001 in Healthy People and targets were set for the next 10 years. The two key targets were to enhance life expectancy and quality of life, and to eliminate health disparities between subgroups of the population. The approach is again extremely comprehensive as there are 28 focus areas and 467 objectives. Extensive consultation was involved in developing the targets as more than 350 organizations were interviewed during a 4-year period. Considerable evidence was provided to the decision-makers before publication of the targets.

The United Kingdom

The *Health of the Nation* was published in 1992 and identified five health targets. This was evaluated after 1 year by the Department of Health and indicated that good progress was being made. However, it must be noted that this was an internal evaluation. An independent evaluation was performed in 1998 by the University of Leeds and the London School of Hygiene and Tropical Medicine. It indicated that there was minimal impact on practice. Therefore, there are mixed reviews of the impact on healthcare practices.

Our Healthier Nation was a second set of objectives published in 1998. Four priority areas were included that were similar to those in the earlier set of initiatives. Due to a change in government at the time, the initiatives were repackaged as National Health Service frameworks, and contain broader, longer-term objectives. There was a "top down" approach to drafting that did not involve extensive consultation before the objectives were set. Implementation was monitored by a broad-based committee, however, there has been no evaluation of the new objectives to date.

Australia

In 1994, the Australian Health Ministry Advisory Council published a set of targets. Four main disease groups were targeted: cardiovascular disease; cancer; injury; and mental health. There has been no independent evaluation so far of the Australian initiatives.

Germany

In Germany, a set of initiatives was developed by the GVG, which is a non-government body. The major members of the GVG include the Hospital Association, Sick Fund Associations, Physicians Associations and other relevant groups. The selection of targets was based on extensive surveys and discussions. The five target areas published in 2001 were diabetes, breast cancer, tobacco consumption, fitness and health competence. It is too soon to evaluate the implementation of the initiatives.

Observations on different health target programmes

A variety of approaches have been employed in developing health target programmes and initiatives. There are a number of key areas in which the programmes can be compared.

Number of targets

Countries such as the UK and Germany have set targets in only a few areas, whereas the USA has set several hundred targets. The argument for having only a few targets is that the selected targets represent the priority areas the country wishes to concentrate its effort on. On the other hand, the argument for having a large number of targets is that all disease areas are being addressed. It is not clear which is the better approach, but it appears that the political situation in a particular country has a great deal of influence over the number of targets selected. For example, the UK has a more centralized system which makes the prioritisation process relatively easy, whereas the health system in the USA is more pluralistic which makes it more difficult to coordinate.

Process

Some countries adopt a more top down approach while others adopt a more bottom up approach. In the absence of the government taking the initiative in setting targets, community groups and professional bodies can initiate the process in bottom up manner.

The process can be more technocratic or more participative. The technocratic approach involves economists and epidemiologists utilizing the available research to develop targets. The participative approach relies more on forums and surveys to gather input from the community in the development of targets.

Some target programmes may be associated with incentive schemes. For instance, in Thailand, the targets are linked with contracts and budgets. If targets are not achieved, no further contracts will be awarded.

Nature of the targets

The nature of the targets also varies considerably. Some health targets are related to structure and inputs (e.g. more funding, more doctors) and others are related to healthcare processes (e.g. shorter waiting time). Health targets can also be lifestyle-orientated (e.g. Smoking cessation). Some targets focus on specific disease groups (e.g. cardiovascular disease) and others on outcome (e.g. reduction in mortality or morbidity).

Different groups tend to favour different types of targets. For instance, politicians are more interested in input and process targets, whereas epidemiologists may prefer targets related to outcome and specific disease groups. The target types are not mutually exclusive.

Evaluation of health target programmes

Overall, most countries have health targets at the political level. However, few have managed to use health targets to influence policy and/or individual practices. It is too soon to determine which approach is the best, as none of the programmes so far have proven to be indisputably successfully.

A major problem is the lack of reliable and comparable health data, especially those involving morbidity and quality of life.

Open Discussion

Ms Loh: I would like to ask the first question. The American example shows they achieved 48% in 10 years, is this a stunning success?

Professor Yuen: One needs to look very closely at the targets they set for themselves; the targets might have been very easy to achieve. One would need to study the programme further to make a definitive conclusion.

Dr Lai: Health targets have been a success in some countries because there is an agency that oversees their implementation. In the United Kingdom, this takes the form of the Commission for Health Improvement. Each local health authority is monitored and graded by the Commission according to their progress. How would the implementation of health targets be monitored in Hong Kong?

The government here appears to be moving towards implementing health targets - the Cancer Coordinating Committee and the performance pledges in the annual policy address. How can we turn these pledges into real health targets?

How will the implementation of health targets fit in with the shift to a ministerial system in which ministers will be responsible for various bureaux?

Disability-adjusted life years (DALYs) are not suitable benchmark measures for Hong Kong as infant and maternal mortality are no longer important factors; the focus should be on quality of life and disease-related disabilities.

Ms Loh: First, I would like to consider whether we are asking the right questions in the Hong Kong health debate. I would also like to suggest that far too many people that have a stake in this debate are excluded from the process.

Second, turning to the topic of what the new ministerial system will do, target policing for me is accountability. How are we going to make the political system more accountable? The government will have to be willing to set standards, targets and goals, and to provide funding for a broad range of initiatives. There will also need to be some process that informs and measures these decisions. How is civil society going to drive these changes and what will the healthcare professionals be willing to do?

Policy has an impact on children and the elderly. The environment and gender must also be considered. Civil society must continue to deliberate on policy and provide the evidence to inform policymakers.

Dr Leong: Health policy is not just medical policy, it is social policy. It should take everything into consideration and be community oriented and driven.

Turning to the final question, I feel that the success of the ministerial system will rest on how the ministers are chosen. If the ministers go through the baptism of vetting by the community at large and if that minister can come up with a policy that enjoys community support, then the community will help to drive policy through.

Professor Yuen: I think we have no choice at this stage but to adopt a bottom-up approach as the government is not going to take the lead. This does not mean that the government will not get involved once the ball has started rolling.

I agree that we need to underpin the targets with evidence and data, but in the absence of available information, we should proceed in a modest manner, identifying areas where we do have some data and work from there. It may be necessary to limit health targets to a few focus areas at the start.

Adjournment:

Alice Chin: On behalf of the Institute, I want to thank all the speakers who have taken time to share their experiences with us today. The question this morning was: Are health targets the way forward as policy initiatives to facilitate better health in Hong Kong? If the answer is yes, then what limits our progress? What would stop health targets from working in Hong Kong? What could help them succeed? We have heard various perspectives and experiences, giving us a regional and an international perspective. This has helped us to understand the political, social and procedural issues involved.

In summary, I would like to quote Dr C H Leong:

“If health is everybody’s business, let’s work on how we can elevate our health status to world standards and on how we can better use the publicly and privately funded resources we have.”

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