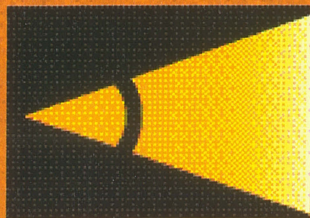

Euro Observer

The Health Policy Bulletin
of the European Observatory on Health Systems and Policies

Spring 2006
Volume 8, Number 1

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Health targets and (good) governance

Matthias Wismar, Kelly Ernst, Divya Srivastava, Reinhard Busse

Good governance in health systems is an ideal which is difficult to achieve in its totality but is said to exist if overarching societal goals and values such as solidarity, equity and participation are realized. It requires a process of decision-making and effective implementation and can be judged on the basis of how government institutions conduct their public affairs, manage resources and respond to their citizen's needs. Standard definitions see good governance as having eight major characteristics: it is participatory, consensus-oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive, and follows the rule of law. Furthermore, it should seek to eliminate corruption, take account of the views of minorities and the most vulnerable in society, and respond to the present and future needs of society.

Governing a health system can be difficult given the complexity involved, with multiple services, provider organizations, and stakeholders. The task is not becoming easier as new challenges emerge, the opportunities to respond to them expand, and public expectations rise. To meet the challenges of providing efficient, effective, and equitable services, countries need appropriate tools and instruments. Is a system of targets one of the tools that can help to facilitate good governance?

Health targets express a commitment to achieve specified outputs in a defined time period, and enable monitoring of progress towards the achievement of broader goals and objectives. They may be quantitative (for example, the immunization rate) or qualitative (for example, the introduction of a national screening programme), and based on outcomes (reducing infant mortality rates) or processes (regular checks of a patient's blood pressure by a physician). Health targets should be 'SMART' – specific, measurable, accurate, realistic and time bound,[1] although in practice many are aspirational, identifying broad directions of travel.

Targets are viewed as a means of defining and setting priorities, creating high-level political and administrative commitment to particular outputs, and providing a basis for follow-up and evaluation.

Health targets as a tool for policy formulation have been promoted by the World Health Organization (WHO) since the early 1980s both globally and in Europe in its Health for All policy. More recently, the United Nations Millennium Development Goals also include health-related targets. Many individual countries now have health targets, established on the national, regional and local level.

This raises a number of questions about the actual experience with health targets in Europe. (1) How widely are health targets used? (2) Have countries achieved the health targets that they have set? (3) What have countries done to support the development and implementation of targets? (4) Is there sufficient capacity to formulate, implement, monitor and evaluate the targets? (5) Have targets generally contributed to improvements in governance for health?

In this article we summarize some experiences with health targets in Europe, based on two forthcoming books that analyse their use from two complementary angles; the first focuses on Health for All in Europe and its influence on policy formulation and implementation[1] while the second looks at health

The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM).

targets and good governance,* and includes case studies from Catalonia (Spain), England, Flanders (Belgium), France, Germany, Hungary and Russia.[2]

The use of health targets

The most recent mapping exercise on Health for All policies employing health targets presents the situation on 31 December 2004. It covers the 52 Member States of the European Region of WHO and includes all policy documents.[1] Three selected results from the analysis of Health for All policy formulation in the Member States are presented below.

Firstly, at the national level, 40 countries have formulated comprehensive health policies employing health targets or are in the process of formulating them. Other countries, such as the Russian Federation have used health targets to formulate sectoral health policies. The level at which targets are set reflects the constitutional settlement in each country. In countries such as Spain, Germany and the United Kingdom, where various aspects of health policy are devolved to regions, Länder, or countries, health targets have been set at sub-national level. This does not preclude targets also being set at the national level, and it is difficult to find a country that does not have health targets at one or more administrative levels.

Secondly, there appears to be no geographical, political, economic or institutional pattern in the use of health targets in policy formulation. Countries in the north and south, east and west, more or less affluent, and countries with NHS and social insurance schemes have employed health targets, albeit of different types and in different ways, in policy formulation.

Thirdly, there has been a sustained interest in employing health targets. Out of the 40 countries, 27 which have a policy currently in place, or are in the process of policy formulation, are building on a previous policy that used health targets.

* The Observatory gratefully acknowledges the financial contribution of Merck & Co., Inc. to this project.

A few countries have undertaken explicit reviews or evaluations of their policies – for example, Catalonia, England, Finland, Lithuania and outside of Europe, the United States.

Health targets are also employed in policy formulation outside Europe. Probably the best known example is the Healthy People Policy in the United States.[3] Other countries such as Australia, Canada, Japan and New Zealand have formulated health targets in the past either on the national or sub-national level or both (for a comprehensive overview see: http://www.euro.who.int/observatory/Studies/20040310_2)

Target achievement

The apparent success, as judged from the amount that has been written on the establishment of targets, appears in a different light when assessing the achievement of targets. Despite the reviews noted above, clear-cut evidence about the success of targets is scarce. Much of the available evidence comes from the United Kingdom, where the use of targets to drive policy implementation throughout all parts of the public sector has reached unprecedented levels. Government ministers have highlighted a number of successes, where targets have been achieved. A frequently quoted example was the virtual elimination of inpatient waiting times longer then nine months in England, achieved by the year 2004.[4] It has been suggested that activities that were made the subject of targets in England but not in Wales or Scotland improved to a greater extent in the former.[5]

In most countries, it is too early to assess the achievement of targets for health outcomes, largely because few countries have established effective monitoring systems, but also because there are often long lags between behaviour change and health outcome. There is, however, some evidence derived from process indicators in some countries. For example, the 2003 French national cancer plan included a range of measures to tackle tobacco consumption, such as increases in the price of cigarettes, educational campaigns and local programmes promoting smoking cessation. Intermediate results have shown a drop in smoking prevalence and a significant increase in the number of people visiting smoking cessation centres.[6] In the Flemish region of Belgium, a programme to promote healthy eating in schools was launched through local health networks. The well-coordinated programme involved working with local food retailers to distribute healthy fruit snacks to school children. Initially, in 2000 only two schools participated, but by 2004, 60 schools were involved and 20,000 pupils were receiving a fruit snack.[7] However, it will be important to ensure that these changes can be sustained.

Some other countries have also reported the achievement of targets, but often it is difficult to know whether any positive developments would have been achieved without using targets. This is the case for Catalonia. The comprehensive evaluation of the Catalonian health targets for 2000 concluded that out of a total of 106 targets that were evaluated, 68 were fully achieved, and 9 partially.[8] However, the lack of a control group meant that it was not possible to quantify how the use of health targets has contributed to the positive results.

The greatest challenge is a lack of data, with information on health and its determinants extremely sparse in Europe. Moreover, while many target-based policies aspire to have an impact on resource allocation and management of services, many targets have been ignored, neglected or dismissed altogether, so it is unsurprising that they seem not to have had any impact.

Finally, it should also be noted that the discussion on achieving targets has been accompanied by evidence of unintended consequences or distortions in outcomes. Examples from England (See case study on page 5) highlight some drawbacks, with evidence of distortion of behaviour, gaming, and a focus on the achievement of targets at the expense of other activities.

Targets and governance

The mixed results of target achievement reflect, in part, a failure to embed health

targets into a broad governance strategy. As already noted, governance in health systems is often weak and limited to ensuring that basic pre-requisites are in place; for example, that pharmaceuticals are licensed and health professionals qualified. Health care needs to be linked to health improvement: this requires the creation of a vision for health, a process of target formulation that incorporates widespread stakeholder involvement, the creation of appropriate incentives, and intelligence gathering. Given the diversity of institutional settings, each country must find its own mix of appropriate governance tools. This may involve actively establishing consensus on priorities, creating ownership of the targets set, securing the credibility of health targets, appropriate use of legislation, establishing systems of accountability, linking targets to budgets and creating managerial incentives and sanctions.

Some countries have tried to create consensus and ownership amongst stakeholders and the public from the beginning of the process of health target development, using horizontal (intra-regional, sectoral and inter-sectoral) and vertical (national-regional) coordination. In France, national and regional health conferences were established to allow stakeholders an opportunity to debate the health problems they faced. This was a way to promote consensus on regional priorities and to foster a partnership between all actors involved.[6] Similarly in Catalonia, Health Councils were created to involve citizen groups and to enable greater public participation in target setting.[8] In Germany, the states (Länder) combined to urge the federal government to define health targets to complement their own health targets.

There are, however, trade-offs between consensus and ownership on the one hand and the credibility of the health targets on the other. The balance between a 'participatory' approach and a 'technocratic' expert-driven approach is a difficult one. Consensus-based health targets may reflect the vested interests of influential stakeholder groups and may undermine the scientific credibility of the targets. On the other hand, scientifically sound targets may be the result of minimal or symbolic inputs from stakeholders, as reported in Flanders.[7]

Making health targets a legal obligation is especially relevant for countries with pluralistic health systems in which the government or the ministry of health is neither the provider nor the purchaser of services. In Flanders, a regulatory framework on preventive health was established by a decree. In France, the Public Health Act (passed in 2004) includes health targets, and implementation is supported by decree (although it remains to be seen if legislation is enforced). In Germany, targets were published in the official journal and targets on health promotion and prevention were tentatively included in the bill on prevention, which was meant to reform comprehensively the financing and delivery of health promotion and prevention. However, the bill stalled during the 2005 elections, creating concerns that enthusiasm for national health targets may wane. In Hungary, the lack of a legal framework was seen as one of the reasons that target setting failed to achieve its objectives.[9]

An effective accountability framework is the key element in ensuring adherence to the pursuit of targets. There is, however, great diversity in the systems that have been established. In Catalonia, the Minister of Health is accountable to the regional parliament for implementation and achievement of health targets. The targets are generally quantitative, with a defined time horizon and linked to a specific indicator that can be used for evaluation. A strong feature of the region's Health Plan is the transparency involved in presenting it to parliament for scrutiny and discussion, although formal approval is not necessary. Furthermore, it suffers from the generally low attention paid by politicians to health; for example, after presenting the evaluation of the targets for 2000, the opposition showed no interest in debating the results.

Each country handles the financing of health targets differently. Some countries provide no additional budget for targets while others provide partial or substantial budgets. France's Cancer Plan, whose main objective was to reduce cancer related mortality by 20% in five years, was allocated a budget of €640 million up to 2007 and created 3,900 jobs. It has seen some success in areas such as reducing the prevalence of addictive behaviours.[6]

The English approach to health care targets has been much more effective with the introduction of Public Service Agreements (PSAs) for target setting.[10] The performance-based system involved a range of monitoring mechanisms, including a controversial point system for providing a public assessment of providers. Strong managerial incentives were introduced, including financial rewards, access to a 'performance fund' and some elements of increased autonomy. Furthermore, the jobs of senior executives of poorly performing organizations came under threat and the performance indicators became a prime focus of ministerial attention.[10] Subsequently, a new system of paying GPs (the Quality and Outcomes Framework) has been implemented, in which payments are based on achieving a certain number of points for activities such as maintaining registers of patients with particular diseases or achieving high levels of blood pressure measurement. While this approach has achieved some successes, it also has sparked debate due to its cost-enhancing elements: the targets were intended to stretch GPs, but in its first year almost all achieved close to the maximum possible score, causing the salary budget to be exceeded substantially.

The gap between ambitions and capacity

Most health targets are not embedded in a broad governance strategy and therefore have little impact on allocation and management within health systems. Given these limitations, one would expect that countries would focus their limited capacity on a handful of health targets. However, in most cases the contrary seems to be the case.

According to the study of the impact of Health for All in Europe,[1] the number of national health targets varies widely. Catalonia has defined more than 100

targets and there are over 400 English health care targets. Defining a large number of targets may have its merits by providing a comprehensive health picture and accommodating diverse interests through the definition of targets. However, it is questionable whether this approach establishes priorities or focusses limited resources in the most efficient way.

It is also arguable whether a government or a ministry of health has the capacity to exert influence in so many different areas, services and organizations at once. The English health care system has tried to deal with the complexity of a large number of targets by combining a multiplicity of targets into a single indicator of performance. A composite performance indicator is seen as a means of securing popular, political and media attention to performance issues. On the other hand, the single indicator approach has attracted criticism because they can be impossible to interpret, combining quite different measures, and because they often incorporate implicit, but potentially contentious value judgements.

Not only is the number of health targets ambitious in many countries, but countries have also defined health targets that go beyond health care to address health in other policies and sectors. Frequent problems regarding these intersectoral approaches have been reported since they are related to the administrative difficulties of working interdepartmentally and intersectorally.

Many countries have recognized that their capacity to define and implement targets is limited by a lack of health intelligence, human resources or comprehensive information systems to allow monitoring and compilation of data for evaluation. Hungary, for example, found that a reason for the slow acceptance of the new public health approach in health services was due to a lack of knowledge and skills on the part of public health professionals. The School of Public Health at the University of Debrecen has sought to meet this need by creating a comprehensive programme of public health training for established professionals.[9] The School has also made considerable progress in developing, in association with the national public health service, the health intelligence infrastructure needed to monitor the process, output and outcome of the targets set.

Health targets require careful formulation; otherwise, it may be impossible to operationalize and evaluate them. Catalonia had reported that five targets have not been evaluated because of incorrect formulation or the difficulty or excessive costs involved in obtaining data. Even well-defined targets may produce some adverse effects. They may have the potential to distort the quality of care as seen in the English experience (see case study), where the incentive to achieve targets has also led to a few examples of hospitals fabricating data.

Health targets as a driver for better governance

Some countries that have put effort into developing health targets may not have achieved them. However, they seem to have strengthened their governance functions by reinforcing the health intelligence infrastructure, establishing a heath system vision and rearranging the health policy arena. While the introduction of health targets may not yet have produced the desired effects, they have spurred a number of changes in the policy and institutional context which may set the stage for more effective actions towards achieving targets in the future.

Prior to the introduction of its Health for All policy, Hungarian health policies covered mainly administrative, financial and legal aspects of health services. Following the policy, the health status of the population was, at least formally, placed at the centre of health policy making.[9] The need to monitor processes, outputs and outcomes of targets in Hungary has also led to the development of a health monitoring system.[11]

Both in Belgium and in France, enthusiasm for health targets needs to be considered in the context of wider health policy reform. In Flanders, the health target approach was embedded within a broader reorientation of health policy, which coincided with partial devolution and was strongly inspired by 'management by objectives' and evidence-based policy making. In the French case, the health targets are a part of the Public Health Policy Act which focuses accountability for the achievement of targets on the government, reorganizes various public health functions and fosters coordination.

Conclusion

Health targets have diffused widely across Europe and have been adopted in many countries. However, experience has been rather mixed. There are some exceptions, where there has been successful implementation of targets, but in many cases it is difficult to attribute success specifically to the targets in place; and all too often, the formulation of targets has not led to their achievement.

Analysing the reasons for the limited success of health targets reveals insufficient use of governance mechanisms in their formulation and implementation. Examples include a lack of policy analysis and evaluation for defining targets, the lack of synchronicity between health players and a lack of adequate monitoring and evaluation systems. Governments often exert little influence to support health target development, and in many cases the intelligence available does not allow monitoring or evaluation. In light of these deficiencies, it is surprising that many countries have formulated over-ambitious targets which cannot be met by existing governance mechanisms. Moreover, when it comes to intersectoral health targets, targets have failed to become an integral part of non-health sectors. On the other hand, the countries that have embarked on defining health targets and have put some effort into achieving them have made progress in strengthening their governance capacity.

Health targets are not a silver bullet that solves all health system challenges nor are they a simple tool since they realize their potential only if they are embedded into broader governance strategies. The utility of health targets will depend on the political will to launch such strategies and to provide the necessary infrastructure and health intelligence. However, at

least as long as good governance is the aim, the use of some sort of health targets seems inevitable.

REFERENCES

1. Wismar M, Figueras J, Srivastava D (eds). *Health for All in Europe: Relevance, Outputs, Processes and Determinants*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006 (forthcoming).

2. Wismar M, McKee M, Busse R, Srivastava D (eds). *Good Governance for Implementing Health Targets: Defining Targets, Exerting Influence and Using Intelligence*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006 (forthcoming).

3. US Department of Health and Human Services. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington D.C.,1991.

4. Bevan G, Hood C. Have targets improved performance in the English NHS? *British Medical Journal* 2006;332,419–22.

5. Hauck K, Street A. *Do Targets Matter? A Comparison of English and Welsh National Health Priorities*. York: Centre for Health Economics, University of York, 2004.

6. Polton D, Paris V. Targets in the French health system. In: M Wismar, M McKee, R Busse, D Srivastava (eds). *Good Governance for Implementing Health Targets*, 2006.

7. Van den Broucke S. Targets in the Flanders health system. In: M Wismar, et al (eds). *Good Governance for Implementing Health Targets*, 2006.

8. Tresserras R, Brugulat P. Targets in the Catalonia (Spain) health system. In: M Wismar, et al (eds). *Good Governance for Implementing Health Targets*, 2006.

9. Vokó Z, Ádány R. Targets in the Hungarian health system.In: M Wismar, et al (eds). *Good Governance for Implementing Health Targets*, 2006.

10. HM Treasury. *Public Services for the Future: Modernization, Reform, Accountability*. London: The Stationary Office, 1999.

11. McKee M, Ryan J. Monitoring health in Europe: opportunities, challenges and progress. *European Journal of Public Health* 2003;13(3 Suppl):1–4.

Matthias Wismar is a Health Policy Analyst at the European Observatory on Health Systems and Policies in Brussels.

Kelly Ernst is a Research Officer at the European Observatory on Health Systems and Policies in Brussels.

Divya Srivastava is a Research Officer at LSE Health, The London School of Economics & Political Science.

Reinhard Busse is Professor and Department Head for Health Care Management at Technische Universität Berlin, and an associate research director of the European Observatory on Health Systems and Policies.

England: incentives and local focus

The Blair government elected in 1997 believed firmly in the virtue of targets across all government activities. From 1998, the Treasury set the Department of Health (DH) challenging strategic targets in the form of 'Public Service Agreements' (PSAs), in common with all other government departments.[1] A distinctive feature of PSAs has been their focus on the outcomes rather than operational activities of public service delivery.

A central role of the DH was to devise operational instruments to secure these targets. To this end, a crucial outcome of the NHS Plan was the development of a system of 'performance ratings' for individual NHS organizations. The most important determinant of an organization's rating was its performance against a set of about ten 'key indicators', which was dominated by measures of various aspects of patient waiting.

Compared to previous target regimes, the most striking innovation associated with performance ratings was the introduction of strong managerial incentives dependent on the level of attainment.[2] These included financial rewards, such as unfettered access to a 'performance fund' and some element of increased organizational autonomy. Doctors who perform poorly are a risk not only to their patients but also to the organizations they work for. The jobs of senior executives of poorly performing organizations came under severe threat, and the performance indicators (especially the key targets) became a prime focus of managerial attention. More recently, the best performers in the acute hospital sector became eligible to apply for 'Foundation' status, implying considerably greater autonomy from direct NHS control. Many feel that this system gives managers better focus and a real lever with which to affect organizational behaviour and clinical practice.

There is no doubt that performance ratings have delivered major improvements in the aspects of NHS care that they targeted.[3] England's use of targets to drive policy implementation has reached unprecedented proportions and there are a number of successes to highlight this, such as the rapid elimination of the longest inpatient waiting times. Moreover, compared to Wales and Scotland, which have not implemented performance ratings, targeted aspects of English health care have improved markedly, even though funding levels are less than the other two countries.[4]

However, the discussion on achieving targets has also been accompanied by some evidence of unintended or distorted outcomes. Examples shown in Box 1

Case study material extracted from Smith PC. Targets in the English health system, In: M Wismar, M McKee, R Busse, D Srivastava (eds), *Good Governance for Implementing Health Targets: Defining Targets, Exerting Influence and Using Intelligence*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006.

Box 1: Target distortions in England

A target for ambulance providers to reach patients within 8 minutes (requiring the availability of large numbers of ambulances) conflicted with a target for emergency departments to transfer or discharge patients within 4 hours.	The emergency departments did not want to accept patients from ambulances until they were ready for them so the ambulances were used as 'target-free' waiting areas. The solution identified by the ambulance providers was to purchase tents to erect in hospital car parks.
A target to treat all patients on a waiting list for non-urgent surgery	Achieved by keeping patients on the untargeted waiting list for the initial outpatient appointment (which was required for them to join the targeted waiting list) as long as possible.
A target to ensure that all patients obtained an appointment with a GP within 48 hours	Achieved by preventing patients from making appointments more than 48 hours in advance (requiring them to spend lengthy periods on the telephone the day before they wanted an appointment).

highlight some drawbacks, with evidence of distortion of behaviour, gaming, and a focus on the achievement of targets at the expense of other activities.

These distortions have not hindered the implementation of an even more ambitious targets scheme for general practitioners (GPs). Most GPs are independent practitioners who are contracted to provide specific services for the NHS under a GP contract. In 2004, a new contract was implemented that incorporated an ambitious system of quality targets and incentives.[5] About £1.3 billion, around 18% of GP income, is distributed annually on the basis of quality measures.

The new GP contract is one of the most ambitious attempts yet to combine clinical quality targets and incentives into physician remuneration.[6] In its initial form, it included 146 indicators of quality across seven areas of practice. It has some parallels with the 'performance ratings' regime. However, clinical quality plays a much greater role in the GP contract than in performance ratings, and individual earnings are more directly at risk. Most importantly, it seeks to reward cost effective practices, in the form of the structure, processes and outcome of health care.

The scheme's structure also offers some important advances. Its 'balanced scorecard' approach seeks to reflect the relative importance of different primary care activities and their impact on health. By basing remuneration on an aggregate score, GPs remain free to decide on their own priorities. The scheme rewards practices (rather than individual physicians), so is likely to encourage teamwork and peer review, and it has made a real difference to GP incomes.

There are a number of reasons for the increasing influence of targets in England. First, their range and specificity has increased markedly, moving from long-term, general objectives towards very precise, short-term targets. This has been accompanied by a proliferation of targets. Second, the specification has moved progressively from the national to the organizational, to the practice level. This local interpretation of national targets is likely to have more resonance with individual practitioners. Third, some attempts have been made (at least with the GP contract) to engage professionals in the design and implementation of the targets regime. Fourth, organizations have been given increased capacity to respond to challenging targets, in the form of extra finance, information and managerial expertise. Finally, and perhaps most crucially, very concrete incentives have been attached to the targets.

REFERENCES

1. HM Treasury. *Public Services for the Future: Modernization, Reform, Accountability.* London: The Stationary Office, 1999.

2. Hood C, Bevan G. *Governance by Targets and Terror: Synecdoche, Gaming and Audit.* Oxford: All Souls College, 2005.

3. Bevan G, Hood C. 2006. Have targets improved performance in the English NHS? *British Medical Journal* 2006;332,419–22.

4. Hauck K, Street A. *Do Targets Matter? A comparison of English and Welsh National Health Priorities.* York: Centre for Health Economics, University of York, 2004.

5. Department of Health. *Investing in General Practice: The New GMS Contract.* London: Department of Health, 2003.

6. Smith PC, York N. Quality incentives: the case of UK general practitioners, *Health Affairs* 2004;23(3),112–18.

Hungary: targets driving improved health intelligence

Hungary's target-based public health policy making began over ten years ago with the first governmental decree in 1994, 'Public health priorities until the Millennium'. Since then, several other decrees have been passed and target-based public health programmes have quickly expanded beyond the borders of the health policy. The programmes aimed to implement modern, intersectoral, multidisciplinary public health actions, and emphasize the government's responsibility, and the involvement of civil society, local authorities and the private sector.[1] Targets exist across a variety of areas including mortality and morbidy reduction in socially-excluded groups, prevention of new HIV infections and increased mammography screening in women between 45–65 years.

The new public health approach initially was accepted slowly within the health sector and outside of the health administration; and the programmes were not integrated with other health policies. This was attributed to a lack of knowledge and necessary skills on the part of health professionals. In response, at the University of Debrecen a Faculty of

Case study material extracted from Vokó Z, Ádány R, 2006. See Reference 1.

Public Health was established where the Departments of Preventive Medicine, Behavioural Sciences and Family Care co-operated to contribute to the more widespread acceptance of new concepts and roles of public health within the health service system.

In 2003, following parliamentary approval of the 'Johan Béla National Programme for the Decade of Health', it was realized that the health monitoring system was only capable of providing information on targets at the national level. Therefore, most targets could not take into account the huge social and geographical inequalities in health that existed in Hungary. This led to professional criticism of the actual target values set.

The programme, however, had a boosting effect on health monitoring. Traditionally, different health monitoring activities were the responsibility of different institutions – for example, the Central Statistical Office (CSO) was responsible for mortality registration while notification of communicable diseases fell under the National Public Health and Medical Officers Service; and the aggregated data was only published yearly by the CSO. Before the late 1990s, little coordination existed between the different institutions. Although the content of the health statistical system was regularly reviewed from a statistical point of view, the actual needs of health policy making and evaluation did not play an important role in the development of the system. Another reason for the limited use of health data in policy making was that the end products of the monitoring system were mostly aggregated data, and was not presented in a format that could be easily used for policy purposes.

The target-based nature of the public health programmes, and the need to monitor their processes, outputs and outcomes necessitated the development of the health monitoring system itself, which was further supported by the achievements of the European Union Health Monitoring Programme.[2] New methods, like regular state-of- the-art health surveys,[3] the general practitioners sentinel station programme[4] and public health reports are now becoming part of the monitoring system.[5]

The first regional health observatory (not only in Hungary, but in central-eastern Europe) was also established in the North East region at the end of 2005. This body of six counties and the University of Debrecen collects and analyses (mainly using GIS methods) demographic, mortality, morbidity and socio-economic data, as well as data on health care services, and supports health policy makers by providing relevant and accurate intelligence. In the framework of the National Development Plan 2007-2013, the extension of the network to the whole country will be defined as one of the aims in the future development of public health services.

Health has become an increasingly important issue on the political agenda in Hungary. At the political level, the health of the population has been declared a priority, together with reducing health inequalities. These political priorities, when confronted with the poor health of the population, has served as an ethical and political basis to develop national public health programmes – with targets at their core.

REFERENCES

1. Vokó Z, Ádány R. Targets in the Hungarian health system, In: Wismar M, McKee M, Busse R, Srivastava D (eds). *Good Governance for Implementing Health Targets: Defining Targets, Exerting Influence and Using Intelligence.* Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006 (forthcoming).

2. McKee M, Ryan J. Monitoring health in Europe: opportunities, challenges and progress. *European Journal of Public Health* 2003;13(3 Suppl):1–4.

3. *National Public Health Update 2003 Hungary*. Budapest: Johan Béla National Centre for Epidemiology, 2004. (www.oek.hu/oekfile.pl?fid=523, accessed 1 February 2006)

4. Széles Gy, Vokó Z, Jenei T, et al. A preliminary evaluation of a health monitoring programme in Hungary. *European Journal of Public Health* 2005;15:26–32.

5. *National Health Interview Survey 2003 Hungary – Executive Update*. Budapest: Johan Béla National Centre for Epidemiology, 2004. (www.oek.hu/oekfile. pl?fid=533, accessed 1 February 2006).

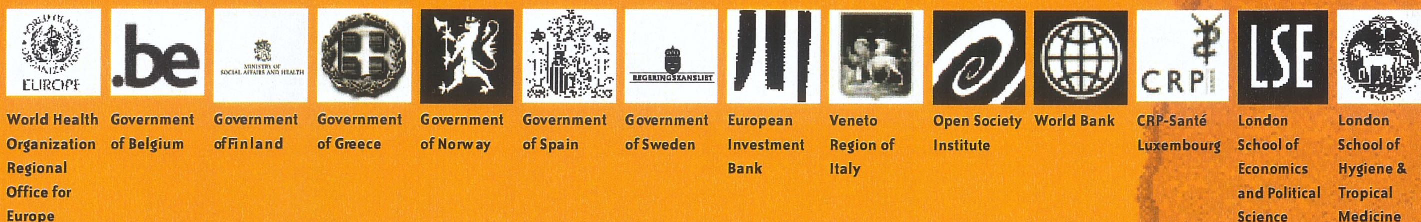
Russia: when target setting fails

Health was seldom a policy agenda priority in the former USSR or Russia. In general, when targets were set they were broadly defined, infrastructure-oriented and almost never outcome-oriented. Target setting in the USSR, and subsequently in Russia, was largely driven by the dominant political ideology irrespective of its relevance or appropriateness. The sciences vital to setting targets, and which look at the determinants of diseases and compare health indicators across countries and segments of the population, were not utilized. Moreover, comparisons of unhealthy behaviours and poor population health between the USSR and the western world were considered dangerous because public health and demographic indicators could reveal socioeconomic differences. As a result, targets had to be politically sensitive rather than relevant or necessary.

Therefore, despite a seemingly long history of target setting, there has been very limited experience in setting targets in the format of health outcomes. In addition, an almost complete lack of public health professionals and epidemiologists, and a very small number of demographers in Russia, makes this task extemely difficult. A lack of skilled capacity to produce

Case study material extracted from Danishevski K, 2006. See Reference 1.

THE EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES IS A PARTNERSHIP BETWEEN



health objectives is rooted in removing the public health approach from health policy in general, leading to unrealistic targets: for example, using change in life expectancy as a short - t e rmperf o rmance evaluation indicator is currently being mooted.

Furthermore, the absence of independent data collection systems has often led to data unreliability. For example, medical personnel have been asked to provide the data that their evaluations will be based upon; and there are many examples of how targets can be achieved by modifying definitions, using fraudulent data, or setting targets that can be reached without the need for an explicit government policy.[1]

Other factors that have contributed to the failure of target setting in Russia are the prevailing ideology of system success and the inability of political and administrative leaders to acknowledge mistakes and openly search for solutions. For example, over several decades attempts to address the growth of non-communicable diseases, in a context of declining health expenditure, created a situation where life expectancy began to fall.[2] The official reaction to this situation was not an attempt to redress the problem at hand, but rather, the decision was taken not to publish life expectancy figures in annual reports from the late 1960s until only recently.

Collecting and using intelligence is vital in setting any health targets. In Russia, the scarcity of epidemiological skills currently leads to poor and non policy-relevant presentation of data. Even when the information is passed on to decision makers, they are seldom able to use it. Moreover, channels for providing information to decision makers are not formalized and many of the statistical reports end up on the shelves of the statistical agencies themselves.

In 2004, a number of committees were established to develop indicators for monitoring health targets and to use them as the basis for funding decisions. However, in view of the distorted incentives for underreporting or inaccurate reporting, further monitoring might not lead to improvements in building intelligence infrastructure. Also, an effective targets implementation strategy requires routine monitoring and correction, as well as final evaluation and the development of a follow-up strategy in case of a failure to achieve targets. In Russia, prevailing attitudes are difficult to overcome; in the past, the system of planning might have been more effective in the USSR if communist ideology had permitted some notion of criticism, objective and independent evaluation and debate. The party would not admit to failures in reaching set objectives and this made targets effectively self-achievable.

Given this situation, questions may be raised about the relevance of target setting in Russia and whether incentives could be better aligned to encourage accurate reporting and data collection.

Russia's experience with target setting reflects yet another area of transition; as past practices are not fit for purpose the very nature and strategic objectives of targets need to be re-developed. Moreover, health intelligence, such as it exists, currently does not inform policy making and as a first step, building capacity for better data collection and dissemination is vital.

References

1. Danishevski K. Targets in the Russian health system In: Wismar M, McKee M, Busse R, Srivastava D (eds). *Good governance for implementing health targets: Defining targets, exerting influence and using intelligence.* Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006 (forthcoming).

2. Tulchinsky TH, Varavikova EA. Addressing the epidemiologic transition in the former Soviet Union: strategies for health system and public health reform in Russia. *American Journal of Public Health* 1996;86(3):313–20.

Editor
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Editorial Team
Josep Figueras
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Ellen Nolte
Sarah Thomson

To join the mailing list, please contact
Anna Maresso
Observatory – London Hub
Tel: +44 20 7955 6288
Fax: +44 20 7955 6803
Email: a.maresso@lse.ac.uk

Euro Observer is published quarterly by the European Observatory on Health Systems and Policies, with major funding provided by a grant from Merck & Co., Inc., Whitehouse Station, New Jersey, USA.

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WHO ECHP
Rue de l'Autonomie, 4
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Email: info@obs.euro.who.int
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Westminster European
westminster.european@btinternet.com

ISSN: 1020-7481