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Health and health care targets

What lessons can Belgium learn from other countries?

Jessica Martini (OSE) & Alban Davesne (OsloMet University)

www.ose.be
Rue du Luxembourg 3 | 1000 Bruxelles | tél : 32 (0)2 537 19 71 | e-mail : info@ose.be

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This study was produced as part of the research agreement (2022-2024) between the European Social Observatory (OSE asbl) and the Belgian National Institute for Health and Disability Insurance (NIHDI), financed via article 56 (1) of the law on compulsory health and disability insurance (Loi relative à l'assurance obligatoire soins de santé et indemnités), coordinated on 14 July 1994. The facts and views expressed in this publication and any errors that remain are the sole responsibility of the authors.

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Table of contents

List of tables

List of figures

List of boxes

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It was written by Jessica Martini (European Social Observatory, OSE) and Alban Davesne (OsloMet University, seconded to the OSE from October 2022 to January 2023). Jessica Martini was responsible for the design of the study and the overall coordination of the work. She conducted the literature review on the general topic of setting health targets, explored the cases of Austria and Germany, and drafted the corresponding chapters as well as the introduction to this paper. Alban Davesne collected and analysed data on Sweden's health target programme and summarised them in the corresponding chapter. Both authors contributed to the horizontal analysis, to the drafting of the conclusion and the review of the paper.

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Executive summary

This study was commissioned by the Belgian National Institute for Health and Disability Insurance (NIHDI) with a twofold aim: first, to understand how health and health care targets are set, monitored, and interlinked in other European countries, with a particular focus on the governance processes and on the collaboration between different actors and levels of government; and second, to draw conclusions relevant for Belgium on how to improve the setting and monitoring of health and health care targets, based on lessons learned from international experience. It should be noted that the term 'target' is used here to generally indicate a commitment to achieve specified results within a defined time period, in relation to either the health status of the population, a health determinant, or health care services. In practice, various other terms are used to express this concept, notably the terms 'goals' and 'objectives', which are often used interchangeably with 'targets'. Despite the conceptual differences between these terms and given the fact that they are used in different ways internationally, we have decided to use 'targets' throughout the report in a comprehensive way to generally refer to aims related to health and health care. Other terms, such as 'goals' and 'objectives', will be only used when we wish to stress a different meaning, or when they are specifically used by the authors or programmes cited. This report is structured in six chapters.

The first introductory chapter describes the policy context within which the study was developed, recalls the research questions explored and presents the methodology used. The policy context is that of the reflection launched in 2021 by the Belgian health authorities with the aim of using national health and health care targets as an instrument to guide health policies and establish a pluriannual budgetary trajectory for health care. The six research questions concern the following aspects: i) how health and health care targets are set in other countries; ii) how health and health care targets are monitored; iii) how the health care targets are embedded within the health targets; iv) the extent to which and how the health and health care targets are linked to the budgetary process; v) the main strengths and weaknesses of these strategies; and vi) the lessons that can be learned for Belgium. Regarding the methodology, a qualitative comparative case study was conducted, primarily based on a literature review. Two main areas of literature were examined between May 2022 and March 2023. First, scientific and grey literature was collected in relation to the general topic of setting health targets. The aim was to understand how the issue is addressed in the literature and what lessons can be learned from international experiences in general. The original articles and books reviewed address country experiences in setting, implementing, and monitoring health and health care targets; only documents dealing with high-income countries and with macro/national level targets were retained. Second, separate reviews were conducted specifically for three case studies: Austria, Germany, and Sweden. All three

countries have at least a decade of experience with setting health targets, thus offering substantial insights into their implementation, follow-up, and evaluation. Equally important in selecting these cases is the fact that in these countries, as in Belgium, health competences are shared between different levels of governance; these countries have thus been confronted with the challenge of bridging national targets with fragmented decision-making and/or implementation processes. In this respect, official documents were collected from the websites related to the health target programmes and/or the relevant national health authorities. When available, scientific articles were also included to complete the analysis. A thematic analysis was performed with the aim to explore the following aspects: background and rationale behind the setting of health targets; overall governance of the health target programmes; specific areas covered; selection process; formulation process; implementation and funding; monitoring and evaluation; communication strategies; strengths and weaknesses.

The second chapter summarises the state of the art by presenting how the literature and key international documents have addressed the issue of setting health targets at national level. It should be noted that the term 'targets' is most often used in the literature, which reflects how the topic emerged in the public health debate. The bulk of the literature was actually published between the 1990s and the beginning of the 2000s, when several health target programmes were initiated, following a new public management approach and a series of WHO strategies that set health targets either internationally or at European level as part of the *Health for All* strategy and other health promotion initiatives. Despite national specificities, common patterns emerge, and conclusions can be drawn in terms of content and process. In terms of content, public health and health care targets are never clearly separated but are instead interlinked and embedded within a global approach. The way targets are formulated may vary depending on the approach favoured, and a mix of different types of targets is usually used. The literature notably distinguishes between aspirational, managerial, and technical targets; between outcome-oriented, process-oriented, and structure-oriented targets; and between quantitative and qualitative targets. Regarding the process, it is stressed that the most successful programmes are those involving all stakeholders and counting on a broad societal and political consensus. For this consensus to be achieved, however, a long-term process is necessary, including systematic consultations and wide-ranging negotiations. Although essential to the implementation of the health targets, adequate funding as well as monitoring and evaluation systems are generally lacking. Finally, in several decentralised health systems, the national targets often serve as common frameworks for action and as guidelines for the development of health targets at state/regional level.

The third chapter shifts the focus to the country case studies by describing how the *German health targets network* ([1]) **was developed.** This is one of the various initiatives that have been developed in Germany with the aim to build consensus and coordinate the actions of stakeholders involved in the pluralistic and highly fragmented health system. The Network was launched in the year 2000 as a pilot project by the Federal Ministry of Health. Since 2007, it has become a permanent coordination network with the status of a sponsorship initiative that is financially supported by some state authorities, health insurance organisations, and health providers' organisations. It brings together about 140 organisations, including representatives from the federal government, states, and municipalities, as well as statutory and private health insurance, professional associations, patient representatives, trade unions, scientific institutions, and pharmaceutical companies. Its coordination is in the hands of a non-profit organisation, the Association for social security research and policy (GVG e.V.). All in all, ten national health targets have been developed so far. In terms of content, they focus either on a specific disease or on an issue related to health promotion or health care ([2]). Each topic is however addressed through a comprehensive approach that covers basically all fields affecting the health of the population and health care: from prevention, treatment, rehabilitation, and care to public health. No specific time horizon is fixed; rather, most targets are formulated in qualitative terms as a description of the specific desired evolution. In terms of process, each target was developed separately: some of them were published only recently and others have been updated over time. The selection and formulation process involved working groups made up of all relevant stakeholders and experts, and followed a systematic methodology based on a set of criteria and specific requirements. Although the whole process draws strongly on an evidence-based approach, consensus finally plays a key role, decisions being pragmatically taken based on the willingness of stakeholders to engage with a topic and/or towards specific targets. The national health targets are not binding per se, since their implementation is voluntary. In 2015, however, most of the targets were integrated into the Social Code Book V, which means that the sickness funds must take them into account for activities related to prevention and health promotion. All documents published by the network highlight a great concern for monitoring and evaluation; yet this remains ad hoc and focused on actions taken by stakeholders involved in the network. By prioritising sector-based participation and consensus-building over the enactment of a national strategic vision, the network reflects a lack of federal political leadership but offers a methodologically sound example of how health targets could slowly make their way into national law.

1. *Forum Gesundheitsziele Deutschland.*
2. The ten topics are: type 2 diabetes, breast cancer, reduction of tobacco consumption, growing up healthy, health literacy and patient sovereignty, depressive disorders, healthy ageing, reduction of alcohol consumption, health around birth, and patient safety.

The fourth chapter addresses the case of Sweden by analysing the 2018 national public health policy 'Good and Equitable Health'. This policy structured a new health strategy around one overarching goal and eight target areas covering broad determinants of health ([3]). The government also instructed the Public Health Agency of Sweden to identify indicators for the monitoring of health status and the social determinants of health. The policy itself is not new. Sweden, along with other Nordic countries, started working with health targets in the mid-1990s and has continued to revise them ever since. This long history lends itself to a longitudinal study of the evolution of the programme. A key finding in this respect is that setting targets and indicators has become an important part of the government's efforts to promote an overarching 'equal health' agenda. The Swedish government has always taken a pro-active role in setting the general principles of the national public health policy, while providing few details as to how various state agencies, local authorities and stakeholders should/could implement it and how it is financed. The legislation is first and foremost intended as a roadmap for a national health policy. A second, and connected, finding is that entrusting the public health agency with the coordination and monitoring of the strategy has helped to foster its continuity and consistency over the years and has elevated the status of health actors within national and local administrations (contributing to an institutionalisation of public health). However, developing a nationwide indicator-based implementation process that matches the ambitious goal set by the government has been a challenging task for the public health agency. Weak political governance, diffuse division of responsibilities and insufficient coordination with other state agencies and local authorities have been identified as recurring problems in a particularly fragmented and decentralised administrative system. The limited influence of the policy on the health care sector illustrates the limits of the government's inter-sectoral ambitions. Furthermore, the lack of a clear set of policy targets and sub-targets has also hampered the application of the follow-up structure. However, recent policy documents hint at renewed efforts at resolving this implementation gap, building on lessons learned from the past and showing the importance of a long-term commitment to the policy.

The fifth chapter presents the *Austrian Health Targets* ([4])*.* These were launched in 2012 as a set of ten national health targets resulting from a broad participatory selection process. Their content reflects a comprehensive *'health in all policies'* approach focused on social determinants of health: while one target specifically aims to secure the sustainability, efficiency and quality of health care services, all other targets address factors that may

3. The overarching goal is to eliminate health inequalities within a generation. The eight target areas are the following: early life, education, work, income, housing, health behaviour, participation, and health care.
4. *Gesundheitsziele Österreich*.

influence the health of the population ([5]). In 2012, only the overall general description of the desired evolution for each target area was launched. The specific content of each target, namely the sub-targets and associated actions and measures, was formulated in a second stage by separate working groups involving all relevant stakeholders: public authorities at federal, state, and municipal level, social insurance funds, social partners, health care professionals, health and social care institutions, patient organisations, and academic experts. The working groups operated successively and progressively to promote participation and avoid overload. Interestingly, the only target for which no strategy has been developed yet is the target on health care. This is partly due to fact that another parallel initiative has established a target-based government mechanism for health care. While this participatory and progressive approach is similar to that followed in Germany, the Austrian federal government plays a key role, much like in the Swedish case. The former Federal Ministry of Health launched the initiative and continues to steer it with the support of the Austrian National Public Health Institute; the targets were approved by the Austrian Council of ministers, thus enabling the participation of other ministries in the working groups, such as the ministry in charge of sport or the environment. The targets are intended to serve as a general guiding framework for Austria's public health policy and reforms until 2032 and have already inspired the development of health targets in several states ([6]). Implementation, however, is on a voluntary basis and no funding is specifically allocated to the initiative. Despite these shortcomings, linkages have been sought with existing programmes and a monitoring and evaluation process is regularly organised for most of the targets. As a result, Austria has recorded a good implementation rate for most actions planned. While overall closer to the Swedish strategy than the German network in its scope and leadership, the Austrian programme has managed to incorporate some of the participatory approach of the latter.

The last chapter concludes by summarising the main lessons that can be learned from the international experience and by proposing policy recommendations for Belgium. Beyond the significant institutional differences between the Swedish national health system on the one hand and the social health insurance systems of Austria and Germany on the other hand, our study shows that the way the health target programmes are set actually transcends these differences: while the German participatory and consensus-based approach seems the opposite of the Swedish more centralised policy, the Austrian programme has seemingly managed to include a mix of characteristics from both processes. More specifically, findings show that the approaches taken to developing health targets vary across scales with

5. The following ten areas are targeted: living and working conditions, equity in health, health literacy, natural resources, social cohesion, growing up healthy, healthy and sustainable diet, physical activities, psychosocial health, health care services.
6. States which have already developed and published their own health targets include Carinthia, Lower Austria, Upper Austria, Salzburg, Styria, Tyrol and Vienna.

two main poles: attention paid to agenda setting and framing vs monitoring and evaluation; bottom-up vs top-down processes; technical vs political basis; sectoral vs cross-cutting approach; qualitative vs quantitative approach. They provide an illustration of possible processes and make it possible to further investigate lessons from the literature on target setting in other countries. Six main specific conclusions can be highlighted.

1. *Our findings show the importance of setting up an overall governance structure that combines open participation and clear stewardship*. There needs to be a balance both in the type of stakeholders involved, and in the instruments used to support participation, while ensuring overarching consistency of the policy framework. In this regard, Austria seems to be somewhere in the middle of the range, between the mainly bottom-up network developed in Germany and the more top-down policy of Sweden.
2. *The selection of targets must be based on both evidence and broad consultations*. Prior in-depth analyses are important to understand the current health situation and the priorities. In practice, however, the actual selection of targets is most often also based on political considerations, including, for example, the feasibility and measurability of a particular priority. Moreover, although both health and health care targets are included, the linkages between the two areas have been only partially clarified. In this regard, Austria and Sweden are interesting examples of health care targets embedded within an overall framework based on a 'health in all policies' approach. They also highlight the risk of the health care target being further developed in parallel strategies.
3. *The formulation stage appears to be a key moment of the target-setting process.* It is at this point that the target content is clarified through the development of sub-targets, indicators, and concrete actions. How this is done varies from one country to another, but in general, we can say the processes used follow a participatory, systematic, and iterative approach. In Austria and Germany, templates and specific criteria or principles are used to guide this work. This is intended to make the process more transparent and to standardise the way the different targets are developed. In Sweden, particular care is taken to draw on lessons learned from past experience. In any case, clear decisions should be made during this stage, to ensure no ambiguity even in systems providing greater flexibility in implementation.
4. *Any voluntary implementation needs to be supported over the long term by a support structure, clear incentives, and an accountability framework*. A voluntary approach can be justified if the primary aim of the targets is to stimulate debate on health priorities. To ensure engagement over the long term, however, a series of aspects should be considered. The benefits that stakeholders can derive from such a strategy should be made clear to all of them; responsibilities should also be clearly defined among the different stakeholders and authorities; and resources should be made available,

including management and administrative skills, adequate information, as well as financial resources. This last aspect seems to be the weakest point of all the target-oriented initiatives studied.

5. *The monitoring and evaluation process is often considered as a learning process to which attention is paid from the very beginning*. In all three countries, the situation analyses carried out to identify priorities are also used to point out what data are needed, where information gaps exist, and how the information system can be improved to measure progress towards the priorities set. Interestingly, however, our findings also show that dedicated resources are needed to ensure that evaluations effectively take place. One common way of compensating for the lack of resources is to rely on existing data and structures. Moreover, the focus should be on both outcomes and processes.
6. *Finally, developing creative communication strategies is key*. In all three countries studied, a variety of media are used to communicate about the health and health care targets, from scientific and administrative reports to dedicated websites and user-friendly materials, including factsheets and short videos. These strategies are expected to promote both the external visibility of the targets among the wider public and internal reflection and coordination among the stakeholders more directly involved in the target setting process.

Chapter 1. Introduction to the study

This study explores international experience in the setting of health and health care targets, with a view to drawing conclusions relevant for Belgium based on lessons learned from this experience. It should be noted that the term 'target' is used here to generally indicate a commitment to achieve specified results within a defined timeframe in relation to either the health status of the population, a health determinant, or health care services. Reviews of health target programmes (Busse & Wismar, 2002; Obyn, Cordon, Kohn, Devos, & Léonard, 2017; Ogbeiwi, 2021) show that, in practice, various other terms exist to express this concept, notably the terms 'goals' and 'objectives', which are often used interchangeably with 'targets'. Yet, a slight conceptual difference exists among these terms; they are often used within the same framework, where they are usually ordered hierarchically from the more general long-term aims ('goals') to the increasingly more specific aims to be achieved in the medium and short term ('objectives' and 'targets' respectively). Despite this conceptual difference and given the fact that these terms are used in different ways internationally, ([1]) we have decided to use 'targets' throughout the report in a comprehensive way to refer to aims related to health and health care, independently of their degree of specificity or time horizon. We will use the other terms only when we wish to stress the difference in content and timeframe, or when they are specifically used by the authors or programmes cited.

This introductory chapter describes the policy context within which the study was developed, recalls the aim and the research questions explored, and presents the methodology used.

1.1 The context: a Belgian reform of health and health care targets

The National Institute for Health and Disability Insurance (NIHDI) has mandated the European Social Observatory (OSE) to explore how health and health care targets are used in other countries and which lessons can be drawn from their experience for Belgium. Our research is intended to contribute to the reflection launched in 2021 by the Belgian health authorities with the aim of using national health and health care targets ([2]) as an instrument to guide health policies and establish a pluriannual budgetary trajectory for health care.

The intention of setting clear targets is stipulated in the coalition agreement reached by the federal government in 2020. This states that both its health and health

1. We will come back to these definitions and international practice in more detail in chapter 2.
2. These are defined as follows in French and Dutch : objectifs de santé interfédéraux / interfederale gezondheidsdoelstellingen, objectifs de soins de santé stratégiques / strategische gezondheidszorgdoelstellingen, initiatives politiques opérationnelles / operationele beleidsinitiatieven (Vandenbroucke, 2022).

care policies will be based on clear targets, and that a monitoring system will be set up in connection with them. The declared goals are 'to reduce health inequalities between the most and least advantaged people in terms of healthy life expectancy by at least 25% by 2030, to reduce the number of preventable deaths by 15%, and to regain a place in the group of the ten European countries where the number of expected healthy life years is the highest, while continuing to guarantee high accessibility and good coverage of the health care system' (Accord de gouvernement, 2020, p. 14). The clearly stated intention is that the health targets will be set based on consultation with the federated entities and the stakeholders engaged in the health care sector. The policy note presented by the Ministry of Health in 2022 explains that these national health targets should serve as a compass to implement and evaluate policy measures. A 'health in all policies' approach as well as a whole-of-government approach should be promoted for their implementation, since health-promoting policies depend not only on the ministries responsible for public health but involve other sectors as well (Vandenbroucke, 2022).

Two parallel processes have been set up with a view to preparing this policy. First, the Federal Public Service Public Health, with the support of Sciensano and the Belgian Health Care Knowledge Centre (KCE), was mandated to develop a minimum set of long-term health targets based on comparisons with other EU Member States, but also on historical trends and future projections of existing health indicators (Vandenbroucke, 2022). Second, in 2021 the NIHDI launched a reflection on a pluriannual budget trajectory for the health insurance budget, to be based on health care targets (INAMI, s.d.-b). Preparatory discussions resulted in two reports, one drafted by the NIHDI stakeholders (Groupe de travail Quintuple Aim budget pluriannuel, 2022) and one by a scientific committee (Comité scientifique budget pluriannuel, 2022). Based on these reports, the federal government submitted a policy note to the General Council and the Insurance Committee of the NIHDI in July 2022, in which it suggested developing the pluriannual budgetary trajectory following a three-stage process: i) the setting of inter-federal health objectives; ii) the setting of health care targets within NIHDI; and iii) concrete initiatives to be implemented by the stakeholders. The aim is to set the NIHDI budget on the basis of the national health care targets rather than as the sum of negotiated partial budgets (Vandenbroucke, 2022). A first development in this direction was achieved with the budget trajectory adopted for the period 2022-2024: a series of transversal projects were selected based on a new methodology integrating health care targets (INAMI, s.d.-a). Moreover, a law regarding the pluriannual budget trajectory and the health care targets was adopted in November 2023, which set the basis for the recent launch of a Commission in charge of the health care targets. In April 2024, the Interministerial Conference on Public Health also approved the three following inter-federal health targets: prolonging life span in good health; reduce health inequalities; and ensure the healthiest possible environment.

1.2 Aim and research questions

Against the background described above, the aim of our study is twofold. First, we wish to understand how health and health care targets are set, monitored, and interlinked in other European countries, with a particular focus on the governance processes established and on the collaboration between different actors and levels of government. And second, we seek to draw conclusions relevant for Belgium on how to improve the setting and monitoring of health and health care targets, based on lessons learned and good practice from international experience.

Accordingly, the research questions that guided this study concern the following six aspects: i) how health and health care targets are set in other countries; ii) how health and health care targets are monitored in other countries; iii) how the health care targets are embedded within the health targets; iv) the extent to which and modalities by which the health and health care targets are linked to the budgetary process; v) the main strengths and weaknesses in the way health and health care targets are set, monitored, interlinked, and funded in other countries; and vi) lessons that can be learned from these international experiences for the development and implementation of health and health care targets in Belgium.

1.3 Data collection and analysis

The study is based on a literature review carried out in two steps between May 2022 and March 2023. The first step aimed to assess how the topic of setting health targets is addressed in the scientific literature and official international documents and what is already known about it. In this regard, searches were made on different databases and research engines, notably PubMed, Google and Google scholar, using the following key words: health targets, health goals, health objectives, target setting, priority setting. Searches were also made based on the name of specific health target programmes, such as, for example, *Health of the Nation, NHS Five year forward view, NHS Long-term plan* for the UK, or the American *Healthy people*. Grey literature was also collected by searching the website of Belgian and international health organisations, such as the KCE, the World Health Organization (WHO), the European Observatory on Health Policy and Systems (EOHPS), and the Organisation for Economic Co-operation and Development (OECD). The reference lists of the publications retained were also searched, to identify additional relevant publications for inclusion. All documents were selected based on several criteria. Regarding the type of sources, only original articles, books, and reports were included; editorials, comments or letters were usually excluded, unless specific lessons learned from country cases were discussed. The content searched was focused on specific country experiences and target-oriented programmes, with particular attention to national processes of setting and monitoring health

targets related to the health and health care sector in general. In other words, documents related to the setting of health targets for specific diseases or programmes were not retained. In terms of context, only documents exploring this issue in European or high-income countries from other regions were included. Finally, a time criterion was used, including documents published from 1985 onwards. This date limit was chosen as it corresponds to the publication of the strategy *Targets for Health for All* by the WHO Regional Office for Europe, after which many European countries started their own target-oriented programmes (WHO/Europe, 1985). All identified articles were first screened for titles and abstracts. Access to the full text was then checked and its content further assessed for eligibility and inclusion. If publications identified at this stage specifically addressed the experience of one of the countries studied in the second step, they were excluded from the list and retained for analysis during this second stage, unless they contained more general information on the topic.

The second step was part of a comparative case study focused on the experience of the following three countries: Austria, Germany, and Sweden. Table 1-1 summarises the criteria by which these countries were chosen. The first concerned their experience in setting health targets. In this regard, the three countries developed target-oriented programmes, which have been extensively documented over time. These are the Austrian health targets (*Gesundheitsziele Österreich*), the German health targets forum (*Forum gesundheitsziele.de)*, and Sweden's national public health policy 'Good and equitable health at all levels'. Second, in these three countries, just as in Belgium, multi-level governance is in place for the health sector. This aspect is particularly important to understand how different stakeholders may be involved in setting, implementing, and monitoring health targets that are national in scope, and notably how authorities at different levels may cooperate on such a system. Finally, the type of health system was also considered, to explore whether and how this dimension may impact the setting of health targets and whether (or not) common patterns could be found among different health systems. In this respect, we included two countries – Austria and Germany – that have historically developed their health system based on a social health insurance model, like Belgium, but we also included one country with a national health service system: Sweden. During the design of the study, preliminary searches were conducted on other countries as well, but they were finally not retained for this study. These are notably England and France, for which the prominent role played respectively by NHS England and by the French central government was considered less comparable to the multi-level governance of Belgium; but also the United States and New Zealand, excluded due to the final choice made to focus on European countries only.

Tab. 1-1. Criteria for the selection of the case studies

Country	Experience in setting health targets	Multi-level governance	Type of health system
Austria	Austrian health targets (BMSGPK, n.d.)	- The federal government is responsible for the legislative framework, including regulation of social health insurance - States regulate hospital care - Self-governing bodies of social health insurance and of health professionals negotiate collective contracts related to ambulatory care, rehabilitative care and pharmaceuticals	Social health insurance system
Germany	German health targets forum (GVG, n.d.)	- The federal level sets the overall legal framework - State governments are responsible for hospital planning and supervise public health services often implemented by local-level authorities - Corporatist bodies of health care providers and sickness funds hold decision-making power within the statutory health insurance system	Social health insurance system
Sweden	National public health policy 'Good and equitable health at all levels' (Regerinskansliet, 2018)	- The national government is responsible for the legislative framework and general guidelines for health and medical care - Democratically elected local assemblies are responsible for the funding and provision of health care services - National agreements (for instance on wages) are negotiated between local authorities, trade unions and/or the government	National health system

For each country included in the study, a literature review was carried out to collect data about the content and the process of their health target programmes. Grey literature was notably collected, such as reports, factsheets, and webpages produced by stakeholders involved in the setting and implementation of the health target programmes. For Austria and Germany in particular, websites specifically dedicated to the target programmes provide access to a broad range of documents and were used as primary sources of information (BMSGPK, n.d.; GVG, n.d.). International documents from the EOHPS and OECD were also included, to collect information relevant to understanding the overall context of these programmes. Scientific articles that specifically deal with the programmes studied were also reviewed, so we could distance ourselves from the official narrative and gain external insights, notably in assessing the programmes. These articles were retrieved during the first step of this study, as well as

through specific searches carried out on the database and search engines PubMed and google scholar, using the name of each programme as a key word.

The methodology used for data collection has some limitations. Since the literature is the primary source from which information was collected, the country cases presented here notably reflect the way they are addressed in formal documents and presented to the general public. Scientific analysis and assessment reports provided some information on the problems and possible limitations of the actual implementation. Indeed, further research to be directly carried out among the stakeholders involved might help to better understand the programme implementation and 'reality'. It should be highlighted that interviews with key stakeholders had been initially planned but were not carried out due to the reduction of the study timetable and consequent time constraints. However, for Austria and Germany, an informal exchange was organised via MS Teams with two experts with direct experience of the programmes in these countries. These exchanges were a chance to check the information collected through the literature review and to collect additional information when specific data were missing or not sufficiently clear. The specificities of governing with targets in a Nordic context were discussed with social policy scholars when the draft report and specifically the chapter on Sweden were presented at OsloMet University in March 2024.

Qualitative methods were used for data analysis. In both steps, a thematic analysis was carried out for the following overarching themes: overall context of the health-target programmes; content of the programmes; stakeholders involved; decision-making and target-setting process; implementation, including funding; communication strategies; monitoring and evaluation. Table 1-2 summarises the sub-themes that were explored in association with each overarching theme. Some sub-themes were specifically used for the country cases, but most of them were also used to analyse the overall topic of health target setting. The themes and sub-themes are based on classic analysis frameworks for policy and health systems, and notably consider the different stages of a policy cycle (de Savigny & Adam, 2009; Howlett, 2011).

Tab. 1-2. Themes explored within the qualitative thematic analysis

Overarching themes	Sub-themes
Context	- Historical background to the health target programmes - Health system governance and financing - Values on which the health system is based - Policy reforms and strategies relevant to understanding the programme studied
Content	- Overall scope - Areas covered - Linkages between health targets and health care targets - Time horizon - Structure of the health targets
Target-setting process	- Underpinning rationale and goal(s) pursued - Stakeholders involved - Mechanisms used to set the targets - Mechanisms used to ensure coherence among stakeholders - Timeframe used - Legal basis
Implementation process	- Type of commitment (binding vs voluntary) - Mechanisms used to ensure implementation - Links made with the budgetary process - Coordination among stakeholders
Communication strategy	- Tools used for internal communication among stakeholders - Tools used for external communication and raising public awareness
Monitoring and evaluation process	- Mechanisms in place to monitor the programme implementation and the progress achieved - Stakeholders involved and extent of cooperation among them - Use of monitoring results
Overall assessment	- Main impact - Strengths - Weaknesses - Opportunities - Threats

The thematic analysis was conducted using NVivo combined with tables for structured data extraction. A narrative synthesis was developed for each of the themes, either in relation to the overall topic of setting health targets or with reference to the specific country programme developed by Austria, Germany, and Sweden. At the end, a cross-cutting analysis was

performed to identify common patterns and main lessons learned and to develop policy recommendations for Belgium.

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Chapter 2. What the literature tells us about health target setting

This second chapter provides an overview of how the academic literature and key international documents have addressed the issue of setting health targets at national level. It particularly explains concepts and principles related to health target setting, with a twofold focus, on the overall context of health target programmes and on the governance of the target-setting process. Specific practices are sometimes mentioned for illustrative purposes, but they will be described in more depth in chapters 3 to 5, dedicated to the country cases.

2.1 The overall context of health targets

This section situates health targets in their context. It traces the history of the use of targets as a governance tool for the health sector, flags the underpinning rationale that explains the growing interest in health targets over the past decades, and provides conceptual definitions that help better understand what a health target is.

2.1.1 Pathway to health targets as a governance tool

The setting of health targets is today commonly seen as a key governance tool for steering health policy. It is part of what the World Health Organization (WHO) has defined as the 'leadership and governance' building block (or function) of a health system, which involves 'ensuring strategic policy frameworks combined with effective oversight, coalition building, accountability, regulations, incentives and attention to system design' (de Savigny & Adam, 2009, p. 31). As Srivastava and McKee (2008) recall, however, this is based on the very strong assumption that governments and any other organisations with responsibility for health and health care have clearly defined what they want to achieve in terms of health outcomes. Yet, a brief overview of the pathway towards the setting of health targets shows that the need to define these outcomes is not self-evident: it relies on the understanding of the state's responsibilities for the health sector at a certain period of time.

The notion of setting health targets as a tool to steer health policy emerged in the 1950s based on the 'management by objectives approach' used in the private sector, and may be linked to literature on new public management (Srivastava & McKee, 2008; Van Herten & Gunning-Schepers, 2000a). Initially, however, the focus was mainly on inputs, and targets were formulated in terms of the number of hospital beds, number of health professionals per 1,000 inhabitants, or the amount spent on health care (Lager, Guldbrandsson, & Fossum, 2007; McKee & Fulop, 2000). When formulated in terms of health gains, the targets were often part of disease-specific programmes (McGinnis, 1982).

Only during the 1970s was a new understanding of health introduced with the concept of 'health promotion'. One of the founding documents in this regard is the Lalonde report, published in 1974 by the Canadian Minister of Health. A new conceptual framework was outlined, which considered health as an outcome of human biology, environment, lifestyle and health care organisation (Lalonde, 1974). The understanding of public responsibilities and action concerning the health sector evolved accordingly. The United States, supported by McGinnis, one of the pioneers of *management by objectives* for health, opened up the way with the release of two reports: the 1979 Surgeon General's report on health promotion and disease prevention and the 1980 report on health objectives for the nation. The first reviewed the principal preventable health problems facing the American population and proposed quantified goals to be attained by 1990, together with strategies that might be used to address them. The second report further detailed those strategies by setting specific and measurable objectives across priority action areas (McGinnis, 1982).

This shift towards broad health targets was supported by WHO with its *Health for all* (HFA) strategy. This was first launched at the Alma-Ata international conference on primary health care (WHO, 1978), and officially endorsed in 1981. According to this approach, 'the main social target of governments and WHO should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life' (WHO, 1981, p. 11). This strategy was renewed in 1998, when the deadline for achieving the goal was extended to 2020 (WHO, 1998). Governments were invited to formulate and implement national policies, strategies, and action plans and to monitor progress made. As a result, a long series of strategies that were directly inspired by the HFA framework followed at both supranational and national level.

For the European region in particular, the HFA strategy was reflected in 38 specific targets to be achieved by the year 2000 (WHO/Europe, 1985). These were then reduced to 21 targets to be used as benchmarks against which to measure progress made in improving and protecting health of all people for the twenty-first century (WHO/Europe, 1999). Another key step towards the setting of health targets at European level was the adoption of the '*Tallin Charter*' in 2008, which invited member states of the WHO European region to move from values to action by setting 'objectives that are linked to the goals and "actionable" by policy [… and that] should be specified in a measurable way to enable explicit monitoring of progress' (WHO/Europe, 2008, p. 3). Another key strategy is '*Health 2020',* a policy framework that was proposed to support action across government and society in order to improve equity and governance for health (WHO/Europe, 2013).

This international move towards setting health strategies was reflected at country level in the development of target-oriented health programmes by both national and local public authorities. England is a case in point; its experience in setting health targets dates back to 1992, when the white paper '*The health of the nation*' was published in response to the WHO's HFA strategy (Dorange & Haim-Nemerson, 1998). A review of health targets set in 18 European countries conducted in 1998 revealed that 12 of them had been inspired by the WHO throughout the target-setting process, including, for instance, Austria, France, Germany, Spain and Sweden (Van Herten & De Water, 2000). Outside Europe, we have already mentioned the case of the United States. Since the launch of '*Health objectives for the nation'* in 1980, the US has renewed a target-oriented programme every 10 years, entitled '*Healthy people'* (Obyn, Cordon, Kohn, Devos, & Léonard, 2017a). Still within the English-speaking world, Australia and New Zealand are often mentioned for their long experience in setting health targets (Beaglehole & Davis, 1992; Busse & Wismar, 2002; Dorange & Haim-Nemerson, 1998).

These experiences were launched during the 1990s and despite national and local specificities. This trend shows how countries have been guided in their efforts to set targets by WHO strategies adopted either in relation to the HFA approach or to the field of health promotion. These include the '*Ottawa charter on health promotion*' (WHO, 1986) and the subsequent recommendations on health promotion agreed upon in Adelaide (WHO, 1988). International initiatives established not specifically for health but including targets related to health and health care have also influenced these processes. This is, for instance, the case of the United Nations agenda for sustainable development, which covers the period 2015-2030 and whose third goal is to ensure healthy lives and promote well-being for all at all ages (UN, 2015).

2.1.2 Rationale behind the setting up of health target programmes

The overall rationale behind the setting of health targets reflects the assumption underpinning the management by objectives approach, i.e. that it is possible to set common strategic goals, and that breaking them down into clear objectives and targets, as well as monitoring progress made in their respect, helps to focus actions and improve their efficiency (Van Herten & Gunning-Schepers, 2000a). Targets are thus used as a governance tool to provide leadership, guidance and strategic direction, to rationalise health policy and make stakeholders accountable for their actions (Van Herten & Gunning-Schepers, 2000b).

In this sense, the target setting is closely associated with the possibility of measuring progress made and outcomes achieved in the health sector, as was for

example explicitly stated in the Tallin Charter mentioned above (WHO/Europe, 2008). In other words, target setting is directly linked to the performance of the health system. The WHO notion of governments' 'stewardship' of the health system was actually first introduced in its World Health Report on the performance of health systems (WHO, 2000). It thus made a direct link between the functions of a health system and the goals to be achieved ([9]). Consequently, well-defined and appropriately used targets are generally considered as an effective tool to secure improved health system performance (Smith & Busse, 2010; Wismar, McKee, Ernst, Srivastava, & Busse, 2008). Interestingly, a review of health target programmes (Obyn et al., 2017a) shows that their declared aim is most often formulated in positive terms that emphasise the functions of setting priorities, bringing stakeholders together, and mobilising action for health, rather than the function of evaluating health policy, which might be perceived more negatively by stakeholders.

Furthermore, the development of health target programmes is often justified by the need to achieve specific overarching goals. A review of health target programmes (Wismar & Busse, 2002) shows that these goals may relate either to the health status of the population, or to the health care services, or even to issues that are not directly related to health. Among the programmes reviewed, only a few referred to health goals only, such as the improvement of health equity and equality, or the reduction of morbidity and mortality. Most programmes also referred to the aim of reforming the health care sector, for example, to prioritise resource allocation, to promote cost-effectiveness, or to reorganise the governance of health services. Other programmes were also linked to broader governance issues, such as international competitiveness or the wish to improve transparency and participation ([10]). At international level, this tension between various rationales is illustrated by the European framework *Health 2020;* its two strategic objectives are to improve health for all and reduce health inequalities, while also improving leadership and participatory governance for health (WHO/Europe, 2013). It is also important to note that some of these overarching goals reflect those assigned by WHO to the health system, such as improved health (in terms of both status and equity), improved efficiency, and responsiveness to people's expectations (WHO, 2000). Additional health system goals are identified in the literature, namely ensuring social and

9. This link between targets and performance is well illustrated by the case of New Zealand, where health targets were used between 2007 and 2020 as 'a set of national performance measures […] designed to improve the performance of health services' (Ministry of Health, 2021). They have actually now been replaced by the *Health system indicator framework*, a new approach to health system performance measurement. For more information, see: www.health.govt.nz/new-zealand-health-system/health-system-indicators-framework.
10. It may be interesting to note that in one case (that of North Rhine-Westphalia), the health target programme did not refer to health goals at all, but rather put forward reasons related to health care only; achieving better health outcomes was presented as a measure to improve the efficiency of health care (Wismar & Busse, 2002).

financial protection (de Savigny & Adam, 2009), as well as improved health security and increased resilience (WHO, 2021), which could also be used as overall rationales for developing health target programmes.

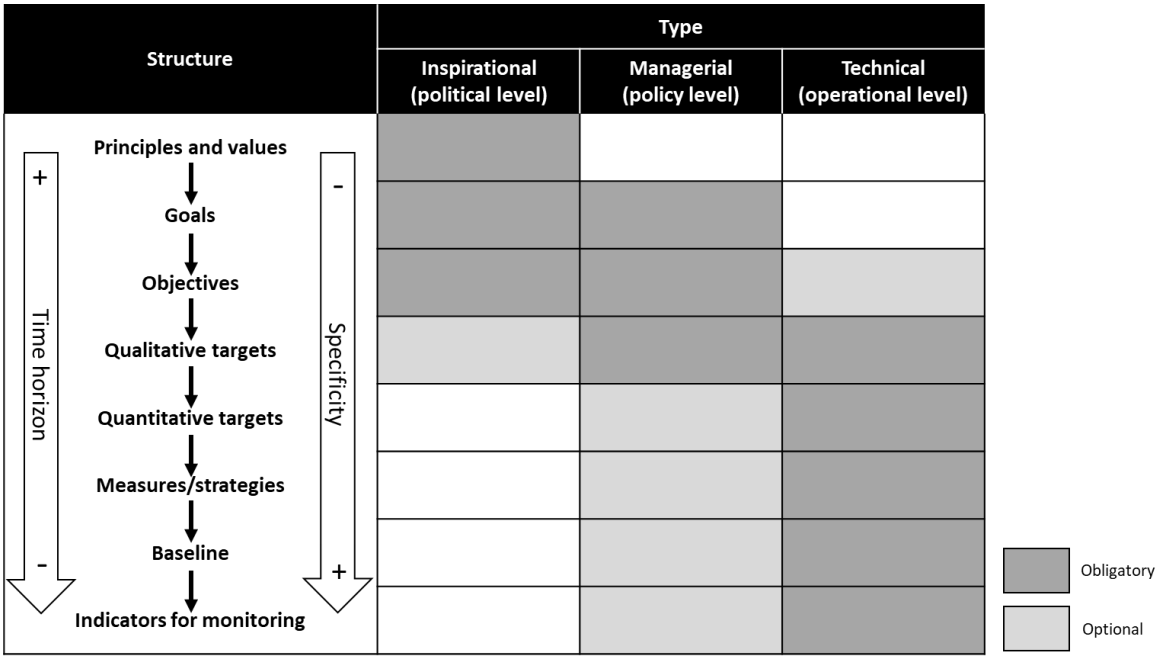
All these goals contain the basic values underpinning the rationale for health targets. Clark and Weale (2012) refer to social values, i.e. 'universal' moral or ethical values that are conveyed by the social, cultural, religious, and institutional features of a particular society at a given period of time, and that may shape both the content and processes of decision-making. Among the most prominent values, the authors notably flag five content values: clinical effectiveness, cost effectiveness, justice/equity, solidarity, and autonomy/freedom; as well as three process values: transparency, accountability, and participation. If we look at country experience, Ahn and colleagues (2012) found that the priorities set for the health care system of South Korea were mostly focused on content values such as clinical effectiveness (efficacy and safety) and cost-effectiveness, and less on process values like participation. The last target-oriented programme adopted in the United States, *Healthy people 2030*, promotes the values of equity and participation by aiming to achieve health equity, create healthy environments, and engage cross-sector stakeholders in health policy-making (Fromknecht, Hallman, & Heffernan, 2021). If we look at international organisations, the strategies related to *Health for All* and health promotion were clearly focused on the content values of equity and solidarity (WHO, 1981, 1998), while also considering cost-effectiveness and promoting the process values of transparency, accountability, and participation (WHO/Europe, 1985, 1999, 2008). Irrespective of the specific values, Van Herten and Gunning-Schepers (2000b) stress the importance of explaining the values underpinning the target setting from the very beginning of the process, and call for regular discussions of these values as the process moves forward. In fact, values may change over time following epidemiological or societal developments that must be considered.

2.1.3 What exactly is a health target?

It is difficult to provide a clear and single definition of what is generally named 'a target' in the literature. Not only are the various terms, such as 'targets', 'goals' and 'objectives', used interchangeably, as we mentioned in chapter 1, but the way these terms are used may also differ in different conceptual designs. The comparative study conducted by Busse and Wismar (2002) points out, for example, that the terms 'area of action' and 'goal' in the Australian health target programme correspond to what New Zealand calls respectively 'goal' and 'objective'; and that the term 'objective' in the American programmes reflects what other programmes refer to as a 'target'.

Yet, general definitions and common patterns can still help to understand the way targets are structured in the different programmes. In fact, despite the tendency to present and consider 'a target' (or 'a goal') as a single entity, targets are only seldom formulated in such terms. Most often, a target is part of a cascading multi-level structure where different terms are organised in a hierarchy. Table 2-1 illustrates how the different terms are used in this cascading approach, by listing principles and values as the basis on which goals are set, followed by objectives and targets (be they qualitative or quantitative), by measures and strategies for implementation, as well as by baselines and indicators to be used for monitoring progress.

Tab. 1-1. Cascading structure and types of targets



Source: adapted from Van Herten and De Water (2000).

The hierarchy on which the cascading approach is based usually follows two main logics: the targets move downwards to a shorter time horizon and to a higher degree of specificity. Thus, goals usually set general orientations and define very generally what should be achieved in the long term. Objectives set out in more detail how the goals should be attained; they are more specific and are often expected to be met in the medium term. Targets provide further guidance and are even more specific than the objectives since they fix concrete achievements to be attained in the short term. They can be formulated in both qualitative and quantitative terms. Measures and strategies provide detailed roadmaps including concrete actions to be implemented in the short and medium term to help achieve

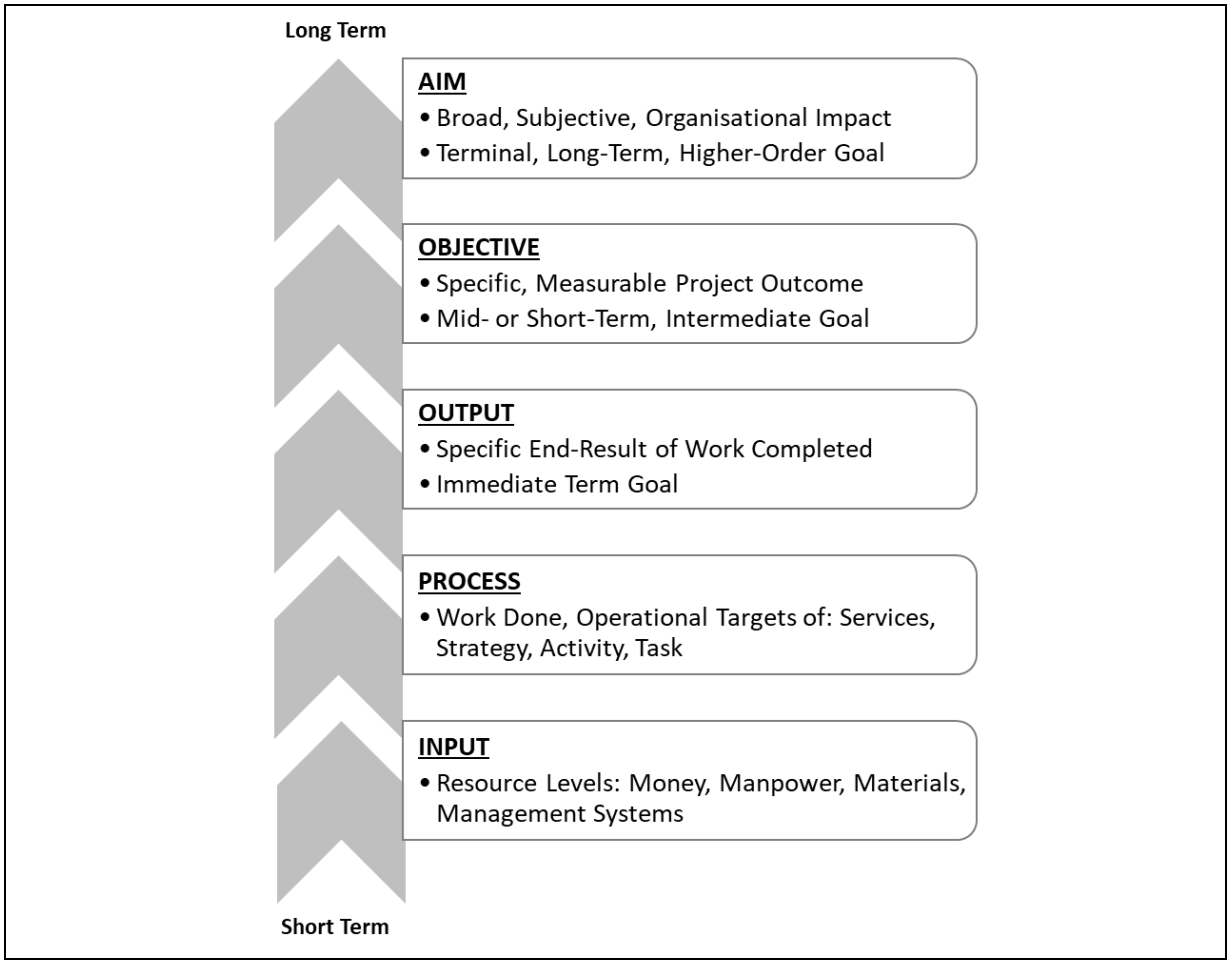
the targets. At the end of the list, a baseline and indicators can be used for monitoring (Busse & Wismar, 2002; Van Herten & Gunning-Schepers, 2000b).

The time horizon considered varies a great deal from country to country. A review of target programmes conducted by KCE (Obyn, Cordon, Kohn, Devos, & Léonard, 2017b) shows considerable variation, from 4 years in France, to 10 years in the United-States and 20 years in Austria. It should also be noted that timeframes are not always clearly set, notably in the case of more aspirational goals.

The degree of specificity gives rise to another typology, which refers to the way targets are formulated and used (see Table 2-1). Based on definitions proposed by Van Herten and Gunning-Schepers (2000b), *aspirational targets* set at political level provide guidance to the overall process and are the responsibility of the government; they are most often defined as principles and values, as goals or objectives, but qualitative targets may also be aspirational. *Managerial targets* set at policy level are the responsibility of the minister of health or of other governing bodies responsible for health and health care; they are more often defined as goals, objectives, or qualitative targets, but may also include the other type of targets included in the list in Table 2-1. Finally, *technical targets* suggest specific, mostly quantitative achievements, as well as actions to be implemented by stakeholders at the operational level; they are more often defined as qualitative and quantitative targets, baseline, and indicators, although sometimes operational objectives may also be set.

The content of the targets can also address different dimensions. The following three types of targets can be identified: *outcome targets*, which involve a change in outcomes (e.g. reduction in mortality and morbidity); *process targets*, which are oriented towards a change in process (e.g. to improve quality of care); and *structure/organisation targets*, which aim to bring about structural and organisational changes (e.g. in legislation or regulation, in resources, etc.). Outcome targets are often defined as strategic targets, while process and structure/organisation targets are considered as being more operational (Obyn et al., 2017b). This typology is based on an input-output model. Ogbeiwi (2021) applies it to health care and proposes a linear directional framework including five levels, from the short to the long term, as described in Figure 2-1: *input* targets focused on resources; *process* targets focused on services; *outputs* or immediate term goals focused on specific results; *objectives*, which are defined as mid- or short- term, intermediate goals focused on outcomes; and *aims*, which are final, long-term goals focused on the broad impact to be achieved.

Fig. 2-1. Classification of targets based on an input-output model.



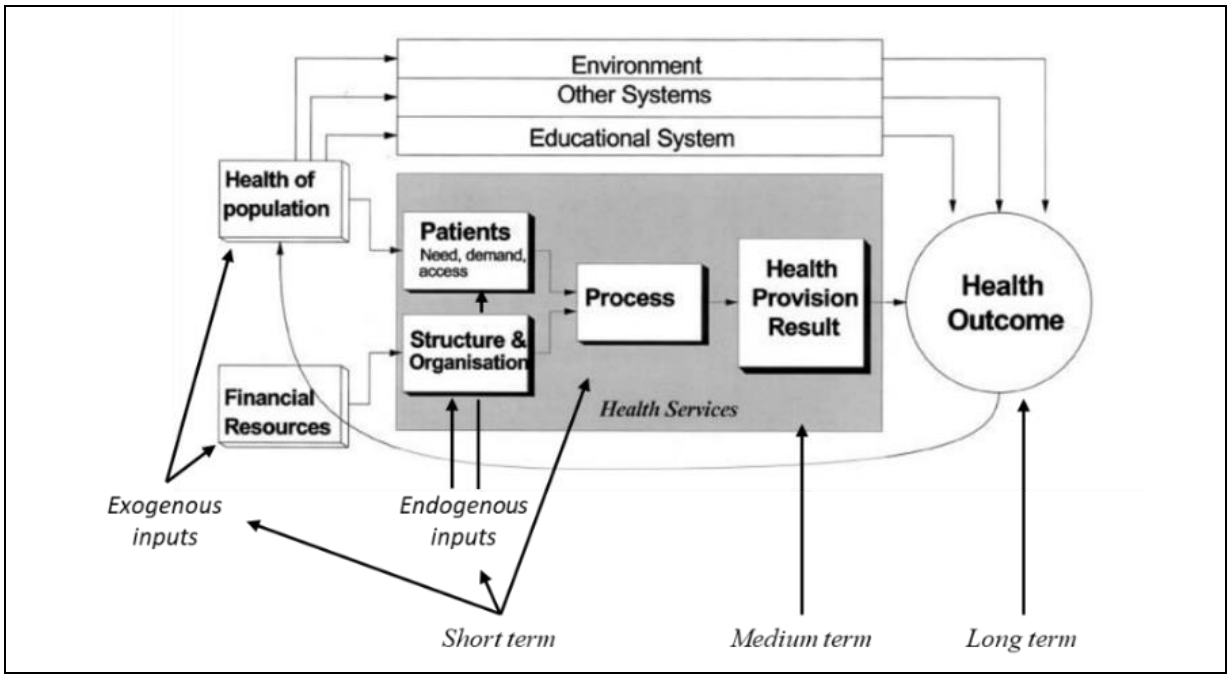
Source: adapted from Ogbeiwi (2021).

We conclude this section on the definition of health targets by discussing the distinction between health and health care targets. The review of health target programmes conducted by KCE (Obyn et al., 2017b) shows that these two types of targets are usually not clearly separated: programmes, whether comprehensive or more focused, usually include both health and health care targets. To conceptualise the linkages between these two types of targets, Busse and Wismar (2002) suggest applying the input-output framework to the health system, placing health services at the centre, as illustrated in Figure 2-2. According to this framework, *health targets* are geared to outcomes that can be obtained in the long term and depend on factors that are both inside and outside the area of health services; *health care targets* are geared to outcomes (results) that can be directly attributed to health care provision and can be achieved in the medium term; and *short-term targets* are geared to specific inputs and service processes ([11]). This framework is useful because this type of design

11. Busse and Wismar (2002) distinguish between *exogenous inputs*, i.e. the current health status of the population and the financial resources, and *endogenous inputs* related to patients (i.e. needs,

is often used to assess the performance of health systems and might thus facilitate links between health target setting and health system monitoring and evaluation. Moreover, this framework makes it possible to identify the areas targeted and whether the focus is placed on health outcomes, or on health care, or even on other sectors (environment, education, housing, etc.) from a health promotion perspective. The actual focus depends not only on the type of stakeholders involved but on a variety of contextual factors that make it difficult to set specific patterns.

Fig. 2-1. Linkages between health and health care targets



Source: adapted from Busse and Wismar (2002).

2.2 The process of health target setting

This section examines in more depth how the process of health target setting was addressed in the literature and relevant official documents. It presents preliminary remarks on the overall governance of health targets, notably in relation to participatory approaches applicable to the overall process of target setting. It then discusses the different stages of this process, which can be viewed in the same way as any other problem-solving process, usually referred to as the 'policy cycle' in terms of policy analysis (Howlett, 2011). The following stages are particularly discussed: i) the agenda setting, including the situation

demands, access to services) and to the structure and organisation of services. *Process* is defined as the set of actions that bring together these two inputs, e.g. during a medical consultation.

analysis and the selection of priority problems; ii) the formulation of targets and concrete action plans suitable for addressing these priority problems; iii) their implementation; iv) the monitoring and evaluation of progress made and achievements. At the end, elements related to communication strategies will also be briefly presented. Although these stages are presented separately for analytical purposes, it is often difficult to separate them out, and the process should be understood as, rather, a back-and-forth process.

2.2.1 Overall governance of the health targets

The analysis of the overall governance of health target programmes shows a clear move towards multi-stakeholder and multi-sectoral processes over the past four decades. WHO strategies adopted in relation to HFA and health promotion have notably supported the following three approaches linked to the development of health targets: the *health in all policies approach*, the *whole-of-government approach*, and the *whole-of-society approach*. These approaches are closely interlinked and are based on a broad understanding of health and its determinants. They acknowledge that these determinants go beyond the health (and the health care) sector and, to be addressed, need the intervention of multiple stakeholders engaged both within and outside the health sector, and within and outside the government (and other possible institutional governing bodies), thus also including for example communities, civil society organisations, and the private sector. A detailed definition of these three approaches is provided in box 1, based on the *Health 2020* strategy of the WHO Regional office for Europe (WHO/Europe, 2013).

Box 1. Governance approaches for setting health targets

***Health in all policies**: It is designed to make governance for health and well-being a priority for more than the health sector. It works in both directions, ensuring that all sectors understand and act on their responsibility for health while recognizing how health affects other sectors.*

***Whole-of-government approach**: It involves multilevel (from local to global) government actions, also increasingly involving groups outside government. This approach requires building trust, common ethics, a cohesive culture, and new skills. It stresses the need for better coordination and integration, centred on the overall societal goals for which the government stands. In countries with federal systems or in which the regional and local levels are politically autonomous, extensive consultations across levels of government can strengthen whole-of-government approaches. Accountability is required at all levels and in all systems.*

***Whole-of-society approach**: It goes beyond institutions: it influences and mobilises local and global culture and media, rural and urban communities, and all relevant policy sectors, such as the education system, the transport sector, the environment, and even urban design. It is a form of collaborative governance that can complement public policy. It emphasises coordination through normative values and trust-building among a wide variety of actors. By engaging the private sector, civil society, communities and individuals, the whole-of-society approach can strengthen the resilience of communities to withstand threats to their health, security, and well-being.*

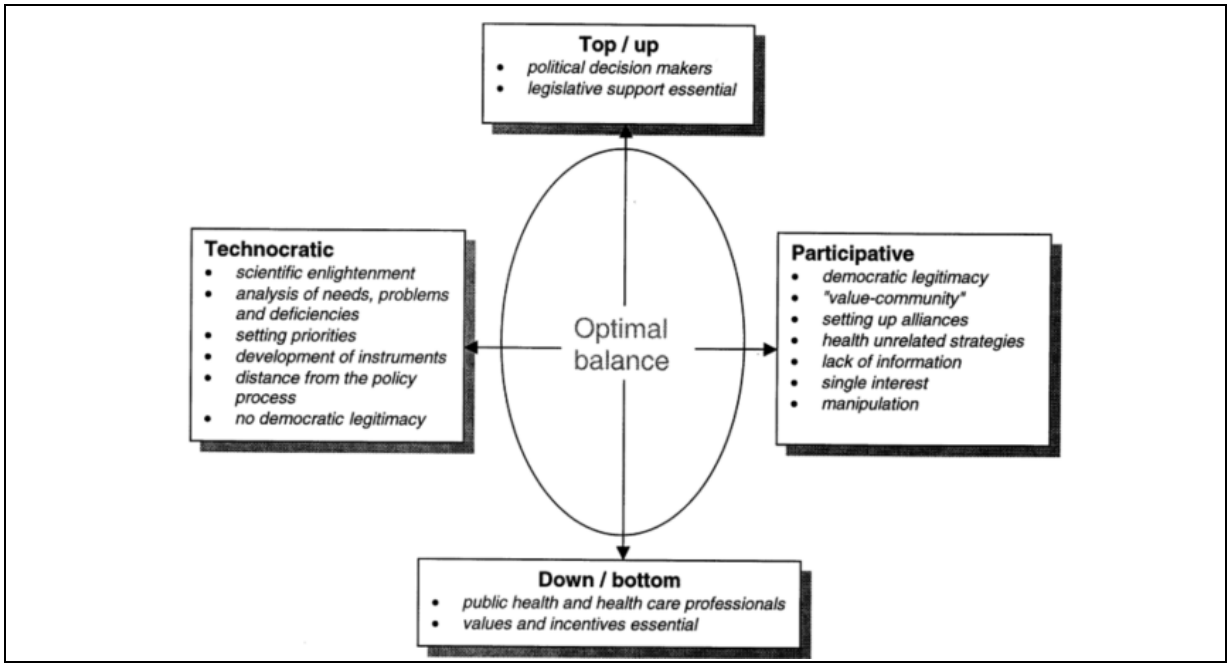
Source: WHO/Europe (2013).

Participation of all relevant stakeholders is widely considered as one of the key success factors of any health target programme (Srivastava & McKee, 2008). Participation ensures a comprehensive understanding of wicked problems such as those related to health, for which most often no straightforward solution exists, supports consensus on priorities and how to address them, and helps to strengthen ownership. In the United States, for example, the presence of strong partnerships and alliances outside the government is among the factors identified as enabling the adoption of successive 10-year health target programmes since the 1980s (Van Herten & Gunning-Schepers, 2000a).

In practice, the type of stakeholders involved and the relationship among them vary from country to country and depend strongly on the governance mechanisms of the country in general and of the health sector in particular. For example, governmental actors may play a greater role in countries with a national health system, where health care provision is highly controlled and regulated by the public sector; while corporatist and private organisations may play a greater role in countries where health professions are self-regulated, notably in social health insurance systems, or countries where the health system has been privatised (Srivastava & McKee, 2008).

In all cases, for the process to be successful, the number and type of stakeholders involved should reflect a good social and political compromise. Van Herten and Gunning-Schepers (2000b) illustrate this compromise as a balance between four poles along a horizontal and a vertical axis (see fig. 2-3). The horizontal axis goes from the 'technocratic' approach on the left, where health targets are set by scientific and technical experts, to the 'participative' approach on the right side, which involves the wider public. A balance should be struck here by weighing up the pros and cons of the two poles. The technocratic approach ensures scientific rigour, provides in-depth analysis of needs, problems, and deficiencies, and clarifies why and how priorities should be set; at the same time, it is also distanced from the political process and lacks democratic legitimacy. On the other side, the participative pole has greater democratic legitimacy, can draw on common values and facilitate alliances; however, it may favour the emergence of strategies not related to health and based on misinformation, single interests, or manipulation. The vertical axis goes from policymakers at the top to health professionals and all other stakeholders responsible for implementing, executing, and running the health target programme at the bottom. The interaction between these two poles is crucial for ownership and successful implementation of the health targets; a right balance should be found between top-down programmes that are initiated by policymakers and carried out on their behalf by other organisations, and bottom-up strategies that are at least initiated by the operational stakeholders.

Fig. 2-2. Balance of stakeholder involvement in target-setting programmes



Source: Van Herten and Gunning-Schepers (2000b).

To conclude, by considering the type of stakeholders to involve, we briefly focus on three key specific groups: central governments, decentralised authorities, and parliaments. At government level, health target programmes whose rationale is explicitly based on the principle of health in all policies usually involve representatives from different sectors, going well beyond the health and health care sector. In the United States, for example, the federal interagency workgroup that leads efforts for the development of *Healthy people* is chaired by the Department of Health but also includes members from other departments, such as agriculture, education, housing, justice, etc. (Obyn et al., 2017b). If competences for health are devolved across different levels of governance, connections are usually made between the national and the state/regional/local levels. Again in the United States, one coordinator for each state is appointed to liaise with the national level and to support the alignment of state plans with *Healthy people* (Obyn et al., 2017b). Interestingly, parliaments are not always involved in the setting of health targets as the programmes are often designed in a 'top-down' way from governments and their administration (Wismar and Busse 2002). Yet, evidence from England shows that discussion in the Parliament was a crucial feature enabling the *Health of the Nation programme* to become cross-party and more broadly owned (McCarthy 1999). Experience also shows that Parliament can play a key role in holding the executive accountable, by reviewing progress reports and denying financial incentives in case of low results, as in Catalonia (Ernst, Wismar, Busse, & McKee, 2008).

In terms of instruments, persuasion and appeals to mutual self-interest are key in striking a right balance among stakeholders and building coalitions for health (Srivastava & McKee, 2008). The literature acknowledges that, while participation and consensus are necessary on the one side, conflicts are inevitably the other side of the setting process: since targets are expected to bring about change, they challenge de facto traditional practice. And the more stakeholders are involved, the greater the risk is that these conflicts may arise. To resolve these potential conflicts, Dorange and Haim-Nemerson (1998) recommend focusing on the common ground for action to improve health. Notably in inter-sectoral approaches, leadership, negotiation, and adapting to existing agendas and priorities are considered to be more effective than simply seeking to impose the health agenda. The authors mention the case of Australia, where inter-sectoral collaboration and trust was built by focusing on well-defined projects rather than open-ended commitments.

The literature also flags the central role that governments must play in balancing conflicting claims, e.g. for priorities and resources, and in making very clear decisions on what targets are retained in the end (Smith & Busse, 2010). This arbitration and decision role is expected to avoid a situation where compromises are watered down and very general targets are set, but also to ensure that targets reflect the public interest and not the individual perspective of single groups. As Schang and Morton (2017) argue, complementary logics of target-setting may actually be used in synergy on a target-by-target basis. They present Scotland as a good example of this: the government was found to use *experimental approaches* based on participation and learning processes, where targets are informed by a multi-stakeholder and multi-sectoral perspective and where means for change are ambiguous; and to use *hierarchist approaches* based on stewardship where the ends and means are well known from the beginning. Scotland seems however to be the exception. A review of seven health target programmes in Europe (Ernst et al., 2008) actually finds that the two logics are rarely combined: countries focus on either hierarchist regulation and accountability, or take an experimental, deliberative and learning-oriented approach.

We will see hereafter that the principles described above regarding the need to strike a balance between stakeholders and between different governmental logics are at the core of all stages of the setting process.

2.2.2 How to set the health priorities to be targeted

To set health targets, the nature of the problems to be addressed should be known. For this purpose, relevant quantitative and qualitative information should be collected and analysed on the health of the population as well as on broader determinants of health,

including data disaggregated over different groups (Srivastava & McKee, 2008). In this respect, Krieger and colleagues (2015) advise that it is better to rely on long-term data, such as 50-year trends, to set quantitative targets, whether for on-average rates or for health inequalities (Krieger et al., 2015). McKee and Fulop (2000) stress the importance of considering the overall context, including also any political, practical, and technical constraints. Box 2 lists a series of questions that can be considered to analyse the current situation.

Box 2. Questions to be considered when analysing the existing situation

1. *What is the health status of the population being considered?*
2. *What are the most important health problems?*
3. *How big are these health problems?*
4. *What are the past trends in these health problems and which factors are responsible for these trends?*
5. *What will be the size and nature of the problems at a given endpoint if nothing is done?*
6. *Which interventions are available for these problems and how effective and efficient will these interventions be?*
7. *What will be the situation at a given endpoint if interventions are implemented?*
8. *Which stakeholders should be involved in the analysis?*
9. *How will they be involved?*

Source: adapted from Van Herten and Gunning-Schepers (2000b).

Once the situation is assessed, choices should be made, and priorities identified. The series of questions that can be considered during the selection process are listed in box 3. These mainly concern the procedures to be followed to select health priorities, as well as which stakeholders should be involved and through what mechanisms.

Box 3. Questions to be considered when selecting priorities to be targeted

1. *How will the health priorities be selected?*
2. *Which stakeholders should be involved?*
3. *How will they be involved?*

Source: adapted from Van Herten and Gunning-Schepers (2000b).

For priority selection, four approaches have been identified in the literature. The first approach is *selection by example*, i.e. adopting health targets formulated as part of initiatives developed elsewhere. In Germany, for example, North Rhine-Westphalia aligned its health target programme to that of the WHO European region, while other states decided to align themselves with targets developed at federal level in order to ensure a more concerted and effective policy (Wismar, Philippi, & Klus, 2008). In the same way, American states draw

on the national programme *Health people 2030* to develop their own *State health improvement plans* by aligning either with the whole framework or with specific components (Fromknecht et al., 2021).

A second approach is *selection by benchmark*, which involves selecting targets in areas where improvements are needed, since current results lag behind the national or the international average. This was found to be the case of the state of Schleswig-Holstein, which selected targets in the area of children's health where the German average was higher (Wismar, Philippi, et al., 2008). In France, too, health targets were defined based on a comparison with European averages (Obyn et al., 2017b)

A third approach is *selection driven by criteria*, which may address various dimensions. Criteria may involve epidemiological considerations, such as morbidity and mortality rates, or may relate to direct or indirect economic costs, such as the burden on total expenditure on health and social services or working days lost due to illness (Dorange & Haim-Nemerson, 1998). They may consider ethical aspects, which allow consistency between ethics and targets and make sure stakeholders' action is guided in the same direction (Liss, 1999). More pragmatic criteria may be included, such as alignment with government priorities, availability of baseline data, scope for implementation by stakeholders (Schang & Morton, 2017), as well as the existence of effective intervention and actual feasibility (Wismar & Busse, 2002).

A fourth approach is *selection by political relevance*. Wismar and colleagues (2008) cite, for example, the choice of breast cancer as a target area for a German disease management programme, despite criticism from many experts. Another example comes from Scotland, where recommendations made by a working group following a lengthy process of deliberation were only partially endorsed by the executive (Bauld, Day, & Judge, 2008).

The four approaches are not necessarily mutually exclusive, and they are all driven by values. These influence decisions about which examples to align with, which benchmark to focus on, which criteria to use, and of course what has more political relevance. In the words of Wismar and Busse (2002), even within the most 'technocratic approaches', where targets are technically chosen from epidemiological data, the evidence basis is not the only criterion used, and values also partially explain the final choices. In fact, there may even be different interpretations of what should be considered a major health problem, and, in the end, priorities are selected as the result of a compromise.

For this compromise to be achieved, participatory mechanisms are often put in place to perform the situation analysis and the target selection. International

experience suggests that these mechanisms may differ and be held at different stages. A review of health target setting in nine American states (Fromknecht et al., 2021) shows that, depending on the health department, stakeholders were involved either early, for instance at the stage of community health assessment and in the framework of steering committees guiding the prioritisation process, or late, in order to offer expertise on priorities already set. Stakeholders' feedback was promoted using different methods, such as dot voting, or electronic ranking based on a set of criteria. Similarly in England, the recent development of the *NHS Long term plan* saw the establishment of a NHS Assembly that regularly gathered experts and stakeholders, as well as the possibility for the public to participate in meetings, events and online surveys (NHS, 2019). Among other participatory mechanisms used, we can mention the national and regional 'health conferences' that were established in France with the aim to promote discussion on existing problems and build partnerships for future implementation. Health conferences were also created at state and local (city and town) level in North-Rhine Westphalia (Smith & Busse, 2010), while health councils were created at central and provincial level in Catalonia (McCarthy, 1999).

2.2.3 How to formulate health targets

A key stage in target setting is the formulation process. This consists in clarifying the priorities selected by setting explicit targets and action plans, outlining what exactly must be achieved, how this is expected to be done, what stakeholders will be responsible for that process, and how progress will be supported and monitored. The series of questions to be considered at this stage are listed in box 4.

Box 4. Questions to be considered when formulating health targets

1. *Which stakeholders should be involved in the process?*
2. *What kind of targets will be set, and which steps should be taken?*
3. *Which requirements should the targets meet?*
4. *Who will be responsible for the choices made?*
5. *Which actions are necessary to achieve the targets?*
6. *Who will be responsible for those actions?*
7. *How will progress towards the targets be measured?*
8. *What will be regarded as a success?*
9. *What is the consequence if a target is not achieved?*

Source: *adapted from Van Herten and Gunning-Schepers (2000b).*

Strategies for target formulation vary widely and display the same tensions as those between technocratic and participatory approaches, between top-down and bottom-up processes, that we mentioned above (see section 2.2.1). The review conducted by Wismar and Busse (2002) shows contradictory examples. In some countries, governments outline the overall mission only and then act as mediators and managers of multiple stakeholders invited to help further develop targets based on their expertise. In other countries, governments work in a top-down way, initiating and developing the health target programme, before consulting other stakeholders whose advice only partially influences the structure or content of the final programme.

The structure and number of health targets may vary from one programme to another. As mentioned in the introduction (section 1.1.3), health targets are usually formulated as part of a cascading structure where targets are ordered hierarchically based on their time horizon (from longer to shorter term) and their degree of specificity (from the less specific inspirational targets to the more and more specific managerial and technical targets). The exact number of targets varies from programme to programme, as described in the review conducted by KCE (Obyn et al., 2017b): among the countries surveyed, the United States had 1,200 targets linked to 42 topics, France had 100 targets, while New Zealand had just 7 targets conceived of as more general priorities. The literature generally suggests setting a limited number of targets, by focusing on those priority areas where change is critically needed and by using other instruments to ensure that standards are maintained in the areas that have not been targeted (Smith & Busse, 2010). Past experiences either at global, national, or regional level actually reveal difficulties in managing and completing programmes with too many targets. Moreover, although targets make it possible to cover several areas in a comprehensive way, they also risk dispersing efforts, losing focus, and weakening priorities. To reduce this risk, some of the more comprehensive programmes explicitly highlight which targets take priority. In the United States, for instance, some of the objectives are selected as 'leading health indicators' to drive action toward improving health and well-being (Obyn et al., 2017b).

Concerning the methods used to formulate targets, the literature suggests as a general rule that targets should be SMART, i.e. specific to what is to be achieved, measurable with data that allow monitoring, achievable and accurate enough for progress to be assessed, realistic, and time bound (Wismar, McKee, et al., 2008). Smith and Busse (2010) review the following desirable principles for setting targets: i) indicators should be directly relevant to the primary objective or be an obviously adequate proxy measure; ii) definitions need to be precise, practicable, and consistent over time; iii) indicators should be straightforward to interpret and avoid perverse incentives; iv) indicators should be based on adequate sample sizes, and technical properties of the indicator should be satisfactory; v)

indicators should not impose an undue burden in terms of cost, personnel, or intrusion on those providing the information. In practice however, only few programmes fully align with these principles. This is also because, while these principles may well guide the setting of quantitative operational targets, they are less suitable for qualitative inspirational or managerial targets. In fact, different methods are used for individual cases. The review conducted by KCE (Obyn et al., 2017a) shows that programmes with a long list of health targets tend to set them in a systematic and pragmatic way. For example, in the American programme *Health people 2020*, quantitative targets are fixed according to a default 10% improvement over the baseline. Targets from the French programme *100 Objectifs de santé,* on the other hand, are fixed by taking the EU average as a reference point that must be achieved or at least maintained. On the contrary, programmes with a reduced number of targets and with targets more focused on process tend to formulate them in a more customised way with the aim to guide concrete actions. As a result, targets are more precise and may, for instance, be linked to specific resources.

Finally, targets are often accompanied by supplementary information, such as evidence about the issue addressed or recommendations for the stakeholders. As illustrated in Figure 2-1, specific actions and measures are often set as operational tools to guide implementation. They propose a range of interventions, tasks, and activities, as well as resources and time frames to implement them, and assign clear responsibilities. For example, targets on heart disease and stroke in the English programme *Our healthier nation* were explicitly presented as a responsibility shared among various stakeholders, including the government and national organisations, local actors and communities, and even the individuals themselves (Dorange & Haim-Nemerson, 1998).

2.2.4 How to support the implementation of health targets

Once priorities are set and targets formulated, implementation is the next stage of the health target programme. Box 5 lists the series of questions that can be considered at this stage. As Van Herten and Gunning-Schepers (2000b) stress, these questions reflect those already discussed during the formulation of the health targets, but the focus here is on obtaining commitment and defining accountability.

Box 5. Questions to be considered when implementing health targets

1. *What are the opportunities, threats, and constraints?*
2. *What are the organisational requirements?*
3. *What are the financial requirements?*
4. *Who will be responsible and accountable for what?*

Source: Van Herten and Gunning-Schepers (2000b).

Stakeholders can be encouraged to commit to implementing targets by building political alliances, consensus, and a sense of ownership. This may entail the use of incentives, both monetary and non-monetary, enabling individuals and organisations to appreciate the benefits of supporting the health target programme. As Wismar and Busse (2002) note, although stakeholders have clear motivations to participate in bottom-up initiatives, they still need room for manoeuvre and support, or even sometimes legislative backup. On the other hand, decision-makers see enough benefit in the bottom-up initiatives to accept or support them. The United States provides an example of non-monetary incentives. Here, the federal government supports the integration of *Healthy People* national targets into the *State health improvement plans* by providing communities, states and organisations with tools that facilitate the use of the national framework, such as accessible data and evidence-based resources. Some form of soft regulation was also introduced. The development of the state plans was linked to the possibility of accreditation for the states' health departments by the Public Health Accreditation Board; the accreditation enables states to use their plans as a mechanism for public health collaboration, organisational accountability, and regular health improvement (Fromknecht et al., 2021). Another way to keep motivation high and favour local implementation consists in setting national health targets without fixing precise outcomes in advance, but leaving room for the stakeholders to adapt them based on local baselines and possible contextual difficulties (Smith & Busse, 2010).

An additional way to support implementation is to clearly assign responsibilities and accountability. In this respect, a review of health target programmes (Wismar & Busse, 2002) flags how the major role assigned to subordinated health authorities and local actors in target implementation contrasts with their low involvement in previous stages of the target-setting process; moreover, mostly only minor roles are assigned to academic institutions, health professional associations, and private industry. In terms of accountability, while stakeholders should be accountable for the specific activities for which they accept responsibility, the government and the minister of health may be accountable for the overall programme (Van Herten & Gunning-Schepers, 2000b). Past experiences show that lack of adequate accountability frameworks may hamper the achievement of the targets set. For instance in Hungary, the targets were focused on public health but, despite the monitoring of outcomes at national level, no accountability mechanisms ensured that stakeholders committed to their achievement (Smith & Busse, 2010). According to Ernst and colleagues (2008), the accountability frameworks should be transparent and based on established rules and regulations, for example in binding mutual agreements or contracts. Besides incentives, sanctions should also be carefully designed. Emblematic here is the case of England, where contracts in the form of 'public service agreements' were used between 1998 and 2010. They included targets, mostly quantitative, that reflected the national objectives of the National

Health Service (NHS) and linked funding to their achievement. In case of target attainment or good performance, financial rewards or more autonomy were given to NHS organisations. In case of failure, sanctions were planned, such as the replacement of senior managers. This approach was, however, highly criticised for the adverse consequences it generated: it supported massive dysfunctional responses and opportunistic behaviours by stakeholders, who tried, for instance, to distort or misreport data (McKee, 2008).

It should be noted that 'good will' and 'model' also figure among the instruments used to secure implementation of health target programmes (Wismar & Busse, 2002). The first assumes that a consensus exists among all stakeholders on the importance and necessity of the health targets and, therefore, the majority will choose to commit to their achievement. The 'model' instrument relies on the leading ability of the governing body that initiates the programme and assumes that other institutions will adapt their own strategies to align with the health target programme. Some programmes are actually designed with the primary aim to stimulate debate on health priorities and are thus not especially meant for implementation. However, if this is the case, this rationale should be clearly mentioned and considered during monitoring and evaluation.

As a concluding remark, the literature highlights the need to link the implementation of health target strategies to adequate resources. In fact, commitment in the target setting process cannot only be based on consensus, but it also requires stakeholders' willingness to engage. This can be supported through communication, coordination mechanisms, and monitoring processes, but it also involves adequate time and sufficient human, material, and financial resources (Van Herten & Gunning-Schepers, 2000a). Regarding human resources, authors stress the need for a high level of public health management skills and leadership, administrative skills, scientific and technical expertise, and community empowerment (Ernst et al., 2008; McKee & Fulop, 2000; Van Herten & Gunning-Schepers, 2000b). With regard to financial resources, a review of health target programmes (Wismar & Busse, 2002) highlights that even when resource allocation and cost-effectiveness are mentioned as rationales for setting targets, no programme makes clear reference to financial resources for health services; and, in general, this aspect is usually neglected. According to the OECD (2022, 2024), aligning health sector targets and financial resources by taking a pluriannual perspective is among the good practices to put in place when setting the health budget in order to fund more resilient health systems. This can be developed, for example, by using medium-term expenditure frameworks. The OECD also mentions other good practices to improve the transparency of the health sector budget, including drawing a distinction between baseline costs and new policy proposals when evaluating spending needs; and the use of explicit criteria when developing the budget.

2.2.5 How to ensure monitoring and evaluation

The final step of health target setting is the monitoring and evaluation (M&E) of progress made and outcomes achieved. In fact, this step does not come at the very end, but should be planned from the beginning of the target setting process. We described above how most debates held during target selection and formulation focus on the measurability and feasibility of the targets. Moreover, as in any policy cycle, the results are expected to contribute to the reflection on the relevance of health targets and to feed into the discussion on possible problems during implementation. They should thus be used to confirm, adapt, or reject strategies, to update the health target programme, as well as to review responsibilities. This is why stakeholders involved in setting health targets are usually also invited to participate in follow-up meetings and joint reviews throughout the implementation process and at regular time intervals (Schang & Morton, 2017). The series of questions that can be considered at this stage are listed in box 6.

Box 6. Questions to be considered for the monitoring and evaluation of health targets

1. *How to measure progress in outcomes? (in this respect, see also the question addressed in the policy formulation phase)*
2. *How to measure performance?*
3. *Was the policy effective?*
4. *Was the policy efficient?*
5. *Which lessons can be learned (technical, organisational, financial, etc.)?*
6. *Is additional action needed to achieve the initial target?*

Source: Van Herten and Gunning-Schepers (2000b).

Some remarks are particularly flagged by the literature in relation to M&E. First of all, there is a need for adequate resources. Overall, a well-functioning health information system is considered as being key to any health target programme. Srivastava and McKee (2008) recall that this involves not only data collection but also data analysis; therefore, analytical and epidemiological skills should also be considered when thinking about resources. Beyond human resources, equally important are the financial and material resources, as well as sufficient time (Van Herten & Gunning-Schepers, 2000a). A second crucial aspect of M&E is the coordination between different information agencies and levels of the health system, notably in cases with decentralised systems between the national and the regional/local level. In this respect, the case of Hungary is cited as an example of monitoring providing only partial information due to the lack of data from the regional level, although many targets were implemented there. As a third point, M&E should reflect the different targets pursued and thus

focus on outcomes, process, and structures/organisations. In this sense, the rationales and goals underpinning the setting of the health target programme should also be monitored and evaluated. Ernst and colleagues (2008) identify three domains that can be selected for evaluation, which are listed here, from the more specific and technocratic to the broader and more comprehensive: i) whether the specific targets have been achieved; ii) the impact that individual targets have on the desired outcomes; and iii) the success of using health targets, i.e. the impact the health target programme is having on, for instance, the overall governance of the health system. These domains are not mutually exclusive but are complementary. They involve the use of both quantitative methods geared to outcomes and qualitative methods geared to processes. The fourth and last remark draws on the argument of Schang and Morton (2017) that M&E should serve both learning and accountability, and that the two logics may well coexist within the same health target programme. In this regard, the authors call for reconsidering the strict separation usually made by literature on health care performance management between 'measurement for improvement' and 'measurement for accountability'.

The results of the M&E are usually reported both to the stakeholders directly involved in the health target setting and to the wider public. In the case of decentralised countries, the national authorities usually report to the decentralised levels as well. In New Zealand, for example, the Ministry of Health used to report on progress achieved towards the annual health targets agreed with each district health board on a quarterly basis (Obyn et al., 2017b). Broader communication aspects are further explored in the next section.

2.2.6 Communication strategies related to health targets

Throughout the target-setting process, communication strategies are important to facilitate coordination and support commitment by the stakeholders. In fact, providing regular information can ensure visibility and transparency of the process and help to keep stakeholders' motivation high. In this respect, public reporting of progress can be used as a tool to support implementation by focusing management on targets and ensuring accountability (Srivastava & McKee, 2008).

For dissemination purposes, many health target programmes have dedicated websites. These usually provide broad information on the programme, about its history, content, and results achieved, but they may also contain overall information on the topics addressed. They are designed to support transparency and accountability, for example by giving access to evaluation reports and data visualisation tools and enabling data tracking over time, as well as to support implementation. For example, the website for the American *Healthy people* programme includes a section with tools for action and evidence-based resources, and

it gives professionals and communities an opportunity to interactively share their story on how to use and implement the target programme in their own field (HHS, OAHS, & ODPHP, n.d.)

Dissemination to the wider public is sometimes also carried out through the issuing of newsletters to which people can subscribe free of charge. This is, for example, the case of the English *NHS Long Term Plan*, for which two newsletters could be subscribed to during the target-setting process: the 'Future health and care update' for regular updates on health and care services, and the 'In touch bulletin' for information on the latest events and consultations as well as on possibilities for patient representatives to get involved in advisory groups (NHS, n.d.).

2.3 Conclusion

This chapter reviewed some of the principles behind the setting of health targets and the steps followed throughout this process, based on literature dealing with the experience of other countries. We conclude here with two main points: what impact has been found by assessments of health target setting and what main lessons can be learned from the literature?

2.3.1 What is the impact of setting health targets?

The impact of health targets in terms of health gains is difficult to assess. On the one hand, stakeholders tend to focus on readily managed aspects of health care, while neglecting the management of broader public health issues. As a consequence, improvements are often observed in some specific short-term aspects of health care services, while the achievement of longer-term health targets is less straightforward (Smith & Busse, 2010). On the other hand, many other societal processes may explain the achievement of targets, making it difficult to claim a direct link between the existence of health target programmes and improved health outcomes. To illustrate this point, Bauld and colleagues (2008) note that despite England being classified as one of the countries with the most advanced targets for reducing health inequalities, progress was poor and the gap was widening rather than narrowing within English society, while countries without such targets seemed to be making excellent progress in this field.

There seems, however, to be clear evidence that the process of target setting may have a positive impact on the overall governance of the health and health care sector. Past reviews reveal improved coordination within and between political levels, for example in Germany (Wismar, Philippi, et al., 2008) and France (Obyn et al., 2017b). The introduction of policy innovations, in terms of participatory approaches or topics addressed,

was also flagged. The overall benefits that can be derived from setting health targets are summarised in Table 2-2.

Tab. 2-2. Benefits of setting health targets

Stages of the setting process	Benefits
Agenda setting (situation analysis and selection)	- Gives insight into the health of the population - Reveals gaps in knowledge - Gives insight into the consequences of alternative strategies - Stimulates debate - Supports priority setting - Increases the transparency of health policy
Formulation	- Provides a common language - Increases awareness and commitment among stakeholders - Ensures consistency among several health programmes - Shows up deficiencies in the health policy - Supports leadership and strategic direction
Implementation	- Inspires and motivates partners to take action - Improves commitment - Fosters accountability - Guides the allocation of resources
Monitoring and evaluation	- Provides concrete milestones for evaluation and adjustments - Provides opportunities to test the feasibility of the targets - Provides opportunities to take action to correct deviations - Exposes data needs and discrepancies

Source: adapted from Van Herten and Gunning-Schepers (2000a).

The table lists the benefits associated with each stage of the target-setting process. During the agenda setting, the situation analysis enables a better understanding of multiple dimensions of population health, reveals possible gaps in knowledge, and provides insight into potential trends and consequences of alternative strategies, thus supporting the development of proactive intervention. The selection process stimulates debate on the different problems and possible solutions, supports priority setting and increases the transparency of health policy, notably when based on explicit criteria. This is also true for the formulation stage, which is often conducted through a structured process that stimulates debates and provides a common language to stakeholders from different sectors and programmes. This in turn improves stakeholders' awareness and commitment, favours the emergence of a transversal vision, enhances consistency among different health (and non-health) programmes and shows up potential deficiencies in health policy. As Dorange and

Haim-Nemerson (1998) found in Australia, the setting of health targets shifted stakeholders' focus from cost containment and efficiency to the health status of the population and its broad determinants, thus enabling a more substantial discussion on health system investments and the legitimacy of government-wide commitment. Through the mediating and managing role played by the health governing bodies and the commitment of stakeholders to be held responsible for specific targets and actions either over the short or long term, this stage also supports leadership and strategic direction and improves overall management. The implementation of targets may play a model role by inspiring and motivating other stakeholders to take action aligned on the specific targets set. It thus may improve commitment and, when well-regulated and monitored, fosters accountability. It finally also helps to guide the allocation of human, material, and financial resources. Regarding monitoring and evaluation, the following benefits are identified: target setting provides concrete milestones for evaluation and adjustments, as well as opportunities to both test the feasibility of the targets and intervene to correct possible deviations. It also exposes data needs and discrepancies. In this respect, past reviews highlight that most countries launching health target programmes had to develop new systems of data collection in order to be better aligned with target monitoring (Fulop, Elston, Hensher, Mckee, & Walters, 2000; Obyn et al., 2017b). England is often mentioned as a case in point. From the very beginning of the target development, it became apparent that an enhanced data collection system was needed to monitor progress in relation to morbidity and risk factors. As a result, new modules were added to the annual *Health survey for England* and disaggregation of data per groups of population was improved (Srivastava & McKee, 2008).

Alongside the benefits, setting health targets may also generate side effects and be counterproductive. We have already mentioned the opportunistic behaviour developed by some stakeholders from NHS England to avoid sanctions for failing to achieve quantitative targets (see section 2.2.4). Their tendency to focus only on measured aspects of performance, while neglecting other clinical priorities, was also demonstrated (Smith & Busse, 2010). These drawbacks highlight the need to develop a target framework that is able to guide stakeholders' behaviour through a sufficiently balanced set of incentives and sanctions. The next section summarises a series of lessons learned and recommendations.

2.3.2 What main lessons can be learned from the literature?

The previous section on the impact of health targets provides us with a first preliminary lesson learned from the literature, expressed as follows by McCarthy (1999): 'the process of setting health targets may be as important as the targets' (p. 1664). This process varies widely from country to country, depending on the contextual political, practical,

and technical constraints, and no one-size-fits-all model can be found (McKee & Fulop, 2000). However, some common strengths and weaknesses can still be identified. Table 2-3 summarises these in relation to the main aspects and stages of the target-setting process.

Tab. 2-3. Common strengths and weaknesses of health target programmes

	Strengths	Weaknesses

Overall governance	- Involvement of stakeholders
	  o from the health sector and beyond
	  o from different levels of governance
	  o political and operational
	- Effective coordination mechanisms
		- Limited number of stakeholders and little ownership and acceptability
		- Individual interests and ambiguous support from some stakeholders
		- Focus on multi-sectoral approach, neglecting the health care sector itself

Priority setting (situation analysis and selection)	- Adequate and different types of information - Good technical support - Set process of target selection	- Lack of comprehensive and comparable data - Lack of transparency about target selection
Formulation	- Limited (manageable) number of priorities and indicators - Focus on well-defined projects and on common ground among stakeholders	- Focus on measurable issues - Targets may lack credibility or not be sufficiently explicit - Lack of prioritisation
Implementation	- Targets clear for implementation - Clear accountability framework - Effective regulatory system based on a balanced mix of incentives and sanctions - Adequate resources, including funding, time, and management skills	- Lack of accountability framework - Insufficient resources, notably financing
Monitoring and evaluation	- Adequate health information system, providing sufficient disaggregated data per population group and local context - Public reporting of progress	- Inadequate monitoring system - Lack of comprehensive and comparable data - Focus on measurable progress
Communication strategy	- Adequate communication to the general public and between stakeholders - Guidance material for national targets to be used at decentralised/operational level	- Lack of adequate communication strategies

Source: authors.

Concerning the overall governance of the health targets, the main strengths relate to the use of participatory approaches and coordination mechanisms which can effectively involve stakeholders from the health and other sectors, from different levels of

competence, both political and operational in nature. Evidence from past experiences (Wismar, McKee, et al., 2008) shows that broad participation is key for the sustainability and implementation of the health targets. On the contrary, programmes defined by a limited number of stakeholders and taking, for example, a more technocratic approach often faced problems of ownership and acceptability (Wismar & Busse, 2002). At the same time, the literature acknowledges that there may also be problems with participation itself, notably concerning the particular interests of the different groups. These can generate the risk of conflicting claims but also of frustration among stakeholders whose interests are not reflected in the health targets set (Fromknecht et al., 2021; Van Herten & Gunning-Schepers, 2000a). Interestingly, concerning the implementation of these multi-stakeholder and multi-sectoral approaches, Smith and Busse (2010) warn against the risk of neglecting and marginalising the health care sector itself. They point out the need to set priorities across all different sectors so to ultimately have an impact on both the health care sector and on broader social determinants of health.

Specific to the priority setting, most strengths and weaknesses relate to the quantity and quality of the information used to assess the situation and select priorities. In this respect, the literature stresses the importance of having comprehensive and comparable data from different public health disciplines and disaggregated for the different groups and contexts (Obyn et al., 2017a; Wismar, McKee, et al., 2008). On the other side of the spectrum, the frequent lack of correct data is related to changes in standards, the complexity of some health conditions, the introduction of new diagnostic technologies, as well as to changes in the way data are recorded (McKee, 2008). An additional strength is the technical support that the administration and experts can provide to assist with the agenda setting over time (Van Herten & Gunning-Schepers, 2000a). The transparency of the target selection is another aspect which is key to enhancing legitimacy and consensus among the stakeholders.

Concerning the formulation stage, past experience shows that a reduced number of priorities and indicators can facilitate the management of the target-oriented programmes as well as prioritisation (Fromknecht et al., 2021). Moreover, focusing on well-defined projects and actions based on common ground among stakeholders was found to facilitate consensus and commitment to the health targets (Dorange & Haim-Nemerson, 1998). At the same time, these same strengths may entail some weaknesses, such as the risk of focusing on measurable but less important issues (Van Herten & Gunning-Schepers, 2000a). The literature also draws attention to the way targets are formulated, pointing out failures in cases where targets have lacked credibility or were not sufficiently explicit to support implementation (Wismar, McKee, et al., 2008).

For the implementation to be successful, the clarity of both the targets and the accountability framework are key. An effective accountability framework notably requires clarity about how responsibilities are shared among the stakeholders involved and, particularly, among the different governance levels. In this respect, McKee and Fulop (2000) recall that health targets may be successfully developed either at national or regional level; they stress, however, the importance of identifying which level is most appropriate for developing health targets in the particular political context, and of clarifying who is responsible for the targets based on the relationship existing between the central and the regional/local governments. Furthermore, while a sense of ownership is important, stakeholders' commitment must be supported by an effective regulatory system based on a balanced mix of incentives and sanctions (Smith & Busse, 2010). Finally, another key point stressed across the literature is the need for adequate resources, including funding, sufficient time, and management skills (Obyn et al., 2017b; Van Herten & Gunning-Schepers, 2000a; Wismar, McKee, et al., 2008).

Concerning monitoring and evaluation, the need for adequate health information and monitoring systems is a recurrent issue. For the situation analysis, sufficient disaggregated data is needed to monitor progress comprehensively and make relevant comparisons (McKee, 2008). Also here, authors warn about the risk of focusing on measurable progress only and stress that progress in untargeted domains should not be neglected (Obyn et al., 2017a). Public reporting of progress is also found to facilitate implementation as well as accountability (Srivastava & McKee, 2008).

Finally, communication to both the wider public and the stakeholders involved is another key dimension of any health target programme. A lack of adequate communication strategies has indeed been found to be an important weakness (Obyn et al., 2017b). Furthermore, developing adequate guidance material and supplementary information to accompany the health targets can be crucial in supporting implementation of the targets and in the use of national targets as inspirational tools to which regional, local and operational stakeholders can align their own action plans (Fromknecht et al., 2021).

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Chapter 3. The German experience in setting health targets

This chapter is dedicated to the *German health targets network* ([12]). This initiative aims to coordinate all relevant stakeholders of the German health system by providing a forum where national health targets can be jointly developed. The first part presents the overall context of the network, while the second part describes in more depth the health target setting process. The conclusion provides an assessment and flags some of the main lessons that can be learned from the German experience.

3.1 Introduction to the German health targets

This first part situates the health targets network in its overall context by providing an overview of the governance and financing of the German health system, tracing the history and rationale behind this initiative, and finally presenting the content of the health targets that have been set to date.

3.1.1 A complex social health insurance system

The German health system is fundamentally a social health insurance system and is guided by the core principles of solidarity and shared responsibility of the insured ([13]). Its governance is decentralised and rather complex, the health policy competencies being shared between the federal, state and local level governments and between the government(s) and self-governing corporatist bodies of the health care providers and sickness funds.

At federal level, there is no national health plan or long-term strategy. The Ministry of Health holds few powers. It mainly sets and coordinates legislation related to prevention and health promotion, drugs and medicinal products; it supervises the main corporatist bodies at federal level; and it contributes to international health policies. Concerning health care provision, the federal government only sets the overall legal framework of the social health insurance, including the benefits to be granted from the statutory health insurance (SHI)

12. *Forum gesundheitsziele.de.* The English translation, 'German health targets network' is the translation used in English documents relating to the programme (Brzoska et al., 2015; Obyn, Cordon, Kohn, Devos, & Léonard, 2017). It was also chosen to facilitate comparison with the Austrian programme, whose English translation contains the label 'health targets'. It should however be noted that a recent report on the German health system translated the programme's name as 'Health Goals Forum' (Blümel, Spranger, Achstetter, Maresso, & Busse, 2020).
13. Information contained in this section is based on Blümel et al. (2020); OECD and EOHSP (2023); Schmitt (2023).

schemes, their provision and financing. This basic framework is established in the Social Code Book V - SGB V ([14]).

Based on this legal framework, the decision-making power is held by the Federal Joint Committee, which is the highest self-governing body responsible for the regulation of the social health insurance. This multi-stakeholder body includes both payers (i.e. associations of sickness funds) and providers (i.e. associations of physicians, dentists, and hospitals), three independent members, and representatives from patients' organisations who can participate and submit proposals but do not have voting rights. The Federal Joint Committee adopts directives related to the benefit basket, reimbursement mechanisms, and quality assurance. Its decisions are binding on all sickness funds, providers, and statutorily health insured patients.

At state level, the 16 German states (*Länder*) are responsible for hospital planning and investments, medical education, and public health services. However, the majority of states delegate the operational responsibility for public health service provision to municipalities, with some differences from one state to another. Coordination among the states takes place through various mechanisms. The most visible is the Conference of health ministers (*Gesundheitsministerkonferenz*), which aims to build consensus and coalitions on regional health legislation, but mainly relies on voluntary mechanisms.

In terms of financing, the German health system is based on multi-payer health insurance, which is mandatory for all legal residents. Two health insurance schemes coexist. The SHI covers approximately 89% of the population and is managed by 96 sickness funds ([15]); it provides a comprehensive benefit package covering a large proportion of costs for in-patient and ambulatory medical care, and for pharmaceuticals. The private health insurance (PHI) covers the remaining 11% of the population. This includes people with an income above a fixed threshold or belonging to specific professional groups, such as the self-employed and civil servants, who may choose to opt out of the SHI. The PHI is managed by 44 companies and, depending on the insurance policy, it provides benefits that are at least equal to those covered by the SHI. It should be noted that in most cases, both insured populations can request services from the same health professionals.

14. Other social code books relate, among others, to the statutory retirement insurance (SGB VI), to the statutory scheme for occupational accidents and diseases (SGB VII), to the rehabilitation and participation of disabled persons (SGB IX) and to long-term care insurance (SGB XI).
15. Data in this paragraph are for 2023 (OECD & EOHSP, 2023). It should be noted that the three biggest sickness funds (the *Techniker Krankenkasse*, the *Barmer GEK*, and the *Deutsche Angestellten Krankenkasse*, DAK) cover over one-third of the German population.

The health system is mainly funded through contributions to the SHI, shared almost equally between employers and employees. These contributions are collected by the sickness funds and transferred to a central reallocation pool, which reallocates the revenues according to a risk-adjustment mechanism. Premiums paid for the PHI do not depend on income, but on age and health risks. Given the division of competences mentioned above, different legislation applies to different services, with the result that public health, ambulatory, in-patient, and long-term care are separate in terms of organisation, financing, and reimbursement. For instance, ambulatory services are usually paid on a fee-for-service basis according to defined price schemes that are different for SHI and PHI patients. Investment in in-patient care is funded by the states, while operating costs are covered by the sickness funds, PHI companies, and user fees. These payment schemes are regulated, for ambulatory care, through negotiations held between the sickness funds and the health care providers' associations, and, for in-patient care, between the sickness funds and the hospital owners. This results in fragmented service provision and limited coordination and continuity of services.

In this pluralistic and fragmented system, various initiatives have been developed to build consensus and coordinate action and funding among stakeholders. The German health targets network is one of them.

3.1.2 The long pathway to improved coordination and integration

The German health targets network was formally launched in the year 2000 by the Federal Ministry of Health. The use of targets as a tool to govern the health sector is however much older in Germany. Target-oriented initiatives were in fact launched in the 1980s by both the federal and state governments, and their collaboration on these initiatives has evolved over time (Gerlich, Schwarz, & Walter, 2023).

In the mid-1980s, the federal government first took the initiative to develop national health targets. Mainly as a reaction to the *Health for All* strategy just adopted by the World Health Organization (WHO) Regional office for Europe (WHO/Europe, 1985), the Ministry of Health commissioned a report with the aim to identify health priorities and develop a comprehensive national policy based on a clear vision and values. The report was published in 1987 and updated three years later; however, no real policy emerged, partly due to political resistance. As Wismar, Philippi, and Klus (2008) recall, the initiative was mostly considered as a socialist instrument and gave rise to ideological confrontation among the major political parties of the time. Additional resistance also came from health care providers, and most notably physicians, who feared reduced freedom in the management and organisation of service provision.

Despite this failure, health targets remained on the agenda throughout the 1990s. The federal states started to adopt their own target-oriented programmes, albeit following different approaches and trends (Wismar et al., 2008). Sickness funds, professional associations, and scientific experts also initiated debates on health targets as potential instruments to better regulate competition among sickness funds and to support the integration of health care, two issues that had been emerging in the German health system at that time (Wismar & Busse, 2000).

This gradual mind shift prepared the ground for the second attempt by the Federal Ministry of Health to introduce national health targets. In 1997, with support from the ministry, the Association for Social Security Research and Policy (GVG e.V.) ([16]) initiated regular discussions between politicians, health care providers, payers, and scientists around the setting of health targets. This process was supported by the federal states two years later, when the Conference of health ministers urged the federal government to adopt a more target-oriented health policy (gesundheitsziele.de, 2013; Maschewsky-Schneider et al., 2009). In the same year, an international expert workshop was organised under the German presidency of the Council of the European Union to debate this topic (Wismar & Busse, 2000).

All this reflection resulted in the launch of the German health target network in the year 2000, as a pilot project funded by the Federal Ministry of Health and coordinated by the GVG e.V. The aim was to bring together all the relevant stakeholders in the German health system to discuss and submit proposals for national health targets to the federal government. In 2007, the project was further institutionalised and transformed into a permanent cooperation network no longer funded by the federal level but directly supported by federal states, health care providers and social security stakeholders (GVG, n.d.-b).

The network mainly relies on the rationale that common national targets are needed in a pluralistic and highly structured health care system such as that of Germany. Targets are expected to enable stakeholders to coordinate and integrate their actions within a common framework and, in turn, to improve their effectiveness and efficiency (gesundheitsziele.de, 2013). Several documents flag this rationale by describing the network as a more systematic and coordinated approach (Klärs & Krämer, 2010), as joint actions

16. *Gesellschaft für Versicherungswissenschaft und -gestaltung e.V*. This is a non-profit organisation which facilitates discussion and evidence-based positions on reforms related to social security, with the aim to support the policy process. Almost all relevant institutions in the field of social security are members of GVG.: statutory social insurance institutions; private health, long-term care, and life insurance companies; professional and occupational pension schemes; health care professional associations (only a few of them); trade unions and employers' associations; as well as researchers and representatives of other relevant institutions.

towards agreed targets (Bermejo et al., 2009; Kröger et al., 2010; Maschewsky-Schneider et al., 2009), and as a steering instrument to orient actions in a certain direction (GVG, n.d.-b; Maschewsky-Schneider et al., 2013). In this regard, different overarching goals are highlighted: to increase efficiency thanks to a more effective use of existing resources; to maintain and improve the health of the population as well as to increase the quality of care; and to strengthen the awareness of health targets among the population (GVG, n.d.-b; Maschewsky-Schneider et al., 2013; Maschewsky-Schneider et al., 2006). Finally, the network approach is inspired by the principles of *health in all policies.* By bringing together stakeholders from different sectors and perspectives, it aims to promote changes in the broad social determinants of health (GVG, n.d.-b; Maschewsky-Schneider et al., 2006).

3.1.3 Ten targets focused on diseases, health promotion, and health care

To date, ten national health targets have been developed by the German network. Each target focuses on a specific topic, which is either a particular disease or an issue related to health promotion or health care. Table 3-1 provides an overview of the topics covered.

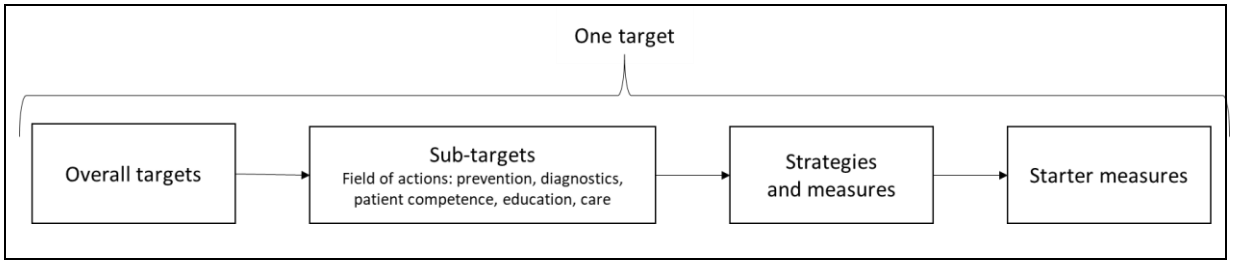
Tab. 3-1. Topics covered by the German health targets

#	Topic covered
1	Type 2 diabetes: Reduction of disease risk, early detection, and treatment
2	Breast cancer: Reduction of mortality, increase in quality of life
3	Reduction of tobacco consumption
4	Growing up healthy: health literacy, physical exercise, nutrition
5	Increase health literacy, strengthening patient sovereignty
6	Depressive disorders: prevention, early detection, provision of long-term treatment
7	Healthy ageing
8	Reduction of alcohol consumption
9	Health around birth
10	Patient safety

Source: adapted and translated from (GVG, n.d.-f).

Each national health target is broken down into a fixed structure illustrated in Figure 3-1. Overall targets (*Ziele*) and sub-targets (*Teilziele*) set the final and intermediate outcomes to be achieved; strategies and measures (*Strategies und Maßnahmen zur Zielerreichung*) define the actions and processes to achieve them, as well as the legal and institutional framework enabling their implementation. In some cases, starter measures (*Startermaßnahmen*) are also highlighted for priority implementation. This structure, and particularly the identification of starter measures, acknowledges the fact that the whole target can only be achieved progressively through parallel and intermediate steps (Klärs & Krämer, 2010).

Fig. 3-1. Structure of German national health targets.



Source: Adapted and translated from gesundheitsziele.de (2013).

The content of the health targets covers all fields affecting population health and health care: education and prevention, diagnostics and treatment, rehabilitation and care, and public health in general. Both public health and health care issues are addressed, in a proportion that depends on the topic. For instance, targets related to health promotion focus more on public health, contrary to targets addressing either a disease or a dimension of health care. This comprehensive approach did stir up some conflict, notably due to the potential overlap with other existing programmes and the difficulty in defining the respective scope. As an example, some stakeholders wanted the health care aspects of diabetes and breast cancer to be excluded from the national health targets, but this was finally opposed by the Federal Ministry of Health (Wismar et al., 2008). The strategies and measures include a mix of structural/legislative actions and of individual/behavioural actions addressing broad social determinants of health, and involve all stakeholders (Klärs & Krämer, 2010). In most cases, the targets are defined in qualitative terms as a description of the specific desired evolution, and no specific time horizon is fixed. To give a better understanding of this approach, table 3-2 presents one overall target and sub-target set in relation to patient safety.

Tab.3-2. Examples of qualitative targets set for patient safety

Overall target 1: Patient safety culture is actively promoted at all levels of the health care system		
Sub-target 1.2	Patient safety culture is embedded in the health care system as well as in the social system. The framework conditions for patient safety culture are continuously being improved.	
Fields of action	Examples of suitable measures	Responsibilities / Actors / Supporters / Institutions
Political, social, and legal framework	- Those responsible for health policy and care consider patient safety in their strategies and measures at national, regional, and international level (patient safety as part of *Health in All Policies*) - …	- Federal and state decision-makers - Self-governing bodies and professional associations - EU - WHO - …
Financing and incentive in the health care system	- The monitoring and financing of health care must be analysed for their impact on patient safety and be geared towards promoting patient safety - …	- Federal and state decision-makers - Institutions of self-government with budget responsibility
Work structures and conditions	- Health care workflows are geared towards patient well-being and patient safety - …	- Health professional associations - Management and executive bodies of all health care and nursing facilities - …
Cooperation and involvement of patients	- Potential risks in the health care process (handovers, sector boundaries, etc.) are analysed and managed by all those involved (doctors, nurses, health insurance companies, etc.) - …	- Federal, states, local policymakers - Federal association of patients - Health care and nursing care facilities - …
Research and development	- The implementation of measures to increase patient safety is based on scientific principles - …	- Federal, states, local policymakers - Scientific institutions - […]

Source: adapted and translated from gesundheitsziele.de (2022, pp. 36-37).

Quantitative indicators and baselines are sometimes suggested to monitor the achievement of specific sub-targets. This is however not systematic and concerns only some national targets, such as those addressing alcohol and tobacco consumption (BMG & gesundheitsziele.de, 2015; gesundheitsziele.de, 2015).

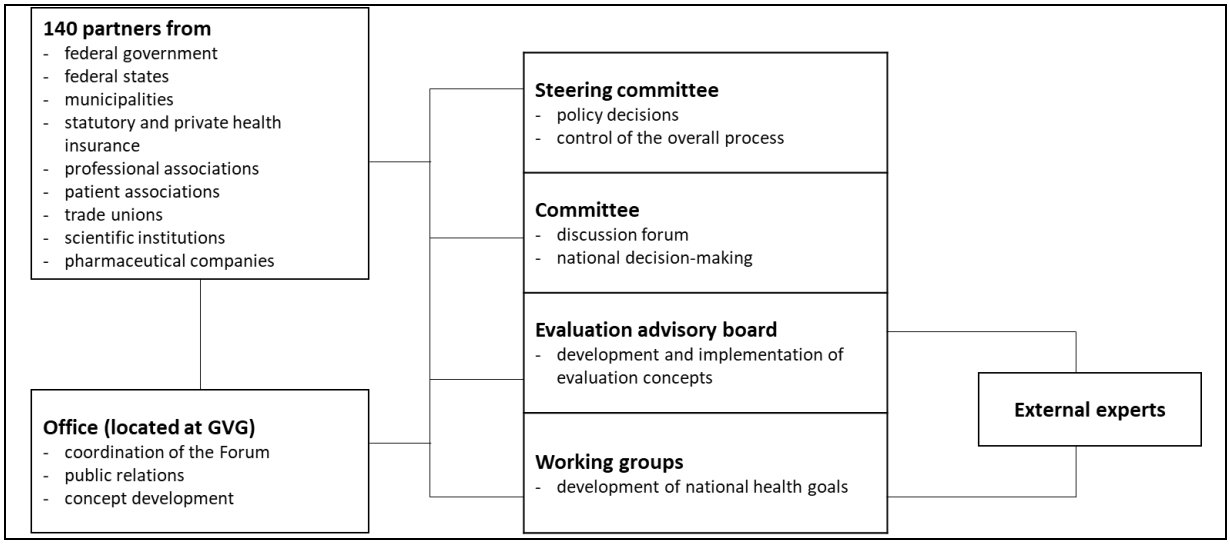
3.2 The target-setting process in the German health targets network

This second part explains how the German health targets network is governed and what mechanisms have been used for setting the agenda and formulating the targets, for their implementation, monitoring and evaluation, as well as dissemination.

3.2.1 Governance based on a broad membership structure

The German health targets network has a broad membership structure. Although the GVG e.V. coordinates the network and hosts it within its premises, it is only one of the stakeholders involved. Figure 3-2 summarises the network's overall governance.

Fig. 3-2. Structure of the German health targets network



Source: adapted and translated from gesundheitsziele.de (2013).

To date, more than 140 organisations from the German health care system, science and society are partner members. They notably include representatives from the federal government, federal states and municipalities, as well as from the statutory and private health insurance, professional associations, patient representatives and self-help organisations, trade unions, scientific institutions, and pharmaceutical companies (GVG, n.d.-a). Some of the partner members have the specific status of *supporting organisations*, as they provide financial support. A comparison of different documents collected shows that these organisations have changed over time, with some of them being constantly in and others providing support only for limited periods. For example, the Federal Ministry of Health and the Conference of the health ministers are mentioned as supporting organisations in 2013 (gesundheitsziele.de, 2013), but no longer appear in another document published more recently

(gesundheitsziele.de, 2022). According to the latter, the network is now supported by the ministries in charge of health and social affairs of twelve federal states ([17]) and by ten organisations including health insurance funds, pension insurance, and medical organisations.

Three separate committees are responsible for the coordination of the network. The *Steering committee* is made up of representatives of all supporting organisations. It oversees the selection of new health targets and makes recommendations for the strategic development of the network. The *Committee* (or Board) brings together representatives of all partner members. It supervises and gives advice on the content of specific health targets and their revision; it gives feedback on evaluation projects; and it officially accepts and adopts new and updated health targets. The *Evaluation advisory board*, which was first set up in 2004, develops strategies for the evaluation of both individual health targets and the overall process of the network, with the support of health scientists from institutions recognised for their experience in the topic addressed (Maschewsky-Schneider et al., 2006; Obyn et al., 2017).

The health target setting is organised in separate working groups. At the beginning of the process, researchers with broad expertise participate in the situation analysis and priority selection by evaluating the relevance of potential new health targets based on existing evidence (Brzoska et al., 2015). Later in the process, the working groups formulating the health targets include not only scientists but also all relevant stakeholders which are members of the network and concerned by the topic targeted. More details on the setting process are given in the following sections. It should be noted that participation in the working group is not mandatory or binding. The stakeholders work voluntarily without any legal basis but based on the principle of self-commitment (Maschewsky-Schneider et al., 2013).

3.2.2 A highly structured priority setting process

The national health targets are set through a systematic methodology. This was refined in 2004 by the Evaluation advisory board, with the aim to promote a multi-stage process enabling comparisons between health targets and enhancing transparency in the way topics are selected (gesundheitsziele.de, 2018). This process is summarised in Table 3-3.

17. Baden-Württemberg, Bayern, Brandenburg, Bremen, Hessen, Mecklenburg-Vorpommern, Niedersachsen, Nordrhein-Westfalen, Rheinland-Pfalz, Saarland, Sachsen-Anhalt, and Thüringen.

Tab. 3-3. Successive stages of situation analysis and selection of German health targets

Situation analysis and preselection of priority topics	A survey is conducted among the supporting and partner organisations which can name topics they consider of high relevance for health policy
	Based on the survey results, the Steering committee preselects a set of topics for which national health targets may be defined
Selection of health targets	Each of the topics preselected undergoes an evaluation process which is conducted by scientific experts
	The topics that obtain the highest scores are selected by the Steering committee to be developed as new national health targets

Source: authors.

The first stage consists of the situation analysis and preselection of priority topics. For this purpose, the Steering committee invites the supporting and partner organisations to participate in a survey where they can name up to three topics they consider as being of high relevance for health policy. Past topics that were not retained in previous rounds but are still considered as being important are also taken into account. Based on an internal assessment of the past and new issues which have emerged, a set of priority topics are preselected by the Steering committee for further exploration as potential new national health targets (Maschewsky-Schneider et al., 2009; Obyn et al., 2017). Experts with a broad expertise in the field are gathered into working groups and asked to evaluate each preselected topic, based on thirteen standardised criteria. These criteria, developed by the Evaluation advisory board (Maschewsky-Schneider et al., 2013), cover several dimensions to ensure a comprehensive evaluation of each topic: severity and prevalence of the disease, potential for improvement, economic relevance, ethical aspects, equal opportunities, importance as perceived by the population, measurability, feasibility, opportunities for participation, and legal considerations. These criteria are explained in Table 3-4. As reported by Brzoska et al. (2015), the criteria are assessed based on extensive review of peer-reviewed and grey literature collected with a geographic focus on Germany, in relation to a period of about 10 years, and using both medical and social sciences databases. Ethical aspects are evaluated based on position papers and declarations by international stakeholders, such as the World Health Organization or the United Nations. The final report drafted by the experts shows the current situation, the health risks, the health advantages, and it points out potential weaknesses in the setting process, such as those related to the lack of comparable and specific data on some issues. The report is reviewed by an external expert before being submitted to the Steering committee.

Tab. 3-4. Criteria used for the evaluation of potential new health targets

Criterion	Definition	Examples of possible indicators
1. Severity in terms of mortality	The health problem causes high mortality	- mortality per 100,000 inhabitants - avoidable mortality - attributable risk
2. Severity in terms of morbidity	The health problem causes a high burden of disease (both at population and individual level)	- morbidity - disability-adjusted life years (DALYs) - days of incapacity at work - rehabilitation cases - premature retirement cases
3. Prevalence	The health problems and their risk factors are highly prevalent in the population	- prevalence - health-protective behaviour - health-risk behaviour
4. Potential for improvement	The health problem can be adequately addressed and improved	- international benchmarking - low compliance despite effective instruments - possibility of intervention - care organisation and quality - existing structures, strategies and measures
5. Economic relevance	The health problem is associated with considerable direct and indirect costs, which can be addressed through appropriate measures	- direct medical expenses (re. in- and out-patient care, dental care, prevention and rehabilitation) - expenditure on pharmaceuticals - indirect medical expenses - income benefits
6. Ethical aspects	The health target is of high ethical relevance and not associated with ethical concerns	- use of already tried and tested instruments - needs assessment
7. Equity	The health target contributes towards mitigating social and health disparities	- gender - socio-economic status - age group - type of school (for children) - migration background
8. Importance as perceived by the population	The health problem is perceived by the population and by politicians to be of high priority	- findings from population surveys
9. Measurability	The achievement of the health target is measurable	- indicators for a primary or secondary analysis are available - indicators can be formulated
10. Feasibility in terms of measures and instruments	Measures and instruments necessary for the implementation of the health target are available	- evidence-based instruments are available - preliminary work on the topic exists

Criterion	Definition	Examples of possible indicators
11. Feasibility in terms of stakeholders	Stakeholders are willing to actively commit to the achievement of the health goal	- willingness to participate (personally or financially) in the development of a health goal - willingness to participate (personally or financially) in the implementation of a health goal
12. Opportunities for the population to participate	The population and those affected by the health problem are able to commit towards the achievement of the health goal	- number of self-help groups and organisations - promotion of self-help - civic engagement - voluntary work - self-management - health literacy
13. Legal framework	The legal basis for measures necessary to implement the health target is available	- legislation at state and federal level already (partially) regulating the issue - who is responsible and to what extent

Source: adapted from Brzoska et al. (2015); gesundheitsziele.de (2018); Maschewsky-Schneider et al. (2013).

Once the assessment reports are delivered by the different working groups, the selection of priority topics to be further developed as national health targets begins. Besides the evidence brought by the experts, the opinion of the network members is considered, notably with respect to the criterion of feasibility (in terms of both instruments and stakeholders). In this respect, a written survey is conducted among the partner members to assess whether they have already worked on the topic, whether procedures and instruments for achieving the target are already available and known, and whether the members are ready and willing to participate in the development and implementation of the health target. The survey proposes closed yes/no questions to the participants; the topics with the highest score are selected in the end. This process is well illustrated by the selection of topics for 2013 described by Maschewsky-Schneider et al. (2013). On that occasion, five issues were preselected and assessed separately by experts: reduction of alcohol consumption, health at the workplace, health around birth, health and migration, and patient safety. These topics were compared based on the criteria mentioned in Table 3-4 and particular attention was given to feasibility and measurability. These two criteria were considered as being poor for health around birth and for health and migration, which were thus not retained. Conversely, the reduction of alcohol consumption and patient safety were positively assessed and therefore retained. For alcohol reduction, the urgent need for action was also decisive. For patient safety, Germany's low ranking at international level and the consequent high potential for improvement was also considered. The fifth topic of health at the workplace was not included, to avoid overlap with other strategies.

At the end of this stage, the Steering committee addresses recommendations on which topics are of highest priority and how they should be pursued as national health targets. Advice is notably given on how to formulate the health targets, e.g. by suggesting definitions and concepts to be used or stakeholders to be involved. Recommendations may also concern topics that have not been selected. In fact, their exclusion does not necessarily mean they are completely dropped. Rather, they can be either integrated into other targets or addressed in a latter phase. Continuing with the above example of the 2013 setting process, the Steering committee recommended to streamline the topic of migration and health as a cross-cutting issue in all targets to be updated and newly developed (Maschewsky-Schneider et al., 2013); the topic of health around birth was again placed on the table and retained a few years later, and a national health target on this topic was finally published in 2017 (gesundheitsziele.de, 2017a, 2017b, 2017c, 2017d).

3.2.3 A formulation process in silos

The formulation stage is carried out progressively and for each target separately as the topics are selected. A different path is followed for each target depending on the topic addressed and the stakeholders involved. As Table 3-5 summarises, while the first five targets were all launched in 2003, the other targets were successively released at different intervals. Likewise, updates were also published at different moments. The separate working groups include representatives of all institutions and organisations, as well as external experts concerned by the topic. The total number may vary depending on the topic. For example, up to 140 organisations participated in the working group on patient safety, including representatives from the health care sector, policy level, science, and civil society (GVG, n.d.-e).

Tab. 3-5. Key dates related to the setting of the German health targets

#	Topic covered	First released	Update
1	Type 2 diabetes: Reduction of disease risk, early detection, and treatment	2003	--
2	Breast cancer: Reduction of mortality, increase in quality of life	2003	2011, 2014
3	Reduction of tobacco consumption	2003	2015
4	Growing up healthy: health literacy, physical exercise, nutrition	2003	2010
5	Increase health literacy, strengthening patient sovereignty	2003	2011
6	Depressive disorders: prevention, early detection, provision of long-term treatment	2006	--
7	Healthy ageing	2012	--

#	Topic covered	First released	Update
8	Reduction of alcohol consumption	2015	--
9	Health around birth	2017	2020
10	Patient safety	2022	--

Source: adapted and translated from GVG (n.d.-f).

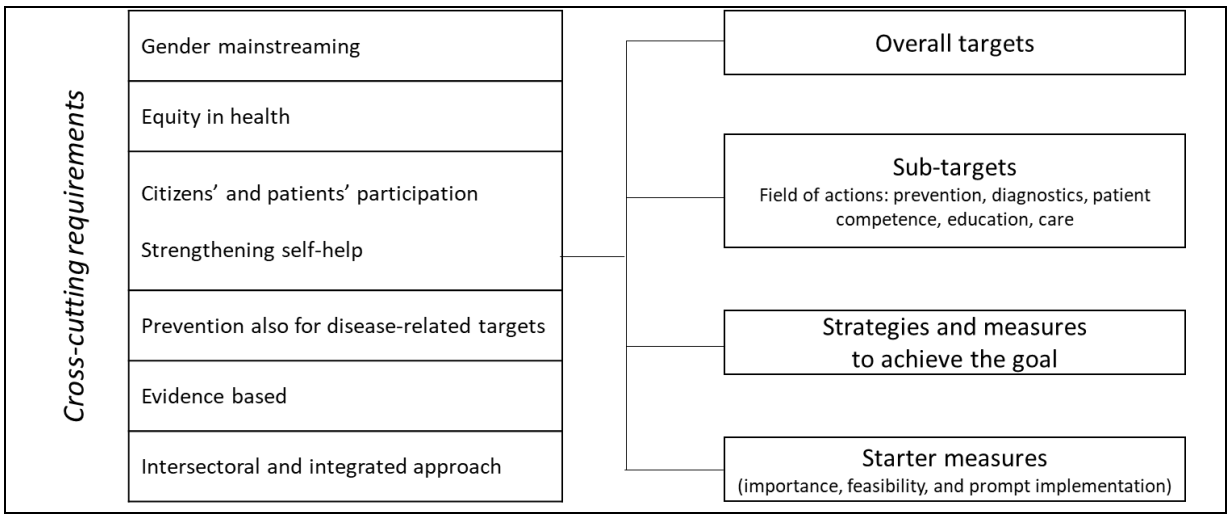
Each national target is formulated following a fixed process that goes through successive stages, and results in the fixed structure described in section 3.1.3. In the first step, the working group analyses the initial situation, identifies fields of action, and draws up an inventory of previous activities and approaches. Overall targets are thus selected; their number may vary, ranging from 2 for patient safety to 13 for healthy ageing. Each overall target is broken down into concrete sub-targets, the number of which is usually small and varies from 1 to 7 ([18]). The sub-targets relate to specific fields of action, specific target-groups and/or specific settings. Strategies and measures are then recommended for implementation, notably based on scientific evidence. When possible, starter measures are flagged for priority implementation among those meeting the following three criteria: importance, feasibility, and prompt implementation. As a last step, stakeholders responsible for implementation and, when possible, relevant indicators are indicated. If appropriate, policy recommendations are also addressed to the federal government (gesundheitsziele.de, 2013, 2022; Kröger et al., 2010).

The formulation of all targets follows specific requirements. First, all targets must meet cross-cutting requirements, which can be used to fix priorities and make choices. As illustrated in Figure 3-3, these are gender mainstreaming, equity in health, participation of patients and citizens, attention to prevention, evidence base, intersectoral and integrated approach. For 'equity', specific key questions were developed in 2014 by the Evaluation advisory board to ensure that the topic is effectively assessed and considered by the working groups during the formulation process. Some of the cross-cutting topics reflect requirements that are fixed by existing federal legislation, notably by the Social Code Book V ([19]) (SGB V), which states for example that primary prevention and health promotion services should contribute to reducing health inequalities related to gender or socioeconomic status (gesundheitsziele.de, 2018). The second requirement for formulating the targets is to follow a SMART approach, i.e. they should be Specific/Simple, Measurable, Achievable, Realistic, and Timely. Particular attention is given to measurability, and the quantification of the sub-targets

18. Exceptions are 11 sub-targets for healthy ageing and 16 sub-targets for the reduction of tobacco consumption.
19. For more details on SGB V, see chap. 3.1.1.

by means of defined indicators is highly recommended. In this attempt, quantitative targets developed by federal states can be used as a basis for the formulation of national targets (gesundheitsziele.de, 2018).

Fig. 3-3. Cross-cutting requirements for the German health targets



Source: Adapted and translated from gesundheitsziele.de (2013)

To conclude on formulation, the above description shows that, although the choice and definition of targets is based on evidence and standardised reflection, consensus and pragmatic approaches play a key role (Maschewsky-Schneider et al., 2009). The national health targets that are finally adopted are the result of negotiations and agreed conclusions which may take time to be reached, depending on several factors, including how controversial the topic is and how divergent the stakeholders' interests are. We can thus see that while the target on reducing alcohol consumption was published two years after the topic was selected by the Steering committee (gesundheitsziele.de, 2015), it took four years before the target on healthy aging was published (BMG & gesundheitsziele.de, 2012b) and almost ten years for that on patient safety, which was released only in September 2022 (gesundheitsziele.de, 2022).

3.2.4 Voluntary implementation only recently (partially) linked to legislation

The German health targets are not binding, but are voluntary agreements among the stakeholders. They are mainly understood as preparatory work and recommendations to be taken up by the stakeholders for further development and implementation. The extent to which the strategies and measures recommended are actually implemented is the sole responsibility of the stakeholders who self-commit to take action in their respective areas of

competence (Klärs & Krämer, 2010). Just like the selection and formulation processes, implementation is mainly bottom-up. In the case of health around birth, for example, most activities were implemented ad hoc at federal state level (gesundheitsziele.de, 2019).

Despite their voluntary nature, great attention is paid to their potential implementation from the very beginning of the setting process. This is notably shown by the focus on feasibility and measurability during the selection stage. The legal framework is also particularly considered both when selecting and formulating the targets. As mentioned in section 3.2.3, a clear link is made between formulation criteria such as gender mainstreaming and equity, and the requirements laid down in the Social Code Book V (SGB V) ([20]). The latter is actually defined as a key reference for the development of national health targets (gesundheitsziele.de, 2018).

An important exception concerns the field of prevention and health promotion. In 2015, more than ten years after the publication of the first national health targets, all existing targets were anchored to the *Preventive health care act* and thus integrated into the SGB V. This integration made the targets partly binding for the sickness funds, which must take them into account for the financing of activities related to prevention and health promotion (Obyn et al., 2017). The subsequent target on health around birth was added after its release two years later (Table 3-6).

Tab. 3-6. German health targets integrated into the Social Code Book

#	Topics	Adopted	Integrated to SGB V
1	Type 2 diabetes	2003	2015
2	Breast cancer	2003	2015
3	Reduction of tobacco consumption	2003	2015
4	Growing up healthy	2003	2015
5	Increase health literacy	2003	2015
6	Depressive disorders	2006	2015
7	Healthy ageing	2012	2015
8	Reduction of alcohol consumption	2015	2015
9	Health around birth	2017	2017
10	Patient safety	2022	--

Source: authors.

20. For more details on SGB V, see chap. 3.1.1.

An official link was made with state laws as well. Also in 2015, the participative platform 'National Prevention Conference' was launched by the *Act to Strengthen Health Promotion and Disease Prevention*. This multi-stakeholder platform is headed by the federal associations of statutory and private insurance schemes and includes stakeholders from the federal, state, and municipal governments, as well as patient representatives and other organisations. Its mission is to develop national guidelines on prevention to be further translated into state law and reviewed every four years. These guidelines should also contain the national health targets.

To conclude on implementation, the voluntary nature of the target implies that no specific funding is sustainably secured (Ernst, Wismar, Busse, & McKee, 2008). Since the federal government disengaged in 2007, the main financial resources of the network come from the supporting members. Their allocations are mainly earmarked for the internal functioning of the network, the target-setting process, and communication strategies. However, recent policy developments and notably the link made with SGB V have had a clear impact on the way the targets are considered in the activities financed by the social health insurance, although limited to the field of prevention and health promotion.

3.2.5 Strong concern for monitoring and evaluation but little accountability

All documents published by the German health targets network highlight a strong concern for monitoring and evaluation. The setting process is described as a 'public health action cycle', i.e. a learning system that is continuously evolving and where targets are updated based on new evidence and evaluation findings (gesundheitsziele.de, 2013, 2018). To ensure coherence and evaluability, all criteria, key questions, and indicators used during the selection and formulation stages are expected to feed into and be used for target evaluation. This is why, although not an active member of the working groups, the Evaluation advisory board provides feedback on the formulation work and obligatory target advice. In this respect, regular meetings are held between the board and two to three members nominated by the working groups. As a result, all reports presenting the national health targets include a last section dedicated to monitoring and evaluation. This provides a preliminary overview of types of indicators and data sources that could be used to map progress made towards the achievement of the target.

Specific evaluation strategies were developed for four national health targets (see Table 3-7). They were commissioned by the Evaluation advisory boards and developed by groups of scientific experts with the aim to link the overall targets, sub-targets, and measures to at least one (possibly several) indicator(s), with a focus on the starter measures. The

strategies provide guidelines on how to evaluate the impact of the measures and the progress made towards the target areas: suitable indicators are defined; routine data sources with nationwide validity are indicated, together with, if relevant, data sources from regional and national pilot projects; the availability, accessibility and usability of quality-assured data are checked; supplementary data are suggested in case of existing data gaps (Bermejo et al., 2009; Maschewsky-Schneider et al., 2006). The underlying assumption is that the network will not be able to collect data on its own, but routine data collected by other stakeholders (e.g. the federal statistical office, the Federal joint committee, social insurance funds, etc.) may help assess progress achieved on specific areas (gesundheitsziele.de, 2018). As Table 3-7 shows, however, only in some cases were the evaluations carried out ([21]). And when this was the case, their findings were mostly used to provide examples and support the implementation of best practices (Bermejo et al., 2009).

Tab. 3-7. Evaluation status of the German health targets

#	Topics	Evaluation strategy developed	Evaluation carried out
1	Type 2 diabetes	-	-
2	Breast cancer	-	-
3	Reduction of tobacco consumption	x	x
4	Growing up healthy	x	x (for a sub-target)
5	Increase health literacy	x	-
6	Depressive disorders	x	x
7	Healthy ageing	-	(planned 2018)
8	Reduction of alcohol consumption	-	-
9	Health around birth	-	-
10	Patient safety	-	-

Source: by the authors based on gesundheitsziele.de (2018) and (GVG, n.d.-c).

The evaluation of the network and the overall setting process were also promoted. A self-evaluation tool was launched in 2007 with the aim to assess on a yearly basis the extent to which recommendations and measures to achieve the national health targets are implemented. The tool consists in a standardised quantitative questionnaire sent electronically

21. For target 7 on healthy ageing, the data collected refer to the planning of the evaluation for the year 2018, but we could not find any evaluation report on this topic.

to the Committee's members. These are asked to involve in their response the responsible departments and/or the member organisations engaged at state, region, or municipality level. Without claiming to be complete, this self-evaluation provides an overview of which overall targets and sub-targets are taken up by the partner members and which measures are most implemented (Klärs & Krämer, 2010). In November 2012, an ad hoc overall evaluation was also launched by the Evaluation advisory board. After a kick-off workshop laying out the basis for the evaluation concept, interviews were carried out among the partner members during the year 2013 to understand what benefits they derived from participating in the network, what relevance the health targets had for them, how they implemented them and how this could possibly be improved. The findings were presented in a follow-up workshop in February 2014 and were used to start work on ways to improve transparency, strengthen public relations, consolidate the setting process, and better integrate cross-cutting requirements (gesundheitsziele.de, 2018). All in all, the strong concern for monitoring and evaluation all along the setting process seems to be more oriented towards feeding the internal reflection of the network than to holding stakeholders accountable for their commitment.

3.2.6 A variety of media support communication and transparency

Communication strategies and transparency receive particular attention. They aim not only to improve the external visibility of the target-setting process but also to support the internal reflection on the network development (gesundheitsziele.de, 2018). As summarised in Table 3-8, a variety of media are used to publicise the national health targets. For each national health target, separate reports are published, providing an overview of the topic and detailing all overall targets and sub-targets. Complementary reports are also published with updating information, proposals for monitoring and evaluation, or with findings on specific projects carried out on the topic, as was the case for the target on type 2 diabetes. The reports are sometimes accompanied by summarising sheets or flyers. The launch of a new health target is sometimes announced by a press release. These documents are all published on the network's website (GVG, n.d.-c), and are sometimes made available in hard copy as well. The two last targets were presented at dialogue events involving representatives from different stakeholders. The event organised for patient safety took place on the WHO international day for patient safety and also included interventions from WHO representatives (GVG, n.d.-d).

Tab. 3-8 Types of communication media used to present the German health targets

#	Topics	WG reports	Flyers / Sheets	Press release	Dialogue event
1	Type 2 diabetes	x	x	-	-
2	Breast cancer	x	x	-	-
3	Reduction of tobacco consumption	x	x	-	-
4	Growing up healthy	x	-	-	-
5	Increase health literacy	x	x	-	-
6	Depressive disorders	x	-	-	-
7	Healthy ageing	x	x	x	
8	Reduction of alcohol consumption	x	-	-	-
9	Health around birth	x		x	x
10	Patient safety	x	x	x	x

Source: by the authors based on (GVG, n.d.-c).

While all documents and events are published and organised by GVG e.V., other federal or state-level stakeholders are sometimes associated. For instance, the Federal Ministry of Health co-signed the press release launching the target on healthy ageing (BMG & gesundheitsziele.de, 2012a), and published the reports dedicated to growing up healthy (BMG & gesundheitsziele.de, 2010), healthy aging (BMG & gesundheitsziele.de, 2012b), and the reduction of tobacco consumption (BMG & gesundheitsziele.de, 2015). For the most recent target on patient safety, the press release was instead co-signed by the Ministry of Labour, Social Affairs, Health and Equal Opportunities of the State of Saxony-Anhalt and by the Office of the Patients' Representative of the Federal Government (gesundheitsziele.de, patientenbeauftragter, & Sachsen-Anhalt, 2022).

Finally, it should be noted that the stakeholders involved also contribute to the dissemination efforts, thus reflecting the bottom-up approach of the whole setting process. Thus for example, much dissemination work for the target on health around birth was done by scientific journals and professional associations (gesundheitsziele.de, 2019).

3.3 Conclusion: a bottom-up approach focused on consensus building

The German experience with setting national health targets shows how an initiative initially promoted by the federal government has been progressively taken over by federal states and representatives of both the sickness funds and the

health care providers. This was possible due to a broad consensus about the need for common targets to reduce fragmentation and improve the effectiveness and efficiency of the German health system. At the same time, this move resulted in a bottom-up process that combines in itself all the strengths and weaknesses of this kind of approach. There are summarised in Table 3-9 in relation to the overall governance of the German health targets and the different stages of the setting process.

Tab. 3-9. Main strengths and weaknesses of the German health targets

	Strengths	Weaknesses
Overall governance	- Large number and variety of stakeholders - Strong support from the public health community - Geared towards consensus - Effective coordination mechanisms	- No parliamentary debate - Stakeholders outside the health sector on ad hoc basis - Inconsistent federal support - Lack of an overarching federal vision - Possible divergent views and interests - Lengthy process to achieve consensus
Agenda setting (situation analysis and selection)	- Standardised selection driven by criteria - Broad consultation methods - Experts from a wide range of disciplines	- Criteria less suitable for more thematic and population-related topics
Formulation	- Standardised procedure	- Possible drawback of target quantification
Implementation	- Attention given to feasibility of targets - Comprehensive approach for each target - Linkage to federal legislation - Linkage with state initiatives	- Largely relies on voluntary implementation - Binding only to a limited extent - No specific funding
Monitoring and evaluation	- Attention paid to measurability of targets - Link with existing information systems	- No clear accountability framework - Bias related to self-evaluation - Difficulty in evaluating target impact
Communication strategy	- Broad dissemination strategies - Attention paid to transparency	--

Source: authors.

In terms of governance, the German health target network provides a forum where a large number and variety of stakeholders can debate and build consensus. Its

success relies on several factors. The membership structure, coordinated by an association, GVG e.V., with the support of joint committees, helps to give legitimacy to the debate and reduce political polarisation, as it is primarily presented as an exchange and advice platform (GVG, n.d.-a). The strong support from the public health community and the considerable efforts made to coordinate all stakeholders were also key (Wismar et al., 2008). In this respect, the German case clearly shows how achieving consensus is a lengthy process and requires management of divergent, and even conflicting, views and interests. Despite this wide-ranging participation, the German process mainly involves stakeholders from the health and health care sector. Although the *health in all policies* approach is referred to as a key principle and the targets are guided by a comprehensive approach, the involvement of stakeholders from beyond the health sector remains limited or ad hoc. The federal Parliament is another stakeholder that is particularly absent from the target-setting process and has no oversight of it. The support provided by the federal government has been inconsistent over time, depending on the topics addressed and the interests of the ministers in place (Wismar et al., 2008). All in all, the initiative suffers from a lack of clear political leadership: targets remain separate from each other and are not part of an overarching federal strategy (Blümel et al., 2020). Moreover, these stakeholders might agree on the least common denominator, given their conflicting policy interests, diminishing the original ambition of the health target.

For the agenda setting, the situation analysis and target selection is conducted through a broad consultation process and involves experts from a wide range of disciplines. This approach enables the network to address different topics progressively as needs emerge. The standardised selection process also helps to justify the priorities chosen, as they are based on clear criteria, evidence and comparisons among different topics. Despite the dominance of this technocratic approach, great weight is still attached to political considerations, notably feasibility and stakeholders' willingness to engage. Moreover, the expert opinions are not neutral either, and reflect the views and expertise in the working groups at that time. Similarly, Brzoska et al. (2015) point out that criteria used to assess the relevance of targets are mainly problem- or disease-oriented, and thus less suited to assessing broader topics that are theme- or population-oriented. The relevance of combining epidemiological evidence with qualitative information on broader societal determinants of health is underscored.

The same remarks are true for the formulation stage, which is highly standardised and evidence based. While the relevance of setting quantitative and measurable targets is stressed, possible drawbacks of target quantification are also pointed out. These include the risks of tying up resources that could be used elsewhere and of demotivating stakeholders if they fail to achieve the targets for which strong obligations were set (gesundheitsziele.de,

2018). In fact, most targets are formulated in qualitative terms and describe the desired outcomes or process to be achieved and implemented, without clear time boundaries or specific results. This reflects the consensus orientation of the whole setting process and the wish to ensure broad acceptability and flexibility for the stakeholders.

Acceptability and flexibility are key for the implementation of the German health targets which mainly rely on stakeholders' self-commitment. Specific actions and strategies are linked with each sub-target and attention is paid to their feasibility and to the development of a comprehensive approach (Maschewsky-Schneider et al., 2009). Nevertheless, no financial resources seem to be specifically earmarked for implementation. Certainly, linking the health targets to the federal legislation, as well as to state initiatives, was an important milestone for the target implementation. The inclusion in Social Code Book V notably had an impact on the way the sickness funds finance prevention and health promotion activities. This move towards a binding initiative is however only partial, with its scope limited to this field only. Moreover, in line with the complex governance of the German health system (see 3.1.1), decisions about how to implement the guiding principles of the SGB V remain in the hands of the sickness funds and health care providers represented on the Federal joint committee.

Accordingly, the lack of a clear accountability framework or the evaluation of only a few targets is no surprise. Despite the considerable attention paid to monitoring and evaluation on paper, scarce resources are available to carry out evaluations. This is why the network interestingly tried to make the link with data and sources already existing within the German health information system and already used by the network's members. In so doing, however, discrepancies between existing routine data and data needed to evaluate the national health targets were highlighted, due to the lack of suitable data or to the insufficient representativity of data available from regional and local level (Bermejo et al., 2009; Maschewsky-Schneider et al., 2006). Self-evaluation and internal monitoring have been used to assess the overall process, but this involved methodological bias and the findings inevitably reflected only partial results related to those members of the network who agreed to participate. Overall, experts acknowledge how difficult it is to evaluate the specific impact of targets, as a variety of additional factors may influence the results (Maschewsky-Schneider et al., 2006). Moreover, the non-achievement of specific targets does not automatically mean that the underlying measures were unsuccessful (gesundheitsziele.de, 2018). This shows how important it is to properly identify what is monitored and what underlying goals are pursued through the process of target setting and implementation.

Finally, regarding communication, broad dissemination strategies have been developed by the network. The individual stakeholders involved also play a key role in this regard, notably the scientific community, which provides technical and methodological support. The communication efforts are intended to improve transparency, both externally towards the general public and internally towards the members of the network. This is in turn expected to improve visibility and inspire commitment.

3.4 References

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Chapter 4. The Swedish experience in setting health targets

This chapter focuses on the case of Sweden, a country that has been experimenting with health targets for almost 30 years. It specifically explores the national public health policy 'Good and equitable health at all levels', which outlined the overarching goal and overall structure of the national public health work. The first part presents the overall context in which the policy was developed, including a review of previous initiatives, while the second part describes in depth various aspects of the health target setting process. The conclusion provides an assessment and flags some of the main lessons that can be learned from the Swedish experience.

4.1 Introduction to the Swedish health targets

This first part situates the Swedish public health policy in its overall context by presenting key aspects of the governance and financing of the Swedish health system, retracing the history and rationale behind the health targets, and finally describing the content of the policy.

4.1.1 A decentralised and fragmented national health system

Health care in Sweden is universal, tax funded, and mostly provided by public providers ([22]). Regional and local authorities play a key role in the purchase and provision of care and enjoy a great deal of political and financial autonomy. The governance of the Swedish health system is characterised by a strong tradition of elected local self-governments responsible for operating publicly financed hospitals. During the 1970s and 1980s, Sweden largely also completed the decentralisation of primary care services. As a result, the 21 regions are currently responsible for most of the funding and provision of health care services to their populations. The regional and local authorities are represented at national level by the Swedish Association of Local Authorities and Regions (SALAR – *Sveriges Kommuner och Regioner* in Swedish). From the 1990s onwards, the Swedish health system has been reorganised by New Public Management reforms such as purchaser-provider separation, intra-public sector competition, partial primary care privatisation and performance measurement – with some regional variations given the decentralised nature of the system. Both the national and local authorities have developed a keen interest in knowledge and performance-based forms of governance of health care services.

The government, through the Ministry of Health and Social Affairs, works to meet the objectives set by the Parliament (*Riksdag*) in the areas of health care, health and social insurance. It is responsible for overall health policy, through regulation, guidelines, and multilevel agreements. Government agencies are directly involved in health care and public health and play an essential role in the day-to-day management and monitoring of the system. The National Board of

22. Information contained in this section is based on Ågren (2003); Janlöv et al. (2023); OECD and EOHPS (2023).

Health and Welfare (NBHW – *Socialstyrelsen*) develops norms and standards, supervises health professionals, provides support, maintains health data registers and official statistics, provides analysis, and disseminates information. The Public Health Agency of Sweden (PHAS – *Folkhälsomyndigheten*, formerly the National Institute for Public Health – *Folkhälsoinstitutet*) has the task of promoting health and preventing diseases by providing the government, national agencies, municipalities, and regions with knowledge based on scientific evidence.

In terms of financing, health expenditure amounted to 11.2% of the Swedish gross domestic product in 2021. About 86% of the total is public expenditure. Most of the remaining health spending is paid directly by households, while voluntary health insurance only accounted for about 1%. Health care spending is largely financed by local taxation. Regions and municipalities levy proportional income taxes to cover the services that they provide. A smaller portion of local health budgets comes from direct national transfers, subsidies to the regions for outpatient medicine and specific national programmes. The central government has thereby indirectly increased its influence on local policies through targeted grants (e.g. local authorities adhering to specific national targets, for instance on waiting times, receive additional funding) – leading to a process of 'soft' recentralisation of health policymaking.

With an average of 83.1 years life expectancy at birth in 2022, among the highest in the EU, Sweden has a comparatively good health status with less pronounced gender and socio-economic inequalities than the EU average. Sweden has a long tradition of public health work and data collection on population health. The government has taken an active role through legislation and regulations, supervision and financial incentives. Sweden does not have a single public health law. Instead, public health provisions are integrated into other laws and regulations. At the national level, the Public Health Agency of Sweden has the main responsibility for public health, but given its inter-sectoral nature, about 40 state agencies are relevant to public health in some capacity. Regional and local authorities are also directly or indirectly involved in public health work. Regions are mainly responsible for primary care, municipalities are responsible for social services and school health services, as well as food control, water and sanitation. The regional administrative boards (*länsstyrelserna*) are also relevant as the government's representatives in the regions. Various non-government organizations also contribute to public health work.

4.1.2 An incremental reform inspired by international policy developments

The national public health policy 'Good and equitable health at all levels' was presented by the government in 2018, but the development of health targets and indicators in Sweden has been an incremental and iterative decision-making process since the mid-1990s. The policy, which drew inspiration from both international and local initiatives, went through three main political phases – each linked to a formal vote in the Parliament. This background is

necessary to fully grasp the ambition, scope, and limitations of the current policy, which is grounded in incremental changes and policy learning.

- International and national context behind the policy

The Swedish national public health policy has been largely inspired by international and European initiatives. The WHO *Health For All* strategy heavily influenced the work of the 1997-1998 Public Health Commission (Nationella Folkhälsokommittén, 1998). The 2015-2017 Commission for Equity in Health later took extensive inspiration from the WHO Commission on Social Determinants of Health, led by Sir Michael Marmot, and the UN Agenda 2030 for sustainable development (Regerinskansliet, 2018). The policy has also been influenced by various developments at European level, and in particular the Council conclusions on *Health in All Policies* during the Finnish Presidency in 2006 (Lundberg, 2018a). Over the years, Swedish experts and policymakers have also followed closely the examples set by other Nordic countries as well as England and the United States ([23]).

Several local strategies based on health targets, also influenced by international initiatives, emerged before the government started working on a national framework. Since Östergötland County Council drafted its first programme in 1987 (Rydin Hansson, 2000), many regions and municipalities have followed suit ([24]). In turn, the proliferation of local and regional strategies across Sweden has created a favourable environment for the emergence of a national framework.

- Phase 1: 'Objectives for Public Health' (1985-2005)

National public health targets were first introduced in 2003, following an eight year-long drafting and consultation process summarised in Table 4-1. But the origins of the policy are older. The conceptual groundwork for the national public health policy was laid by a 1984 reform introducing a new inter-sectoral approach to public health work (Regerinskansliet, 1985). A 1991 bill further emphasised the need for local participation, coordination and long-term development in public health (Regerinskansliet, 1990). This process led to the creation of the Public Health Institute in 1992, which would later become the Public Health Agency of Sweden. In its early years, however, the agency remained focused on the development of individual health programmes and was not yet involved in the coordination of a national public health policy. In 1995, the government appointed a

23. See for example Kommissionen för jämlik hälsa (2016, pp. 95-96); Nationella Folkhälsokommittén (1998, p. 121).
24. Other examples include: Västra Götaland Region, Gothenburg, Stockholm, Malmö, and the Commission for equity in health in the Örebro Region (Lundberg, 2018b).

National Public Health Commission (*Nationella folkhälsokommittén*) made up of members of the Parliament, civil servants, researchers, and national experts (Regerinskansliet, 1995). The primary task of the Commission was to identify the most pressing public health issues and propose national targets for the first time. The Commission was also specifically tasked to set up a mechanism by which public health interventions would be measured, monitored, and evaluated. As stated in the Commission directive: 'Producing targets is important, but at least as important is the process that leads there and that continues after the target has been produced. The targets should serve as support and inspiration at national, regional, and local level. Targets should be one of the starting points in pro-active and multisectoral public health work at all levels' (Regerinskansliet, 1995, p. 1). The Commission began its work in April 1997 and submitted a first report to the Ministry of Social Affairs in March 1998 (Nationella Folkhälsokommittén, 1998). The purpose of this report was to set out some key principles which would guide the formulation of national targets. The Commission consulted more than 500 actors (national agencies, local actors and non-governmental organisations). It also published seven debate papers on specific topics, as well as 14 supporting thematic reports on its work. Two subsequent reports were published. The second suggested a preliminary framework for national targets and strategies (Nationella Folkhälsokommittén, 1999). The third report summarized the Commission's recommendations (Nationella Folkhälsokommittén, 2000). This extensive work led to the identification of an overarching goal, to achieve 'good health on equal terms', together with 18 health policy targets and 50 sub-targets. The Commission also identified the relevant actors and proposed indicators for monitoring the various sub-targets.

A bill proposal inspired by this preparatory work was published by the government in 2002 and adopted by Parliament in April 2003, based on an agreement between the Social Democratic government and its Left and Green Party partners (Regerinskansliet, 2002). The government, however, did not entirely follow the Commission on several key proposals. Some changes were mostly formal: the overarching goal of the policy was reformulated to 'creating societal conditions for good health on equal terms for the entire population' and the 18 health policy targets were reduced to 11 to avoid overlapping priorities. More substantively, however, the government replaced the term 'target' by the more neutral concept of 'target area'. Only two target areas were given specific sub-targets and only a few of those sub-targets included a timeframe ([25]). The bill did not mention the indicators developed by the Commission and deferred to the follow-up process for their determination. The government also refused to follow the Commission's controversial suggestion to pass a law making local authorities responsible for drafting their own strategy to implement the national targets (Kommissionen för jämlik hälsa, 2016). According to Lager, Guldbrandsson, and Fossum (2007), a likely explanation of this cautious approach was the lack of consensus identified during the consultation process: 'opinions about the targets being too

25. We only found the following specific sub-target: 'Compared to 2002, the absence from work because of sick leave should be halved by 2008' (Regerinskansliet, 2002, pp. 59-60).

vague and, at the same time, opinions about the targets being too governing' (Lager et al., 2007, p. 417).

The then Public Health Institute was commissioned to develop indicators connected to the target areas and to collect data on the development of these indicators, in collaboration with other national authorities such as Statistics Sweden (SCB) and the National Board of Health and Welfare (NBHW). The first Public Health Policy Report was published in 2005, with 36 main indicators and 47 sub-indicators linked to the 11 target areas (Statens folkhälsoinstitut, 2005).

Tab. 4-1. Milestones of phase 1 towards the current Swedish public health policy

Year	Milestones of phase 1
1995	Government directive to the National Public Health Commission (Regerinskansliet, 1995)
1998	First Commission report setting out key guiding principles for the formulation of health targets, followed by written opinions from referral bodies (Nationella Folkhälsokommittén, 1998)
1999	Second Commission report proposing preliminary national goals and strategies, followed by written opinions (Nationella Folkhälsokommittén, 1999)
2000	Final report from the Commission laying down recommendations, followed by written opinions (Nationella Folkhälsokommittén, 2000)
2002	Government bill introducing the eleven target areas (Regerinskansliet, 2002)
2005	First Public Health Policy Report linking indicators and sub-indicators with health target areas (Statens folkhälsoinstitut, 2005)

Source: Adapted from Lager et al. (2007).

- Phase 2: 'A renewed Public Health Policy' (2006-2014)

A second phase began after the publication of the first Public Health Policy Report, which is summarised in Table 4-2. Two years after the 2006 elections, the new right-wing government launched a revision of the policy, which was approved by Parliament in June 2008 (Regerinskansliet, 2008) ([26]). The revised bill introduced a reformulation of certain target areas, with a stress on freedom and individual choice. A more subtle change occurred in the implementation of the policy. The previous inter-sectoral approach gave way to a narrower focus on the core competences of the public health agency. For almost ten years, most of the progress occurred in target areas where the agency had established expertise, such as addiction and HIV/AIDS. Both areas were given their own strategy, objectives, and follow-up structures adapted from existing policies – and were largely considered as successful by stakeholders and evaluators. In other areas, the implementation of the

26. Since the government did not propose major changes to the initial framework, no consultation was deemed necessary.

public health policy continued at a slower pace. Overall, the second Public Health Policy Report, published in 2010, had over 120 indicators (Statens folkhälsoinstitut, 2010). However, an evaluation by the Swedish Agency for Public Management (*Statskontoret*) found that their quality and relevance was uneven, and suggested improvements to the follow-up structure (Statskontoret, 2013).

Tab. 4-2. Milestones of phase 2 towards the current Swedish public health policy

Year	Milestones of phase 2
2008	Revised bill with reformulated objectives (Regerinskansliet, 2008)
2010	Second Public Health Policy Report proposing over 120 indicators (Statens folkhälsoinstitut, 2010)
2013	Inquiry on the strategy and follow-up structure (Statskontoret, 2013)
2014	Creation of the Public Health Agency of Sweden through a merger of several existing agencies

Source: Authors.

- Phase 3: 'Good and Equitable Health' (since 2015)

The third and current phase of the policy started in the aftermath of the 2013 evaluation, when the Social-Democratic Party returned to power and formed a minority government in September 2014 (its key milestones are summarised in Table 4-3). On 3 October 2014, incoming Prime Minister Stefan Löfven, during his first policy statement to the Parliament, announced the appointment of a National Commission for Equity in Health (Lundberg, 2018b). A few months later, the Commission was formally set up and asked to deliver proposals for a revision of the public health framework, 'with the overarching goal of eliminating avoidable health inequalities within one generation' (Regerinskansliet, 2015).

The emphasis on the inter-sectoral dimension of public health was a departure from the more individual-centred view of health determinants and the 'narrower' approach of the second phase – which the Commission for Equity in Health called 'problematic in order to achieve good and equitable health across all policy sectors' (Kommissionen för jämlik hälsa, 2016, p. 148). The new overarching goal was also closer to the initial ambition of the 2003 bill, which stated that 'the starting point for all public health work is the equal value of all people' (Regerinskansliet, 1995, p. 34). The Commission indeed understood its mission as providing a new impetus for the implementation of this initial principle: 'The question one should reasonably ask is why, almost 15 years later, we need a new Commission with a similar mission. The answer is partly to be found in the fact that social disparities in health have not actually decreased over these years, but rather have increased. Does this in turn mean that the premise, ideas, and proposals that led our health policy in 2003 were wrong?' (Kommissionen för jämlik hälsa, 2016, p. 88). According to the Commission, the implementation of the policy was primarily what needed to be improved upon.

The first preliminary report submitted by the Commission in August 2016 provided a review of the conceptual, political, and scientific underpinnings of the policy (Kommissionen för jämlik hälsa, 2016). The second preliminary report discussed the insufficiencies in the existing public health policy framework and argued for the development of a follow-up structure (Kommissionen för jämlik hälsa, 2017a). The Commission proposed another reduction of the 11 target areas into 8 and called for a clarification of the relationships between state agencies and local authorities. According to the report, strategies for each target area, containing concrete sub-targets and milestones, were to be developed by 2020, followed up and evaluated in cooperation with all relevant national, regional, and local actors. In June 2017, the Commission presented a final report summarizing its recommendations for a new national public health policy (Kommissionen för jämlik hälsa, 2017b). The proposals of the Commission were overall well received, although some administrative bodies asked for further clarifications concerning their role in the process (most notably the National Board of Health and Welfare, which shared with the agency some competences in the field of health monitoring). In April 2018, based on this preliminary work, the government issued a proposal for the reformulation of the overall national public health goal and the revision of the target structure of public health work, entitled 'Good and equitable health – an advanced public health policy' (Regerinskansliet, 2018). In June, the Swedish Parliament adopted the new national public health policy, with the reformulated public health overarching goal and revised target areas. The Public Health Agency of Sweden was then asked to draft a framework to enable systematic and coordinated efforts to support the realization of the reformulated public health policy. In 2020, the agency published a working document on the new follow-up structure (Folkhälsomyndigheten, 2020). Subsequently, the name of the policy was changed to 'Good and Equitable Health – *at all levels*' (our italics), stressing the importance of coordinating national and local policies.

Tab. 4-3. Milestones of phase 3 towards the current Swedish public health policy

Year	Milestones of phase 3
2015	Government directive to the Commission for Equity in Health to revise the public health policy (Regerinskansliet, 2015)
2016	First Commission report devoted to a review of the conceptual and scientific underpinning of the policy, followed by written opinions from referral bodies (Kommissionen för jämlik hälsa, 2016)
2017	Second Commission report discussing the insufficiencies in the public health policy framework, followed by written opinions (Kommissionen för jämlik hälsa, 2017a)
2017	Final Commission report proposing a reorganisation of the 11 'target areas' into 8 'target areas' followed by written opinions (Kommissionen för jämlik hälsa, 2017b)
2018	Government proposal entitled 'Good and equitable health – an advanced public health policy' (Regerinskansliet, 2018)
2020	The Public Health Agency of Sweden published its 'support structure' for implementation (Folkhälsomyndigheten, 2020)

Source: Authors.

4.1.3 An aspirational public health policy geared to an overarching goal

The main component of the 2018 public health policy is the *overarching national goal* to create societal conditions for good and equal health in the entire population and to close avoidable health gaps within a generation. Although its content has only slightly changed since 2003, the overarching goal has been reformulated and has been given a more prominent status in the policy.

The *eight target areas* break down this overarching goal into the most important factors affecting people's health, highlighting the social determinants of health in a life-course perspective. They include early life, education, work, income, housing, health behaviours, participation, and health care, purposefully reflecting a comprehensive inter-sectoral approach. The first seven target areas are key areas where resource scarcity and social vulnerability are particularly crucial for health equity. The eighth and final target area – a health-promoting health care – indicates that the health care system should become better at eliminating the differences that exist between social groups in terms of illness, treatment and consequences of illness or ill-health. It acknowledges the role that health care can play in affecting people's health through health promotion and prevention, treatment, and rehabilitative efforts (Kommissionen för jämlik hälsa, 2017a).

As described above (section 4.1.2), the target areas have been reduced in number and made more neutral over the years, in an effort to clarify that target areas do not constitute targets as such. In the 2018 updated target areas, words indicating a valuation (such as 'good', 'safe' and 'healthy') or a direction (such as 'increased' and 'decreased') have been removed in favour of a thematic framing (see Table 4-4). This streamlined approach has puzzled stakeholders such as the Swedish Cancer Society (*Cancerfonden*), the largest charitable organisation in Sweden, which noted that 'the likelihood that a reformulated overarching goal, together with a reduction in the number of target areas, would be sufficient to increase the intensity of public health work is not very high. The need for a clear national strategy, guidelines and action plan with interim goals for preventive health work remains' (Cancerfonden, n.d.).

Tab. 4-4. The 2018 reorganisation of target areas

Current 8 target areas (2018)	Corresponding 11 initial target areas (2003)
1. Conditions in early life	3. Safe and good growing-up conditions
2. Knowledge, skills, and education/training	2. Economic and social security 3. Safe and good growing-up conditions
3. Work, working conditions, and work environment	2. Economic and social security 4. Health at work
4. Income and economic resources	2. Economic and social security

Current 8 target areas (2018)	Corresponding 11 initial target areas (2003)
5. Housing and neighbourhood conditions	2. Economic and social security 5. Healthy and safe environments and products 7. Good protection against the spread of infection
6. Health behaviours	7. Good protection against the spread of infection 8. Safe and secure sexuality and good reproductive health 9. Increased physical activity 10. Good eating habits and safe food 11. Reduced use of tobacco and alcohol, a society free of drugs and doping, and reduced harm from excessive gambling
7. Control, influence, and participation	1. Participation and influence in society 8. Safe and secure sexuality and good reproductive health
8. Equitable and health-promoting health and medical services	6. A more health-promoting health care

Source: translated and adapted from Kommissionen för jämlik hälsa (2017a, p. 11).

In its 2020 publication on the new structure for the implementation of the policy, the Public Health Agency of Sweden broke down target areas by adding the concept of focus areas (*fokusområdena*) (see annex 5 in Folkhälsomyndigheten, 2022c). The focus areas have been developed to give content to the public health policy and to indicate what issues are being prioritised to achieve good and equal health. Focus areas are in essence an intermediary level, which link target areas and allow for a thematic grouping of *indicators*. Measurable sub-targets and strategies that concretely link indicators to target areas have been added to the framework in a patchy manner. The 2015 Commission for Equity in Health proposed to develop strategies for each target area which would act as drivers for the implementation of the overarching goal, though concrete and measurable *sub-targets* (*delmål*) and *milestones* (*etappmål*). Specific strategies were to be developed and monitored by the public health agency in cooperation with all relevant actors, and would cover a 3-5 year period (Kommissionen för jämlik hälsa, 2017a). As it was deemed difficult to develop strategies for all target areas at the same time, the Commission suggested that they should be developed according to a 'rolling' schedule starting with the first four target areas. The government did not adopt this suggestion, with the argument that it would be too time-consuming at this stage. Instead, the government's proposal referred to existing targets and strategies: the 2016 goal for gender equality and the 2013 goal for enhanced physical activity (Kommissionen för jämlik hälsa, 2017a). Two national strategies, on suicide prevention in 2020 and nutrition in 2024, have also been developed since. In its implementation of the policy, the public health agency has also been collecting and reviewing information on existing policies and government priorities in other

sectors that may be linked to the eighth target area and are relevant to the overarching goal – called national goals (*nationella mål*) in the context of the public health policy ([27]).

In terms of time horizon, the government initially instructed the 2015 Commission for Equity in Health to develop differentiated timeframes for different targets: 'short-term (2-4 years), medium-term perspective (8 years) and one generation (25-30 years)' (Regerinskansliet, 2015, p. 1). Yet the final government proposal published in 2018 and the current follow-up structure only refer to the generational timeframe (30 years) for the completion of the overarching goal.

4.2 The setting process used in Swedish public health policy

This second part explains how the Swedish public health policy is governed and what mechanisms have been used for shaping and formulating the targets, for supporting their implementation and ensuring their monitoring, evaluation, as well as dissemination. It focuses mainly on the development of the public health policy since 2018.

4.2.1 Steering public health in Sweden: a 'soft' top-down governance model

While the policy on good and equitable health does not create any legally binding instrument, the government appointed the Public Health Agency of Sweden as responsible for coordinating public health work at the state level and supporting the target groups (state, regions and municipalities) in the implementation and follow-up of the policy. This happens mostly through the sharing of information, coordination and monitoring. This state-centric, technocratic, and essentially top-down governance structure is counterbalanced by a strong emphasis on participation and coordination throughout the policy process. More details on how this was concretely organised are given in the following sections.

27. For instance, a pre-existing national goal for health care (thus linked to target area 8) was found in the existing legislation and reads: 'The population must be offered needs-adapted and effective health care of good quality. Care must be equal, and accessible' (Kommissionen för jämlik hälsa, 2017a, p. 90).

4.2.2 Target selection: a consensus-oriented and expertise-driven process

The selection of the overarching goal and the eight target areas was carried out between 2015 and 2017 by the Commission for Equity in Health. The Commission was made up of a dozen experts and academics led by Professor Olle Lundberg, and was in constant dialogue with state agencies, regions, municipalities, popular movements, business, research and interest groups through hearings and roundtables. Many of those organisations and associations have set up special shadow groups to follow the Commission's work. As mentioned above, all state and non-state actors also had the opportunity to express their opinion on the Commission's preliminary reports and the government's proposal. This consultation process is a standard procedure for major reforms in Sweden (Swedish Government Official Reports – *Statens offentliga utredningar*), but it was particularly extensive and thorough in this case.

More specifically, the Commission conducted surveys among municipalities, regions, and county administrative boards, as well as 40 public authorities (Kommissionen för jämlik hälsa, 2017a). The Commission also convened *reference groups* (*referensgrupper*) with representatives from all parliamentary parties and selected representatives of municipalities and regions. Finally, government officials from relevant departments were invited to a network group (*nätverksgrupp*) within the government offices ([28]). The Commission organised *dialogues* (*dialoger*) in the form of about a hundred externally arranged seminars, workshops, conferences and other types of forums (Kommissionen för jämlik hälsa, 2017b). In 2016, it participated in four regional conferences in different parts of Sweden, divided into north, south, east, and west. The conferences were organised in collaboration with local municipalities, regions, and county administrative boards. The target group for the conferences was politicians, local officials, managers at government agencies, civil society actors and representatives of business and professionals. A specific dialogue seminar organised in August 2016 brought together 60 civil society organizations (Kommissionen för jämlik hälsa, 2017b). Finally, the Commission held discussions with experts in other policy areas such as gender equality, environment and youth policy, to learn about their experience with health targets (Kommissionen för jämlik hälsa, 2017a), as well as experts from other Nordic countries (Nordiska ministerrådet, 2016).

4.2.3 Formulation of indicators: a key responsibility of the Public Health Agency

After the overarching goal and target areas were approved by the 2018 Parliament decision, the formulation of focus areas and indicators was left to the public health agency. Between 2020 and 2022, the agency has published a series of working documents to explain its internal processes, in particular regarding the choice of indicators, and to update the

28. Ministries of Labour, Finance, Culture, Enterprise and Innovation, Social Affairs and Education.

public about its 'extensive work with additional data orders from various authorities, definitions, and analysis of data' (Folkhälsomyndigheten, 2022c, p. 8).

Identifying indicators for each focus area has been an iterative process building on previous attempts and a trial-and-error approach, in which the public health agency has shown a willingness to engage with critical feedback. For instance, the 120 indicators initially published in 2005 were considered too numerous by the Swedish Agency for Public Management (Statskontoret, 2013), undermining the policy relevance of the follow-up structure ([29]). While keeping a large and complex set of indicators monitoring social determinants of health, as well as the health status of the population from a life-course perspective, the public health agency found a way to enhance the impact of the monitoring structure by creating 30 *core indicators* (Folkhälsomyndigheten, 2022c). These core indicators are a selection of indicators that are particularly relevant for a quick and clear assessment of whether, and if so at what pace, the country is moving towards greater equality in each target area. The agency has been mostly using them in its publications, while other indicators are available for more advanced users. The core indicators can be broken down into groups based on gender, age, level of education and country of birth. They also provide comparable data at regional and local level in most cases, and are updated on an ongoing basis, whenever new data are available. Current core indicators are listed in Table 4-5.

Tab. 4-5 Core indicators for achieving the overarching goal in each target area

Health status of the population	- Life expectancy - Premature mortality - Self-assessed general state of health - Mental stress - Overall measure of morbidity or good health
Target area 1. Conditions of early life	- Risky use of alcohol when enrolling in maternal health care - Children enrolled in preschool, age 3 - Preschool teacher with university degree in education
Target area 2. Knowledge, competences, and education	- Teachers with a pedagogical college degree in elementary school - Students in year 9 with a high school qualification - High school diploma within four years of starting education
Target area 3. Work, working conditions and work environment	- Long-term unemployment - Young people who neither work nor study - Demand control at work - Physical load of the work
Target area 4. Income and livelihood opportunities	- Financial standard, percentiles, median

29. The 2005 follow-up structure covered about 40 health determinants and had over 120 indicators.

	- Persistently low financial standard, relative - Persistently low-income standard, absolute - Over-indebted
Target area 5. Housing and local environment	- Housing deficit in municipalities for certain groups in vulnerable situations - Overcrowding - Refrain from going out alone due to fear - Disturbed by traffic noise, disturbed sleep
Target area 6. Living habits	- Daily tobacco smoking - Risky consumption of alcohol - Physical activity - Eats vegetables daily
Target area 7. Control, influence, and participation	- Voting in general elections - Trust in society's institutions - Trust in others - Exposed to abusive treatment or treatment - Exposed to violence or threats of violence
Target area 8. An equal and health-promoting health care	- Refusal of medical care despite perceived need - MMR vaccination, children - Refusal of dental care due to financial reasons despite need

Source: adapted and translated from Folkhälsomyndigheten (2020, p. 5).

The agency has also launched a systematic review of all existing indicators, many of which were criticised by the Agency for Public Management for not being robust enough or were simply outdated (Statskontoret, 2013). The public health agency has 'cleaned up' its database in 2020 to only keep valid, scientifically based, and measurable indicators. The selected indicators are now expected to fulfil the relevance and quality criteria listed in Table 4-6.

Tab. 4-6. Criteria used to set indicators for the Swedish target areas

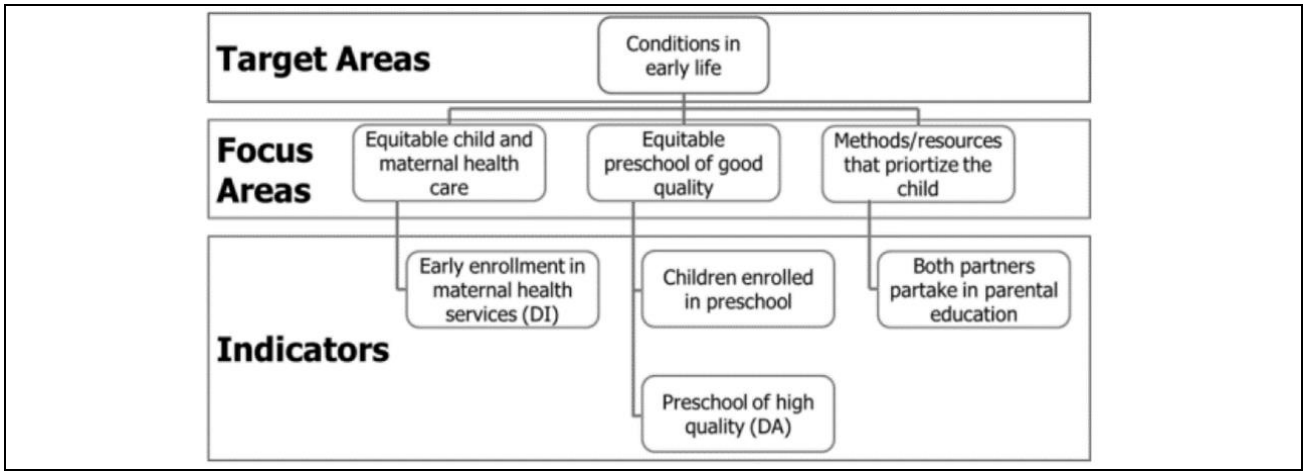
Relevance	- The indicator measures a health outcome that involves a considerable burden of disease - The indicator measures a health outcome that contributes to health inequalities - The indicator should indicate direction, which means that high or low values are expressions that something is good or bad - The indicator measures a health outcome that can be influenced by decisions and measures
Quality	- The best available data or statistics are used, *i.e.* registers, surveys or collected statistics. If there are two equivalent data sources for a given indicator, priority is given to those used in official statistics, other national indicator-based monitoring systems and, above all, those used in the national follow-up to Agenda 2030 - The indicator can be broken down using relevant classification criteria such as gender, age, geographical area, socio-economic background, and other significant background variables

[redacted]	- The indicator can be followed over time. Time series exist or could be built - The indicator can be followed at national level and preferably also at regional and local level - The indicator reflects the situation of different ages, which makes it possible to adopt a life course perspective

Source: adapted and translated from Folkhälsomyndigheten (2020).

The agency has created a structured process for developing new indicators in areas where data was insufficient. As mentioned above, most of the indicators developed prior to 2018 were related to the core expertise of the public health agency, such as alcohol, drugs, doping, tobacco, and gambling (30 indicators, half of them on tobacco use alone), while inter-sectoral areas or sectors overseen by other agencies had fewer and less specific indicators. Solving this problem was particularly challenging, as adding new indicators to the database is resource intensive and time consuming (Folkhälsomyndigheten, 2022c, p. 8). Indicators used in official statistics, other national indicator-based monitoring systems, and relevant United Nations Sustainable Development Goals indicators have thus been prioritised. However, some gaps remained in areas where there is currently no established data collection or where defined indicators are lacking. The agency has therefore created the concept of *Development Area* (DA, see Figure 4-2 for an example) to designate areas where established data is missing, and where a replacement solution should be investigated in collaboration with other government agencies. Development areas are typically outside the public health authority's area of expertise. In some cases, data sources exist but an indicator needs to be defined, often in collaboration with the current register holder. These are called Development Indicators (DI). This means that they are relevant, scientifically valid, and can be influenced, but that they need to be made measurable (Folkhälsomyndigheten, 2021).

Fig. 4-2 Example of the structure of the Swedish target area 'Conditions in early life'



Source: Folkhälsomyndigheten (2020). DI stands for development indicator and DA for development area.

Throughout the process of reviewing and developing indicators, the Public Health Agency of Sweden has been paying specific attention to all grounds of discrimination. While gender and age are well covered by national statistics, information on religion, disability, ethnicity, or sexual orientation is still more problematic to retrieve. Studies are underway to monitor the health of some of these groups, but work has not yet progressed to the point where it has been possible to integrate it systematically into the database (Folkhälsomyndigheten, 2022c). A key factor for further improving monitoring of these issues would be the possibility for the agency to access relevant microdata registers, as opposed to ordering ready-made statistics (Kommissionen för jämlik hälsa, 2017a).

4.2.4 An implementation process based on horizontal and vertical coordination

The adoption of the overarching goal by Parliament in 2018 has provided a new political impetus for the implementation of the public health policy. In May 2019, the government gave the Public Health Agency of Sweden instructions to develop a new plan, or, as the government called it, a support structure (*stödstruktur*) for the implementation and follow-up of the policy, as described in Box 7.

Box 7. Instruction from the government to the public health agency (2019)

'The Public Health Agency of Sweden will develop a support structure for the state's public health work that enables systematic and coordinated efforts. The authority shall present an overall strategy for how this work is to be carried out. The Public Health Agency of Sweden shall also review and state which policy goals are important for achieving the overall public health goal, and whether they are adequate from an equal health perspective. Furthermore, the authority will investigate and propose how each target area can be followed up via a number of valid, scientifically based and measurable indicators that reflect important aspects of good and equal health and underlying conditions at the societal level and that can be followed at national, regional and local level. The review shall take into account all grounds for discrimination. The proposed indicators will start to be used for public health policy follow-up from 1 July 2020.'

Source: Folkhälsomyndigheten (2020).

The public health agency provided explanations about how it intended to implement the policy, in a 2020 working document entitled 'On the way to good and equal health. Support structure for the state public health work' (Folkhälsomyndigheten, 2020). Since the public health policy is not legally binding, the implementation work occurs within the parameters of the division of responsibilities within the Swedish governance system. The support structure therefore focuses on horizontal and vertical coordination, to encourage the implementation of the policy through shared ownership and participation of states agencies and local authorities.

- Horizontal coordination: a national hub for public health policy?

The Public Health Agency of Sweden has to collaborate with other agencies in order to implement the overarching goal in all policy sectors. While national public health policy has enhanced the legitimacy of the public health agency as a knowledge centre, the implementation work occurs within the parameters of the division of responsibilities between state agencies. In this context, getting other sectoral agencies with their own mandate to take ownership of the national targets is not without challenges. In September 2020, the Director General of the Public Health Agency of Sweden conducted *strategic dialogues* with other state agencies, to spread knowledge about the overarching goal of the policy and discuss how target areas relate to other agencies' core activities, with a special focus on establishing partnerships on the topic of occupational health. Coordination between agencies also occurs through appointed contact persons (Folkhälsomyndigheten, 2022c). While the agency has publicly endorsed voluntary collaboration, it also hinted that, if need be, the government could enforce implementation through regulation (Folkhälsomyndigheten, 2020).

Unclear delimitations of responsibilities between the public health agency and other relevant agencies, such as the National Board of Health and Welfare, pose difficulties for the implementation of the policy. This is not new. In 2010, the two agencies carried out a joint review of public health reporting (*Samordnad folkhälsorapportering*) to achieve increased national coordination (Socialstyrelsen & Statens folkhälsoinstitut, 2011). Yet, the National Board of Health and Welfare is publishing its own surveys on health care with little cross-referencing between the two processes. In 2017, the Commission for Equity in Health found that 'active involvement of a wide range of authorities [in the implementation work] has gradually declined over the years' (Kommissionen för jämlik hälsa, 2017a, p. 66), adding that authorities need to 'cooperate better than before' (Regerinskansliet, 2018, p. 41). This assessment still holds despite recent attempts to increase coordination. In the spring of 2021, the Public Health Agency of Sweden received an amended instruction from the government with a clearer assignment to coordinate public health work at the national level (Regeringskansliet, 2021).

Inter-agency coordination challenges are linked to the fact that the overarching ownership of the policy has never been clearly established at Cabinet level. The Ministry of Social Affairs has been the most supportive since 2003. Its units have been restructured in accordance with the target areas and one person was given responsibility for working on the coordination and integration of public health policies at national level (Kommissionen för jämlik hälsa, 2017a). But the policy is not backed by a cross-sector entity within the government offices. Back in 1995, the government had envisaged setting up a *cabinet group* (*Statsrådsgrupp*) chaired by Ministers of Social Affairs and consisting of various relevant ministries (Education, Employment, Civil Affairs, Immigration and Social Security), which would have provided political leadership for the

implementation of the policy. This group has never been set up (Nationella Folkhälsokommittén, 1998). In 2003, the government established a *national steering group on public health issues* (*Nationell ledningsgrupp för folkhälsofrågor*), which did not have a decision-making function as cabinet members were not represented. The group met twelve times between 2003 and 2008 to review target areas, but one participant has later described it as lacking visibility within the government offices (Kommissionen för jämlik hälsa, 2017a). In 2018, the government envisioned a *National council for good and equitable health* (*Nationellt råd för en god och jämlik hälsa*) with representatives from ministries to foster coordination (Regerinskansliet, 2018). It is however unclear whether this initiative has been followed up yet.

- Vertical coordination: fostering multi-level convergence

The role of municipalities and regions has long been identified as a key factor in the successful implementation of a national public health policy, given that most public health work is carried out at local and regional level, but also since local authorities are involved in other relevant sectors (health care, education, housing, etc.). Coordination and collaboration between the state and the local level are well-known challenges for the Swedish administration (Lundberg, 2018b), yet vertical coordination is where the implementation of the policy seems to have had the most impact through learning and policy diffusion (see section 4.2.5).

Back in 1995, the National Public Health Commission stressed the importance of supporting the implementation of the national public health policy by local governments: 'The more decentralised society becomes, the more urgent it becomes to unite behind the same approach. National health goals should be complemented by local and regional goals, tailored to local conditions' (Nationella Folkhälsokommittén, 1998, p. 205). Yet the local implementation of the national policy had to overcome technical difficulties related to the fragmentation of information systems and the fact that different regions and municipalities have come up with different solutions that are not always compatible (Kommissionen för jämlik hälsa, 2017a). The tradition of local self-government was also a major political hurdle. In 2000 the National Public Health Commission proposed legislation through which municipalities and regions would have a responsibility to report to the national level on their work on public health issues (Nationella Folkhälsokommittén, 2000). This provision was opposed by local representatives. In 2003, the government finally rejected the idea, considering it 'unnecessary' and stressing that voluntary reporting was preferable (Regerinskansliet, 2002, p. 1).

The rationale has shifted from monitoring local implementation to providing support and inspiration for public health work at regional and local level. The public health agency was instructed to continue supporting municipalities and regions, giving special priority to developing methodology and providing training on how to follow up health inequalities (Statskontoret, 2013).

Much of the material published by the agency (see dissemination, section 4.2.6) is indeed targeted towards providing useful information and resources to local authorities (Folkhälsomyndigheten, 2020). The public health agency has also invited regional and local representatives to participate in the *National council for good and equitable health* mentioned above, with the aim to foster an exchange of knowledge in both directions. Dialogues have also taken place through the SALAR inter-regional network (Folkhälsomyndigheten, 2022c). In 2021, specific working groups on the implementation of the overarching goal were held with local authorities.

More recently, the government has relied increasingly on county administrative boards (*Länsstyrelserna*), which are responsible for the state local administration besides local authorities, to contribute to the implementation of the national public health policy by acting as a coordinating force and link between the national and the local level. The government has commissioned the county administrative boards in Stockholm and Västerbotten to develop methods for the internal coordination of public health work within local authorities (Regerinskansliet, 2018) and in 2022 issued an assignment for the public health agency to support the county administrative boards in their implementation of the national public health policy (Regeringskansliet, 2022).

- Complex inclusion of public health targets in national and local budgets

Given the inter-sectoral nature of public health policy and its broad scope, linking the public health policy to the annual budgetary process is particularly complex. In 2017, the Commission on Equity in Health considered developing funding models that would stimulate health promotion and promote a long-term social investment perspective, taking into account the consequences and effects for equality. The Commission argued that the government should test the possibility of integrating health equity into budgeting and that resource allocation models used for the distribution of public funds at national, regional, and municipal levels should apply a socio-economic perspective to a greater degree. The Commission also suggested that public procurement could be used as a means of promoting good and equitable health (Kommissionen för jämlik hälsa, 2017b). None of those proposals were however included in the 2018 government proposal.

To monitor the congruence between long term targets and annual budgets, the Public Health Agency of Sweden has mapped out which national budget priorities are particularly relevant to the public health policy overarching goal and has sorted them by target area, in the same way as it has been screening all laws, strategies, and international conventions in search of existing national goals (*nationella mål*) to feed into its follow-up structure. Out of a total of 27 expenditure areas in the 2022 budget bill, 15 were seen as particularly relevant. A similar approach is applied to promote the inclusion of the public health policy in regional and municipal annual budgets.

4.2.5 Monitoring and evaluation of the policy

The national public health policy has been monitored by the public health agency through regular reporting. The agency has developed a model for a collaborative monitoring of national public health work, whereby several actors can jointly identify the need for new knowledge and the public health agency can either individually or in partnership carry out in-depth analyses (*fördjupande rapporter*).

A summary of the evolution towards the overarching goal for the eight target areas and health conditions is published in the annual report 'Public health in Sweden' (*Folkhälsan i Sverige*), formerly named 'Public Health Developments' (*Folkhälsans utveckling*) (Folkhälsomyndigheten, 2023c). This short report focuses on the core indicators listed in Table 4-5, which are presented with text, statistical analyses, interactive maps and charts. The results are also presented online, where they are updated as new statistics become available or new knowledge is produced. More detailed follow-up reports, called 'public health policy reports' (*Folkhälsopolitisk rapport)* were published in 2005 (Statens folkhälsoinstitut, 2005) and 2010 (Statens folkhälsoinstitut, 2010). They reviewed implemented measures and provided recommendations for future initiatives to assist the government with strategic choices, such as prioritizing the most effective measures. Another relevant publication is 'Open Comparisons in Public Health' (*Öppna jämförelser folkhälsan*), an indicator-based report that draws on regional and local statistics and contains about 40 indicators concerning the general health of the population, living conditions, and lifestyle habits. Its latest update was published in 2019 in collaboration with the Swedish Association of Local Authorities and Regions (SALAR) (Folkhälsomyndigheten, 2019).

When it comes to external evaluations, one major investigation was performed in 2013 by the Agency for Public Management (Statskontoret, 2013). As we have shown in section 4.2.3, its findings had a significant influence on the work of the Commission for Equity in Health. Many of its recommendations on the effectiveness of the monitoring system have been followed-up in the 2018 revision of the policy. The Agency for Public Management has investigated the use and added value of the public health policy reports and database. Though surveys and interviews, it has found that the national public health policy has had very little influence on the work of other national agencies: representatives from only two agencies reported that participation in the reporting has strengthened their public health perspective. However, the public health policy reports had a much greater influence on local authorities. The investigation found that 89% of municipalities knew about the policy and 72% reported having used the 2010 public health policy report in their work. A majority of municipalities and regions stated that they felt that public health policy has been helpful in planning their policy, and to a lesser extent in their follow-up (Statskontoret, 2013).

4.2.6 Dissemination of knowledge and communication strategy

More than five years after the launch of the new policy, the public health agency has considerably developed and diversified its communication strategy. An important part of its work since 2020 has been to communicate about the policy and its content. Target areas are extensively showcased in policy documents and on official websites and specific infographics were developed to provide a visual representation (see for example Figure 4-1). A shorter English version of the framework for implementation and monitoring was also published for international audiences (Folkhälsomyndigheten, 2021).

Fig. 4-1. Example of infographic used to present the eight target areas of Sweden

Source: Folkhälsomyndigheten (2021, p. 7).

The agency has set out specific channels through which the results from the monitoring are communicated to the public and stakeholders. The dissemination strategy is based on a mix of digital channels (social media, website, etc.), conferences, and networks to spread knowledge and awareness about the programme (Folkhälsomyndigheten, 2021), which are further detailed here below.

Factsheets on target areas: Fact sheets presenting each target area were published in 2022 and updated in 2023 (Folkhälsomyndigheten, 2022c, 2023a). They provide succinct and accessible basic information on the policy.

Website and online database: The Public Health Agency of Sweden provides descriptive data on all the indicators in an open database available on its external website (Folkhälsomyndigheten, n.d.-a). The website has been revamped and development work will continue in order to increase the accessibility of the database (Folkhälsomyndigheten, 2022c). The website pages *Tema folkhälsa* have also been updated. They contain general information about public health in Sweden, provide information about the goals of public health policy and the relevant actors. They also feature a 'questions and answers' page about the support structure and the public health policy framework (Folkhälsomyndigheten, 2022a). The agency also provides specific explanations of concepts and theoretical frameworks, statistics of various kinds and tools and support to use in the practical work (Folkhälsomyndigheten, 2020). A short version of this information has been translated into English.

Regional and local database: Regional and local actors are a key target group for dissemination. The Public Health Agency of Sweden has recently created a specific website with indicators for municipalities and regions (Folkhalsomyndigheten, n.d.). It is the data availability and quality of the data source that determine whether the indicators can be broken down by region and municipality. The public health agency has had specific dialogues with regions and municipalities about how the database could be tailored to their needs (Folkhälsomyndigheten, 2022c).

User-friendly support material: In 2016, the agency created *FolkhälsoStudio*, an interactive tool for creating customised charts and maps based on selected indicators. The tool contains a selection of factors that affect health and well-being, but also certain health outcomes (Kommissionen för jämlik hälsa, 2017a). *FolkhälsoStudio* has been relaunched with more long-term statistics, including additional disease statistics (Folkhälsomyndigheten, 2022c). The public health agency further developed various support materials in the form of user guides to suggest how to use data in different ways, based on the needs of different target groups. An e-learning pedagogical tool proposes interactive text and learning videos with researchers, politicians and practitioners giving their perspectives on public health work. In addition, pre-packaged products that describe results from the follow-up are made available to download from the agency's website – for example, a short film presenting the most recent statistics has been published in October 2023 (Folkhälsomyndigheten, 2023b).

Thematic conferences and international partnerships: Public events such as seminars and conferences are another way of disseminating knowledge. The support structure has been presented at *Mötesplats social hållbarhet*, a conference regularly arranged by the public health agency in collaboration with SALAR. The target group was elected representatives, national and local civil servants, and civil society organizations. In May 2021, the agency presented the support structure at a seminar organised by the Ministry of Social Affairs (Folkhälsomyndigheten, 2022c). The Agency is also a co-organiser of the Nordic Public Health Conference, which is held every three years. It is primarily aimed at practitioners, decision-makers, administrators, politicians, and representatives of

non-profit organizations in the field of public health. Other target groups are researchers and research institutes, trade associations and private actors with an interest in public health (Folkhälsomyndigheten, 2020). In November 2022, the agency hosted a conference of the International Association of National Public Health Institutes (IANPHI) in which Director General Karin Tegmark Wisell said: 'National public health authorities have received a lot of attention during the pandemic […]. The understanding of their importance has increased, but in many countries they are still under construction and need support to be able to participate in international cooperation regarding different types of health threats and in promoting good and equal health' (Folkhälsomyndigheten, 2022b). Finally, in November 2023, the public health agency hosted a forum (*dialogforum*) with 130 participants from various national and local actors (Folkhälsomyndigheten, 2024). The aim of this event was to have a frank and creative conversation about the strengths and weaknesses of the Swedish public health policy.

4.3 Conclusion: an ambitious national public health agenda in support of local initiatives

After a review of the history of Swedish public health policy and close examination of official documents available at the time of writing, the Swedish policy stands out **as an aspirational framework providing coherence and visibility to public health priorities.** The main purpose of the public health policy is indeed first and foremost to provide a general sense of coherence and a common direction for the future, while safeguarding the autonomy of state agencies and local authorities. Table 4-7 summarises the main strengths and weaknesses of the overall governance of the Swedish public health policy at different stages of the target-setting process.

Tab. 4-7 Main strengths and weaknesses of the Swedish public health policy

	Strengths	Weaknesses
Overall governance	- Clear political commitment to lift health as a national priority - Expertise, resilience, and coherence resulting from the public health agency's long-lasting management and implementation role - State-centric approach but constant concern for consensus-building, openness, and concertation - Parliament's adoption of the overarching goal	- Patchy legal framework for public health - Lack of overall governance and clear ownership across sectors
Priority setting (situation analysis and selection)	- A clear long-term vision keeping public health on the agenda - Extensive and thorough participatory process based on a whole-of-government and whole-of-society approach	- Lengthy process for the revision of the policy - Commission's subsequent proposals not always integrated into the policies adopted - Difficulty to achieve political consensus among all stakeholders involved - Broad blueprint as a basis to be further developed by the public health agency

	Strengths	Weaknesses
Formulation	- In-house expertise of the public health agency combined with outside collaboration - Fine-tuning indicators through ongoing revision and development process - A structured process for developing indicators, including in areas where data are insufficient and related to discrimination	- Initial ambition to create a link between indicators and policy measures partially fulfilled - Difficult to access updated regional and local data as well as relevant microdata registers
Implementation	- Dissemination activities to other parts of government and society - Enhanced legitimacy of the public health agency as a knowledge centre - Horizontal coordination between inter-sectoral state agency - Vertical coordination with local authorities aiming to provide support and inspiration - Positive reception by local authorities and potential for mutually beneficial partnerships	- Not binding policy and dependency on the voluntary participation of other state agencies - Unclear delimitations of responsibilities between the public health agency and other relevant agencies - Complex inclusion of the targets in national and local budgets - Limited influence of the policy on the health care sector
Monitoring and evaluation	- Regular reporting - Learning process - Collaborative monitoring of national public health work with opportunities for civil society advocacy - Revision of the national public health policy based on the results of an external evaluation (of 2013)	- Risk of data unavailability - No recent external evaluation
Communication strategy	- Broad external dissemination to different target groups through various channels and data visualisation - Attention to local authorities' needs via specific regional/local websites	--

Source: Authors.

The strong political focus on tackling health inequalities is a prominent feature of the Swedish public health policy. It expresses a clear political commitment to lift health as a national priority for the government and to mobilise the whole of society. The inter-sectoral approach and long-term perspective are particularly relevant in addressing health inequalities. In this respect, the longevity of the Swedish public health policy is in itself an important achievement. While the direction of the policy changed slightly between 2006 and 2012 towards a more individual-centred approach to health, the need for long-term, goal-oriented, and inter-sectoral work at all levels of society in order to achieve good and equitable health for all seems to be widely accepted (lock-in effect). As an example of the prominence of the policy, the website of the Public Health Agency of Sweden describes the policy as the most important instrument for public health policy work (Folkhälsomyndigheten, n.d.-b).

The governance of the policy is fundamentally based on a state-centric and top-down approach mitigated by a constant concern for consensus-building, openness and concertation. For every key decision, the government has been at the helm through the formal appointment of a legislative commission, which then investigated the issue, led consultations, and proposed a formulation of the overarching goal and structure which was then reviewed by the government and adopted by the Parliament. The Public Health Agency is responsible for implementation, in coordination with state and local authorities, while stakeholders are involved at various stages of the process. This 'soft' top-down approach to inter-sectoral public health governance does have its appeal, especially for a fragmented and decentralised governance system. It is important to note in this respect that the legal framework for public health policies in Sweden is patchy – as laws, regulations and recommendations affecting public health have never been unified into a single piece of legislation. Health targets could thus be viewed as a creative way to enhance the public health orientation of all policies, by establishing an overarching goal and giving a clearer mandate to the Public Health Agency to monitor health inequalities and encourage coordination – while keeping the existing legislative and administrative structures largely unchanged.

A recurring problem with the Swedish public health policy since the mid-1990s relates to the discrepancies between the stated ambition on the one hand, and the formulation and implementation processes on the other hand. The government has appointed a Commission whose work has led to a strengthening of the overarching goal. However, equally important proposals regarding the operationalisation of the policy, such as the formulation of clear and measurable targets, were eventually set aside or left for the implementation phase. The public health agency was thus given a mandate to implement the policy, and subsequently launched its own consultation process to determine how the follow-up structure should evolve, but it has little formal authority to enforce it. While the agency has sufficient in-house expertise to develop indicators and monitor progress, the effective inter-sectoral implementation of the policy is largely determined by the voluntary participation of other state agencies. As the analyst from Cancerfonden puts it, 'a cross-sectoral structure is not wrong in itself, but without overall governance and clear ownership that spans the sectors, there is an imminent risk that commitments will fall through the cracks and that what is done will not be followed up in a systematic way. It becomes, as the saying goes, everyone's mission but nobody's responsibility' (Cancerfonden, n.d.). However, limited implementation does not necessarily mean that the policy does not have any impact. The positive reception from local authorities seems to indicate that coordination through a 'soft' national support of regional and local initiatives could be an effective way to foster implementation.

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Chapter 5. The Austrian experience in setting health targets

This chapter focuses on the Austrian health targets ([30]), a set of 10 national health targets that were launched in the summer of 2012 for a period of twenty years. The first part introduces the overall context in which the targets were set, while the second part describes in more detail various aspects and stages of the target-setting process. The conclusion provides an assessment and flags some of the main lessons that can be learned from the Austrian experience.

5.1 Introduction to the Austrian health targets

This first part situates the health targets in their overall context by presenting key aspects of the governance and financing of the Austrian health system, tracing the history and rationale behind this initiative, and finally describing the content of the health targets.

5.1.1 A social health insurance system reformed over the past two decades

The Austrian health system is a social health insurance (SHI) system guided by the core principles of solidarity, affordability, and universality ([31]) Its governance is rather complex, with the health competences shared between several stakeholders at the federal and the regional level, and the self-governing bodies representing the SHI and health professionals. At federal level, the Ministry of social affairs, health, care, and consumer protection is responsible for regulating the SHI and most areas of health care provision, except for hospital care, for which it defines only basic legislation. Hospital care is in the hands of the nine states (*Länder)*, which are responsible for legislation and implementation in this area, as well as for the provision of public health services, in this case together with the municipalities. Ambulatory care, rehabilitative care and pharmaceuticals are regulated by collective contracts negotiated between the self-governing bodies of SHI funds and of health service providers.

Major reforms of the Austrian health system have taken place over the past twenty years. All were adopted with the aim to reduce its complexity and fragmentation by improving cooperation and coordination among actors. Its governance was particularly reviewed and restructured towards a more target-oriented system. Against this background, the ten Austrian health targets were launched in 2012 by the Federal health commission and the Austrian Council of ministers. We will further explore these targets in the next sections, but it can be already noted here that they were designed as a common framework for action to guide reforms related to health policy until 2032. The reform that followed in 2013 was aligned with this first initiative. It saw the establishment of a target-based governance system bringing together representatives of the federal

30. *Gesundheitsziele Österreich.* This English translation is that used in official documents in English on this initiative.
31. Information contained in this section is based on Bachner et al. (2018) and OECD and EOHSP (2023).

and state governments and the SHI funds in one federal (B-ZK) ([32]) and nine state target-based governance commissions. These are responsible for the planning and financing of the health and health care system, notably based on federal target-based governance agreements. These include goals, specific objectives and target values and outline the reform agenda for a four-year period. So far, two agreements have been adopted, in 2013 and in 2017. The latter has recently been extended to cover the period 2022-2023. While the first was accompanied by state agreements, since 2017 the federal agreement contains guiding principles and priorities for both the federal and the state level. Based on these agreements, national and regional structural plans for health care are adopted, which provide a framework for the integrated planning of health care provision in all sectors, from in-patient and ambulatory care to rehabilitation care. Priorities defined in this framework are to some extent interlinked with the Austrian health targets – we will present how exactly in section 5.2.

The financing of the Austrian health system reflects its governance structure and reform. Accordingly, federal and state actors, as well as the SHI funds, are involved in and contribute to the financing of the health system, which comes from a mix of general tax revenues and compulsory SHI contributions. The financing mechanism was also impacted by recent reforms. In 2020, in order to reduce fragmentation and promote joint action, the SHI funds were merged, and their number was reduced from 18 to 5. One fund absorbed the nine regional funds and today covers about 82% of the insured population. The rest are covered by specialist SHI funds for specific professions such as self-employed workers, farmers, civil servants, and railway workers. In Austria, insured persons are actually assigned to a fund, depending on their type or place of employment or by occupational status, and there is no competition among the funds. Virtually all the Austrian population is covered by SHI. Data from 2019 show a coverage rate of 99.9%.

All SHI funds are members of the Main association of Austrian social security institutions, **which is the self-governing body representing the SHI general interests**. This association negotiates the reimbursement rates for ambulatory and rehabilitation care through collective contracts established with health service providers. It is also responsible for pooling all contributions and allocating them to the SHI funds, which in turn pay the health care providers. Recent reforms were designed to harmonise the benefits across all funds. However, this has been only partially achieved. Today, the benefits provided are broadly the same, but differences remain between the state fund and those covering specific professions.

5.1.2 Targets as part of a reform to reduce fragmentation and promote joint action

32. *BundesZielsteuerungskommission*. In 2017, the B-ZK took over the planning and financing tasks previously performed by the Federal health commission and has thus become the main decision-making body at federal level.

Austria has a long experience with health target setting. It was among the first countries to develop national health and health care targets in the 1990s, following the WHO *Health for all* strategy (Van Herten & De Water, 2000). The specific health targets launched in 2012 reflect the desire of the Austrian authorities to develop a national framework that could complement health targets existing at regional level and guide future reforms and actions towards better health outcomes and containment of health care costs (BMASGK, 2019a). This is why the initiative was initially named *Health target framework for Austria* (BMSGPK, n.d.-g), and is usually presented as a first reform milestone, aiming to reduce the fragmentation of the health system and promote joint planning and implementation between stakeholders. To prepare for their launch, preliminary work was carried out with the support of the Austrian National Public Health Institute (Gesundheit Österreich, GÖG) to study international and Austrian experiences with the setting of health targets. This work mainly served to define the guiding principles and processes on which the health targets should be based.

The declared overarching goal of the initiative is to improve the health of all people living in Austria without discrimination related to their social and economic status, and particularly to increase their healthy life expectancy by 2032. This focus on healthy life expectancy draws on the poor results obtained in this area compared to other EU countries: at the beginning of 2010, the Austrian healthy life expectancy was actually below the EU average (Bachner et al., 2018). To achieve this overarching goal, the initiative was built upon a 'health in all policies' approach, i.e. a comprehensive approach focused on broad determinants of health. This choice acknowledged the fact that the factors influencing population health and health equity are not only related to health(care) but also, and even mostly, related to social and economic aspects such as living and working conditions, lifestyle, etc.

This concern for health determinants was strongly influenced by international policy developments pertaining to *Health for All* and health promotion (Ventura, 2018). In particular, WHO strategies (WHO, 1978, 1986, 1988) are highlighted as key references on which the concepts of health in all policies and of health promotion are based. Links are also made with international commitments such as the Health 2020 framework adopted by the WHO Regional office for Europe (WHO/Europe, 2013) and the United Nations Sustainable Development Goals (UN, 2015), which the Austrian health targets are expected to support at national level.

5.1.3 What are the Austrian health targets about?

Following the 'health in all policies' approach, the ten *Austrian health targets* are designed to be comprehensive. They focus on different factors (related to both health care and other sectors) that may influence health and highlight not only behavioural aspects and individual interventions but also more structural determinants and specific settings (Ventura, 2018). In

particular, the ten following areas are covered: living and working conditions, equal opportunities, health literacy, natural resources, social cohesion, growing up healthy, ([33]) healthy and sustainable diet, physical activity, psychosocial health, and health care. Table 5-1 lists the overall target (*Ziel*) associated with each area.

Tab. 5-1. Areas and overall targets addressed by the ten Austrian health targets

#	Area covered	Overall target
1	Living and working conditions	To provide health-promoting living and working conditions for all population groups through cooperation of all societal and political areas
2	Equal opportunities	To promote fair and equal opportunities in health, irrespective of gender, socio-economic group, ethnic origin, and age
3	Health literacy	To enhance health literacy in the population
4	Natural resources	To secure sustainable natural resources such as air, water and soil and healthy environments for future generations
5	Social cohesion	To strengthen social cohesion as a health enhancer
6	Growing up healthy	To ensure conditions under which children and young people can grow up as healthily as possibly
7	Healthy and sustainable diet	To provide access to a healthy and sustainable diet for all
8	Physical activity	To promote healthy, safe exercise and activity in everyday life through appropriate environments
9	Psychosocial health	To promote psychosocial health in all population groups
10	Health care	To secure sustainable and efficient health care services of high quality for all

Source: adapted from BMSGPK (n.d.-c).

Each overall target is broken down into a fixed structure that includes three sub-targets (or impact goals, *Wirkungsziele*). As illustrated in Table 5-2, these sub-targets are defined in qualitative terms as a description of the desired impact to be achieved. In line with the topics addressed, most of these sub-targets are either related to public health or go beyond the health sector. Direct links are however made with the health care sector whenever relevant. Thus, target 3 on health literacy aims, among other things, to empower patients and enable their active participation in health care management. Both target 6 on growing up healthy and target 9 on psychosocial health address the issue of access to health care for their respective population group, namely children and young people, and people with psychosocial and mental disorders.

33. This area focuses specifically on the health of children and young people.

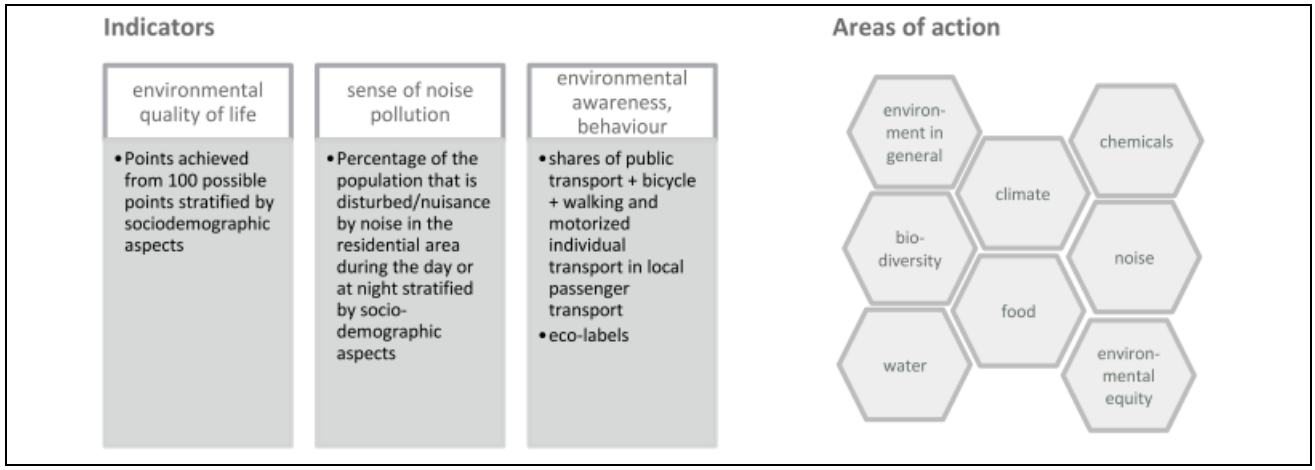
Tab.5-2. Sub-targets defined for the Austrian health targets 4, 5 and 7

Overall target	Sub-targets
4. To secure sustainable natural resources such as air, water and soil and healthy environments for future generations	1. To maintain and strengthen the foundations for a healthy life by dealing responsibly and sustainably with resources and living space. 2. To avoid, identify, monitor and, if possible, reduce environmental impacts with potential effects on human health 3. To promote / strengthen awareness of the relationship between environment and health among the population and decision-makers and to ensure environmental equality in the best possible way.
5. To strengthen social cohesion as a health enhancer	1. Expand opportunities for social participation for all and thereby promote inclusion. 2. Promote respect and solidarity between and for people and social groups in order to strengthen social cohesion in society. 3. Recognise diversity as an enrichment as well as a challenge for society, take into account the needs of minorities and disadvantaged groups, and uphold and enforce their rights.
7. Healthy and sustainable diet	1. Create a cross-sectoral political, legal, and economic framework for a sustainable food system that enables all people to consume a healthy diet. 2. Ensure a broad range of health-promoting and sustainable food and meals. 3. Render food environments health-promoting and sustainable.

Source: adapted from BMASGK (2019b); BMSGPK (2022a, 2022b).

In addition to the sub-targets, each overall target is further broken down into indicators and concrete measures and actions (*Massnahmen*). The indicators are both quantitative and qualitative, thus covering outcomes, processes, and overall structures. Figure 5-1 gives an example of indicators and areas of action defined, illustrating those set for one sub-target linked to securing sustainable natural resources (target 4).

Fig.* 5-1. *Example of indicators and areas of action for the Austrian targets



Source: BMASGK (2019c).

The measures and actions are systematically allocated to organisations that agree to take over their implementation and coordination. While most of the actions are defined in relation to the sub-targets, overarching actions that support the whole health target are sometimes also included (BMASGK, 2019c). For some targets, a specific mention is also made to clarify when actions are considered as being starter measures (BMGF, 2014a, 2014b, 2017), when they are considered by the working group to have a high impact on reaching the health targets, and when funding is missing for these highly ranked measures, which are thus proposed for funding under the initiative *Austrian health targets* (BMGF, 2014a). Finally, benchmarks are also set, in order to observe the extent to which the actions are effectively implemented.

5.2 The process of setting the Austrian health targets

This second part describes in more depth how the Austrian health targets are governed and what mechanisms have been used for their selection, formulation, implementation, monitoring and evaluation, as well as dissemination.

5.2.1 Participatory governance steered by the federal Ministry of Health

The Austrian health targets are an initiative of the former Federal Ministry of Health, which steers the whole process with the support of the Austrian National Public Health Institute. The process remains, however, participatory and based on a 'health in all policies' approach, a whole-of-government approach and whole-of-society approach (Ventura, 2018).

The initiative is coordinated by a plenary involving around 40 institutions representing all relevant stakeholders, both policymakers and from civil society. These are representatives of federal and state authorities covering various sectors; social insurance institutions; social partners; scientific experts; health-related professional organisations; patients' and citizens' associations representing various groups including children, young people, and the elderly; and the Austrian Anti-Poverty Network ([34]) (BMSGPK, n.d.-h).

As described in the following sections, separate intersectoral working groups are responsible for the development of each health target. These working groups involve members of the plenary but also external experts from organisations with expertise in the area targeted. All in all, between 25 and 55 members from different organisations and sectors participate in these groups. To promote this intersectoral perspective, all groups are co-led by two organisations that are active in the targeted area but belong to different sectors. These are most often

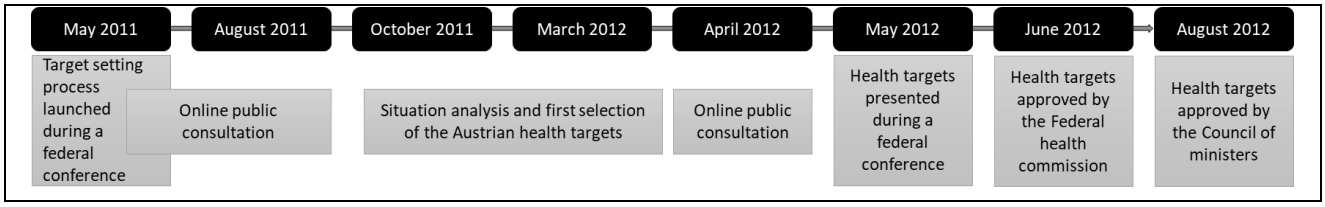
34. The network (*Armutskonferenz*) was established in 1995 and connects more than 40 welfare organisations, education and research institutions or social initiatives in order to raise awareness and provide policy support about poverty and social disparities, including related to health and health care (Bachner et al., 2018).

representatives of the federal government, but sometimes also representatives of either the social insurance or of civil society (BMSGPK, n.d.-b).

5.2.2 Broad participatory priority setting

The first phase of the initiative started in May 2011 and adopted a broad participatory approach, from the very beginning of the situation analysis and target selection. As Figure 5-2 illustrates, this process took about one year. After a kick-off conference, a public consultation was conducted online, which invited the Austrian population to share their views on how to promote health. About 4,500 suggestions were collected (BMSGPK, n.d.-m). Afterwards, the plenary members gathered in five successive workshops between October 2011 and March 2012. Small groups worked on individual topics and their specific results were discussed in plenary sessions. Besides the public opinion expressed in the online survey, the participants also considered background documents developed by the National public health institute, which provided information on the relevance of each topic area, the connections with existing health targets, action plans and strategies, and possible fields of action for implementation (BMSGPK, n.d.-k). A first proposal of ten health targets resulted from this work. These were submitted to the public via a new online consultation and then presented in a federal conference, before they were officially approved by the Federal health commission and by the Council of ministers during the summer of 2012 (BMSGPK, n.d.-m).

Fig. 5-2. Milestones for the agenda setting of Austrian health targets



Source: Adapted and translated from BMSGPK (n.d.-m).

In 2012, the overall targets were adopted, to be pursued for ten specific topic areas (see Table 5-1). They were selected using a set of basic guiding principles that had been defined by the plenary on the basis of suggestions put forward during the kick-off conference and the online public consultation (Federal Ministry of Health and Women's Affairs, 2017). They are listed in table 5-3. The first three principles reflect the rationale behind the initiative and call for the setting of health targets geared towards health determinants, based on a 'health in all policies' approach, and promoting health equity. The remaining principles invite the stakeholders to consider the resources available to gear targets towards public health and sustainable results, and to base the targets on evidence, using language that is also understandable for nonexperts. The two last principles of

feasibility and measurability mirror the concern for the implementation, monitoring and evaluation of the targets (BMSGPK, n.d.-l).

Tab. 5-3. Basic principles guiding the setting of health targets

Principles	Short description
1. geared towards health determinants	geared towards personal, social, economic and environmental factors influencing population health
2. health-in-all-policies approach	considering that diverse policy areas may contribute to health and well-being and ensuring that stakeholders from all policy areas are actively involved
3. promoting equal opportunities	reducing health and social inequities as a general requirement for all areas
4. geared towards resources	alignment with resources in terms of strengths and opportunities
5. geared towards public health	geared towards benefit in terms of health of the entire population and individual population groups
6. geared towards the future and sustainability	geared towards long-term benefits for population health
7. evidence-based, geared towards effectiveness and relevance	corroboration of sensibility and relevance by facts and figures
8. comprehensible	use of everyday language that is understandable for non-experts as well
9. feasibility/affordability/commitment	geared only towards measures that can actually be implemented
10. measurability	use of both process- and outcome-indicators to monitor progress towards the achievement of targets

Source: adapted from (BMSGPK, n.d.-l; Federal Ministry of Health and Women's Affairs, 2017).

All these principles were also used to guide the successive stages of the target-setting process, namely formulation, implementation, and monitoring and evaluation. These are described in the next sections.

5.2.3 A separate, gradual and intersectoral formulation process

The formulation and operationalisation of the ten health targets correspond to what has been defined as phase 2 of the initiative. Here, the target content was further developed by separate intersectoral working groups through a gradual process that started in April 2013 and was carried out successively for the different targets (see Table 5-4). This was explicitly intended to favour participation in the working groups and to avoid overload for those stakeholders concerned by more than one target. Overall, four to seven workshops were held to achieve an agreement

among the stakeholders on each target. Sometimes, sub-groups worked in parallel, as in the case of the target on psychosocial health (BMSGPK, n.d.-b). Smaller coordination rounds within the core team of each group and electronic consultations were also organised (BMASGK, 2019c).

Tab. 5-4. Milestones for the formulation of the Austrian health targets

Target topic	Formulation period	No. of workshops	Year of final report	Year of update
1. Living and working conditions	Jun 2013 – May 2014	5	2015	2017
2. Equal opportunities	Oct 2013 – Oct 2014	6	2015	2017
3. Health literacy	May 2013 – Oct 2013	4	2014	--
4. Natural resources	Jan 2017 - Jun 2018	6	2019	--
5. Social cohesion	Oct 2019 – Jun 2021	4	2022	--
6. Growing up healthy	Apr – Sep 2013	5	2014	2017
7. Healthy and sustainable diet	Jun 2019 – Apr 2021	7	2022	--
8. Physical activity	Sep 2014 – Jun 2015	5	2015	2019
9. Psychosocial health	Apr 2016 – Oct 2017	6	2017	2019
10. Health care	--	--	--	--

Source: by the authors, based on BMASGK (2019b); BMGF (2014a, 2014b, 2015a, 2015b, 2015c, 2017); BMSGPK (2022a, 2022b, n.d.-b, n.d.-m).

A standard procedure based on a common template was used to define the individual health target strategies. This included three sub-targets (or impact targets) and suitable indicators, as well as concrete measures and actions to achieve them, and clear responsibilities and timetables for implementation (BMSGPK, n.d.-b). This formulation process was guided by the basic principles listed in Table 5-3 (section 5.2.2). Moreover, specific criteria were used to select the actions: i) consensus exists in the working group that the action will contribute to achieving the sub-target(s); ii) coordination and funding of the action are well defined; iii) medium to high outcome is expected. To the extent possible, the supra-regional and innovative nature of the actions was also considered. Meaningful actions for which no institution took responsibility for coordination were set aside in a theme repository. In the end, the catalogue of actions listed by the working groups aimed to provide an overview of existing actions and to stimulate new actions in line with the sub-targets defined. It should be noted that the formulation process did not finish with the publication of the first report. The strategy and action plans developed for each individual target are regularly updated, as summarised in Table 5-4 (BMSGPK, n.d.-b).

A last word on the formulation process concerns the tenth health target on health care, for which no strategy has been developed yet (see Table 5-4). This is due to the difficulty of applying an intersectoral perspective to health care, but also to the fact that most targets related to this topic have been set in the framework of the health care reform launched in 2013. If we look at the overall target set in 2012, this aims to secure sustainable and efficient health care services of high quality for all. The description of this target refers to services that are well-coordinated, integrated, of assured quality and centred on patients, but also sustainable and efficient; it gives priority to enhancing prevention and primary health care and ensuring non-discriminatory access to health care services; and it calls for improved planning and financing based on joint accountability and monitoring systems (Federal Ministry of Health and Women's Affairs, 2017). All these aspects are covered by the federal target-based governance agreements and the related national structural plans for health care adopted since 2013 (see section 5.1.1). For instance, the last agreement adopted in 2017 sets four strategic goals and eleven objectives with concrete indicators in relation to the following areas: ambulatory care and notably primary health care; patient satisfaction by optimizing care and treatment processes; health literacy and health promotion; and fiscal sustainability of the Austrian health system (Bachner et al., 2018).

5.2.4 Voluntary implementation supported by linkages with existing strategies

The implementation of the measures and actions defined in the target strategies is expected to start once the working groups complete and publish their report (BMSGPK, n.d.-b). The stakeholders' engagement is voluntary, which is flagged from the very homepage of the initiative website (BMSGPK, n.d.-i). Here, the mission statement signed in 2016 by the stakeholders is posted. In it, the representatives of different organisations and policy areas commit to working closely together to develop a common framework of action and jointly implement measures that can improve the quality of life and health of the Austrian population.

Different measures are taken to support this voluntary commitment and ensure that the actions planned are implemented. First, as mentioned, much attention is paid during the formulation process to ensuring that at least one organisation can take responsibility for the coordination and implementation of individual actions (BMASGK, 2019c). Second, as far as possible, collaborations with other stakeholders are established for each topic, even by merging with other initiatives. For example, the work carried out on health literacy (target 3) was taken over by the *Austrian platform on health literacy* in 2015; and the working group on growing up healthy (target 6) joined the Committee for child and youth health. Cooperation across institutions is also at the core of the actions defined. For instance, a dialogue on healthy and active aging has been set up for the period 2019-2023 to support the implementation of target 1 on healthy living and working conditions. This dialogue involves the federal Ministry for social affairs, health, care and consumer protection, the Austrian social insurance, and the Austrian Health Promotion Fund. An additional

example are the regional early childhood intervention networks established to support families in need from pregnancy onwards (until, at the latest, the youngest child's third birthday) and contribute to the achievement of target 2 on equal opportunities and health equity (BMSGPK, n.d.-b).

Implementation is also supported by the fact that the health targets are expected to be used as a common framework to guide policy strategies adopted until 2032, in line with the rationale declared for this initiative. At federal level, they were anchored in the government programme adopted for the period 2013-2018 ([35]). In this programme, implementing the health targets was defined as one of the goals for the health sector, with the aim to support prevention and health promotion and increase the healthy life expectancy of the Austrian population. Specific areas of action mentioned in this regard were health in the workplace, addictions, mental health, risk factors related to non-communicable diseases, and food safety (BKA, 2013). Since 2014, the health targets have also been a component of the Austrian health promotion strategy, and, to the extent possible, they have been aligned with national strategies adopted within and outside the health care sector, such as the Child and youth health strategy or the National movement action plan (BMSGPK, n.d.-m; Ventura, 2018). With respect to health care, it should also be noted that, since 2018, parts of the targets set within the structural plans for health care may be made legally binding. The Austrian health targets are also a guiding principle in the health care reform, as also stated in an agreement document between the federal and state governments running until 2024. The national health targets have also been used to guide the setting of health targets at state level. The general and broad formulation of the overall targets and sub-targets aims to encourage their use by state authorities and organisations. To date, six out of nine states have already adopted their own health target programme (BMSGPK, n.d.-f) ([36]).

Linking the Austrian health targets to existing activities and strategies is also a way to ensure funding for implementation of the action plans established by the working groups. In fact, besides the resources allocated to support the overall functioning of the initiative (decision-making and coordination processes, monitoring, dissemination activities, etc.), no specific funding is earmarked for target implementation. The activities planned are, rather, funded through other channels, which are often linked to the core activities, competences and budgets of the institutions that are mainly responsible for them. For example, under the Health promotion strategy, at least two-thirds of the budget destined for specific state funds must be spent on prevention targeting specific groups or activities, such as early childhood and health literacy, which are also covered by the health targets (OECD & EOHSP, 2021).

35. However, no explicit mention of the Austrian health targets was found in successive programmes (BKA, 2017, 2020).
36. These include Carinthia, Lower Austria, Upper Austria, Salzburg, Styria, Tyrol, and Vienna.

5.2.5 A comprehensive monitoring and evaluation framework

A comprehensive monitoring process has applied to the Austrian health targets from the beginning. This is guided by the basic principles listed in Table 5-3 and is designed following a trial-and-error approach. The aim is to ensure transparency and regularly improve the target setting process by using the findings for strategic steering and appropriate adjustments (Griebler, Winkler, & Antony, 2019). The whole process has been supported by the Austrian National Public Health Institute and coordinated by the plenary, while decision-making has been in the hands of the federal decision-making bodies (BMSGPK, n.d.-e).

To monitor the progress made towards the ten overall targets as a whole, a baseline was developed in October 2013 (Petra Winkler & Anzenberger, 2013). Meta indicators were set by experts from the Austrian National Public Health Institute as well as representatives of the federal Ministry of Health, the Main association of Austrian social insurance institutions, the plenary of the Austrian health targets, and Statistics Austria. Meta indicators were selected based on the following criteria: their availability and use within existing projects and strategies, to avoid collection of additional data and to enable comparison with the baseline; their international comparability, to assess progress also based on international trends; their relevance for the topics targeted; and the existence of data disaggregated by age, gender, socio-economic status, and region. Three overarching quantitative indicators aim to measure progress towards the whole framework in terms of life expectancy, healthy life expectancy, and self-reported health. To measure progress towards each health target, there are two to five quantitative outcome-indicators as well as one or two qualitative indicators geared to processes such as policy implementation, monitoring and reporting ([37]).

To monitor the achievement of the sub-targets and actions associated with each overall target, specific indicators are proposed by the respective working groups (BMSGPK, n.d.-b). A feasibility study is then carried out by the Austrian National Public Health Institute to check if the indicators are suitable enough for assessing the impact of the sub-targets, if a database is available to collect data over time and, against this background, if the sub-targets are sufficiently ambitious and realistic. Based on the results, recommendations are made on either the indicators or the database to be used, but also on the sub-targets themselves. A baseline for the indicators selected is also developed at this stage. A concept note was published to present and support the monitoring process (Petra Winkler, Griebler, & Haas, 2014). This fixes the schedule for carrying out the routine monitoring of actions related to the ten health targets. As Table 5-5 summarises, the

37. For the tenth health goal on health care, the quantitative meta-indicators include: the use of preventive medical check-ups and the share of health expenditure by sector (care-prevention, in-patient-ambulatory) in the health care system. The qualitative meta-indicators focus on the implementation of strategies targeting performance and quality of care (Petra Winkler & Anzenberger, 2013).

results of the feasibility studies were published for 7 out of 10 targets, and those of the monitoring were published for 6 targets (BMSGPK, n.d.-j). For targets 5 and 7, the feasibility study was conducted through more supportive and interactive methodologies that were directly integrated to the process of indicator setting developed within the working groups or with the working group leaders. The monitoring was also performed but the factsheets have not yet been published.

Tab. 5-5. Overview of the health targets that have been monitored so far

Target (topic)	Written feasibility study	Year of monitoring report
1. Living and working conditions	2015	2017
2. Equal opportunities	2015	2017
3. Health literacy	2014	2017
4. Natural resources	2019	--
5. Social cohesion	--	Not yet published
6. Growing up healthy	2014	2017
7. Healthy and sustainable diet	--	Not yet published
8. Physical activity	2016	2018
9. Psychosocial health	2018	2019
10. Health care	--	--

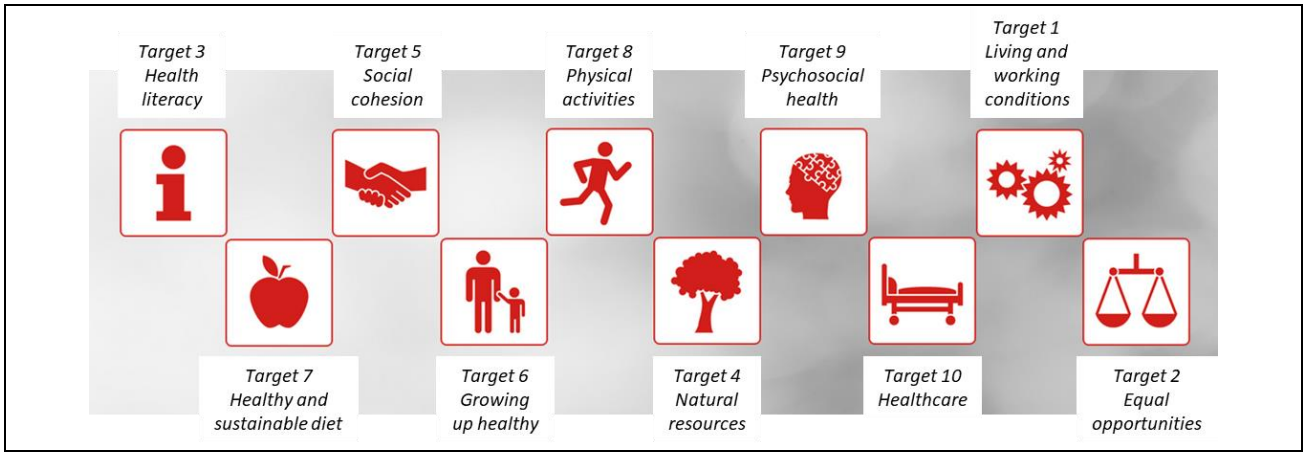
Source: synthesis by the authors based on BMSGPK (n.d.-b).

Whenever possible, synergies are sought for carrying out the monitoring. Thus, most of the activities that have been conducted to date were carried out in coordination with the monitoring of other strategies, such as the target-based health governance reform, the health promotion strategy, or the Child and youth health strategy (BMSGPK, n.d.-e). In some cases, such as for the health target on natural resources, the working group decided not to set their own target values for the indicators, but to rely on values already existing at national or international level (Petra Winkler & Delcour, 2019). Regarding the health target on health care, no specific monitoring report has been published yet, but most indicators related to this topic have been monitored under the other initiative in place, the federal target-based governance agreement. Finally, findings from the monitoring of the Austrian health targets are used to provide information relevant for other initiatives, such as the monitoring of the UN Sustainable Development Goals (Griebler et al., 2019).

5.2.6 Communication as a guiding principle

Particular attention is paid to the visibility and public understanding of the Austrian health targets, in line with the guiding principle of comprehensibility (see section 5.2.2). As mentioned, a conference was organised when the initiative was launched in May 2011, as well as one year later for the presentation of the ten targets. Furthermore, the communication strategy was completely refined between 2016 and 2017 (Ventura, 2018). A new website was developed (BMSGPK, n.d.-i), accompanied by an infographic associating each target with a specific logo (see fig.5-3), and a specific slogan aiming to strengthen the corporate identity of the initiative ([38]). The website highlights the multistakeholder intersectoral approach: the homepage flags the whole-of-government approach by displaying statements from four federal ministries involved in the initiative ([39]); the page dedicated to the members flags the whole-of-society approach by displaying statements from patient representatives, civil society organisations, health professional organisations, and representatives from the state and federal level. Detailed information is given on the content and decision-making process and the documents produced by the working groups can be accessed. In addition, separate short videos are available presenting the whole initiative and the individual targets (BMSGPK, n.d.-a).

Fig. 5-3. Infographic used to present the ten Austrian health targets



Source: Adapted from BMSGPK (n.d.-a).

Internal communication among the members of the plenary is also strongly promoted. Besides the workshops organised separately by the individual working groups, plenary workshops

38. The slogan is 'Austrian health targets. Think further. Get further' (*Gesundheitsziele Österreich. Weiter denken. Weiter kommen*) (BMSGPK, n.d.-i).
39. The minister of social affairs, health, care and consumer protection; the minister for sport; the minister for climate action, environment, energy, mobility, innovation and technology; the minister for Europe and the constitution (BMSGPK, n.d.-i).

are held twice a year. These have served to share and discuss the results achieved by the various working groups in relation to the formulation of the health targets and to the implementation of specific measures and actions. They are also an opportunity to inform the stakeholders on ongoing policy developments at federal and regional level, to debate with academic experts on specific topics and challenges, and to reflect on issues such as the relationship between the health targets and national and international strategies, for example the government programmes or the UN's Sustainable Development Goals (BMSGPK, n.d.-k).

Finally, work related to the health targets is also presented in both political and scientific fora, such as the Austrian Council of ministers and public health conferences. Besides the scientific scope, the aim of these dissemination activities is to ensure that the topics targeted remain high on the political agenda (BMSGPK, n.d.-b).

5.3 Conclusion: an intersectoral policy-guiding framework

The Austrian experience with setting national health targets was regarded as being among the best practices internationally (BMSGPK, n.d.-d; Ventura, 2018). It actually shows how a whole-of-government and whole-of-society approach can be developed under the leadership of the federal Ministry of Health to support joint planning and actions towards health targets.

If we look at the results achieved ten years after the initiative was first launched, the main results have been clearly those achieved in terms of process. The initiative is considered to have been successful in shaping high-level strategies and decisions taken either within the health decision-making bodies or the Austrian Council of ministers (Bachner et al., 2018). As mentioned, the health targets were anchored in government programmes and linked to reform processes, such as the target-based health governance reform related to health care services and strategies related to health promotion. They have also guided the setting of health targets at state level. The capacity to involve stakeholders from different sectors is also highlighted for the support it provides to the operationalisation of a broad vision of health and its determinants. This is explicitly highlighted on the website and in documents related to the initiative.

In terms of outcomes, the progress made has been rather mixed. With respect to the overarching goal of improving the healthy life experience of the Austrian population, this is still below the EU average, according to recent data (Bachner et al., 2018); and risk factors and unhealthy lifestyle remain important drivers of mortality in Austria (OECD & EOHSP, 2021). Likewise, regarding the aim of cost containment, the Austrian health system remains relatively expensive compared to other European countries, with health spending per capita of almost 4,000 € in 2019 (OECD & EOHSP, 2021). To balance this point, however, it should be noted that time was among the key dimensions stressed by the initiative from the very beginning: the time horizon was set until 2032, and the targets were deliberately set in progressive stages to support the sustainability of the

process, i.e. to avoid stakeholders becoming overloaded, promote ownership and consensus, and to support a trial-and-error process.

We summarise the main strengths and weaknesses of the Austrian health targets in Table 5-6, by listing those associated with the overall governance of the targets and with the different stages of the setting process.

Tab. 5-6. Main strengths and weaknesses of the Austrian health targets

	Strengths	Weaknesses
Overall governance	- Whole-of-government approach - Whole-of-society approach - Broad support based on trust building - Open processes - Led by the federal minister of health	- Diverging interests and motivations - Risk of overlap with existing initiatives - Limited by stakeholders' time, availability, and capacity
Agenda setting (situation analysis and selection)	- Broad participatory process - Driven by guiding principles	--
Formulation	- Co-leadership of the working groups - Common template - Deliberately progressive process	- Separate process for target 10 on health care
Implementation	- Attention to feasibility - Linkages with existing strategies - Responsibilities shared	- Mostly voluntary - Lack of regular/sufficient funding
Monitoring and evaluation	- Promotion of a learning process - Link with existing monitoring processes - Clear support from the Austrian National public health institution	- Risk of data unavailability
Communication strategy	- Learning approach internally - Wide external dissemination - Attention to public understanding	--

Source: authors.

Concerning the overall governance of the health targets, we already mentioned that the strength of the initiative is its multi-stakeholder, 'health in all policies' approach. The whole-of-government and whole-of-society approaches especially allow the involvement of stakeholders from different sectors but also playing different roles, from decision-makers at federal and regional level, to institutions and organisations involved at operational level, and representatives of patients' and more largely citizens' interests. The whole-of-government approach was notably supported by the involvement of the Austrian Council of ministers, which gave the various ministries a clear mandate to engage with the initiative. Another interesting aspect is that the coordination mechanisms in place aim to support networking and exchange of knowledge and practice, more

than achieving consensus. The regular workshops organised by the plenary are expected to let participants share different perspectives and ways of thinking on an equal footing and thus contribute to building trust and cooperation (BMSGPK, n.d.-k). In this respect, several conclusions were drawn in the assessment conducted by Ventura (2018). This shows that solid arguments are needed concerning the co-benefits that other sectors can derive from engaging in such health initiatives, in order to ensure their involvement. In fact, there was frequently reluctance to become involved in intersectoral cooperation, and stakeholders could only be encouraged to participate if they felt that engaging with the health targets could further their own interests and motivations. At the same time, there is a risk of overlap with other initiatives, and stakeholders may find it difficult to find sufficient time and resources to continue to be involved in the long term. To support this process, the signature of a joint statement was considered a valuable tool in framing stakeholders' motivations and interests and promoting intersectoral cooperation. It should also be noted that the stakeholders were not involved all together at once. On the contrary, their involvement was organised step by step, starting with those stakeholders which already shared same views and interests in health targets, while approaching at a later stage those stakeholders with different interests and which were less convinced about the approach. The working groups are actually designed to be inclusive, with no limit on the number of partners, so that new stakeholders can be involved as needed. Rather than avoiding the presence of 'critical voices', this aspect has been promoted to encourage constructive debates and keep challenging the target-setting process. A final key factor enabling the overall functioning of this governance approach is clearly the leadership retained by the federal Ministry of Health, which most participants have considered as a key condition for the success of the joint process.

In terms of agenda setting, the broad participatory mechanisms put in place at an early stage supported the development of a comprehensive approach addressing factors that go beyond the health care system and include wider social determinants of health (BMFG & GÖG, 2017). The preliminary work conducted prior to the launch of the health targets, to develop the guiding principles on which to base the setting process, is also considered crucial to guide the process and define where to go and how from the beginning (Ventura, 2018).

This intersectoral approach is reflected in the formulation stage, not only in the membership of the working groups but also in their coordination mechanisms, with co-leadership by representatives of institutions engaged in two different sectors. Moreover, while common template and guiding principles were followed by all working groups, each of them worked separately and at different intervals, reflecting stakeholders and dynamics that were specific to the topic targeted. In this respect, it seems to us surprising that the only target for which no strategy has been developed yet in the framework of the health target initiative, is that on health care. The process around this topic seems to have moved separately, as part of the parallel reform introducing a target-based governance for the health care system.

Concerning implementation, although the engagement of stakeholders is largely voluntary, some good practices have been put in place to support commitment and implementation. Examples of this are the emphasis placed on the feasibility of the actions planned during the formulation stage, the assignment of clear responsibilities to members of the working groups and the identification of secured funding, as well as the linkages with existing strategies and initiatives. Despite these efforts, Ventura (2018) acknowledges that the implementation of actions and new initiatives is often hampered by a lack of financial means.

Documents collected show considerable attention paid to monitoring and implementation. This was conceived as a learning process and as a way to stimulate ideas on how to implement existing measures further, but also how to develop new actions (Delcour, Antony, & Griebler, 2018). The systematic link sought with existing information system processes was a way to make monitoring more effective. Moreover, the Austrian National Public Health Institute emerges as having played a key role in the monitoring and evaluation of the health targets, but also in the whole target-setting process, by providing the stakeholders with data and methodological support in the various stages of the initiative. In terms of weakness and limitations faced, several documents highlight the difficulty of ensuring monitoring and evaluation in the long term due to the lack of routine data or to the costs needed to carry it out (Griebler, Grabenhofer-Eggerth, Gruber, & Winkler, 2018; Petra Winkler & Delcour, 2019).

Finally, the efforts put into communication strategies are seen as additional enabling factors, as they promoted both internal ownership and external visibility among the wider public, policymakers, and scientific experts. This in turn helped to strengthen societal consensus and commitment around the health targets. Incidentally, the publication of some documents in English reveals willingness to also share the experience outside Austria.

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Chapter 6. Lessons learned and policy conclusions

This study explored international experiences in setting health and health care targets with the aim to draw conclusions relevant for the Belgian health authorities, which have started a reflection on using national targets as an instrument to guide health policies and establish a pluriannual budgetary trajectory for health care. A review of the scientific and grey literature dealing with this topic was conducted and completed by an in-depth study of three initiatives implemented in countries with long experience in setting national health targets: the Austrian health targets, the German health target network, and the Swedish national public health policy. The focus was particularly on the governance processes used to set health and health care targets, i.e. the stakeholders and the coordination mechanisms involved; the steps and criteria used to select the priorities to be targeted; the way targets are formulated; the support given to their implementation; the strategies for monitoring and evaluating progress and weaknesses; and finally communication tools used to disseminate information on the targets set.

Several lessons can be learned from the comparison of the three cases. The studies showcase specific approaches to national health and health care targets, their level of ambition, methods and outcomes. These specificities do not inevitably diverge, and the way the health target programmes are set may well have greater ramifications: the Austrian initiative illustrates how it is possible to include a mix of characteristics from both the German participatory and pragmatic approach and the Swedish more centralised steering. More specifically, the findings show that the approaches pursued to developing health targets vary along scales with two main poles: emphasis on agenda setting and framing vs monitoring and evaluation; bottom-up vs top-down processes; technical vs political basis; sectoral vs cross-cutting approach; qualitative vs quantitative approach. They provide an illustration of possible processes and allow us to examine in more depth lessons emerging from the literature on target setting in other countries. These lessons are presented below in relation to the five dimensions highlighted all along this study: overall governance mechanisms, priority selection processes, formulation of targets, implementation, monitoring and evaluation, and finally communication strategies. Based on these lessons and for each dimension, policy conclusions are drawn for Belgium.

6.1 Need for well-balanced health target governance

Lessons learned regarding the overall governance of the health targets revolve around the importance of setting up a structure that combines open participation and clear stewardship. There needs to be a balance both in the type of stakeholders involved and in the instruments used to support participation, while ensuring overarching coherence for the policy framework. Participation is largely presented in the literature as being crucial for building ownership and commitment among stakeholders, and there has been a clear move over the past twenty years towards whole-of-government and whole-of-society approaches. At the same time, as suggested by Van Herten and Gunning-Schepers (2000), the number and type of stakeholders involved should

reflect a good social and political balance between the political and the operational level, but also between technical experts and the general public. In terms of instruments, 'soft' methods of coordination based on persuasion and appeals to mutual self-interest help to build coalitions and support consensus and joint actions towards the targets set (Srivastava & McKee, 2008). For them to be completely effective, however, stewardship and leadership from the government are also deemed necessary (Smith & Busse, 2010).

The type and number of stakeholders, as well as the specific governance structure ensuring their participation, should be tailored to the objectives pursued by the initiative. Participation is cited as an important feature of all three initiatives in Austria, Germany, and Sweden, but the way this is promoted varies greatly from one country to another, on a scale extending from bottom-up to top-down approaches. The German health targets network involves the greatest number of stakeholders of the three (about 140), and is most clearly a bottom-up structure, as it is financially supported and mainly led by operational stakeholders (i.e. health insurance, health professionals, and state authorities), with no clear steering role from the federal government. It could be argued that a bottom-up approach fosters consensus, but it also comes at the cost of reduced consistency, political ambition and innovation. In practice, even a bottom-up model is based on a selection process that tends to reproduce the existing structures and practices of the health system. The German network is indeed based on membership, which means that only co-opted members are consulted and involved. As a result, the process is primarily driven and oriented by stakeholders from the health care sector, despite the stated intention to foster a multisectoral approach. Stronger involvement from public authorities, such as in Austria and Sweden, seems to mitigate the risk of fragmentation and allow for a more innovative and ambitious multisectoral approach, provided that the government and health authorities have a clear vision of what they aim to achieve when engaging in target-oriented policymaking. At the opposite end of the spectrum from the German bottom-up approach, Swedish public health policy is an example of a top-down and essentially state-centric initiative. Two key aspects of this model have been identified: the explicit overarching goal of curbing health inequalities was established at an early stage, and has provided a blueprint for the whole process, and the national public health agency has been given a central role in organising the policy. The Swedish case is an interesting example of how a national government could use new governance mechanisms to strengthen its steering capabilities in a very fragmented field. The involvement of stakeholders has been guaranteed throughout the decision making and implementation process. However, the Swedish ambitions have not been supported by sustained high level political leadership, and leading intergovernmental coordination has been challenging for the public health agency. One of the striking lessons from the Swedish case is that, in a fragmented field such as health, establishing a clear national policy coordinated by a central actor is an important step. Building strong partnerships and meaningfully engaging the whole of government is another steeper step that requires political momentum – because health rarely stays at the top of the governmental agenda for long. Austria is in the middle

of the scale: the health target initiative has actually been steered by the federal Ministry of Health from the beginning but, at the same time, it is coordinated by a multi-stakeholder plenary involving stakeholders from different levels and different sectors. The multi-sectoral approach is clearly reflected in the governance structure, with all working groups being co-led by organisations from two different sectors. This was notably possible thanks to the fact the Austrian Council of ministers was regularly informed about the Austrian health targets and has taken them into account for decision-making. Such a compromise between steering and participation seems to be the best suited to the realities of health policies and politics in most European countries. It is interesting to note that in our three cases, the differences in approaches to public health steering and stakeholder participation do not necessarily match the traditional health system typologies – reinforcing the notion that while institutions do matter, there is indeed potential for making governance choices that mitigate or even counterbalance the existing structures. In our view, the introduction of health targets is an opportunity to take stock of the main strengths and weaknesses of national health policies, and to try to do things differently. But health targets can only achieve so much.

The involvement of local authorities and their relationship with the central government can also be located along this bottom-up vs top-down scale. Involvement of local authorities has been flagged as an important component of the policy in all three countries. But the German health targets network is the only case in which local authorities are indeed in the driving seat. As said, the German states that participate in the health target network have taken over its financial support and, partly, the leadership on some targets, since the federal government has stepped down from what was initially a federal pilot project. National health targets were intended to inspire national policy, but they have often been taken up at local level first and then uploaded to the national level – although it took more than ten years before most of the targets were integrated into the federal Social Code Book. Austria and Sweden follow a more traditional top-down logic, where national targets were developed to inspire and promote target-oriented action by local authorities. Both countries have had interesting results in doing this. Although some local programmes were launched prior to the national initiatives and have partly inspired them, the most recent regional/local programmes have often been aligned with the national targets. In Sweden, local authorities have often voiced demands to receive more guidance and support from the national agencies.

In all three cases, experts have also played a key supporting role. However, while in Germany external experts support the evaluation advisory board and the working groups in more ad hoc ways, a specific administrative unit has been officially mandated to support the Austrian and Swedish governments all along the health target setting process, namely the Austrian national public health institute and the Swedish public health agency. They have provided technical but also procedural knowledge and have contributed to the continuity of the target-oriented initiatives over time. In the case of Austria, this expert role is explicitly intended to support the involvement and participation of all other stakeholders, by providing technical and methodological advice and by

helping to facilitate the debate within the working groups and plenary sessions. Moreover, both in Austria and Sweden, the expert participation has been further balanced by broader consultations of the general public, notably on the selection of priorities to be targeted.

It should be noted that setting up a specific governance process can be seen as an objective in itself. This is particularly evident in the case of Germany, where the national health targets are expected first and foremost to improve coordination of stakeholders and enable integration of actions within a health system that is highly fragmented. In the case of Austria and Sweden, we also find this drive for improved coordination and integration, but this procedural objective is linked to a more substantial overarching goal – in both cases to promote equity in health and thus improve health for all by addressing the broader social determinants of health. Making all these different goals explicit from the onset is very important in order to assess progress made not only in terms of the target-specific outcomes, but also in terms of processes and overall governance outcomes. As recalled by Liss (2003), the absence of quantitative targets with specific deadlines does not necessarily mean that a target-oriented initiative is ineffective, if its main purpose is to inspire and motivate stakeholders or to help acquire legitimacy, allies and resources. These underpinning purposes (and corresponding values) need to be clarified for the success of the targets to be correctly assessed.

The final remarks on the overall governance of targets relate to the management of conflicting interests and/or indifference. Because it is more specifically focused on health and health care policies, the German health target network is particularly attentive to achieving consensus among stakeholders, while in the other two countries the governance processes are more oriented towards building trust and fostering cooperation through the sharing of different perspectives and practice, both within the health sector and beyond it. Consensus, trust, or coordination take time and their building inevitably stirs up conflicting views and interests. This explains why all three initiatives essentially rely on long-term processes. In none of the countries studied were targets developed altogether at once. Each topic was worked on separately and step-by-step in Germany, and even in Austria and Sweden, the content of the initial common framework was deliberately broad and intended to be further developed in more depth. In Austria, the number of stakeholders involved was also only progressively increased. Although information on conflict is often missing in the official documents collected, the fact that some targets have needed more time to be developed than others may be seen as a consequence of difficulties in finding a compromise that satisfies all stakeholders involved. In Sweden, the government has often responded to perceived conflicts or indifference by delaying and/or diluting the formulation of the most specific provisions and relying on a consensual and relatively broad approach of 'coordination'. The scientific literature has largely highlighted the need to proactively design governance processes that can prevent conflicts both within the health sector and across policy areas. Yet, as we have suggested previously, a more silent threat also needs to be taken into account, especially in the case of public health

targets: indifference, lack of awareness and low prioritisation by other sectors. By focusing exclusively on building consensus, there is a risk that the setting of health targets could become a protracted process with little scientific relevance or potential societal impact. Once again, a prior assessment of domestic politics and a clear evaluation of the intended scope of the policy (whole-of-government or more narrowly focused on health policies) are key to identifying the main threat (conflictuality or indifference) and planning accordingly.

Policy recommendations

1. Comprehensively map all stakeholders to be involved with a view to identifying their respective missions, interests, and positions.
2. Clarify the governance structure of the health targets and the roles the different stakeholders will play within it.
3. Put in place mechanisms enabling the involvement and active engagement of authorities from different levels of power as well as from the same level, including from different sectors in case of a 'health in all policies' approach.
4. State explicitly what the underpinning values and goals are in terms of governance process.
5. Set governance instruments enabling participation but also steering and conflict management capabilities.
6. Design health target setting as an iterative and progressive long-term process.

6.2 Priority selection based on evidence and broad consultations

For the selection of targets to be relevant, it must be rooted in a prior in-depth analysis of the health situation. In this respect, the literature has stressed the importance of considering the context broadly, including the political, practical and technical constraints (McKee & Fulop, 2000) and of taking a long-term perspective (Krieger et al., 2015). In all three countries studied, the situation analysis draws on a mix of consultation process and expert evidence. In Austria and Sweden, the public was consulted by means of online surveys or conferences. Sweden is the only country where the Parliament was involved, albeit mostly as part of the formal legislative process. The evidence-based approach is mostly followed in Germany, where a key role is given to experts, whose analysis is as standardised and systematic as possible and is based on a review of a set of specific criteria. Concerning the evidence, the lack of adequate and comparable data is regularly pinpointed as the main weakness hampering the quality of the situation analysis and then the selection of relevant targets. As the German case illustrates particularly clearly, this stage is often used by experts to flag gaps in existing data and to suggest improvements that should be made within the health information system, in order to correctly assess the situation and monitor progress in the various areas targeted.

The subsequent selection of targets (or of target areas) is often based on a mix of evidence-based and political considerations. As identified in the literature (Wismar, Philippi, & Klus, 2008), targets can be selected following four main approaches: by aligning with priorities set

in other national or international experiences; based on benchmarking and results obtained at national and international level; based on scientific criteria; or according to political importance. As the three countries studied here show, target selection is often the result of a mix of these considerations. Both in Germany and Austria, a series of criteria (or principles as they were named in Austria) have been used. These are expected to make the selection process more transparent, and evidence based. In both cases however, considerable importance was finally given to the criterion of feasibility. This is particularly subject to political negotiations and is key to implementation; it relies on the willingness of stakeholders and the concrete opportunities they have to engage towards the achievement of a specific target. This political negotiation is most evident in Germany, where partner members are specifically surveyed on their commitment and willingness to engage with pre-selected topics; their responses have a strong influence on which topics are finally selected. Alignment with international examples and attention to benchmarking are also features of both the Austrian and Swedish systems, where international initiatives were used to guide the development of the national framework and the selection of target areas.

The selected priorities cover both public health and health care. Past reviews of health target programmes show that most of them address both areas in a comprehensive way (Busse & Wismar, 2002; Obyn, Cordon, Kohn, Devos, & Léonard, 2017). The way the two are interlinked varies, however, depending on the focus and the approach used. In Germany, each target focuses on a separate topic that has emerged as a priority and addresses it comprehensively, including sub-targets that range from prevention to health care and rehabilitation. The perspective however is primarily that of the health care sector. In Austria and Sweden, targets are fundamentally based on a 'health in all policy' approach. As a result, only one target (out of 10) in Austria and one target area (out of 8) in Sweden are specifically dedicated to health care, while the other targets and target areas address broader social determinants of health. Most importantly, the different areas covered are not separate but are part of a single framework geared towards an overarching goal that aims to improve population health. This puts forward a clear vision of what the Austrian and Swedish governing bodies want to achieve as well as of how to do it. The idea of a framework is important in this respect, as well as the need to clarify how health, health care and possibly other sectors are interconnected and what the benefits are for the different areas and sectors to be in the framework. Busse and Wismar (2002) suggested designing these interlinkages within an input-output framework for the health system, where health(care) services are at the centre and help to transform various inputs into specific results and outcomes, to which of course also other sectors can contribute. Using health system frameworks or health system performance frameworks (for Belgium see Gerkens et al., 2024) to conceptualise targets and the links between the different areas they address might help clarify the target framework, facilitate communication to the stakeholders involved as well as to the general public, and support the sense of joint action towards common goals. In the case of a design based on health system performance frameworks, this would also facilitate the monitoring and evaluation process. We come back to this point further below.

Policy recommendations

7. Conduct a comprehensive and in-depth analysis of the existing situation, considering both the evidence and the perspective of the stakeholders involved as well as that of the general public.
8. Ensure the selection process is transparent by clarifying which criteria and principles will guide the selection of priorities, including the political considerations to be considered.
9. Clarify how the different (health and health care) target areas are linked to each other as part of a common framework.
10. Use this stage to start reflecting on monitoring and evaluation and possible improvements to be made to the health information system.

6.3 Formulation as a key, participatory, and systematic process

The formulation process is the next key stage which allows further clarification of what exactly is expected as well as how this can be achieved. It can somehow be considered as part of the implementation itself, and certainly as an essential step towards implementation, since the discussion between stakeholders on priorities and actions to be achieved and implemented is per se already contributing to the underpinning goal of the target-oriented programmes of building consensus, trust and fostering joint actions. This is notably the case of Austria and Germany, where the need to reduce fragmentation and favour coordination between stakeholders is clearly a rationale behind the setting of health targets. We have thus seen that, contrary to Sweden, where the formulation process was in the hands of the public health agency, both in Austria and Germany the formulation process was taken over by separate working groups involving a variety of stakeholders. This participation was considered crucial, also in view of identifying what actions could be implemented towards the health targets and which stakeholders could take the lead in their implementation.

How targets are formulated may vary, although this process often follows a systematic and iterative approach. In the three countries studied, each overall target (or target area) is broken down into the same structure, ranging from longer-term qualitative targets to shorter-term quantitative indicators, and with a general tendency to keep the total number of qualitative targets and indicators limited. In terms of content, it should also be said that, although most of the literature about targets refers to the need for them to be SMART (i.e. Specific/Simple, Measurable, Achievable, Realistic, and Timely), in practice this is not always the case. Our study shows that, although great attention is paid to the quantification and the setting of specific indicators, more qualitative descriptions of specific desired evolutions are often included, and time limits are not always fixed. Concerning the methodology used, both Austria and Germany rely on systematic approaches. Templates were used to standardise the work done by the different working groups, and specific requirements were set to guide the formulation process. In this regard, just as for the selection, the evidence basis is not the only criterion put forward, but pragmatic and political considerations also come on board during this stage. In order to ensure implementation, particular attention is notably paid to actions that are already implemented and that could be funded or scaled up, as well as to

the existing legal framework and the linkages that could be made with other initiatives and programmes. In the case of Sweden, the attention paid to lessons learned from past experience highlights another important aspect of the formulation process, which can be seen as an iterative process that requires time to end up in a full coherent and completed target strategy and that is actually never really ended. This is something also stressed in Austria and Germany, where some of the targets were already updated a few years after their first formulation in line with the idea that the whole target setting is a continuous learning process.

A final lesson is that clear decisions should be made at this stage so as to leave no ambiguity about expectations, even where there is greater flexibility for implementation. In fact, starting specific discussions on multilevel coordination and stakeholder involvement is key to ensuring that important elements of the policy are not ignored. Leaving room for too much uncertainty about what is expected from various actors (and what is not) could have detrimental effects on implementation. This is firstly because uncertainty creates inefficiencies and delays; secondly, and more importantly, because the political momentum for key decisions is likely to fade away and any pending decision left for a later stage is unlikely to be enacted. This is one of the key lessons of the Swedish case, where government officials and experts involved in the drafting of the policy have made many broad statements about the importance of cross-sector and multi-level coordination, as well as expressing commitments to include stakeholders, but refrained from giving any specific blueprint for the implementation of the policy. The Public Health Agency of Sweden was thus left with the difficult task of not only fine-tuning indicators and ensuring the viability of the follow-up structure, but also of translating broad commitments about coordination into a governance structure.

Policy recommendations

11. Consider the formulation as an iterative long-term process punctuated by regular updates.
12. Promote participation in this stage through clear and standardised modalities.
13. Clarify the criteria and principles that should guide the formulation process.
14. Keep the focus on issues where clear changes are both needed and feasible.

6.4 Voluntary implementation needs sustained support

In terms of implementation, our review of the literature highlights that voluntary engagement can be justified if the stated aim of the targets is to stimulate debate on health priorities. Interestingly, all three initiatives studied in this report have paid more attention to the process of target selection and formulation than to their effective implementation. In Germany, the target strategies developed by the working group are mainly understood as preparatory work and recommendations, and implementation has long remained voluntary. In Austria, the mission statement signed by the stakeholders in 2016 officially lays down this voluntary engagement to work together in target setting and implementation. In both countries, this has

resulted in a strong focus on those priorities and actions for which a broad consensus exists and where actions and funding have already been developed and invested. In this sense, this issue of target feasibility is here particularly key. Likewise in Sweden, most attention has been paid to coordination and policy dissemination. In this respect, the three cases highlight the importance of prioritising internal coordination, within the government and state agencies and with broader stakeholders from society and operational bodies.

To ensure continuous progress and a sustained commitment from stakeholders, a support structure as well as a clear incentive and accountability framework are needed. The stakeholders should clearly understand what benefits they can obtain from participating actively in target setting and from engaging in actions towards the targets. As the cases of Austria and Germany show, stakeholders' support for the initiative relies on the possibility of influencing the decision-making process, sharing information, and putting forward their own priorities and actions. Yet, to support engagement and motivation over the long term, other instruments should complement these 'soft' incentives. In both countries, the fact that the health targets were anchored to existing strategies or national legislation has clearly contributed to stakeholders' commitment. This has enabled the optimisation of programmes and resources but has also made some of the targets partly binding for all stakeholders. Assigning the actions planned to the responsibility of specific stakeholders is also a way to support coordination of actions and accountability. In Sweden, continuity has been provided by relying on one 'hub' for coordinating the policy internally and externally. It has contributed to the resilience of the policy through the years but has also resulted in a lowering of its initial ambitions. The lack of a dedicated inter-agency implementation structure has created a situation in which the agency bears most of the responsibility for the implementation of the policy and needs to regularly reach out to other agencies for support.

To support commitment and effective engagement, a variety of resources are needed, including management and administrative skills, adequate information, as well as financial resources. Yet, this seems to be the weakest point of all target-oriented initiatives. The lack of financial resources is particularly flagged in the international literature and has also emerged in the countries studied in this report. Here, the absence of specific funding earmarked for the implementation of targets is partly compensated for by the fact that synergies are built with other existing programmes and that funding thus comes from them. This is notably the case in Austria and Germany for targets specific to health promotion; the potential remains however ad hoc and rather limited. In Sweden, the Commission on Equity in Health also recommended better integration of the health equity target into budgeting, to further support financial collaboration between national agencies, and to use public procurement to promote good and equitable health. None of its recommendations were however retained. The three cases show how challenging it is to link health targets with the national budgetary process. Aligning targets and financial resources is, however, essential to support more resilient health systems, as recognized by the OECD (2022, 2024), which recommends doing so by

setting a clear pluriannual budget. This is the core aim of the reflection and reform process initiated by the Belgian authorities. A first result along these lines was achieved with the selection of cross-cutting projects funded under the 2022-2024 budgetary trajectory, based on the new methodology integrating health care targets; further work is however needed for the targets to guide the whole pluriannual budget. A lesson learned in relation to this last point is that it is essential to clarify if and how the targets are precisely linked to the whole pluriannual budget or to part of it. Finally, as the three case studies suggest, the national budget should also take into account the various resources from multiple organisations and different sources that can be pooled to achieve the same targets.

Policy recommendations

15. Promote voluntary engagement through 'soft' instruments supporting self-commitment and short-term alignment with targets.
16. Introduce a support structure and some form of incentives to support stakeholders' and public authorities' engagement over the long term.
17. Assign clear responsibilities within a defined accountability framework.
18. Ensure that sufficient resources are allocated to the implementation of targets.

6.5 Monitoring and evaluation as a learning process

The monitoring and evaluation of targets is a key issue that is usually discussed from the very beginning of any target-oriented initiative. As mentioned above, the situation analysis carried out in the first stage of the process, to identify priorities, brings to light what data are needed, where information gaps exist, and what improvements can be made in the information system in order to measure progress towards the priorities set. This aspect clearly emerges from all three case studies, with close attention paid to quantitative indicators and baselines from the very beginning. In Germany in particular, attention to data is already flagged in the pre-selection stage, where experts describe the current situation and point out possible problems for the setting of targets and monitoring of progress, due to lack of data on specific topics.

As noted in the literature, for the monitoring and evaluation to be effective, resources are needed, as well as coordination among the different information agencies. The lack of dedicated resources, either human and financial, largely explains why, despite the close attention to monitoring, only few targets are effectively and regularly monitored in countries like Austria and Germany. Here again, the key strategy used to mitigate this problem is that of setting indicators and relying on data that already exists. It is also considered essential to use available baselines and ensure that data can be collected over long periods. The case of Austria also highlights how more supportive and interactive methodologies can be developed to integrate the processes of setting indicators, studying their feasibility, and conducting the effective monitoring and evaluation.

To have comprehensive monitoring and evaluation of the health targets, both outcomes and processes should be assessed. In terms of outcomes, a key lesson from the literature is the importance of defining clearly what goals, objectives, targets and values are pursued and thus need to be assessed. This means that besides the evaluation of the specific health and health care targets set, it is key to make it explicit what overarching goals are expected from the setting and implementation of the health (care) targets and what values underly them (Van Herten & Gunning-Schepers, 2000; Wismar & Busse, 2002). In terms of process, the Austrian and German cases show that the target-oriented initiatives too underwent an internal assessment. The results were only partially used to hold stakeholders accountable; the primary goal was rather to feed into the internal reflection by learning from the past and making the necessary adjustments. It should be noted that this is the area where scientific experts probably play the major role. Particularly where the target-oriented initiative is more institutionalised and led by the central government, as in Austria and Sweden, a specific agency is mandated to support the monitoring process. This does not mean that it is the only body responsible, but that it can support the monitoring and evaluation process by developing baselines and evaluation strategies. This is particularly evident in Austria, where the overall work done by the Austrian National Public Health Institute for the development of meta indicators, which were used to assess the overall target framework, was then completed by the working groups' reflection on indicators that are specific to the various targets.

Policy recommendations

19. Design the monitoring and evaluation as a learning mechanism to be integrated all along the target-setting process.
20. Clarify which organisations should be involved in monitoring and evaluation, as well as their respective roles.
21. Build synergies and collaboration with existing initiatives, to facilitate collection of comparable data over the long term.
22. Focus the monitoring and evaluation not only on outcomes but also on process, including the achievement of the underpinning goals and values pursued.

6.6 Creative communication and dissemination strategies

A final remark to conclude this report concerns the importance of communicating broadly about the target-oriented initiative. In fact, the more transparent the target-oriented initiative, the more the targets are visible to the general public and the greater is the sense of ownership for the stakeholders involved. This double purpose is evident in Austria, Germany, and Sweden. Here, the need to ensure external visibility has been met in various ways: dedicated websites in Austria and Germany, infographics in Austria and Sweden, and user-friendly material summarising key reporting in all three countries. In Austria in particular, one of the guiding principles of the targets is their 'comprehensibility'. In Sweden, the public health agency can use its know-how and resources to communicate efficiently to the local authorities. All three countries use a series of tools, such as coordination meetings, reports and factsheets, statistical data, etc., to support the

internal reflection and exchanges among the organisations involved, enhance the corporate identity of the initiative, and present results. Other key audiences that are targeted for dissemination include the scientific experts, policy decision-makers, as well as international organisations. In this latter respect, the willingness to promote the target-oriented initiatives internationally explains the translation of some of the documents and webpages into English. This is indeed an important dimension of the policy, in a context of increasing internationalisation and Europeanisation of health policies.

Policy recommendations

23. Present both the targets and the target-setting process in ways that make them visible and clear for the wider public.
24. Design the communication strategy to keep all stakeholders informed and foster their sense of ownership and commitment.

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