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Setting targets for Health 2020

The purpose of Health 2020 is to improve the health and well-being of European populations. Using the best available evidence, its implementation across the countries of the Region should reflect this purpose and gain this end result. The SCRC has previously debated and agreed on the use of targets to measure progress with and success of the implementation of Health 2020. This short discussion paper proposes a process and mechanisms for the development of such targets. SCRC members were requested to provide guidance and comments on this draft proposal, suggest necessary revisions and nominate experts to serve as focal points for the further development of targets for the European Region.

Установление целевых показателей для политики Здоровье-2020

Конечная цель политики Здоровье-2020 – улучшить здоровье и повысить уровень благополучия жителей Европы. Ее практическое осуществление странами Региона с использованием наилучших имеющихся фактических данных должно отражать эту цель и привести к ее успешному достижению. Применение целевых показателей для количественной оценки прогресса и успешности в реализации политики Здоровье-2020 было обсуждено на уровне ПКРК и утверждено его решением. Настоящий краткий документ содержит предложения, касающиеся процедуры и механизмов разработки таких целевых показателей. Членам ПКРК было предложено дать рекомендации и замечания по этому проекту, указать на необходимые изменения и назначить экспертов-координаторов для дальнейшей разработки целевых показателей для Европейского региона.

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Introduction

The purpose of the Health 2020 is to improve the health and well-being of European populations. Using the best available evidence, its implementation across the countries of the Region should reflect this purpose and gain this end result. The question relating to targets is whether, and how, targets can assist this purpose. Targets are not an end in themselves; they are a means to an end, which is to motivate and inspire the take-up of Health2020 and its implementation. Taken together, all the targets should ultimately aim to promote health and well-being, by setting realistic goals and monitoring progress towards those goals as the Health 2020 policy is implemented.

This short paper sets out some of the issues that have emerged from experience and the literature on targets, which were discussed at a meeting of the Health 2020 Internal and External Steering Group in February 2011 as well as the two following SCRC meetings. Moreover, it proposes a working process for the target and indicator development, it outlines potential methodologies, with examples in the area of noncommunicable diseases (NCDs), and provides a draft roadmap for the implementation of this process.

1. Background – the rationale for targets

In our context of Health 2020 a target can be defined as "a desired goal". The desired goal is health improvement at the outcome level, and outcome targets would be drafted in these terms of, for example, reductions in mortality or morbidity. In addition, where improvements in health at the outcome level can be linked to processes or outputs, with adequate scientific evidence, targets can legitimately be drafted in input, process or output terms, including increases in public health expenditures or introduction of legislation fostering public health.

In thinking about the role of targets in Health 2020, some consideration needs to be given to the principles of performance measurement and accountability. In the case of Health 2020, this discussion is complicated as in this case accountability can only be collectively attributed to and shared among Member States. If citizens collectively are the ultimate principal in a complex accountability chain, we should ask how well the policy and the systems serve those citizens.

1.1 The use of indicators

One of the difficulties is to find the appropriate mix of indicators that can validly and reliably reflect progress towards strategic goals. In health policy the time lags between policy interventions and their impact on health status, as well as the difficulties of attributing an impact to specific policy interventions, has usually encouraged the use of process or output indicators over outcome indicators.

It is the coherence of process, output and outcome indicators that lies at the centre of measuring progress towards the targets. All need to be measured as long as the causal link cannot be ascertained. All need to evolve in a dynamic fashion as the link is being tested, for example when process indicators improve, is there an improvement in outcome indicators?

1.2 The use of targets

Historically, in the WHO European Region targets were first suggested as part of the first common health policy: the European strategy for attaining health for all. The European Strategy called for the formulation of specific regional targets to support the implementation of the strategy. Aptly described as a “wonderful blend of today’s realities and tomorrow’s dreams”, 38 specific regional targets were adopted at the thirty-fourth session of the Regional Committee in Copenhagen in September 1984, together with 65 regional indicators to monitor and assess progress. The European HFA policy and Targets were updated in 1991 and a renewed policy “Health21 – health for all in the 21st Century” was adopted by the WHO Regional Committee for Europe in 1998.

More generally, targets have been associated with reductionist views of system behaviour and performance, as well as with mechanisms of hierarchical thinking and control. However, the present literature on health systems increasingly considers these as systems characterized by complexity and uncertainty and targets may contribute to improve clarity of expectations, motivate performance and improve accountability in this context.

Targets should be adaptable and dynamically assessed; in the context that policy implementation is a heuristic process which is never definitively completed. A crucial theoretical consideration concerns the availability of data. All targets for health depend for their utility upon the availability of comparable data of reasonable quality and reliability. In practice this is often a key constraint. This consideration needs to be kept clearly in mind as the Health 2020 targets are formulated, either for Regional or country use. However, experience in the European Region has shown that setting targets and indicators can be a huge motivating factor in countries collecting and incorporating in their routine information systems the necessary data to inform Public Health policy even where in the past such data did not exist.

There are some positive elements in an assessment of the utility of targets. These can be summarized as follows:

- targets, for example the Millennium Development Goals (MDGs), can be very successful in raising awareness and facilitating political and organizational support;
- targets can reflect a scientific view on the future, in terms of achievable improvements in population health;
- targets can provide a learning experience for stakeholders;
- targets can be seen as a tool for strengthening accountability and communication;
- targets can provide a map for partners;
- targets can serve as a reference point for day-to-day action; and
- targets can provide motivation for action.

However some possible negative characteristics of the use of targets can also be described:

- targets can be difficult to align with strategy;
- there is a risk that priority will be given to targets that can be measured easily (“what can be measured gets done”);
- targets are liable to “bureaucratic capture” – elements of the organizational bureaucracy justify their existence in terms of a target and every element wants one!;
- targets are subject to a “law of diminishing returns”- achieving the last few percentage points of a target may be very resource demanding;

- targets may be associated with "gaming" – managing the target rather than the task;
- targets may be seen as burdensome and de-motivating, if the targets are too many or too complex; and
- targets are often expressed in terms of averages, e.g. the MDGs, hiding distributive or equity issues that will be fundamental for Health 2020.

These issues were considered at a Health 2020 Internal and External Steering Group on 25 February 2011. The following main points were made concerning the use of targets within Health 2020. Targets in Health 2020 should:

- recognize country autonomy by being set at European rather than country level, hence targets should be relevant for the whole region and at the same time considered of significant importance for every Member State (there may be profound differences in outcomes among countries and one approach would be to use the best country rate for each indicator as a target for Europe);
- be inspirational and promote learning and engagement;
- avoid overly simplistic quantitative targets by recognizing complexity;
- refer mostly to the "what" and not the "how";
- be realistic and doable;
- be understandable and measurable;
- look at trends where possible;
- be limited in number (participants proposed that there should be around 10-15 targets in total);
- be a mixture of quantitative and qualitative targets (it was suggested to set qualitative European targets, but to put a requirement on countries to set quantitative targets and decide themselves how great a commitment they would like to make). Another possibility for targets would be a percentage reduction with respect to a reference year, although this would have to be adjusted with a sliding scale in order to avoid penalizing countries with better performance;
- be a mixture of outcomes, determinants, risk factors and process. There should be a good balance between different types of targets t set targets for risks is easier and it is easiest to set process targets);
- include input targets, such as on investment, capacity and resources. It was noted that input targets for health may be output targets for other sectors;
- include some "close-the-health-inequalities-gap" type of targets;
- include policy and technical targets. Policy targets could be, for example, health systems targets within health financing (e.g. budget declaration), while technical targets could, for example, be built in on the MDGs; and
- Member States should be encouraged to develop their own national targets for health (and include local levels where depending upon the country interventions may be implemented); the specific context should be the development of national policies for health.

At the Internal and External Steering Group, the Regional Director for Europe provided a summary of conclusions.

- targets should be included in Health 2020;

- targets should be relevant for the whole Region, we especially need targets for the whole WHO European Region on cross-border issues;
- a mixture of quantitative and qualitative targets should be formulated, for example qualitative targets might be set at European level and countries encouraged to set quantitative targets on their own;
- a limited number of targets should be set (perhaps 10-15), which should be realistic but at the same time inspirational;
- Member States should be involved in the development of Health 2020 and the development of national policies for health, while WHO needs to convince countries to commit themselves to targets as countries may use European targets when it makes sense for them to do so;
- a translation exercise would be useful to assist countries, for example by the use of tool kits prepared by the WHO Secretariat; and
- mechanisms for accountability need to be considered, including perhaps WHO evaluations, and published intercountry comparisons?

Decisions would need to be taken on the process and frequency of monitoring the targets, taking into account the resources needed for monitoring in countries and for the WHO European Region. New data collection may have resource implications. An exercise to establish baseline data may be required.

A further consideration is the need to make explicit reference to existing globally set targets and strategies at the global level that all countries have agreed. Here the MDGs are crucial, as are other global and regionally set targets. The working group may wish to more formally review these global and regional commitments.

2. Principles and areas for Health 2020 targets

Targets for Health 2020 should be SMART, that is:

- Specific
- Measureable
- Achievable
- Relevant
- Timely

Specific targets are more likely to be accomplished than general goals; hence targets must be clear and unambiguous. In order to arrive at measureable targets, concrete criteria for measuring progress must be established. For targets to be achievable, they must be realistic while at the same time set against a defined time scale. Targets are considered relevant when they represent objectives towards which the policy is able to work. Targets must be grounded in a timeframe, preferably with deadlines, even if they are likely to be purely symbolic.

Every target should represent real progress and may be qualitative or quantitative. The SMART objectives should apply for both *qualitative* and *quantitative* targets. Targets can and probably should be set for inputs, processes and outputs, as well as outcomes of the Health 2020 policy.

The six areas for target development commensurate with the Health 2020 approach and discussed and agreed at the SCRC meeting on 12th May 2011 include:

1. **Governance** for health and well-being;
2. Tackling the determinants of health and **health inequalities**;
3. Investing for **healthy people** and empowering communities;
4. Tackling systemic risk: the major **burden of disease**;
5. Creating healthy and supportive environments and assets for a healthy environment (including **risk factors**); and
6. Strengthening people centred **health systems**.

This may include two high-level targets per area, in addition to *potential* subtargets. For each target and subtarget, an indicator has to be identified which must not only be measurable but data or information have to be available. If such information has first to be collected afresh, it will hamper the process.

For each area some conceptual considerations are discussed below and possible illustrative targets are put forward, solely as a basis for further discussion and debate by the SCRC. In addition to the conceptual considerations for each of the six areas, attention should also be given to the attributes of the overall package of European targets, balancing for example process and outcomes targets.

2.1 Governance for health and well-being

The new European health policy cannot succeed without considerable changes in the way in which governance for health is handled. This means taking a systemic approach to new types of leadership, engagement and democratization. The issues here include the adoption of an explicit focus on health as a human right, a global public good, a component of well-being and a matter of social justice, as well as the adoption of whole-of-government and whole-of-society models and approaches to allow for health protection and promotion through intersectoral work and Health in All Policies.

The initiatives outlined below will often – but not always – be spearheaded by the Ministry of Health, whose leadership role will expand from being (in many cases) the manager of the health care system to actively engaging with all sectors to make health a cornerstone of national development.

Possible target areas may include:

- specific, objective initiatives to establish high-level governance for health – with a direct link to the head of government – which bring together all sectors of government to engage in synergistic policy-making for health and well-being;
- the country explicitly recognized the human right to health in published/ official health policies, strategies and plans;
- the country demonstrates commitment in legislation and government actions, and in multiple sectors of society, to the expansion of governance for health through Health in All Policies;
- objective existence of specific mechanisms and rules to ensure effective collaboration between the health sector and other sectors on issues affecting health and well-being. Health impact considerations should be incorporated in decision-making in all sectors and activities. These mechanisms also consider the distribution of opportunities and impacts. The contribution of these mechanisms is assessed on a regular basis by independent bodies and through citizen involvement; and

- improved governance capacities for health through objective mechanisms for civil society action and the expansion of self governance for health (health literacy, empowerment, self reliance etc).

There are specific tangible commitments and results from working with other sectors which illustrate this. The following may serve as examples:

- Taxation
  - objective parliamentary initiatives and legislation reflecting taxation of tobacco and alcohol; and
  - achieving full implementation by all European countries of the Framework Convention on Tobacco Control (FCTC) and the global alcohol strategy, as demonstrated by input, process and output indicators/targets.
- Regulation
  - joint work with the transport sector resulting in effective regulations on alcohol and driving; joint work with agriculture and food sectors resulting in effective regulations on food quality and safety; and
  - joint work with environmental sector resulting in health-focused environmental regulations.
- Education
  - working with the education sector resulted in regulations aiming to ensure healthy school environments and increasing health literacy.
- Cooperation
  - working with the food industry, food retailers etc resulting in regulation in order to ensure lower levels of salt, trans fats and sugars in the diet; and
  - working with agriculture to objectively promote a diet richer in fruit and vegetable and with less meat.

2.2 Tackling the determinants of health and health inequalities

One of the main approaches characterizing Health 2020 is that of tackling the social determinants of health and inequalities in health. Recent reviews of the social determinants of health indicate the importance of focusing on early childhood development; hence consideration might be given to a target related to this issue.

Given the importance of income and education in relation to health inequalities, other options might include an increase in the proportion of households that have an income sufficient to support health and well-being, or in the number of years of education.

Issues here include the health and well-being of the population of the WHO European Region overall and the differences among and within countries (“closing the gap”).

Possible target areas may include:

- creating a formal mechanism for addressing inequalities and reducing them, concerning both the health system and other sectors;
- reducing health inequalities in the WHO European Region – here two targets could be considered: one for reducing the gap among countries and one within countries;

- increasing health literacy; and
- downstream targets which could result from the above, including increases in healthy life expectancy or reductions in the burden of disease (DALYs and/or mortality) in European countries with large improvement in lower social classes.

2.3 Investing for healthy people and empowering communities

Health 2020 places a strong emphasis on people and people-centred policies and systems through a life course approach with special concern for the disadvantaged. Moreover, the WHO definition of health puts physical, mental and social *well-being* at the centre of health, rather than the mere absence of disease. Measuring health rather than disease is a methodological challenge which has recently received more attention and should be further explored in this target-setting exercise.

Two or three targets may be formulated addressing the health of the very young, older people, and vulnerable groups, including minorities, migrants and Roma. For example, a target might be formulated related to the reduction of child poverty.

Well-being targets, including health perception are not currently mainstreamed but may wish to be discussed by the SCRC. In order to facilitate the discussion, the WHO Secretariat performed a rapid review of the literature on well-being indicators and composite indices. A total of 3,242 documents were identified; of those 159 citations included indicators or measurements. These 159 were retrieved and examined for a) the availability of definitions of well-being, b) descriptions of tools for measurement and c) a differentiation of subjective and objective measures as inclusion criteria. Several reports were identified (full review available from Secretariat upon request) which describe well-being measures in the following areas:

Economics:
Economic security (incl. employment, retirement)
Defensive expenditures (prisons etc)
Leisure (time & access)
Non-market activities (beyond GDP)

Health:
Subjective quality of life (happiness)
Mortality & life expectancy
Morbidity (measured)
Nutrition

Education:
Inputs (school enrolment, expenditures etc)
Outputs (graduation rates, completed years of schooling, literacy & other cognitive skill rates)
Competencies (measured)

Societal/Community:
Political voice (legislative guarantees, independence from corruption etc)
Access to health care
Social connections (political engagement, voluntary work etc)

Security:
Personal security – subjective low fear of crime, disasters
Crime

Environment:

Transport (public, quality, access, commuting time)
Work/occupational
Housing
Pollution
Access to safe water

The only measures of well-being that all reports have in common concern the areas of economic security (employment, disposable income, etc) and morbidity. With one exception all reports specifically recommend and include measures of subjective well-being, such as self-reported health or health perception in their tools; in this regard, the Commission on the Measurement of Economic Performance and Social Progress[1] is particularly insistent. Two publications propose a composite index of well-being. It will be important for the Regional Committee to discuss and identify the relevant well-being domains for Health 2020 which merit further work by the Secretariat.

Empowering communities implies that public health and health system policies and governance should be people centred and focused on the life course approach. The overall vision is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. The health system should be designed around citizen and stakeholder needs and abilities.

Possible targets may include:

- reducing child poverty;
- achieving a significant improvement in child health and well-being;
- increasing disability-free life expectancy;
- creating people-centred services for the elderly and implementing policies allowing for palliative care and dying with dignity;
- developing specific policies which focus on the health of vulnerable groups e.g. migrants, the Roma; and
- developing new targets and indicators to measure health rather than disease.

2.4 Tackling systemic risk: the major burden of disease

In the European Region, noncommunicable diseases (NCDs) are responsible for the largest proportion of mortality; they accounted for about 80% of deaths in 2008. NCDs also dominate the list of the leading causes of the disease burden in Europe. Emerging and re-emerging communicable diseases remain a significant public health problem, as do external causes of death and disability, especially for young people.
Issues here include tackling the major elements of the disease burden across the full range of determinants.

Possible targets may include:

- reductions in the burden (DALYs, mortality) of selected diseases (see chapter IV); and

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[1] Stiglitz JE, Sen A, Fitoussi J-P. *Report by the Commission on the Measurement of Economic Performance and Social Progress.* Paris, CMEPSP, 2009 (http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf).

- implementation of effective strategies for NCDs designed explicitly to reduce the disease burden and implementation of effective strategies for communicable diseases, in particular HIV/AIDS and MDR TB.

The indicators to estimate progress with these targets will likely be disease and mortality based.

2.5 Creating healthy and supportive environments and assets for a healthy environment

In this area the core is about three main areas of interventions: making the healthy choices the easy choices; ensuring a safe (reduction/elimination of harmful exposures) and creating physical and built environments that are conducive to health; and investing in creating conditions (health assets) that will enhance the ability of individuals, communities and populations to maintain and sustain their health and well-being. These assets can be identified at the level of individual, group or entire community.

Possible targets may include the following points.

a. Actions of governments and civil society to promote health and fight disease (with a significant public health and health system contribution). Specific targets could be developed in the following areas:

   - enhancing the abilities and opportunities for people to make and sustain healthy choices through:
     - curbing the use of tobacco and reducing exposure to tobacco smoke (smoke free public places)
     - reducing salt and trans-fats consumption
     - halting the obesity epidemic (access to healthy food and opportunities for active living)
     - halting HIV/AIDS epidemic
     - reducing the harmful use of alcohol (access)
     - increasing physical activity (for example building cycling lanes); and
   - reducing exposure to chemical environmental pollutants, and harmful physical and biological factors in the environment, especially through protecting vulnerable subpopulations, such as children, pregnant women, etc.

b. Working with governments (including local governments) and civil society to build healthy and supportive environments (urban health is increasingly important) and health assets:

   - for example older-age friendly cities
   - Health literacy
   - Social networking

c. Strengthening the role of local governments in health promotion (for example this is a major government priority in most Nordic countries).

2.6 Strengthening people-centred health systems

The issues here include the creation of health systems which are effective across the whole spectrum of health promotion, disease prevention, therapy and rehabilitation and which are affordable and do not impose an intolerable financial burden on users.

Accordingly the targets selected in relation to public health and health systems should respond to the four key functions of health systems:

- enhancing health system governance for greater accountability and performance;
- strengthening health financing arrangements for greater resource mobilization, more equal resource distribution and greater efficiency of spending;
- improving access to and quality of public health and individual health services; and
- overcoming key barriers in resource generation for high quality health system inputs.

Possible targets might be framed around issues such as: whether coherent policy frameworks are in place; the share of out-of-pocket payments for health expenditure; the level of public spending on health in relation to overall general government expenditures; the potential years of life lost for medical conditions amenable to prevention and management in health care setting; potentially preventable admissions; pharmaceutical supply and regulation, and geographical distribution of care for example.

Possible targets include:

- enhancing health system governance for greater accountability and performance;
- ensuring affordable, high performance and person centred health systems (NB Targets could be set for processes and outputs that the health system can itself achieve e.g. mechanisms of patient participation, the establishment of integrated disease management programmes);
- improved population coverage related to immunization, screening, and reduced prevalence of antimicrobial resistance;
- overcoming key barriers in resource generation for high quality health system outputs;
- strengthening health financing arrangements for greater resource mobilization, more equal resource distribution, greater efficiency of spending and the avoidance of catastrophic out of pocket expenditures;
- improving access to and quality of public health and individual health services;
- evidence of commitment to strengthening of public health capacities and services (e.g. minimum budget for public health and health promotion, effective legislation, etc); and
- ensuring health security in the Region.

3. Process for target setting in Health 2020

The process for target and indicator setting is not trivial and previous experience during the Health for All approach in the 1980s and 1990s and more recently the goal setting for the Millennium Development Goals (MDGs) has shown that a well-organized mechanism is important to achieve SMART outcomes. The process of target setting will need to include a monitoring framework and structured reporting, as well as elements of interpretation of indicators and targets.

The process of target setting has to be participatory without being too complex and cumbersome. The WHO Secretariat proposed forming a small working group on targets and indicators composed of the following members:

- five national experts from Member States (represented in the SCRC and the High Level Forum) with expertise in the six areas highlighted above, in addition to expertise in health information;
- senior staff from the Regional Office for Europe; and
- staff with experience and expertise in target setting and health information from Regional Office for Europe and from the five areas above.

SCRC members endorsed the proposal of establishing this group and agreed on representatives for the group at the May 2011 SCRC meeting in Geneva. The representatives of the following Member States have been nominated for this working group:

- Andorra (Current Chair of SCRC)
- Poland
- Sweden
- Turkey
- Ukraine
- The United Kingdom of Great Britain and Northern Ireland
- Former SCRC Chair, Dr Vladimir Lazarevik (the former Yugoslav Republic of Macedonia)

The group is chaired by a representative of a Member State with strong background in this area (Sweden). It is co-chaired by the WHO Regional Director for Europe. The group meets *virtually* (i.e. via video or teleconferencing) every 1-2 months and physically in connection with the SCRC and Regional Committee meetings. The group can co-opt other experts as required but it is expected that most of the background work submitted to the group would come from the WHO Regional Office for Europe staff members. The group should maintain close links with the Measurements and Targets Task Group of the European Social Determinants (Marmot) Review and other relevant groups.

The *terms of reference* for this group were agreed in the first teleconference and for the duration of this working group as follows:

- finalize the modus operandi of the working group including a roadmap (*potential draft roadmap outlined under last heading*);
- summarize the results of the discussions within the SCRC and WHO Regional Office for Europe in relation to Health 2020 targets and examine previous target setting exercises (documented by Agis Tsouros's group);
- agree on the technical methodology/ies used for target and indicator setting; the group should place particular emphasis on recommending a process and methodology for the development of qualitative targets;
- identify salient issues for presentation at the upcoming RC61 in Baku;
- establish two high-level targets for each major area, and discuss and propose up to two subtargets for each high-level target;
- research and propose indicator(s) for each target that follow the principles outlined under heading (2) and for which information is available;
- oversee the consultation with Member States which is to be coordinated by WHO Regional Office for Europe; and

- propose and finalize the targets to be presented at Sixty-second Regional Committee for Europe in connection with the finalized Health 2020 policy.

4. Methodologies for target setting and identification of indicators – examples from targets area four (burden of disease)

The technical methods used for target setting and indicator development vary according to the objectives to be attained. One set of methods is presented below in an **extremely simplified** way for illustrative purposes (NB: these are only illustrative due to time constraints). Targets shown in this section have been selected from the area of NCDs and suggestions made by the DNP Division have been respected.

4.1 The counterfactual method

This method is based on comparing a biologically achievable or theoretical minimum with existing reality as described by available information. This was first introduced by Murray and Lopez[2] in 1999 as a taxonomy of counterfactual exposure distributions that assist with mapping policy implementation options. These include distributions that correspond to a theoretical minimum, a plausible minimum, a feasible minimum and a cost-effective minimum of any risk factor or target described. In terms of risk factors and resulting burden of disease, this method takes account of the fact that certain burden of disease will be unavoidable, no matter how favourable the environment.

An illustration is given below using premature mortality from cardiovascular diseases (CVDs), which could be a target for NCDs (using premature mortality is *purely for illustrative purposes* and may not be appropriate, as it excludes the elderly as an important vulnerable group). The target content can be formulated in different ways, including:

- a reduction of CVD mortality in the WHO European Region by 2020 by at least x% with the most significant reductions achieved in countries with currently the highest rates; and
- a reduction of CVD mortality in the European Region to the current EU15 (or other) average. This would immediately become a quantified target, as it would state that the European Region average should decline from 111/100 000 in 2010 to at least 98/100 000 in 2020.

The indicator for this target could be the “standardized death rates (SDRs) from CVD per 100 000 in the age group 0-64 years”. Fig. 1 shows the SDRs from premature CVD of all countries in the European Region. It also shows the average rates for the EU12, the EU15 and CIS countries. To achieve an SDR of zero would be a *theoretical* but not physiological plausible minimum rate. It could be argued that given the right environment and conditions, all countries in Europe should be able to attain the lowest rate (in this case the rates of Israel) as it is already a biological reality, hence *plausible*. Alternatively, it could be argued that countries with the highest rates should be able to attain the average of either the whole region, EU12, EU15 or CIS as definitely a *feasible* minimum. In order to debate a *cost-effective* minimum, further information from intervention studies will be required. The choice of the standard (the

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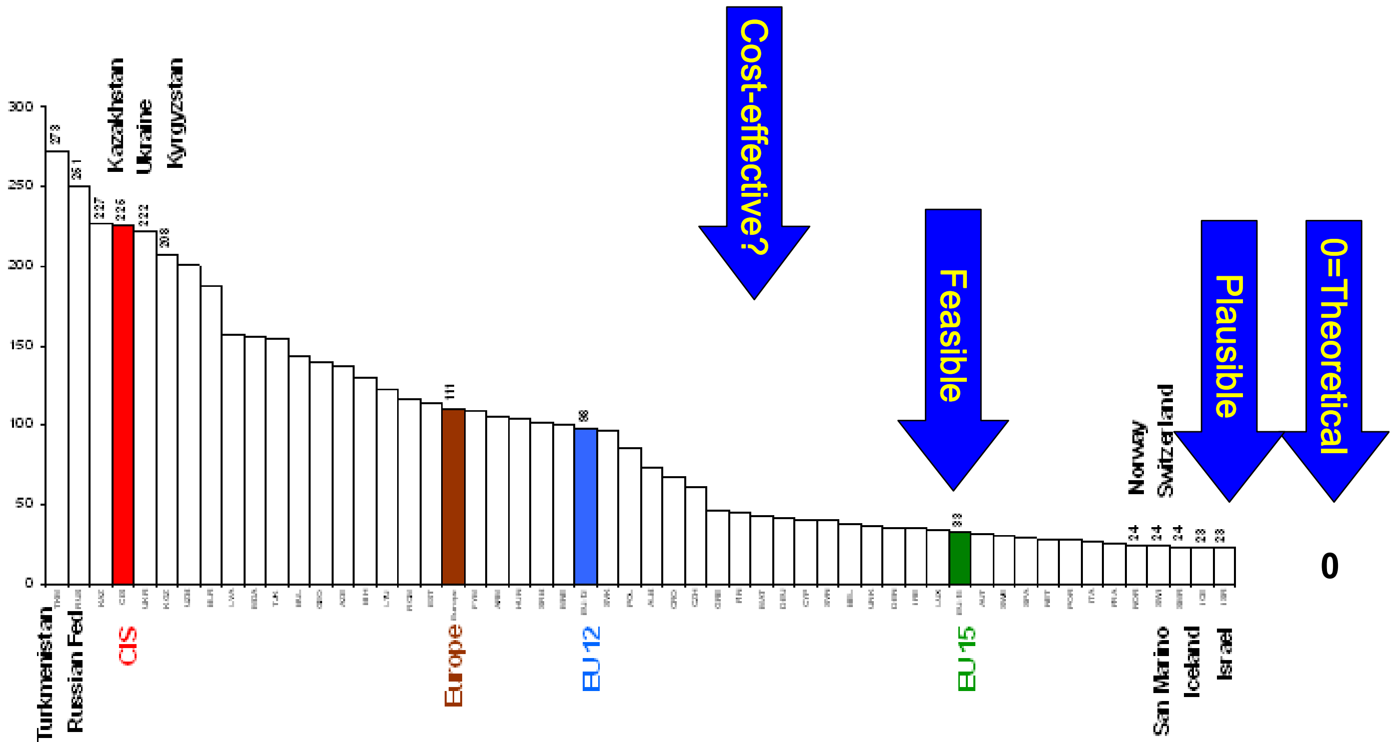
[2] Murray CJL, Lopez AD. On the comparable quantification of health risks: lessons from the global burden of disease. *Epidemiology*, 1999; 10: 594-605.

'counterfactual') against which progress will be compared and the target be set would either be through expert opinion, consensus or other methods (described further below).

Fig. 1: SDRs per 100 000 for CVD in both sexes aged 0-64 years*



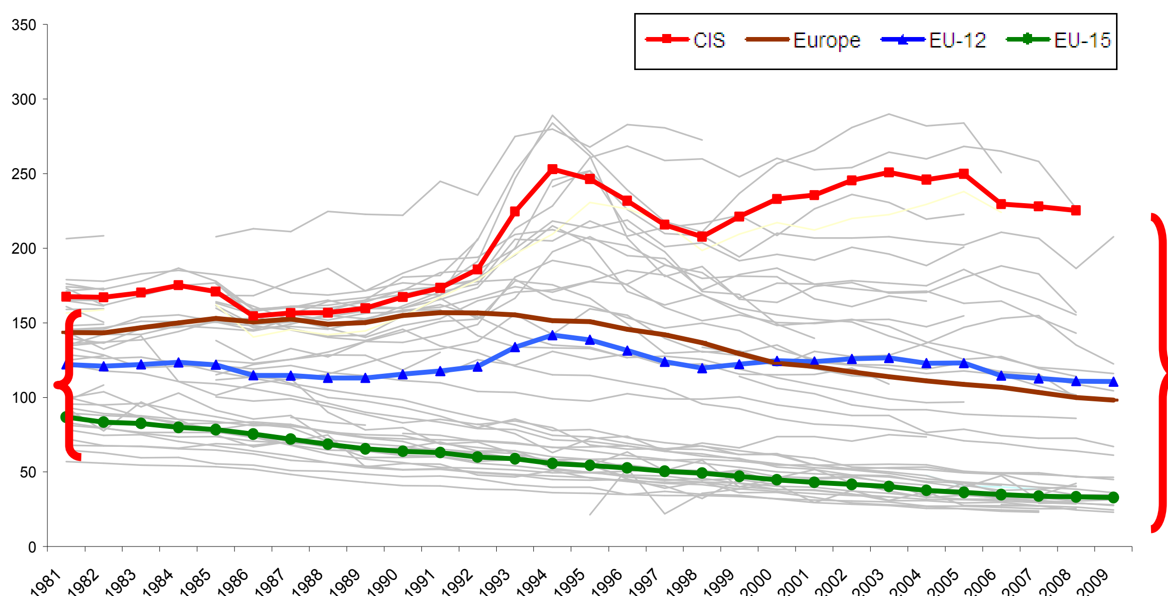
* latest year of reporting varies from country to country

The difference between the highest-rate and the lowest-rate country in Fig. 1 is more than ten-fold. The difference between the highest rate and the EU12 average, for example, is 2.5-fold. Depending on which rate is used as the counterfactual or target rate, the percentage reduction of the target would vary. Alternatively, the positive reverse of mortality, i.e. life expectancy, can be used; the highest life expectancy in the region can be used as counterfactual for regional comparisons, thus describing health rather than mortality.

In order to quantify this sensibly, further steps would be required. These are outlined below (NB: There are numerous factors which determine the differences in rates but an important one is overall mortality where low rates of cause-specific mortality may only be a reflection of high rates of competing mortality from other avoidable causes).

Another illustration in CVD mortality demonstrates how *trends* in rates can be used to arrive at a target, this time in the area of inequalities. Fig. 2 below shows how premature mortality from CVD has changed over time in Europe. It demonstrates, among other things, that the differences in rates between different parts of the Region have increased over time, particularly in the last 20 years. This may lead to the formulation of a target that reads as "a reduction in the inequalities in CVD mortality within the European Region by x%". The indicator would be the "proportional difference in CVD mortality between the highest and the lowest countries". Alternatively, the target could be to "reduce the differential of CVD mortality between CIS countries and the EU average by x%" but many different options are available.

Fig. 2: SDRs per 100 000 for CVD in both sexes aged 0-64yrs over time



In order to assess whether a quantified target is realistic, further analysis is required. This would include the examination of correlations using predictor variables, particularly those that are prone to interventions or the analyses of quintiles where the countries within the "best quintile" are examined for commonalities. This requires more detailed knowledge of the effectiveness of interventions to reduce either risk factors/determinants or disease directly.

Such an analysis would examine the commonalities of countries/regions with the highest and the lowest rates (further detail on this method is available upon request).

4.2 Other methods

This section is not exhaustive and does not list all available methods but briefly outlines two other approaches that can be used for the refinement of target setting in the areas described above (NCD burden):

- **Pooling of intervention studies**: Studies examining and quantifying the effect of interventions (including cost–effectiveness) from various countries in Europe can be pooled and the per cent reduction of the outcome (due to the intervention) can be used as a quantifier for the target. These are important as they link directly with policy options.

  Theoretical example: Aggressive use of 'statins' and certain health systems improvements have reduced CVD mortality by 5% in some countries; hence the target could be a 5% reduction in premature CVD mortality rates.

- **Comparative risk assessments**: Studies examining and quantifying the effect of risk factors on disease, as well as predicting development of disease burden based on predictions with changes in the determinants over time. There is plenty of literature on this subject, especially from the WHO Regional Office for Europe.

  Theoretical example: Reduction in tobacco consumption has impacted CVD mortality with reduction of 10% in some countries; hence the target could be a 10% reduction in premature CVD mortality rates.

The working group proposed should agree on the methodologies used for target setting and indicator development. It should make special efforts to propose qualitative targets, which may require an additional process of identification and consultation.

5. Roadmap for target setting in Health 2020

This section outlines a *potential* roadmap for the working group described under section 3 in relation to the six target areas outlined in section 2. This draft roadmap will require extensive revision and refinement by the working group.

Time frame	Action/s	Outputs	Responsible Officer/s
By 15 May **2011**	Composition of Targets Working Group and modus operandi agreed with SCRC	Target Working Group	Health 2020 lead WHO Regional Office for Europe
By mid-June	1) Terms of Reference and roadmap for group finalized 2) Analysis of SCRC/WHO discussions and other target setting exercises performed	1) Detailed roadmap and action plan 2) Summary paper	1) Chair and WHO staff 2) WHO staff
By end August	1) Key issues and questions identified for RC 61 2) Content of technical briefing to RC agreed and prepared	1) Summary paper 2) Presentation and short paper	1) WHO and Chair 2) WHO and Chair
By end October	1) Methodologies for target and indicator setting analysed and proposed 2) Draft targets and indicators identified for discussion in SCRC and High-Level meeting in Jerusalem (November 2011)	1) Summary paper 2) Summary paper	1) Member of working group (TBA) and/or WHO 2) Member of working group (TBA) and/or WHO
By January **2012**	Comprehensive paper developed for written consultation with Member States	Consultation paper	WHO Secretariat
By April 2012	1) First round of final targets, subtargets and indicators following written consultation with MS: - Governance - Inequalities - Healthy People - Healthy Environments & well-being - Burden of disease (NCD focus?) - Health Systems Performance 2) Discussion and agreement of targets to go forward to RC62	1) Discussion documents for circulation to WHO and SCRC? (others?) 2) NFF of necessary revisions	1) Members of working group and WHO 2) Leads of each target group & Chair