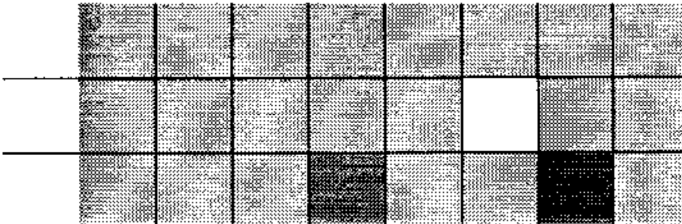
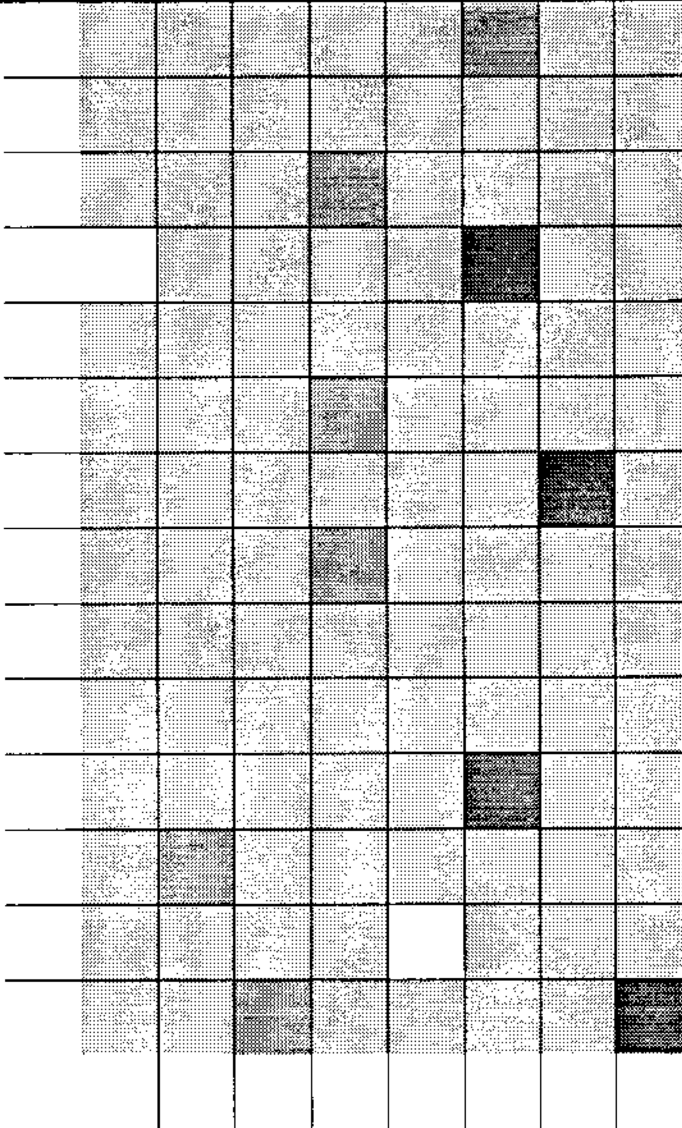
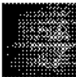
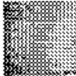


HEALTH GOALS and TARGETS IN AUSTRALIA



Information Circular No. 28

EPIDEMIOLOGY AND HEALTH INFORMATION BRANCH

April 1994

PURPOSE IN SETTING GOALS AND TARGETS

Health goals and targets are used in an increasing number of countries to indicate the direction and pace of change considered desirable in pursuing improvements in the health of populations. They provide tools to monitor and review progress and to guide resource allocation (Nutbeam et al, 1993:5). Goals and targets can also focus attention on the challenge of improving equity and efficiency in achieving better health.

In October 1991, the Commonwealth Department of Health, Housing and Community Services awarded a grant to a team from the University of Sydney, Department of Public Health to review the existing national health goals and targets, and to recommend directions for the development of a national strategy to promote their implementation. One of the major aims was to assist in improving the effectiveness of health promotion in Australia.

The report *Goals and Targets for Australia's Health in the Year 2000 and Beyond, 1993,* produced by the review team used health goals to represent a vision for the future - the outcomes of which, in light of current knowledge and resources, the country might reasonably hope to achieve. In contrast to goals, targets are specific and measurable.

The Australian report (1993:13-14) not only emphasised the importance of preventing avoidable disease and minimising its impact on the quality of life, but also focused attention on the possibility of changing lifestyles and living conditions to improve health. The report included targets which relate to health literacy and health skills, and, in order to represent fully the social and environmental determinants of health, new goals relating to healthy environments were also proposed.

There appear to be many technical problems associated with the monitoring of the Australian National Health Goals and Targets in their published form. Those involved in monitoring progress towards the goals and targets have identified numerous errors in the technical quality of several of the goals and targets and their respective national baselines. A large number of targets were set, but many of them were not measurable. Several of the baselines used were problematic, and there were inconsistencies in standardisation across the report. The Epidemiology and Health Information Branch publication, *Queensland Progress in Achieving National Health Goals and Targets for Preventable Mortality and Morbidity, 1993,* released in March, 1994, monitors trends for Queensland and addresses some of the technical problems identified in the national report.

HEALTH GOALS AND TARGETS IN AUSTRALIA

The framework developed in the Australian report (1993:13-14) included a range of goals and targets grouped in four areas:

- preventable mortality and morbidity;
- healthy lifestyles and risk factors;
- health literacy and health skills; and
- healthy environments.

A fifth group examined opportunities to develop separate but related targets for the health care system though no goals and targets were actually set in this chapter of the report. The full set of targets are in the National Health Goals and Targets publication (1993). They are currently being refined by four implementation committees.

The following section discusses targets set in Australia for preventable morbidity and mortality. Cardiovascular disease, cancer, injuries and mental health are focused on, as they are the four national priority areas set by the health ministers. The other three major groups of targets will be discussed in subsequent reports.

Cardiovascular mortality and morbidity
(Appendix, Figures 1 and 2 for Queensland)

Cardiovascular disease remains the leading cause of death in Australia . The mortality rate for males is significantly higher than for females. There is evidence that at least three of the major risk factors for cardiovascular disease - smoking, physical inactivity, and blood pressure levels - are higher among low socioeconomic groups. Primary prevention needs to be extended and intensified to ensure that all socioeconomic and ethnic groups share in the decline in heart disease mortality (Nutbeam et al, 1993:33-34).

Targets included:

- to reduce mortality from heart disease among men aged 30-64 years (by 30 percent by the year 2000 from a baseline in 1986 of 145 deaths per 100,000);
- to reduce mortality from heart disease among women aged 30-64 years (by 25 percent by the year 2000 from a baseline in 1986 of 44 deaths per 100,000);
- to reduce mortality from stroke among men aged 30-64 years (by 60 percent by the year 2000 from a baseline in 1986 of 23 deaths per 100,000);
- to reduce mortality from stroke among women aged 30-64 years (by 55 percent by the year 2000 from a baseline in 1986 of 18 deaths per 100,000); and
- to reduce mortality from circulatory disease among ATSI males and females aged 30-64 years to that of the non-Aboriginal population (Aboriginal mortality: Males 3.4 per 1,000, Females 2.5 per 1,000; non-Aboriginal mortality: Males 1.5 per 1,000, Females 1 per 1,000).

Proposed targets included:

- to reduce the morbidity and disability associated with cardiovascular disease, peripheral vascular disease, and stroke among adults aged 65 years or more;
- to reduce mortality from cardiovascular disease among low socioeconomic groups aged 30-64 years to that of higher socioeconomic groups ; and

- to prevent an increase in cardiovascular mortality with increasing length of residence in Australia among new immigrants aged 30-64 years (Nutbeam et al, 1993:34-35).

Preventable cancer mortality and morbidity
(Appendix, Figure 3 for Queensland)

Cancer remains the second most common cause of death in Australia.

(a) Cervical Cancer

Despite being substantially preventable, cervical cancer is the sixth most common cancer among women (Nutbeam et al, 1993:36-37). A geographical study of SLAs based on the Index of Economic Resources, ABS, 1986, showed that the mortality rate from cervical cancer was significantly higher in the least advantaged quintile than in the most advantaged (EHIB, unpublished data). Much of the mortality from this condition is likely to be prevented by the effective implementation of organised Pap Smear screening programs.

Targets included:

- to reduce mortality and morbidity from cervical cancer among women aged 18-70 years who have been sexually active and have a uterine cervix (i.e. have not had a total hysterectomy) (by 30 percent by the year 2000 from a baseline in 1987 of 3.5 deaths per 100,000).

Proposed targets included:

- to reduce mortality and morbidity from cervical cancer among ATSI women aged 18-70 years, women aged 18-70 years from low socioeconomic status, and NESB women aged 18-70 years.

(b) Breast Cancer

Breast cancer is the most common cause of cancer-related death in Australian women. In contrast to cervical cancer, the incidence of breast cancer is higher among females of higher socioeconomic status (Nutbeam et al, 1993:40).

Target included:

- to reduce breast cancer mortality among women aged 50-69 years (by 10 percent by the year 2000 from a baseline in 1990 of 72.8 deaths per 100,000).

(c) Skin Cancer

Australian skin cancer rates are the highest in the world and it is the most common type of cancer in Australia in terms of incidence. There is no evidence of difference in rates of incidence of skin cancer, or skin cancer mortality by socioeconomic status (Nutbeam et al, 1993:42).

Proposed targets included:

- to reduce mortality from all skin cancers among the whole population; and
- to reduce the rate of skin cancer mortality among men aged 20 years or more to that of women.

(d) Lung Cancer

Lung cancer is the most common primary cancer in Australian males and the third commonest in females (Nutbeam et al, 1993:44-45).

Targets included:

- to reduce mortality from lung cancer amongst all males (by 12 percent by the year 2010 from a baseline in 1990 of 58.4 deaths per 100,000); and
- to reduce mortality from lung cancer amongst all females (by 8 percent by the year 2010 from a baseline in 1990 of 16.8 deaths per 100,000).

Proposed targets included:

- to reduce mortality from lung cancer amongst Aborigines and Torres Strait Islanders and all people from low socioeconomic groups.

Injury mortality
(Appendix, Figure 4 for Queensland)

Injuries contribute more to premature (age < 65) years of life lost than cardiovascular disease and cancer combined (Nutbeam et al, 1993:47, 49).

Injury mortality is age dependent (Queensland Health, 1993:3). There are three peaks in the age specific mortality rates:

- Early childhood (0-4 years) - drowning is the major cause of death.
- Adolescence/Early adulthood (15-24 years) - motor vehicle accidents are the major cause.
- Elderly (>70 years) - falls are the major cause.

Targets included:

- to reduce all-cause mortality from injury and poisoning for the whole population (by 20 percent by the year 2000 from a baseline in 1990 of 46 deaths per 100,000);
- to reduce mortality from injury and poisoning among the Aboriginal population towards that of the non-Aboriginal population (by 50 percent by the year 2000. Baseline rate ratios in the late 1980s were 3.5 for males and 3.8 for females); and

- to reduce mortality from injury and poisoning among all males towards that of females (by 20 percent by the year 2000 from a rate ratio in 1990 of 2.7).

Mental Health Problems and Disorders

Mental health problems and mental disorders afflict at least 20 percent of the Australian community at any one time (Nutbeam et al, 1993:81-85). Goals were set and targets proposed for five focus areas:

- Schizophrenia and severe mental disorder
- Organic mental disorder
- Post traumatic stress disorder
- Depression, anxiety disorders, somatization syndromes
- Conduct disorders

Proposed targets included:

- to reduce the prevalence of mental disorders among all young people and adults 13 years or more; and

- to reduce the prevalence of mental disorders among ATSI adolescents and adults.

INTERNATIONAL EXPERIENCE WITH HEALTH GOALS AND TARGETS

National health goals and targets have been used in a number of countries. *In Targets for Health for All* (1985:8-9) 38 targets were specified by the European Region of WHO to achieve health for all by the year 2000. There were targets for health improvement, targets for activities needed to bring them about, and targets designed to promote implementation of the whole strategy. In *Healthy People 2000* (1990) the U.S. made a commitment to increase the span of healthy life for Americans, to reduce health disparities among Americans and to achieve access to preventive services for all Americans.

In June 1991, the Secretary of State for Health in the United Kingdom published *The Health of the Nation: A consultative document for health in England.* The English Government has focussed increasingly on the need to redirect policy and health services to the achievement of health. In this consultative document, the secretary proposed to place emphasis on securing genuine improvements in health for which targets can be set at either national or local level, and progress monitored.

In New Zealand, targets for improvements in health have been established based on indicators derived from existing data sources. For 1992-93, 143 targets were defined. They are published in the 1992-93 Health Indicators and Performance Targets Dictionary. Each indicator has definitions of numerator, denominator and data source, and these permit consistent monitoring across Area Health Boards.

How does Australia compare with other countries in setting goals and targets?

In comparing the goals and targets set in the Australian report (Nutbeam et al, 1993) with those set in other countries it is apparent that there are several advantages in the Australian approach which apply to preventable mortality and morbidity, as well as to the three other major groups. First, it set targets aimed at high risk groups which is in contrast with the European approach *Targets for Health for All* (1985), which just set targets aimed at the general population under 65. Also, the Australian report (1993) set targets to reduce inequality by socioeconomic status, gender and ethnicity, though it does not apply this concept consistently across the report. In comparison, the WHO report did not set targets aiming to reduce inequalities amongst these subgroups.

Another strength of the Australian report (1993) was that it set targets to reduce high risk behaviours, which was also a strategy used in the U.S. in *Promoting/Preventing Diseases: Objective for the Nation* (1980). However, the Australian report did not put forward detailed descriptions of how to change high risk behaviours. In contrast, both the U.S. (1980) and the European Region of WHO (1985) reports put forward more detailed solutions. Also, the U.S. report *Healthy Communities 2000: Model Standards* (1991) put the objectives of *Healthy People 2000* into practice and encouraged communities to establish achievable interventions.

The limitation of only basic implementation concepts being discussed in the Australian report (1993) has been recognised, and implementation committees have been set up in four priority areas - cardiovascular disease, cancers, injuries and mental health. Their reports are due for completion in mid 1994.

HEALTH GOALS AND TARGETS IN QUEENSLAND

The setting of goals and targets is not new to Queensland. The 1987 publication *Health 2000: Achieving Health for all Queenslanders,* though overlooked by the National Review Team (Nutbeam et al, 1993:9), put forward a statewide initiative to prevent disease and promote health. Specific targets to reduce mortality rates for major diseases were set for the whole of the population (1987:4). They were as follows:

- A 20 percent reduction in heart disease mortality by 2007.
- A halt to the increase in cancer mortality by 1995 and a 5 percent reduction by 2005.
- A 20 percent reduction in stroke mortality by 2007.
- A 25 percent reduction in accident mortality by 2007.

Queensland progress in achieving health goals and targets

The figures in the Appendix indicate how Queensland has progressed towards achieving the targets set in 1987. It is important to note that these targets were set earlier and are different from the national goals and targets which are reported on in the publication

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Goals and Targets for Australia's Health in the Year 2000 and Beyond. There has been a decline in death rates from ischaemic heart disease and stroke, and for both of these diseases death rates in 1991 were below the projected targets for 2007 (Figures 1 and 2). A similar pattern is found for accident mortality rates (Figure 4). The improvement in mortality for these three conditions has been very marked. For example, accident mortality rates fell by 27.9% from 1985 to 1991, while mortality rates for ischaemic heart disease and stroke fell in the same period by 17.5% and 20.9% respectively. Figure 3 shows that death rates from cancer have remained relatively stable, although the cancer trends are the result of a complex set of factors.

While the 1987 Queensland approach was not perfect, it had several advantages. An end point could be readily calculated from the rate in the base period, the indicators were measurable and ICD codes were specified for each target so that progress could be consistently monitored. The framework for the 1987 Queensland goals and targets was simple in contrast with the Australian Health Goals and Targets (1993) report which proposed around 400 targets. While there was no social justice perspective in formulating the targets, mortality rates for disadvantaged populations may be calculated and compared to the total state where populations can be identified. The 1987 Queensland targets address a higher proportion of preventable mortality than the 1993 national targets, principally because of the whole population approach.

FUTURE OBJECTIVES

There should be a reduction in the number of targets set in Australia for narrow age bands. Also, targets need to be set for health services. The health services and healthy environments sections are relatively poorly developed. These two areas need to set structural type goals rather than disease type goals.

The Medicare agreement assures the future of the development of the National Health Goals and Targets. An agreement was made that the oversighting of the NHGT process should be cooperative between the Commonwealth and the States.

The Health Ministers agreed that the framework presented in the national report provides an appropriate mechanism for pursuing outcome measurements and integration of the delivery of hospital and other services.

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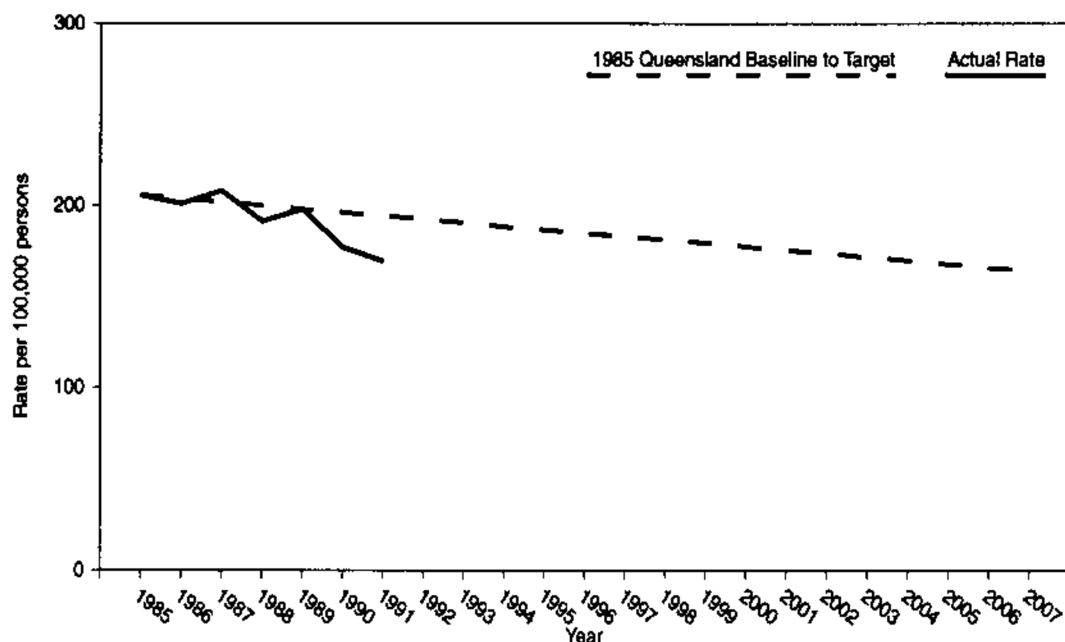
APPENDIX

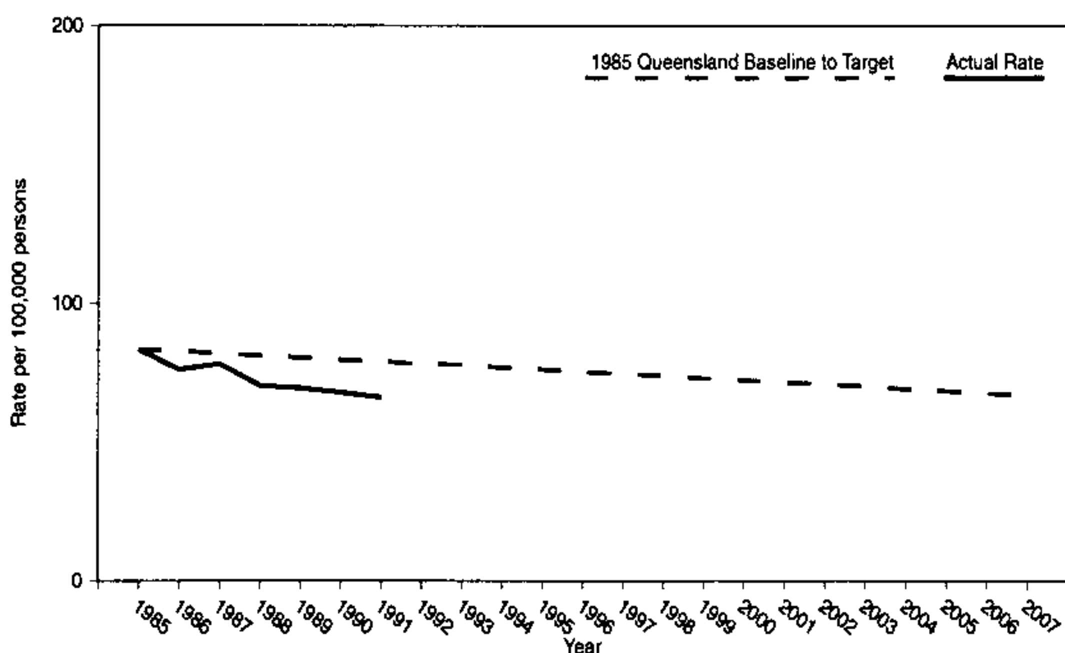
Figure 1: Ischaemic Heart Disease Mortality Rates (ICD 410-414), All Persons, Queensland, 1985-1991 and Year 2007 Target



Note: Rates standardised to the Australian Population 1988

Source: Epidemiology and Health Information Branch, Queensland Health, derived from Registrar of Births, Deaths and Marriages Cause of Death data.

Figure 2: Stroke Mortality Rates (ICD 430-438), All Persons, Queensland, 1985-1991 and Year 2007 Target

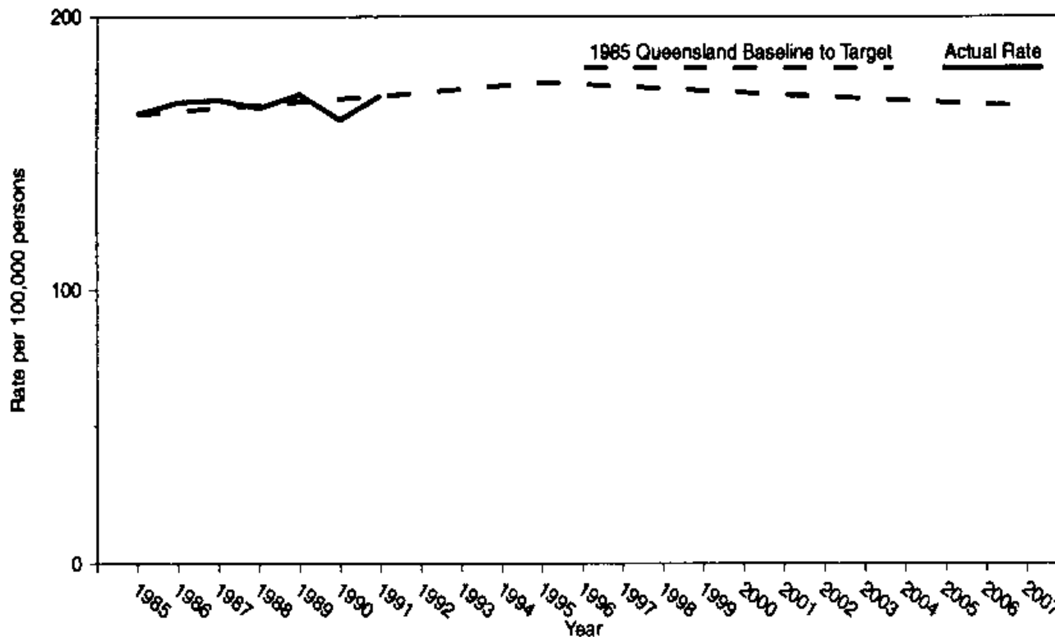


Note: Rates standardised to the Australian Population 1988

Source: Epidemiology and Health Information Branch, Queensland Health, derived from Registrar of Births, Deaths and Marriages Cause of Death data.

APPENDIX (cont)

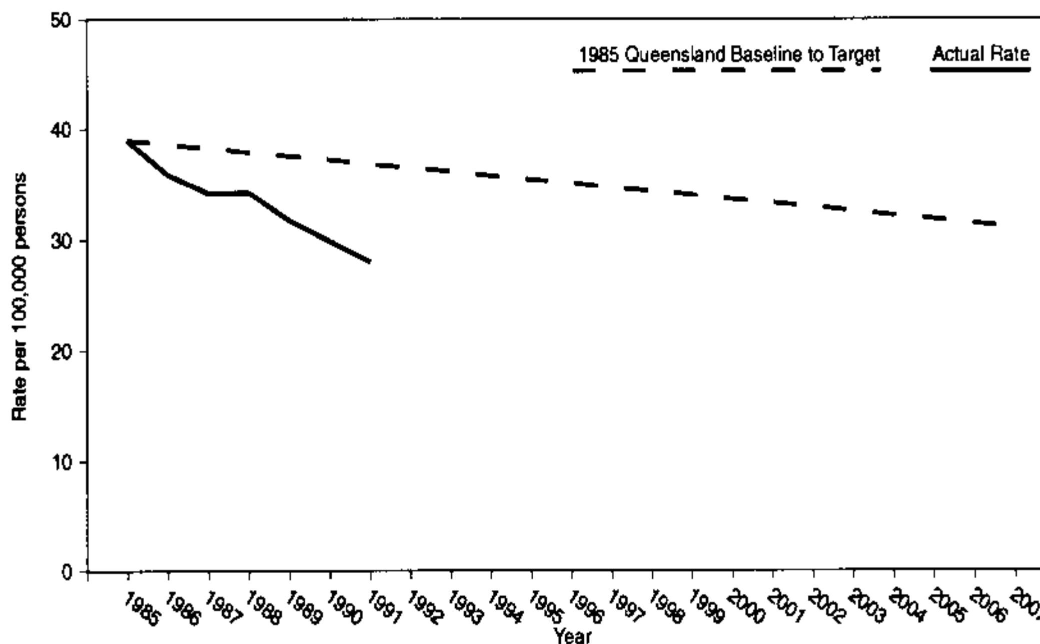
Figure 3: Cancer Mortality Rates (ICD 140-208), All Persons, Queensland, 1985-1991 and Year 1995 and 2005 Targets



Note: Rates standardised to the Australian Population 1988

Source: Epidemiology and Health Information Branch, Queensland Health, derived from Registrar of Births, Deaths and Marriages Cause of Death data.

Figure 4: Injury Mortality Rates (ICD 800-929), All Persons, Queensland, 1985-1991 and Year 2007 Target



Note: Rates standardised to the Australian Population 1988

Source: Epidemiology and Health Information Branch, Queensland Health, derived from Registrar of Births, Deaths and Marriages Cause of Death data.