ABSTRACT

Health promotion research and practice reveal that goal setting and monitoring have gained increased acceptance at international, national, provincial/state, regional and local levels. The global adoption of health goals as a strategy for population health promotion has occurred even though few protocols or guidelines to support the health goals development process have been published. Limited study has occurred on the variation in approach to health goals planning, or on the complex, multiple forces that influence the development process. This paper describes conclusions drawn from an exploratory and descriptive case study that tracked the pathways to health goals in British Columbia (BC) and uncovered nearly 100 factors that influenced the final version of health goals adopted by the government of BC.

Influencing factors included: (a) positive perceptions of the benefits of health goals, (b) the role of a trusted health goals champion, (c) positioning of the goals as government rather than health ministry goals, (d) the format and agenda of the health goals consulting process, and (e) political reluctance toward highly specific or measurable goals with targets.

ABRÉGÉ

La recherche et la pratique en promotion de la santé révèlent que la détermination d'objectifs en matière de santé et le suivi de ces objectifs sont de plus en plus acceptés aux niveaux international, national, provincial/étatique, régional et local. L'adoption générale des objectifs en matière de santé comme stratégie de promotion de la santé de la population s'est faite malgré le fait que peu de protocoles ou de lignes directrices appuyant le processus de développement des objectifs ont été publiés. Un nombre limité d'études ont été réalisées concernant l'éventail des approches dans la planification des objectifs ou sur les complexes et multiples forces qui influencent leur processus de développement. Cet article décrit les conclusions tirées d'une étude de cas exploratoire et descriptive qui a suivi l'évolution des objectifs en matière de santé en Colombie-Britannique (C.-B.) et a révélé près d'une centaine de facteurs qui ont influencé la version finale des objectifs de santé adoptés par le gouvernement de la C.-B.

Entre autres facteurs d'influence, il y a eu : (a) les perceptions positives des bénéfices des objectifs de santé; (b) le rôle d'un leader crédible; (c) l'établissement des objectifs comme étant ceux du gouvernement plutôt que ceux du ministère de la santé; (d) la forme et les objectifs du processus de consultation; (e) la résistance politique à adopter des objectifs tout à fait mesurables ou dotés de cibles.

Factors that Facilitated and Challenged the Development of Health Goals and Targets: The British Columbia Experience

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Health goals and targets have gained increased acceptance as a strategy for population health promotion by countries and regions around the world. Early indications of health goals appeared in the late 1970s in the US. A comprehensive framework for health was outlined in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*.¹ This publication, inspired in part by the Lalonde report, *A New Perspective on the Health of Canadians*,² and led by the US Public Health Service, disclosed a shift in emphasis from health care to health promotion and disease prevention as detailed in the release of *Promoting Health/Preventing Disease: Health Objectives for the Nation*.³ This publication delineated 225 specific objectives and targets for improving the health of Americans over a 10-year period.

In 1978 at an international conference on primary health care held at Alma Ata, a policy framework of *Health For All* was established which called for all citizens of the world, by the year 2000, to attain a level of health that would permit socially and economically productive lives. The Declaration of Alma Ata⁴ defined the features of *Health For All* as a global strategy, formally adopted in 1981 by the Member States of the World Health Organization.⁵

In 1985, WHO's European Regional Office published its first round of health goals in *Targets for Health for All 2000*.⁶ This report was updated in 1991 based on broad consultation among European member states.⁷ Other countries and regions followed in the adoption of health goals and targets, including Eastern Europe, Africa, South East Asia, the West Pacific, Australia, Sweden, Germany, and Mexico.⁸

It is interesting to note that even though all Canadian provinces and territories have developed provincial health goals, there have not been health goals established at the national level in Canada. Pinder⁹ notes that various calls for national health goals have been made over the past two decades. As early as 1974, national goal setting was advocated in *A New Perspective on the Health of Canadians*.² Other calls for health goals came from the Ad Hoc Committee on Health Strategies of the Canadian Public Health Association¹⁰⁻¹² and the *Canadian Journal of Public Health*.¹³ Most recently, a report to Health Canada's Population Health Promotion Division on the status and application of health impact assessment in Canada recommended the establishment of national-level health goals as a prerequisite to health impact assessment.^{14,15} Recent initiatives to establish national-level strategic directions and indicators in population health may facilitate further specification of health goals and targets in select areas.

The health goals development process in the province of British Columbia: A case study

The global adoption of health goals as a strategy for population health promotion has occurred even though few protocols or guidelines to support the health goals development process have been published.

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Limited study has occurred on the complex, multiple forces that influence the health goals planning process. This study endeavours to advance knowledge about the process and contribution of health goals as a strategy for population health promotion. Within the context of this study, the term “health goals” refers to a comprehensive planning framework that typically includes the specification of broad goals, measurable and time-limited objectives, measurement or performance indicators, quantified targets, and action strategies.

We tracked the pathway to health goals in British Columbia (BC) and uncovered factors influencing the final version of health goals adopted by the Cabinet of the government of BC. Specifically, we explored the factors that facilitated and challenged the formulation and articulation of the BC health goals. The study was based on the assumption that unless the health goals development process is guided by practices and procedures that are capable of sustaining it, and unless the process yields health goals that reflect population needs *and* are achievable, investments into health goals as a strategy for population health promotion are unjustified.

Study context

The BC health goals project began in October 1994, three years after the release of the 1991 report of the BC Royal Commission on Health Care and Costs¹⁶ which recommended that goals be established for the **health system**. In a policy document entitled, *New Directions for a Healthy British Columbia*,¹⁷ the new government's response to the Royal Commission extended the recommendation for health system goals to include the development of “population health goals”, with a focus on the broader determinants of health. Specifically, the *New Directions* policy recommended the establishment of: “a clear set of health goals for the province that reflect our understanding of how social, economic and environmental factors affect health, and provide a means of measuring our success over time.” (p. 12)

The health goals process spanned nearly three years. The final published version yielded 6 broad goals and 44 associated objectives which addressed health status,

TABLE I Health Goals for British Columbia	
Goal 1:	Positive and supportive living and working conditions in all our communities.
Goal 2:	Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health.
Goal 3:	A diverse and sustainable physical environment with clean, healthy and safe air, water and land.
Goal 4:	An effective and efficient health service system that provides equitable access to appropriate services.
Goal 5:	Improved health for aboriginal peoples.
Goal 6:	Reduction of preventable illness, injuries, disabilities and premature deaths.
Source:	<i>Health Goals for British Columbia</i> , Ministry of Health and Ministry Responsible for Seniors, 1997. ¹⁸

the health system, and the social, economic and environmental influences on health (Table I). Sample indicators to track progress on objectives were offered, although targets and strategies aimed at achieving the health goals were not proposed.

METHOD

This exploratory and descriptive case study was guided by a conceptual framework, or health goals template, that evolved from a comprehensive review of the literature on health goals, and specifically utilized source documents from six national and state/provincial jurisdictions that have adopted a health goals approach. The health goals template comprised three phases that captured and organized key practices and factors associated with health goals development. The *premonitory phase* considered the context and motivation for health goals development; the *formulation phase* addressed the required structures, processes and resources; and the *articulation phase* considered the content of health goals or what health goals eventually articulated. Data collection consisted of 23 semi-structured interviews with key participants, including representatives from government ministries, provincial stakeholder organizations, regional health authorities, and the Office of the Provincial Health Officer. Source documents on the BC health goals initiative were also reviewed. Data analysis was supported by NUD*IST 4.0, a multifunctional software system for the development, support and management of qualitative data analysis projects.

RESULTS AND DISCUSSION

This study uncovered nearly 100 factors that facilitated or obstructed the formulation of the BC health goals and revealed several concessions and trade-offs. Key influencing factors are discussed below.

Perceived Benefits of Health Goals

Positive perceptions of the multiple benefits of health goals set a favourable context for health goals in British Columbia. Most participants viewed health goals as an effective means to: guide health planning, promote health-enhancing public policy, monitor health status and reductions in health inequities, set health priorities, facilitate resource allocation, support accountability in health care, provide guideposts for health impact assessment, encourage intersectoral collaboration, and advance public awareness of the broad determinants of health. Health goals were also envisioned as a way to demonstrate positive outcomes for government investments in health, and as a mechanism to support decisions on spending priorities, especially in light of reduced transfer payments for health from the federal government to provincial coffers.

Leadership by a Trusted Champion of Health Goals

Study participants largely attributed the advancement of the BC health goals agenda to effective leadership by a trusted and highly respected leader or champion. This study suggested also that the champion's personal philosophy on health influenced the formulation process. The BC health goals champion strongly endorsed the broad determi-

nants of health as the overarching philosophy to guide and direct the BC health goals process. The champion's personal commitment to a health-determinants approach was driven by several issues. These included: (a) the mounting scientific evidence that factors that reside outside the health system or health sector influence health, (b) a commitment to educate the public that "health is more than health care," (c) the belief that good health outcomes require more than tinkering with the health care system, and (d) a desire not to follow what many considered to be the narrow focus of health goals developed by other jurisdictions. The outcome was a set of health goals that touched upon all the known influences on health.

Broad-based Government

Endorsement of Health Goals

Positioning the health goals as *government goals* versus *health ministry goals* led to their endorsement by the executive level of all (at that time, 18) government ministries. Broad-based support was important since sectors outside health would be called upon to provide data and to devise and implement strategies to meet goals related to their areas of expertise. Support for the health goals was less ardent at lower levels of the bureaucratic chain. Some representatives from sectors outside health made claims of "health imperialism," where health was seen as overstepping its mandate and involving itself in matters that extended beyond its purview. Moreover, some representatives from the Ministry of Health did not see how their work, which focussed largely on health services, related to the broader socio-economic issues addressed in the health goals. Reluctance to support health goals that extended beyond their own mandate led to a lack of ownership and feelings of alienation among some established health interests. Overall, the regional health authorities accepted the BC health goals, although they expressed some concern about expectations to address the health determinants within limited financial and human resources.

Conditioning the Health

Goals Development Process

Study findings suggest that the BC health goals process was organized and

structured in a manner that ensured the outcome sought by the health goals development team. For example, consultation sought from individuals and groups was based on a set of pre-determined health goals. Several study participants characterized this as "conditioning" the health goals process and some suggested that this approach biased the discussion and did not allow for a full and open exchange of views. Furthermore, consultation sessions focussed on the determinants of health theme and presented evidence on the social, economic and environmental influences on health more than on health-related behaviour and lifestyle issues. In the view of some participants, this amounted to an orchestration of the consultation session whereby participants were positioned to support what was presented to them.

Reluctance Toward

Measurable Health Goals

The health goals initiatives in the United States and Australia suggest some benefits of establishing specific targets. Targets help to galvanize resources toward health promotion actions, monitor progress on health indicators, and stimulate new and augmented health information systems. While health goal measurability or specificity was a clear intention of the BC health goals process, means to quantify expected levels of change or improvement on indicators were not stipulated in the final published version. Two factors account for a lack of specificity of the BC health goals. First, rather than forwarding information to support the articulation of concrete, measurable objectives, government ministries provided suggestions for priority areas and strategies for change and offered only broad advice on goal statements. This response was spurred by concerns that failure to meet projected targets may jeopardize ministry programs and budgets.

Furthermore, political leaders, while supportive of broad goals, were sceptical of operationalizing health goals into measurable objectives and quantified targets. Study participants suggested that political leaders feared that measurable health goals would increase accountability for quantifiable health improvements, require allocation

of scarce resources for actions aimed at achieving the goals, and risk government leadership if targets were not met. Hesitancy about targets by government ministries and concerns by government leaders over the potential for political exposure account for the form and content of the final version of health goals. In the end a compromise was struck: endorsement of the health goals by the Cabinet of the government of BC for health goals without the capacity for measurement.

Population health promotion practice

As outlined above, several facilitating and challenging factors as well as trade-offs or concessions characterized the BC health goals development process. Health goals planning is a complex, socio-political process that requires effective planning and consultation mechanisms, sufficient time and resources, constructive networking and partnering, and strong and sustained leadership. Several challenges face health planners who aim to develop specific, measurable health goals that extend beyond the health sector and address the broad determinants of health. These include, but are not limited to, data availability and quality, sectoral cooperation, technical assistance and expertise, and political commitment and support. For today's health planners and policy makers, health goals may serve as a guiding paradigm to support the development and advancement of several recent trends and emphasis in the health field such as health impact assessment, evidence-based decision making, health reform and reorientation of health systems, population or needs-based planning methodologies, and increased accountability for health outcomes.

This study raises several issues for future inquiry. Methods to encourage and sustain intersectoral support for health goals development should be considered. Ways to operationalize health goals (that address the broad health determinants) into measurable, time-limited objectives and targets should also be examined, as should strategies to overcome resistance toward specificity. The role and influence of the health goals champion also requires attention. Finally, examination is warranted on the relationship between those factors that

influence health goals development and those that influence subsequent implementation and institutionalization of health goals into population health promotion policy.

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