KCE REPORT 292

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

EXPLORATORY STEPS FOR THE FORMULATION OF BELGIAN HEALTH SYSTEM TARGETS

KCE REPORT 292
HEALTH SERVICES RESEARCH

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

EXPLORATORY STEPS FOR THE FORMULATION OF BELGIAN HEALTH SYSTEM TARGETS

CAROLINE OBYN, AUDREY CORDON, LAURENCE KOHN, CARL DEVOS, CHRISTIAN LÉONARD

COLOPHON

Title:	Exploratory steps for the formulation of Belgian health system targets
Authors:	Caroline Obyn (KCE), Audrey Cordon (KCE), Laurence Kohn (KCE), Carl Devos (KCE), Christian Léonard (KCE)
Project coordinator:	Nathalie Swartenbroekx (KCE)
External validators:	Hans Kluge, (WHO Regional Office For Europe), Gaetan Lafortune (OECD), Matthias Wismar (European Observatory on Health Systems and Policies)
External experts:	Hervé Avalosse (Mutualité Chrétienne), Tobias Backhaus (Gesellschaft für Versicherungswissenschaft und -gestaltung e.V. [GVG] *gesundheitsziele.de*, Germany), Lutgart Braeckman (Universiteit Gent - Department of Public health), Christian De Bock (Mutualité Chrétienne), Murielle Deguerry (Observatoire de la Santé et du Social de Bruxelles-Capitale), Lieven De Raedt (FOD Volksgezondheid – SPF Santé Publique), Karin De Ridder (WIV – ISP), Stefaan Desmarest (WIV – ISP), Mireille Goemans (INAMI – RIZIV), Rita Goetschalckx (INAMI – RIZIV), Denis Herbaux (Plateforme pour l'Amélioration continue de la Qualité des soins et de la Sécurité des patients [PAQS]), David Hercot (Observatoire de la Santé et du Social de Bruxelles-Capitale), Joeri Guillaume (Socialistische Mutualiteiten), Catherine Le Gales (Institut Francilien Recherche Innovation Société [IFRIS], France), Murielle Lona (Mutualités Libres), Alain Piette (SPF Emploi – FOD Werkgelegenheid), Françoise Renard (ISP – WIV), Rik Thys (Socialistische Mutualiteiten), Saskia Van den Bogaert (FOD Volksgezondheid – SPF Santé Publique), Pieter Vandenbulcke (Vlaams Agentschap Zorg en Gezondheid), Stephan Van den Broucke (UCL), Johan Van Der Heyden (WIV – ISP), Dominique Vandijck (ICURO, Zorgnet-Icuro, UHasselt), Elisabeth Van Eycken (Belgian Cancer Registry), Chris Van Hul (Onafhankelijke Ziekenfondsen), Vanessa Vanrillaer (Onafhankelijke Ziekenfondsen), Dirk Wildemeersch (Vlaams Agentschap Zorg en Gezondheid)
Stakeholders:	Members of the steering committee: • Representatives of the policy unit of the Federal Minister of Health: Regina De Paepe, Mieke Walraevens • INAMI – RIZIV: Pascal Meeus • FOD Volksgezondheid – SPF Santé Publique: Pol Gerits, Margareta Haelterman • WIV – ISP: Brecht Devleesschauwer, Françoise Renard
Acknowledgements:	Elke Jakubowski (WHO Regional Office for Europe), Govin Permanand (WHO Regional Office for Europe), Szabolcs Szigeti (WHO Regional Office for Europe); France Vrijens (KCE)
Reported interests:	All experts and stakeholders consulted within this report were selected because of their involvement in the topic of health targets. Therefore, by definition, each of them might have a certain degree of conflict of interest to the main topic of this report.

	Membership of a stakeholder group or presidency or accountable function within an institution, association, department or other entity on which the results of this report could have an impact: Murielle Deguerry (Commission communautaire commune de Bruxelles-Capitale – Gemeenschappelijke Gemeenschapscommissie van Brussel-Hoofdstad), Denis Herbaux (PAQS, hospitals and care structures), David Hercot (Commission communautaire commune de Bruxelles-Capitale – Gemeenschappelijke Gemeenschapscommissie van Brussel-Hoofdstad), Rik Thys (De Spiegel vzw), Saskia Van den Bogaert (FOD Volksgezondheid – SPF Santé Publique), Pieter Vandenbulcke (Vlaams Agentschap Zorg en Gezondheid), Elisabeth Van Eycken (BVRO – ABRO, VBS – GBS radiotherapie oncologie). Participation in scientific or experimental research as an initiator, principal investigator or researcher: Karin De Ridder (Belgian Food Consumption Survey 2014, Exposure risk assessments), Stefaan Desmarest (HealthInterview Survey), David Hercot (study on the health system in Brussels). Payments to speak, training remuneration, subsidised travel or payment for participation at a conference: Karin De Ridder (EFSA).
Layout:	Joyce Grijseels
Disclaimer:	• **The external experts were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.** • **Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.** • **Finally, this report has been approved by common assent by the Executive Board.** • **Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE.**
Publication date:	12 October 2017
Domain:	Health Services Research (HSR)
MeSH:	Health Policy, Delivery of Health Care, Health Services Accessibility, Quality of Health Care, Efficiency, Health Promotion, Healthcare Disparities
NLM Classification:	W84
Language:	English
Format:	Adobe® PDF™ (A4)
Legal depot:	D/2017/10.273/61

ISSN: 2466-6459

How to refer to this document?

Obyn C, Cordon A, Kohn L, Devos C, Léonard C. Exploratory steps for the formulation of Belgian health system targets. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2017. KCE Reports 292. D/2017/10.273/61.

This document is available on the website of the Belgian Health Care Knowledge Centre.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
ACE-inhibitors	Angiotensin-Converting-Enzyme inhibitor
AMCRA	Centre of Expertise on Antimicrobial Consumption and Resistance in Animals – Kenniscentrum voor antibioticagebruik en -resistentie bij dieren in België – Centre d'expertise pour l'usage et les résistances aux antibiotiques chez les animaux en Belgique
AMI	Acute Myocardial Infarction
ARS	Agences Régionales de Santé
BAPCOC	Belgian Antibiotic Policy Coordination Committee – Belgische commissie voor de coördinatie van het antibioticabeleid – Commission belge de coordination de la politique antibiotique
CCS	Country Cooperation Strategy
CEpiP	Centre d'Epidémiologie Périnatale
CPOM	Contrats Pluriannuels d'Objectifs et de Moyens
DDD	Defined Daily Dose
DHB	District Health Boards
EC	European Commission
EU	European Union
FCS	Food Consumption Survey – Belgische nationale voedselconsumptiepeiling - Enquête de consommation alimentaire
FOD VVVL – SPF SPSCAE	Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu – Service Public Fédéral Santé publique, Sécurité de la Chaîne alimentaire et Environnement
FTE	Full Time Equivalent
GP	General Practitioner
HGR – CSS	Hoge GezondheidsRaad – Conseil Supérieur de la Santé
HIS	Health Interview Survey – Gezondheidsenquête – Enquête de santé
HIV	Human Immunodeficiency Virus
HSPA	Health System Performance Assessment

ICD	International Common Denomination
IFRIS	Institut Francilien Recherche Innovation Société
IMA – AIM	InterMutualistisch Agentschap – Agence InterMutualiste
INN	International Non-proprietary Name
K&G	Kind en Gezin
MDR-TB	MultiDrug-Resistant Tuberculosis
MRSA	Methicillin-Resistant Staphylococcus Aureus
mSv	Millisievert
MTC	Major Trauma Centres
NHS	National Health Service
NRKP – CNPQ	Nationale Raad voor KwaliteitsPromotie – Conseil National de Promotion de la Qualité
O	Outcomes
OECD	Organisation for Economic Co-operation and Development
ONE	Office de la Naissance et de l'Enfance – The Office of Birth and Childhood
P	Processes
PAQS	Plateforme pour l'Amélioration continue de la Qualité des soins et de la Sécurité des patients - Platform for Continuous Improvement of Quality of Care and Patient Safety
PPP	Purchasing Power Parity
RIZIV – INAMI	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering – Institut National d'Assurance Maladie-Invalidité
S	Structures
SDG	Sustainable Development Goals

SMART	• Specific/Strategic • Measurable/Motivating • Achievable/Agreed/Attainable/Action-oriented/Ambitious/Aligned with goals • Relevant/Realistic/Resourced/Reasonable/Results-based • Time-bound/Trackable
SP	Specialist Physician
SPE	Studiecentrum Perinatale Epidemiologie
UN	United Nations
UN DESA	United Nations Department of Economic and Social Affairs
UNICEF	United Nations Children's Fund
US	United States
VIP²	Vlaams Indicatorenproject voor Patiënten en Professionals
WG	Work Group
WHO	World Health Organisation
WIV – ISP	Wetenschappelijk Instituut Volksgezondheid – Institut Scientifique de Santé Publique

SCIENTIFIC REPORT

1 INTRODUCTION

1.1 Context

Already since the 1980s the World Health Organisation (WHO) has promoted the use of health targets, not only internationally but also at the level of individual countries. Within the currently running agreement "Health 2020", the WHO European Region explicitly states the establishment of a process for target-setting as an imperative for all its 53 member states.[1] Also the European Observatory on Health systems acknowledges the inevitability of using some sort of health targets to achieve good governance.[2, 3] Health targets are generally put forward as a tool to guide health policymaking, to set priorities, to create political and administrative commitment, to monitor health system performance and to increase public accountability.[3] Internationally, an increasing number of countries set health targets, develop implementation plans to reach the targets and report on the progress towards the targets.[4]

At the Belgian level, the need for setting targets has been recommended in the Belgian health system performance assessment report (HSPA).[5] Not only the need but also the willingness to set health targets has repeatedly been expressed in Belgian policy documents, amongst which the Federal Minister of Social Affairs and Public Health's policy note of 2014 [6] and the Country Cooperation Strategy (CCS) agreed between the WHO and Belgium for the period 2016-2022.[7]

1.2 Aim of the project

This is an exploratory project with as main aim to make an inventory of health system targets formulated for the federal government:

- Targets formulated by Belgian actors at the federal or interministerial level
- Targets formulated by supranational organisations and institutions the Belgian government is committed to (mainly WHO, UN and EC)

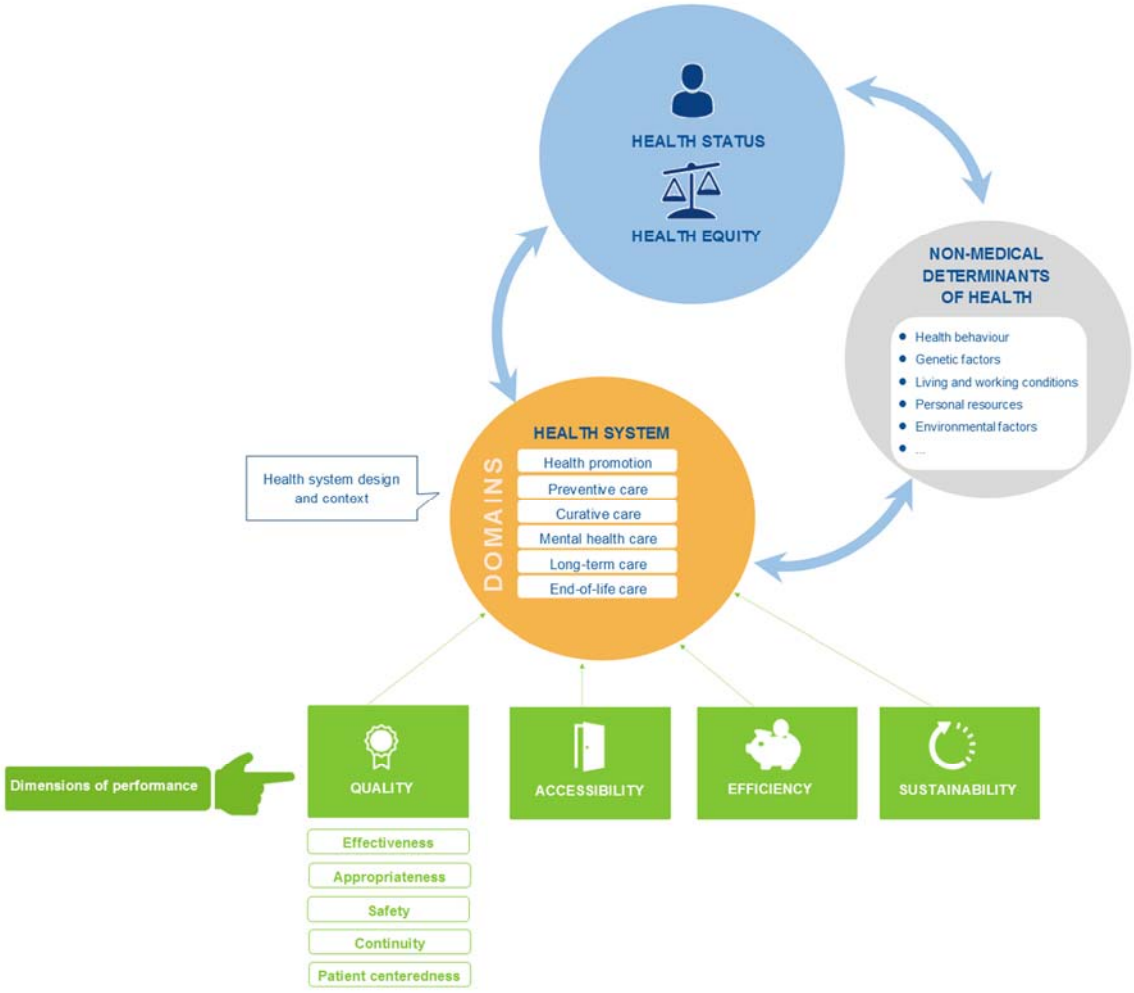
In parallel, we formulate suggestions for structured health system targets based on the indicators of the Belgian HSPA of 2015. These suggestions can be found in appendix.

1.3 Scope of the project: overarching objectives

To set the boundaries of this project, we followed the framework of the Belgian HSPA of 2015.[5] The domains in this framework, developed to evaluate the performance of the health system, at the same time represent the overarching goals for the health system:

- On top of the framework is the twofold goal "**to improve the health status of the citizens**" and "**to reduce health inequalities**". These goals represent the ultimate objectives of the health system: to improve life expectancy and quality-of-life for all people, whilst achieving the smallest feasible differences in health among individuals and groups. These goals also match the statements in the long term vision on sustainable development that was approved by the Federal government and laid down in the Royal Decree of 18 July 2013. Indeed, a good health system is characterised by both *goodness* and *fairness;* it is not only the *overall or average level* of health in the population that matters (goodness), but also the *distribution* of health in the population (fairness). It is not always sufficient to improve the average health of the population, if at the same time inequality worsens or remains high - when the improvements relate disproportionately to those already enjoying better health. The health system also has the responsibility to try to reduce inequalities by improving the health of the worse-off, wherever these inequalities are amenable to intervention.[8]
- In order to improve the health status of the population and to reduce health inequalities, a performant health system is needed. The goal "to ensure a performant health system", can be unfolded into four subgoals:
  - To ensure high-**quality** healthcare: **effective**, **appropriate**, **safe**, **patient-centered** and **continuous** healthcare
  - To ensure **access** to healthcare for all who need it
  - To ensure **efficient** healthcare services
  - To secure **sustainable** healthcare services
- These transversal characteristics of a performant health system are relevant within mainly six domains, resulting in the following cross-dimensional subgoals:
  - To ensure **performant health promotion** interventions
  - To ensure **performant preventive care**
  - To ensure **performant curative care**
  - To ensure **performant mental health care**
  - To ensure **performant long-term care**
  - To ensure **performant end of life care**
- Finally, health is largely influenced by non-medical determinants, like health behaviours, living and working conditions, socioeconomic and environmental factors. These factors depend on diverse policy sectors. This dimension translates into the goal to promote health by a **collaboration across policy sectors and policy levels**. Note that non-medical determinants, with the exception of health behaviours, are not covered by the Belgian HSPA and the present project.

Figure 1 – Conceptual framework for evaluation of the Belgian health system (adapted from KCE report 259 – HSPA)



1.4 Primary viewpoint of this study is on federal competencies

Health policy in Belgium is a shared responsibility of the federal and federated authorities. To facilitate cooperation between the federal level and governments of regions and communities, interministerial conferences are regularly organized. In this project we focus on targets formulated at federal or interministerial level. Targets formulated at the federated level are separately mentioned in appendix.

Even though for some domains of the HSPA framework, part of the competences fall within the responsibility of the federated authorities, we covered all domains in the inventory. After all, in many cases, collaboration across levels - and even across policy domains - is required. Some examples:

- Vaccination:
  - Federal Minister of Health: e.g. reimbursement of vaccines sold in pharmacies, coordination and management of crisis in case of a pandemic crisis
  - Federated ministers of Health: e.g. vaccination campaigns
- Tobacco:
  - Federal minister of Health: e.g. reimbursement of smoking cessation medications
  - Federated ministers of Health: e.g. reimbursement of smoking cessation counsellors, prevention campaigns
  - Federal minister of Finance: e.g. taxation of tobacco products
- Skin cancer:
  - Federal minister of Health: e.g. reimbursement of immunotherapy for skin cancer
  - Federated ministers of Health: e.g. prevention campaigns
  - Federal minister of Consumer Affairs: e.g. consumer warnings at tanning salons
- Nutrition:
  - Federal minister of Health: e.g. composition of food products
  - Federal minister of Finance: e.g. sugar tax
  - Federated ministers of Agriculture: e.g. fruit at school subsidies

2 METHODS

2.1 Guiding of the project

An ad hoc steering committee was created to oversee the overall direction of the project. The members of the steering committee are:

- Representatives of the Minister of Health and Social Affairs' policy unit,
- Representative of RIZIV – INAMI,
- Representatives of the FOD VVVL – SPF SPSCAE,
- Representatives of the WIV – ISP and
- KCE project team.

2.2 Inventory of existing targets

2.2.1 *Definition of "target"*

Different definitions exist for "targets". For the inventory of targets in this project, we used the following definition:

- A target specifies the evolution in health status of the population (or subpopulation) or in a health determinant (which can be medical or non-medical, see Figure 1) towards desired results, evidence-based medicine or scientific recommendations.
- It is **quantified**, either in absolute or relative numbers
- It preferably specifies a time horizon and a baseline
- It can be expressed at the macro (national), meso (hospital) and micro (healthcare provider) level
- Example: *to reduce the number of adult smokers by 10% by the year 2018 compared to the last health survey data of 2013* (Federal Minister of Health of Belgium)[9]

Broadly, a distinction can be made between strategic targets focusing on "outcomes" and operational targets focusing on "processes" or "structures".

- Health **outcome targets** specify desired results, which can be desired changes in "*final health outcomes*" like mortality, morbidity or quality-of-life, or changes in "*intermediate health outcomes*", i.e. health determinants like lifestyle, which can be an in-between step to reach a final health outcome.
- **Process targets** specify actions needed to help get to the intended result, they set targets on processes to improve quality, efficiency, accessibility or sustainability of care. Process targets are used to monitor programmes shorter to the ball than outcome targets.
- Finally there are **structure and organisation targets**, which are more used to monitor political commitments, changes in legislation or regulation and investments in capacity and resources.[10] They translate into targets on e.g. workforce, infrastructure and innovation.

2.2.2 *Identification and sifting of targets*

We screened websites of national and supranational institutions for targets meeting the definition used in this project. In a first step, we searched for objectives in a broad sense of the term. In a consecutive step, we filtered all information to retain only targets that match our definition, i.e. quantified targets. Targets have been excluded when the target topic was not relevant for the Belgian situation (e.g. malaria) or when the time horizon has passed (e.g. targets for 2015). Only targets fitting within the HSPA framework have been included. For instance: targets set by the federal ministers of Agriculture and Public Health on the reduction of antibiotics used in the animal sector, for instance, have not been included as it concerns the animal sector. Targets on a reduction of antibiotics used in the human sector though have been retained.

2.2.3 Validation of national targets by the steering group

Subsequently, the retained targets for RIZIV – INAMI, FOD VVVL-SPF SPCAE, WIV – ISP and political actors were validated and completed by the respective members of the steering group.

2.2.4 Validation and completion of the target inventory in expert meetings

In a next step, three expert groups were created for the following domains:

- Acute curative healthcare and prevention
- Long-term healthcare, chronic diseases, end-of-life care, mental health
- Health promotion and health-environment.

The expert groups were composed of Belgian experts from several government agencies, health insurers, hospital associations, universities, etc. For each domain an expert meeting was organised to discuss and complete the inventory.

2.2.5 Categorisation of targets

Finally, all supranational and Belgian targets were categorised by the domains of the Belgian HSPA. The resulting inventory is presented in **chapter 3**.

2.3 Formulation of suggestions for health system targets based on the indicators of the HSPA

Following the expert groups, target suggestions were formulated by the KCE project team for all of the non-contextual indicators of the HSPA. The target suggestions, as well as the method used to formulate these targets, can be found in **the supplement**.

2.4 Health target systems in other countries

In parallel we examined a selection of target-setting initiatives developed abroad (France, Germany, Austria, Netherlands, United States, England and New Zealand) and in Belgium (notably the Flemish region). For this research we consulted government websites and peer-reviewed articles and performed telephonic interviews to complete the remaining information gaps with one expert from France and one from Germany (see colophon). A variety of other relevant target-setting initiatives (like e.g. in Canada or Australia) exist, but these were not included in our analysis as we found that we had reached saturation in relation to the main topics analysed. The analysis is presented in **chapter 4**.

3 RESULTS: INVENTORY OF TARGETS (ORDERED BY HSPA DOMAIN)

Readers' guide

- For each domain of the HSPA framework, we list the existing supranational, federal and interministerial quantified targets. Since the primary viewpoint in this project is on the federal level, we only list targets formulated at the federal level. Targets formulated at the federated level are documented separately in appendix.
- The presented supranational targets in this list constitute a « gross » inventory. Targets are listed, even when the health problems are not considered priority areas for Belgium or when the target level is not adapted to the Belgian situation.
- The inventory of targets includes a mixture of targets in terms of who they are formulated by (political - administrative/operational - scientific actors), what they focus on (outcomes – processes – structures) and for what level they are formulated (macro – meso – micro).

3.1 Health status

Target	Author of the target
Supranational targets	
Mortality	
• By 2030, **end** preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as **12 per 1,000** live births and under-5 mortality to at least as low as **25 per 1 000** live births • By 2030, reduce the global maternal mortality ratio to **less than 70 per 100 000 live births** • By 2030, reduce by **one third** premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	UN Sustainable Development Goals [11]
• By 2020, a **1.5%** relative annual reduction in overall (4 causes combined) premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases • By 2025: a **25%** relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases • By 2025, reduction in the probability of dying from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases for people aged 30–70 years by **25%**	WHO regional office for Europe (Health 2020) [1] WHO targets on Noncommunicable Diseases [12] WHO 12th General Programme of Work 2014-2019 [13]
• By 2020, reduce hepatitis B and C deaths among people co-infected with HIV by **10%,** in line with mortality targets for all people with chronic hepatitis B and C infection • By 2020, reduce tuberculosis deaths among people living with HIV by **75%** • By 2030, **10%** reduction in mortality by viral hepatitis B or C	WHO [14, 15]
• By 2020, **35%** reduction in tuberculosis deaths	WHO regional office for Europe [16]
Cancer incidence	
• By the end of the Partnership (European Partnership for Action Against Cancer for the period 2009-2013), the objective is for all Member States to have integrated cancer plans**.** The Commission considers that putting such plans in place should make a sustainable contribution to reducing the burden of cancer in the EU, and that the target of a **15%** reduction by 2020 (510 000 new cases) is an achievable result.	European Commission [17]
Indicators based on self-assessed health	
• By 2020, increase the average healthy lifespan of Europeans by **2 years**, by: o improving health and quality of life (with a focus on older people) o ensuring health and social care systems are sustainable and efficient in the long term o enhancing the competitiveness of EU industry through business and expansion in new markets	European Commission [18]
Federal targets	
• In 2050… Life expectancy in good health will be **increased compared to 2010**	Federal long term vision for sustainable development [19]

3.2 Equity and inequalities

Target	Author of the target
Supranational targets	
• Reduction in the absolute gap in under-five mortality between rural and urban areas by **25%** in 2015–2020	WHO 12th General Programme of Work 2014-2019 [13]
Federal targets	
• By 2050: The difference in life expectancy in good health according to education level and gender will be reduced by on average **50%**	Federal long term vision for sustainable development [19]

3.3 Accessibility

Target	Author of the target
Supranational targets	
• Moving towards **universal** coverage (according to the WHO definition) by 2020	WHO regional office for Europe (Health 2020) [1]
• By 2020, **70%** of key populations for HIV have access to a full range of services relevant to sexually transmitted infection and HIV, including condoms	WHO [20]
• By 2025: An **80%** availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities	WHO targets on Noncommunicable Diseases [12]
• By 2030, ensure **universal** access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes • By 2030: Achieve **universal** health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	UN Sustainable Development Goals [11]
Federal targets	
• **Minimum 40 %** of patients are hospitalised in a two- or multi-bed room, for these patients no supplements are billed. The target is set for hospitals that sign the agreement on breast reconstruction with RIZIV – INAMI.	RIZIV – INAMI [21]

3.4 Quality-of-care: Effectiveness of care

Target	Author of the target
Supranational targets	
HIV	
• By 2020, **90%** of HIV-positive pregnant women receiving effective treatment	WHO [20]
Infectious diseases	
• By 2020, **75%** treatment success rate among the MDR-TBa patient cohort	WHO regional office for Europe [22]
Federal targets	
No targets have been identified	

[a] *Multidrug-resistant tuberculosis.*

Note: Quality indicators with target values are not included in the inventory.

3.5 Quality-of-care: Appropriateness of care

Target	Author of the target
Supranational targets	
HIV	
• By 2020, **90%** of people diagnosed with HIV receive antiretroviral therapy • By 2020, **90%** of people living with HIV, and who are on treatment, achieve viral load suppression	WHO [14]
Federal targets	
Antibiotics	
As part of its policy note 2014-2016, the Belgian Antibiotic Policy Coordination Committee included targets on the use of antibiotics: • For hospitals: o choice of therapeutic antibiotic conform local guidelines in **minimum 90%** of cases o indication for antibiotic therapy indicated in medical file in **minimum 90%** of cases o choice of antibiotic in surgical prophylaxis conform local guideline in **minimum 90%** of cases o duration of surgical antibiotic prophylaxis conform local guideline in **minimum 90%** of cases • For ambulatory care:	BAPCOC [23]

o A decrease of total antibiotic consumption from more than 800 prescriptions per 1000 inhabitants per year to **600 prescriptions** by 2020 and to **400 prescriptions** by 2025 o A decrease in use of quinolones from about 10% of the total antibiotic use to **5%** by 2018 o An increase in the proportion amoxicillin versus amoxicillin/clavulanic acid from about 50/50 to **80/20** by 2018	
Antibiotic prescription in first line	
The NRKP-CNPQ (Nationale Raad voor KwaliteitsPromotie; Conseil National de Promotion de la Qualité) at RIZIV – INAMI published recommendations and targets for antibiotic prescriptions in first line: • % patients 15+ with minimum one antibiotic prescription in the year: **10% decrease** in median of the comparison group (from 51.8 to 46.6%) • % prescriptions for amoxicillin, not combined with clavulanic acid (patients 15+): **10% increase** in median of the comparison group (from 47.3% to 52%) • % DDD (macrolides + quinolones + amoxicillin combined with clavulanic acid + cephalosporin) / DDD antibiotics. **20% decrease** in median of the comparison group (from 53.6% to 42.9%)	NRKP-CNPQ [24]
Medical imaging	
Quantified targets, expressed per type of examination and per province: to decrease the consumption of medical imaging to that of the least consuming province. The targets concern examinations in ambulatory care for which discordance is observed with guidelines, for which higher consumption is observed compared to other countries and for which considerable variations in use exist in Belgium.	RIZIV – INAMI Task force on medical imaging [25]
Appropriate drug prescriptions	
% of patients with angor (nitrates) that are treated with platelet aggregation inhibitor: **Increase** in median of the comparison group **by 10%** (from 69.2% to 76.1%)	NRKP-CNPQ [24]
% of patients treated with sartans, if drugs are prescribed that work on the renin-angiotensin: **decrease** in median of the comparison group **by 20%** (from 40% to 32%)	NRKP-CNPQ [24]
ACE-inhibitors: prescription in diabetics (patients >= 50 years) In contrast to the guidelines, the prescriber gives preference to sartans. We hope for an **increase by 10%** in median of the comparison group (from 36.7% to 40.4%)	NRKP-CNPQ [24]
Statins: prescription in diabetics (male patients 50 - 79 years or female patients 55-79 years) We hope for an **increase by 10%** in median of the comparison group (from 63.2% to 69.5%)	NRKP-CNPQ [24]

Note: Quality indicators with target values are not included in the inventory.

3.6 Quality-of-care: Safety of care

Target	Author of the target
Supranational targets	
Blood donation safety	
• **95% / 100%** of blood donations screened in a quality-assured manner by 2020 / 2030	WHO [15]
Blood transfusion safety	
• **50% / 90%** of injections administered with safety-engineered devices in and out of health facilities by 2020 / 2030	WHO [15]
Federal targets	
No targets have been identified	

Note: Quality indicators with target values are not included in the inventory.

3.7 Quality-of-care: Continuity of care

No targets have been identified.

3.8 Quality-of-care: Patient centeredness of care

No targets have been identified.

3.9 Efficiency of the healthcare system

Target	Author of the target
Supranational targets	
No targets have been identified	
Federal targets	
• **Minimum percentages** of low cost prescriptions (quotas) are imposed to physicians and dentists. Low cost prescriptions included in the quotas are: o generic drugs and original drugs for which the price has been lowered to the price level of the generic that belong to the group of "cheapest drugs" within its category (molecule, mg and package size) o drugs prescribed under the International Common Denomination (ICD or INN: International Non-proprietary Name), even if there is no generic alternative; o biosimilars and original biologic drugs that have lowered their price Quotas are set per specialty and range from 16 % for ophthalmologists to 75% for dentists. Physicians receive individual feedback on their low cost prescriptions.	RIZIV – INAMI [26]

N.B. Financial agreements made in the Medicomut and other decision-making committees at RIZIV – INAMI are not included in the inventory.

3.10 Sustainability

Target	Author of the target
Supranational targets	
No targets have been identified	
Federal targets	
Innovation	
The national agreement between physicians and sickness funds includes a premium for GPs with the aim to stimulate the use of e-health services. The agreement does not set targets at national level, put provides extra financing for GPs in function of how many e-health **parameters out of six** they meet.	RIZIV – INAMI [27]
Hospital infrastructure	
Towards an inclusive trauma system for major trauma (KCE report 281): "on the basis of international benchmarks and of estimates of major trauma incidence in our country, the maximum number of Major Trauma Centres (MTCs) in Belgium should be **between four and seven**.	KCE [28]

3.11 Health promotion and lifestyles

Target	Author of the target
Supranational targets	
Health outcomes	
• By 2020, to contribute **to halting the rise** in overweight and obesity in children and young people (0-18 years)	European Commission [29]
• By 2025, **halt the rise** in diabetes and obesity	WHO targets on Noncommunicable Diseases [12]
• By 2025, ensure that there is **no increase** in childhood overweight • The global target on childhood overweight implies that the global prevalence of 7% in 2012 should not rise to **11%** in 2025 as current trends would predict. In addition, the number of overweight children under 5 years of age should not increase from the estimated 44 million in 2012 to 70 million in 2025 as forecasted	WHO [30]
• By 2025, **halt the increase** in the prevalence of overweight among children under five years old • By 2025, a **25%** relative reduction in the prevalence of raised blood pressure[a] among persons aged 18+ years or contain the prevalence of raised blood pressure, according to national circumstances	WHO regional office for Europe [31], WHO targets on Noncommunicable Diseases [12]
• By 2025, achieve a **30%** reduction in low birth weight. This would translate into a 3% relative reduction per year between 2012 and 2025 and a reduction from approximately 20 million to about 14 million infants with low weight at birth	WHO [32]
Lifestyles: Nutrition	
• By 2020, **50 %** of hospitals and primary health care facilities with healthy food offer, including in vending machines and canteens • By 2020, **15 %** increased fruit and vegetable intake • By 2020, **20 %** of children with adequate periods of exclusive breastfeeding according to national recommendations	European Commission [29]
• By 2025, WHO recommends: o **A 30%** relative reduction in mean population intake of salt/sodium[b] as measured by: age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years o In both adults and children, reducing the intake of free sugars to less than **10%** of total energy intake o **Elimination** of trans fats in food (and their replacement with polyunsaturated fats) • Increase the rate of exclusive breastfeeding in the first six months of life to **at least 50%**	WHO targets on Noncommunicable Diseases [12], WHO [33], WHO regional office for Europe [34, 31]
Lifestyles : Physical activity	
• By 2025, a **10%** relative reduction in prevalence of insufficient physical activity	WHO targets on Noncommunicable Diseases [12]

Lifestyles : Substance abuse	
• **200 / 300** sterile needles and syringes provided per person who injects drugs per year by 2020 / 2030	WHO [15]
• By 2025, **at least 10%** relative reduction in the harmful use of alcohol, as appropriate, within the national context[c] • By 2025, a **30%** relative reduction in prevalence of current tobacco use in persons aged 15+ years	WHO targets on Noncommunicable Diseases [12]
Federal targets	
Lifestyles: Nutrition	
• Decrease the number of calories consumed by the Belgian consumer by on average **5%** by the end of 2017, compared to 2012 and to optimise nutritional composition of food products in general • Subtargets are set to reduce the sugar and fat content of food products in shops, restaurant chains and catering companies: o Soda drinks: **- 5%** average sugar content by end 2017; **-10%** by 2020 o Dairy products: **-3%** added sugars by end 2017; **-8%** by 2020 o Breakfast cereals: **-4%** sugars, **+5%** fibres, **+8,5%** whole grain o Chocolate products: **-2,5%** saturated fat o Soya and vegetable drinks: **-4%** sugars o Biscuits: **-3%** saturated fat o Margarines, ice cream, sugar, chocolate and biscuits, bakery products, potato products, snacks and nuts: diverse initiatives on product composition, portion size or awareness campaigns for consumers o Sauces, nectars, processed meat and prepared meals: further commitments to be developed in work groups	Federal Minister of Health Belgium - FEVIA – COMEOS [35]
• Nutritional recommendations for the Belgian population	HGR-CSS [36]
Lifestyles : Substance abuse	
• The number of adult smokers should decrease by 2018 by **10%** compared to the last health survey (data 2013), i.e. less than 17 percent smokers by 2018	Federal Minister of Health Belgium [9]

[a] *Raised blood pressure is* defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg ; [b] WHO recommendation to countries is 5 grams of salt or 2 gm of sodium per day per person. [c] Full definition of harmful use of alcohol taken from the Global Strategy.

3.12 Mental healthcare

Target	Author of the target
Supranational targets	
Health Status	
• By 2020, the rate of suicide (per year per 100 000 population) in countries will be **reduced by 10%**	WHO [37]
Accessibility of care	
• By 2020, **increase by 20%** the proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services	WHO 12th General Programme of Work 2014-2019 [13]
Federal targets	
No targets have been identified	

3.13 Long-term care for the elderly

No targets have been identified.

3.14 Care at the end-of-life

No targets have been identified.

3.15 Preventive care

Target	Author of the target
Supranational targets	
General	
• By 2030, **end** the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	UN Sustainable Development Goals [11]
Sexually transmitted diseases	
• By 2020, **zero** new HIV infections among infants • By 2020, **90%** of people living with HIV know their HIV status • By 2020, **95%** of pregnant women screened for HIV and/or syphilis • By 2020, **95%** of pregnant women screened for HIV and/or syphilis with free, prior and informed consent • By 2030, **90%** reduction in N. gonorrhoea incidence globally • By 2030, **90%** reduction of T. pallidum incidence globally	WHO [14, 20]
Vision health	
• Reduction in prevalence of avoidable visual impairment by **25%** by 2019 from the baseline of 2010	WHO [38]
Heart disease prevention	
• By 2025, **at least 50%** of eligible people[a] receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	WHO targets on Noncommunicable Diseases [12]
Family planning	
• By 2030, ensure **at least 75%** of demand for family planning is satisfied with modern contraceptives	WHO [39]
Anaemia in women of reproductive age	
• By 2025, reduce the prevalence of anaemia among non-pregnant women of reproductive age by **50%**	WHO regional office for Europe [31]
Vaccination coverage and incidence of diseases preventable by vaccination	
Targets in this section have been excluded from the inventory as vaccination is predominantly within the responsibility of the federated entities	
Federal targets	
Vaccination coverage and incidence of diseases preventable by vaccination	
Targets in this section have been excluded from the inventory as vaccination is predominantly within the responsibility of the federated entities	

Note: [a] Eligible persons are defined as aged 40 years and older with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease.

4 GETTING INSPIRATION FROM OTHER COUNTRIES AND REGIONS

4.1 Introduction

In this chapter we briefly examine different modalities of target-setting policies abroad and inland. For each of the selected countries and target-setting initiatives, we zoom in on the following elements:

- Is it a structured target-setting programme or rather and ad hoc formulation of targets?
- What are the stated aims of the target-setting programmes?
- How far does the time horizon reach for the different target-setting programmes?
- Are the targets descriptive or quantified, or a combination of both? In case of quantified targets, what are the methods used to define the target levels?
- How broad is the scope of the target-setting programmes: are they comprehensive or rather selective and focused?
- How are targets communicated to the wider public?
- Which partners are involved in the process?

4.2 Country and programme selection

The countries discussed in this section are the United States, France, Germany, Austria, England and New Zealand as these countries have a dedicated target-setting programme. We added the Netherlands to include an example where targets are set on ad hoc basis. We also included Flanders as inland region with experience in target-setting.

For France we focus on the 100 quantified targets that were annexed in the law on public health of 2004. These targets focused mostly on health outcomes. However, from 2010, with the creation of the Agences Régionales de Santé (ARS), and with a new minister, a new health target approach was followed. A new generation of CPOM was created in the context of the law « Hôpital, patients, santé, territoires ». These new generation CPOMs are conceived to ensure an operational translation of the regional health projects of the ARS. In the new approach, every four years “multiyear contracts for targets and resources” (“contrats pluriannuels d’objectifs et de moyens” (CPOM)) are negotiated, on one hand between the Minister of Social Affairs and Health and each Agence Régionale de Santé (ARS), and on the other hand, between the ARS and the hospitals. Three national priorities form the starting point: to increase life expectancy in good health, to promote equity in health and to develop a qualitative, accessible and efficient health system. These national targets are subsequently unfolded into operational targets within multiyear contracts between the ARS and the hospitals.

In NHS England, since long several target-setting programmes are running at different levels. In this report we focus on the targets as stipulated in the “Next steps on the NHS Five Year Forward View” programme.

4.3 Overview

For a more detailed description of the target-setting policies abroad we refer the reader to appendix.

4.3.1 Structured target-setting programmes versus ad hoc approaches

A distinction can be made between countries with a structured programme dedicated to target-setting (like Germany, the United States, Austria, New Zealand) and countries that set targets on ad hoc basis (like the Netherlands and Belgium). (See Table 1)

Some target-setting programmes have been running for many years now (like in the United States, NHS England, Germany, New Zealand and Flanders). The Austrian programme was developed more recently. As stated above, the French programme "100 Objectifs de Santé" has been reoriented over time.

Table 1 – Structured target-setting programmes versus ad hoc approach

Country or region	Target-setting programme discussed in this project	Website	Start of the target-setting programme
United States	Healthy People	www.healthypeople.gov/	1990
France	100 Objectifs de Santé	www.legifrance.gouv.fr: annexes de la Loi n° 2004-806 du 9 août 2004 relative à la politique de santé publique	2004
France	Contrats Pluriannuels d'Objectifs et de Moyens (CPOM) as revised by the law «Hôpital, patients, santé, territoires»	www.ars.sante.fr/les-contrats-pluriannuels-dobjectifs-et-de-moyens-1	2010
Germany	health-targets.de	www.gesundheitsziele.de/	2000
Austria	10 Austrian health targets	www.gesundheitsziele-oesterreich.at/	2012
NHS England	Targets in the "Next Steps on the NHS Five Year Forward View" (2017)	www.england.nhs.uk/five-year-forward-view/	Several target programmes have been running since 1992
New Zealand	Health targets	www.health.govt.nz/new-zealand-health-system/health-targets	2007
Flanders	Gezondheidsdoelstellingen Vlaanderen	www.zorg-en-gezondheid.be/gezondheidsdoelstellingen	1998
The Netherlands	No dedicated framework or platform for target-setting; targets are set on ad hoc basis		

4.3.2 *Type of targets (outcomes – processes – structures) and level to which targets are imposed (macro – meso – micro)*

Many of the discussed target-setting programmes set targets on a mix of outcomes, processes as well as structures (see Table 2). The French programme "100 Objectifs de Santé" mainly focused on outcome targets.

In Flanders, targets were previously expressed in terms of outcomes, but future targets will focus more on process targets, directly related to health policy measures, as this is considered the best way to move stakeholders to action. Outcome targets were also found less informative to evaluate the impact of policy measures given the many possible confounding factors. Health outcomes will continue to be monitored as important indicators though.

Several of the discussed programmes formulate targets at national level (U.S., Germany, Austria). Other programmes translate targets to the meso level. The CPOM in France, for example, unfold the national and regional strategic targets into targets at the level of single hospitals and socio-medical institutions. The New Zealand targets, another example, formulate targets at national level, but also monitor the targets at the level of single district health boards and primary health organisations.

Table 2 – Focus of the targets (outcomes, processes, structures) and level to which targets are imposed (macro, meso, micro)

Target-setting programme	Focus on outcomes (O), processes (P) or structures (S)	Level to which targets are imposed
Healthy People 2020 (U.S.)	O, P, S	Macro: national targets
100 Objectifs de Santé (France)	Mainly O, P	Macro: national targets
CPOM (France)	O, P, S	Macro: national strategic targets are unfolded into regional targets (for each ARS) Meso: regional targets are unfolded into targets for single hospitals and socio-medical institutions
health-targets.de (Germany)	O, P, S	Macro: national targets
10 health targets (Austria)	O, P, S	Macro: national targets
Gezondheidsdoelstellingen (Flanders)	Shift from O to P	Macro: shift from region-wide targets for the whole population to region-wide targets for settings
Next Steps on the NHS Five Year Forward View (England)	O, P, S	Both Macro and Meso level: deliverables are both expressed at NHS England level as well as at individual trust level
New Zealand	O, P	Macro: national targets Meso: national targets are monitored at the level of district health boards and primary health organisations

4.3.3 Stated aims of the target-setting programmes

Most target-setting programmes have been created with the aim to define priorities, to provide a framework for coordinated action amongst multiple actors, to engage multiple sectors and to increase public awareness on health related matters (see Table 3). What most discussed target-setting programmes have in common is that targets are created in a positive drive for setting priorities, bringing together stakeholders and mobilising action in the field, rather than in a spirit for evaluating health policy which could have a more negative connotation.

Table 3 – Stated aims of the target-setting programmes

	Healthy People 2020 (U.S.) [a]	100 Objectifs de Santé (France) [b]	health-targets.de (Germany) [c]	10 health targets (Austria) [c]	Gezondheids-doelstellingen (Flanders) [c]	NHS Five Year Forward View (England) [c]	New Zealand [c]
Identify nation- or region-wide health improvement priorities;	√	√	√	√	√	√	√
A framework for coordinated action amongst multiple actors; targets as a steering instrument		√	√	√	√	√	√
Engage multiple sectors to take actions to strengthen policies and improve practices	√	√	√		√	√	
Increase public awareness on health related matters; empower individuals; get media attention	√		√		√		
Evaluate health politics		√					
Identify critical research and data collection needs	√						

[a] Aims stated in the mission statement of Healthy People 2020; [b] Goal stated in the Health Act of 2004; [c] Aims stated on the website of the programme

4.3.4 *Descriptive target formulation versus quantified targets*

Some target-setting programmes mainly develop targets in a quantified way (e.g. the US, France, Flanders), other programmes mainly develop targets in a descriptive way, expressing a desired evolution in a qualitative way (see Table 4).

Examples show a variety of approaches for determining the level of quantified targets.

Programmes that formulate a **long list of targets** at the **national level** (like "Healthy People 2020" in the U.S. and "100 Objectifs de Santé" in France) tend to set targets in a **systematic, transparent and pragmatic** way showing broad aspirations in desired evolutions.

We refer to the default 10% improvement target in the U.S. programme and the target to move to EU average in the French programme. Setting targets, especially in terms of health outcomes, indeed is no exact science. Due to the systematic application of a default rule, however, these targets may be more symbolic, their main purpose seems to inspire and motivate.

In contrast, programmes that formulate targets rather at **meso level** and in terms of processes formulate targets in a **customised way**. These targets do not have a symbolic role but are a practical tool to implement direct actions. In some cases these precise targets are linked to financial means, in other cases they are signed in agreements.

Table 4 – Quantified versus descriptive targets

Target-setting programme	Descriptive or quantified targets	Target-setting methods in case of quantified targets
Healthy People 2020 (U.S.)	Quantified	Time horizon: 10 years • Default method: 10 percent improvement over baseline • Preferred method: modelling/projection or on scientific basis • Alternative target formulations: o consistency with national programs/regulations/policies/laws; o total elimination or total coverage; o other
100 Objectifs de Santé (France)	Quantified	Time horizon: 2004-2008 • If in 2000, France was among the last EU countries, the target was to reach EU average by 2008 • In the case of France was among the first EU countries, the target was to maintain the same level by 2008
health-targets.de (Germany)	Mainly descriptive	
10 health targets (Austria)	Mainly descriptive	Time horizon: 20 years
Gezondheidsdoelstellingen (Flanders)	Quantified	Time horizon: 2009-2015 • For example: Previous targets on physical activity: +10% points or -10% points or maintain current level

		• Adapted targets for tobacco, alcohol and drugs
NHS Next Steps on the Five Year Forward View (England)	Quantified	Time horizon: 2017-2019 • Various target-setting methods
New Zealand	Quantified	Time horizon: targets are yearly adjusted

4.3.5 Scope of the target-setting programmes: comprehensiveness versus focus

None of the health target programmes ambitions exhaustiveness, yet some countries set targets for a large set of health topics at once (e.g. the US, France, Austria), whereas other countries focus on a selection of topics at a time (like NHS England and New Zealand) and/or develop targets sequentially topic-per-topic (like Germany and Flanders) (see Table 5).

Of interest is the German approach, where new health targets are selected by a steering committee, based on an assessment of proposals for targets, along the following criteria:

- Burden of the disease: mortality, prevalence and burden of the disease
- Potential for improvement
- Economic relevance and ethical aspects
- Equal opportunities
- Priority of the "problem" from the view of the population
- Pragmatic aspects of health policy: measurability and feasibility in terms of instruments and actors
- Possibility of participation of the citizens/patients
- Legal framework.

Table 5 – Comprehensiveness versus focus

Target-setting programme	Scope
Healthy People 2020 (U.S.)	Comprehensive scope: more than 42 topic areas with more than 1 200 targets • Yet at the same time, focus is drawn to 12 leading health indicator topics
100 Objectifs de Santé (France)	Comprehensive scope: 28 topics with 100 targets
health-targets.de (Germany)	Focus: A health target is developed for the topic receiving the highest score in a selection process • Since 2003, targets have been developed for 9 topics
10 health targets (Austria)	Comprehensive scope: the 10 targets aim to cover health at large
Gezondheidsdoelstellingen (Flanders)	Focus: targets have been developed sequentially, focus on regional competencies.
NHS Next Steps on the Five Year Forward View (England)	Focus: 9 topics
New Zealand	Focus: 6 targets currently running

4.3.6 Time horizon

A distinction can be made between

- programmes with a long term view like in Austria (20 years), the US (10 years), France “100 Objectifs de Santé” (5 years),
- programmes with shorter term views like in New Zealand where targets are reviewed annually, NHS England (2 years) or France CPOM (4 years but revisable each year) and
- programmes where often no end date is fixed, like in Germany (see Table 6).

Broadly, the programmes that formulate targets at macro level have a longer term horizon, whereas the programmes that translate targets to the meso level have a shorter term horizon.

Table 6 – Time horizon of the target-setting programmes

Target-setting programme	Time horizon
Healthy People 2020 (U.S.)	10 years (2010-2020)
100 Objectifs de Santé (France)	5 years (2003-2008)
CPOM (France)	4 years but revisable each year
health-targets.de (Germany)	No end date
10 health targets (Austria)	20 years (2012-2032)
Gezondheidsdoelstellingen (Flanders)	Variable (up to 9 years)
NHS Next Steps on the Five Year Forward View (England)	Short-term: targets formulated in 2017 for 2017/18
New Zealand	Yearly adjustment of targets

4.3.7 Additions to target formulation

The described target-setting programmes do not only formulate targets, they elaborate the targets with extra information, such as:

- Evidence-based information and recommendations for health professionals and consumer information (U.S.)
- Measures and actions to be taken (either recommended, planned or already installed) (Germany, Austria, NHS England, France CPOM, Flanders) (see Table 7).

Table 7 – Structure of target formulation

Target-setting programme	
Healthy People 2020 (U.S.)	For each topic: • "Overview" sheet • "Objectives" sheet with targets • "Interventions and resources" sheet, with: o evidence-based information and recommendations related to the topic o consumer information • 'National snapshots' sheet
100 Objectifs de Santé (France)	70 health topics. For each topic is listed: • Target(s) • Plans for constructing or improving an indicator
health-targets.de (Germany)	Each "health target" is broken down into • Targets ("Ziele"), further broken down into • Intermediate targets ("Teilziele") and • Recommended strategies and actions for implementation ("Maßnahmenempfehlungen")
10 health targets (Austria)	10 Overarching Health Targets ("Rahmen-Gesundheitsziele"), broken down into • Objectives and subtargets, drawn up in separate working groups • Measures and concrete actions and designation of the responsible institutions in the working groups • A benchmark to monitor the implementation of the measures.
Gezondheidsdoelstellingen (Flanders)	Future targets will be set per setting (local community/work/education/leisure time/family/directly to the citizen/care and welfare/good governance). Targets will focus on processes ("x% of municipal authorities/companies/schools/… have installed a health policy that meets the criteria of a "healthy municipality"/"healthy job environment"/"healthy school"/…"), and no longer on outcomes.
NHS Next Steps on the Five Year Forward View (England)	Describes a shared vision based on new models of care for the future of the NHS. A series of measures and targets are set and for each health topic is listed: • What has been achieved in England over the past three years • Key deliverables for each year (2017/2018 and 2018/2019) • How changes will be implemented

4.3.8 Monitoring and publication of results

Depending on the level to which targets are imposed (macro or meso), progress is evaluated and reported on different levels (see Table 8 for details on U.S., France and New Zealand.)

Table 8 – Monitoring and publication of progress towards target achievement

Target-setting programme	Monitoring and publication of progress towards targets
Healthy People 2020 (U.S.)	Monitoring at national level: Infographics are published on the website for each of the leading health indicators to show the nation's progress towards the targets
100 Objectifs de Santé (France)	Evaluation of results at national level after the 5-year period 2004-2008 by the "Haut Conseil de la santé publique"
Health targets (New Zealand)	Monitoring and reporting at regional level: 20 District Health Boards (DHBs; responsible for providing or funding the provision of health services in their region) report their progress towards the targets to the Ministry of Health, four times a year. The results for each DHB are published on the Ministry's website.

4.3.9 Communication of target-setting programmes

The U.S., Germany, Austria, New Zealand and Flanders have dedicated websites on which the targets are published (see Table 1). The websites are generally considered an important vehicle for dissemination of the targets. Of particular interest is the Healthy People 2020 website, which comprises a special section where professionals and communities can interactively share their story on how they use and implement the target programme in the field.

5 DISCUSSION

5.1 The list of targets presented is a gross inventory

5.1.1 This is an inventory of quantified targets only

The presented inventory captures but a small selection of the many government documents in which visions, ambitions, goals, action plans etcetera have been formulated. Throughout our sifting process, it quickly became apparent that only in a minority of documents, both at supranational and federal level, quantified targets have been set. The presented targets therefore do not give a complete picture of the many endeavours undertaken in health policy. When analysing a health domain, descriptive targets are obviously as important as quantified targets, however, within the broad scope of this project, it was not possible to include the nearly endless list of descriptive targets. As the need for setting quantified targets has been expressed in many supranational agreements, we chose to focus on quantified targets.

5.1.2 The inventory of targets includes a mixture of target layers

The inventory of federal targets includes a mixture of

- targets formulated at a **political level**, agreed upon and set by the Minister(s) (e.g. "reduction of adult smokers to 17%"), as well as
- targets formulated in **scientific recommendations** (e.g. nutritional or vaccination recommendations for the Belgian population by HGR-CSS) and
- targets formulated at a more **administrative-operational level**, like targets set within financial agreements (e.g. a financial incentive for GPs to stimulate e-health services which depends on six conditions), or targets set by the Nationale Raad voor KwaliteitsPromotie - Conseil National de Promotion de la Qualité (NRKP-CNPQ).

Targets formulated in scientific recommendations tend to describe "**ideal world" targets for the long-term**, whilst targets set at the administrative-operational level more often formulate **"real world" targets for the short-term**. See Figure 2 for the differentiating levels used throughout this project to distinguish different types of targets.

The inventory of federal targets also includes a mixture of

- targets set at **macro**, i.e. national, level (e.g. "reduction of difference in life expectancy according to education level and gender for the Belgian population by 50%"), as well as
- targets set at **meso**, hospital, level (e.g. "minimum 40% breast reconstruction patients hospitalised in a multi-bed room" for each hospital participating in the agreement with RIZIV – INAMI) and
- targets set at **micro**, healthcare provider, level (e.g. minimum percentages of low cost prescriptions for individual physicians and dentists).

Some targets are set **unilaterally**, other targets are **agreed** with the sector or industry (e.g. targets on sugar and fat content of food products).

The inventory furthermore includes a mixture of

- **outcome targets** (e.g. "end preventable deaths of newborns"),
- **process targets** (e.g. "minimum 50% of eligible people receive drug therapy and counselling to prevent heart attacks and strokes") and
- **structure targets** (e.g. "50% of hospitals and primary healthcare facilities with healthy food offer").

The different layers (macro-meso-micro; outcome-process-structure; political-scientific-operational) **are combined and result in a variety of targets.** Targets formulated at political, scientific or operational level may relate to the macro, meso as well as micro level, and they may relate to outcomes, as well as processes and structures. Targets at the meso level can relate to outcomes, as well as processes and structures. When formulated for the meso level, outcome targets however may require risk adjustment. Targets at the micro level are likely most fit to processes and structures, rather than to outcomes.

As the inventory does not distinguish these different layers, it may not be easy to digest and it may give the impression of a "patchwork" of targets, lacking structure. However, given the broad variety of topics listed in the inventory, with many times only a single or very few targets per topic, we decided to simply list them in row.

Figure 2 – Classification of targets

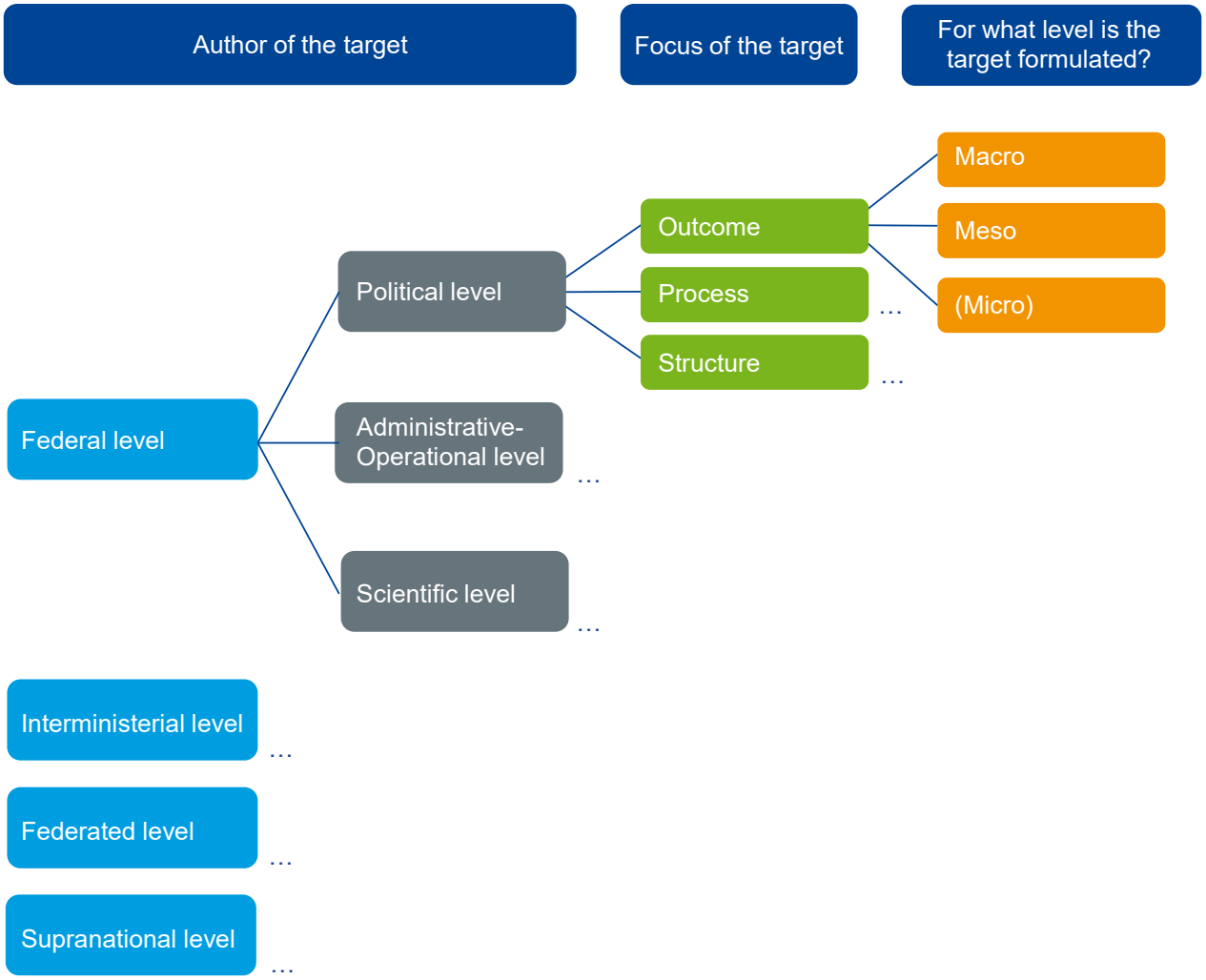


Table 9 – Examples of targets according to the focus of targets (outcome-process-structure) and level to which the targets are imposed (macro-meso-micro)

	Macro	Meso	Micro
Outcome	E.g. Less than 17% adult smokers in Belgium *	E.g. Minimum 70% of patients would recommend the hospital to family and friends ***; Pay-for-performance targets ****	-
Process	E.g. Choice of therapeutic antibiotic conform guidelines in minimum 90% of cases *	E.g. 40% of breast reconstruction patients in a two- or multi-bed room *; 100% of care professionals meeting hand hygiene standards *** ; 90-100% multidisciplinary oncologic consultations for breast cancer patients ***	E.g. Low cost prescription quotas for physicians and dentists *
Structure	E.g. Between 4 and 7 Major Trauma Centres in Belgium *; 50% of hospitals with healthy food offer **		E.g. E-health premium for GPs depending on 6 parameters *

** existing targets formulated at federal level; ** existing targets formulated at supranational level; *** existing targets formulated at federated level; **** illustrative targets*

5.2 What the inventory of federal targets confirms…

5.2.1 Many targets have already been formulated by the federal actors in Belgium…

Many ambitions and goals have been formulated within numerous action plans adopted by federal political actors, to name but a few:

- the joint plan by the Ministers of Health of the federal government and the regions for chronically ill “integrated care for a better health”,
- the action plan for a reform of the Belgian hospital payment system of the federal minister of Health,
- the national “e-health plan” of the federal and regional ministers of Health,
- the pact of the future with the pharmaceutical industry of the federal minister of Health,
- the cancer plan of the former federal minister of Health.

Many administrative and scientific actors furthermore have formulated policy recommendations, like RIZIV – INAMI:

- the action plan named “Actieplan over handhaving in de gezondheidszorg - Plan d'action en matière de contrôle des soins de santé ” for 2016-2017 of RIZIV – INAMI,
- the “White Paper on access to care in Belgium” co-authored by RIZIV – INAMI and Médecins du Monde,

and the Superior Health Council (with e.g. the nutritional recommendations for the Belgian population), WIV – ISP or KCE.

In this project we have put these and many other federal documents under the magnifying glass and filtered them to retain only the quantified targets. **What we observe is that several federal actors have taken initiatives to formulate quantified targets in a variety of domains**.

Especially in the domain appropriateness-of-care, several quantified targets have been formulated, notably on the use of antibiotics, medical imaging and appropriateness of drug prescriptions. In the efficiency domain, targets have been set on low-cost prescriptions. For preventive care, targets have been set for some vaccinations. For health promotion, federal targets have been set on smoking and calory intake. Very specific targets have furthermore been set in the domains accessibility and sustainability. Finally, a very general target has been formulated with regard to health status and health inequalities.

In a number of domains, however, no targets have yet been set. This is the case for the domains effectiveness of care, safety of care, continuity of care, patient centeredness of care, mental healthcare, long-term care for the elderly and care at the end-of-life.

5.2.2 … but the initiatives are not coordinated

The target initiatives however are scattered. They are not supported or steered by a coordinating platform, nor are they communicated as a coherent set of targets to the outside world, and resultantly, they are not very visible - especially to the international community. In this context it was considered an important first step to inventorise and publish on the initiatives already taken in Belgium, so that these can be valorised as much as possible in the consequent steps of developing a federal health target policy.

5.3 What the inventory of supranational targets shows…

Many supranational targets have been formulated, especially in the domains of health status, accessibility (universal coverage), preventive care (especially on vaccinations) and health promotion (mainly on weight status, physical activity, nutrition and substance abuse). Across domains, several targets relating to HIV and sexually transmitted diseases are set. Very few targets were identified in the field of effectiveness of care (only targets identified related to HIV and infectious diseases), on appropriateness of care (only related to HIV) and on safety of care (only related to blood donation and transfusion safety). Some targets are set on mental health (on suicide rate and proportion of persons with a severe mental disorder who are using services).

No targets were identified in the following domains: continuity of care, patient centeredness of care, efficiency, sustainability, long-term care for the elderly and care at the end-of-life.

Many of the targets set by supranational organisations concern relevant health issues also for the Belgian population, however, the global target levels are often not ambitious enough and need to be adapted to the Belgian situation. To give an example:

- “Reduce neonatal mortality to at least as low as 12 per 1,000 live births and reduce under-5 mortality to at least as low as 25 per 1,000 live births” (UN Sustainable Development Goals 2030)

whilst 2015 levels for Belgium are below these targets: 2 per 1,000 live births and 4 per 1,000 live births[a] for neonatal mortality and under-5 mortality respectively. It is clear that most supranationally defined targets need to be tailored to the Belgian situation.

[a] Estimates developed by the UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA Population Division) at childmortality.org

5.4 Health intelligence elements for setting and monitoring health targets in Belgium are abundantly available

Many indicators are available that can be exploited to set and monitor targets. Several health monitoring instruments have already been developed in Belgium at the federal level, measuring the evolution of various health indicators on recurrent basis:

- Health System Performance Assessment (HSPA), developed by RIZIV – INAMI, WIV – ISP and KCE, which measures and evaluates the performance of the health system and serves as backbone for this project
- Health Interview Survey (HIS), developed by WIV – ISP, which measures the health status of the population, their medical consumption, their lifestyle and some socio-economic parameters[b]
- Food Consumption survey (FCS), developed by WIV – ISP, which collects data on food intake, food habits, physical activity and food safety[c]
- IMA atlas, developed by IMA. This database includes data on demographical and socio-economic variables, health status, accessibility of healthcare, prevention, consumption of healthcare and organisation of healthcare. The statistics and indicators are available on an interactive website[d].

Also at the level of the regions, multiple databases have been developed (Vaccinet, SPE, CEpiP, …) and quality indicators for hospitals are developed by the Flemish Indicators Project for Patients and Professionals (VIP²) and the Platform for Continuous Improvement of Quality of Care and Patient Safety (Plateforme pour l'Amélioration continue de la Qualité des soins et de la Sécurité des patients; PAQS).

This list of indicators is not yet exhaustive as many more indicators can be created, on the basis of longitudinal and exhaustive sociodemographic, financial and pathology information available within different datasets managed through the respective federal institutions. Diabetes, lung, nephrology, HIV and TBC patients under treatment are, for instance, relatively easy to detect on the basis of (drug) consumption data. **Though, efforts should be continued to further strengthen the available databases.**

5.5 Critical success factors for targets

Many data are available, however, not all health issues are measurable. To give an example, diabetes that is left untreated, is difficult to measure. Therefore a programme built on quantified targets will not be able to capture all goals of health policy. Though it can be a useful add-on, it cannot be a substitute for the formulation of health policy more in general and attention should be paid that untargeted domains are not neglected.[41] Other drawbacks of quantified targets have been reported such as oversimplification of the policy field, assuming a malleable society and frustration when there are too many and too ambitious targets.[42] Setting quantified targets may also have unintended effects, like data manipulation, to reach the targets.[2]

This raises the point whether it is an absolute must to quantify health targets, or whether it is more appropriate to develop health targets in a descriptive way (simply stating "a decrease" or "an increase" of an indicator). Health target programmes abroad show examples of both approaches. Germany and Austria developed national health target programmes formulating targets mainly in a descriptive way (gesundheitsziele.de ; gesundheitsziele-oesterreich.at). The United States, in contrast, developed a national target programme mainly producing quantified targets (healthypeople.gov/). Both approaches have in common that indicators are identified to monitor the –

b https://his.wiv-isp.be/nl/SitePages/Volledige_rapporten_2013.aspx

c https://fcs.wiv-isp.be/nl/SitePages/Resultaten.aspx?WikiPageMode=Edit&InitialTabId=Ribbon.EditingTools.CPEditTab&VisibilityContext=WSSWikiPage

d http://atlas.ima-aim.be

either quantified or descriptive – targets, and this makes that in the end both approaches are not very different from each other.

There is something to say for both quantified and descriptive, as well as combined approaches but depending on how and the context in which the targets are used, one approach may have benefits over another. In all cases, targets should meet the SMART criteria:

- specific (S),
- measurable (M): either quantified or at least an indicator to be monitored is defined,
- achievable, ambitious or agreed (A),
- realistic (R) and
- time-bound (T).

In addition, health policy analysts have suggested the following conditions for influential targets:

- They are short-term
- They are based at local level (meso) rather than at national level
- Professionals are engaged in the design and implementation of the targets
- Organisations are given increased finance, information and managerial capacity to respond to challenging targets.
- Concrete incentives are attached to the targets. [41]

5.6 Possible next steps

5.6.1 Prioritise topics for target-setting

Prioritisation of topics can for instance be done along a multi-criteria decision analysis. The German health target programme gives an example where target suggestions are prioritised along 13 dimensions, covering mortality, burden of disease, prevalence, potential for improvement, economic relevance, ethical considerations, equal opportunities, priority of the topic from the population's viewpoint, measurability, feasibility in terms of instruments and players, the possibility of citizen and patient participation and legal considerations. Only for the target topic with the highest score, a national target is developed.

5.6.2 Involve stakeholders

Within selected priority areas, targets should be developed in agreement with involved stakeholders. To adapt for instance the supranationally formulated targets on neonatal and child mortality to Belgian norms, experts and stakeholders from the field would need to be brought together (gynaecologists, paediatricians, K&G, ONE, …). Depending on experts' views on what indicators could still be improved, in which subpopulations, by how much, and under what conditions, SMART targets could be formulated, as well as suggestions for policy actions to reach the targets. We refer to the Austrian and German examples where dedicated work groups with concerned stakeholders formulate recommendations on measures and actions to be taken to reach each of the targets.

Given the limited time frame of this project and its broad scope, it was not possible to gather a representative panel of involved stakeholders for each of the indicators to develop realistic yet ambitious targets in a detailed way. Instead we opted to formulate targets in a systematic way (see appendix). However, this systematic method could easily be criticised for being developed in an ivory tower and ignoring the input from experts and stakeholders in the field. We acknowledge this limitation and therefore present the target suggestions as a "straw-man proposal", intended to generate discussion and merely providing a first basis for further work. Bringing together stakeholders has been acknowledged as a critical success

factor for making target-setting programmes an inspiring initiative born by all involved actors.

5.6.3 Work on a coherent set of targets at different layers

Some supranational targets or suggested HSPA targets are aggregate outcome targets that merit to be broken down into more specific outcome targets, in a first step, as well as tangible process, structure and organisational targets, in a second step. To give an example:

- "A 1.5% relative annual reduction in overall (4 causes combined) premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 2020" [43]

This aggregate outcome target is so multifactorial that it is hard to make a link to concrete policy actions. To make this target more tangible, it would need to be broken down into, for instance, a target for cardiovascular mortality alone, which would then need to be further broken down into process targets, like the number of adults who have their blood pressure checked.

5.6.4 Link targets to action plans to foster implementation

Further targets can be formulated along specific action plans or programmes, future or currently running, such as the joint plan on integrated care for chronic patients or the restructuring of the hospital landscape. The indicators in the HSPA have been selected based on a compromise between the conceptual relevance of the indicators (what would be ideal to measure), the feasibility of the data collection for each of the indicators (availability of data) and the manageability of the indicator-set as a whole (number of indicators). This implies that the suggested HSPA targets also remain a selection and are not exhaustive. Following a prioritisation exercise and/or within the context of specific programmes, targets as well as their time horizon, can be adapted and reworked, according to priorities and policy measures planned or taken, with regard to reimbursement conditions, legislation and regulation, investments in capacity and commitments agreed with stakeholders. Keeping in mind however that the development of quantified as well as descriptive targets along different programmes would benefit from a coordinated approach.

Vice versa, the formulation of targets can also generate action plans. We refer to the examples of Austria and Germany where the work groups created for the target-setting programme also formulate measures and actions to be taken to reach each of the targets. In the Austrian health target process, for each action or measure, an institution is designated as responsible for its implementation. This creates ownership of the target and creates accountability.

5.6.5 Develop a more diversified palette of target-setting modalities

Inspired by target-setting methods applied in the U.S. and France, we formulated targets in a systematic way (cfr. appendix). However, the strict application of a limited set of rules does not always result in SMART targets. Therefore it is recommended to develop a broader palette of options for target formulation. In some cases, e.g. in the domain of quality, it may be less useful to set targets based on European comparison or to apply a linear 10 percent improvement rule. In some cases, where there is an optimum (like e.g. caesarean section rate), it is useful to set both maximum and minimum limits. In cases where there are clear EBM recommendations, the target can be set at the maximum, if appropriate taking into account a certain tolerance for exceptions. In case of safety issues, the target is rather to eliminate them as fast as possible. The target-setting options could also be further differentiated depending on whether the indicators are currently increasing or decreasing. Trend analysis should also be performed to check whether the targets are realistic. For some indicators there are also limits to improvement and many targets should be specified for subgroups, like for death at usual place of residence, neonatal mortality rate and caesarean section rate (for which targets could be specified per Robson classification).

5.6.6 *Evolve towards "Health in all policies"*

In this report we followed the backbone of the HSPA report which embraces the overarching goals to improve the health status of the population and to reduce health inequalities as well as the characteristics of a performant health system. Non-medical determinants of health, like education, employment, social security and environmental factors, however are not yet covered by this framework. Experiences abroad show examples of target-setting programmes taking a "health in all policies" approach, acknowledging the importance of collaboration with other policy sectors and at different levels of governance to contribute to population health and health equity. Will this be the next step for the Belgian health system?

RECOMMENDATIONS

***To the Minister of Social Affairs and Public Health and the federal health administrations*:**

- **To continue the initiatives taken in target-setting, yet moving from an ad hoc to a structured approach.**
- **To create a platform to coordinate, support and communicate on target-setting, bringing together representatives of political, administrative, scientific and operational levels from all relevant policy levels and domains.**
- **Different options are open to give form to a structured target-setting process:**
  - **A focused, selective or comprehensive, integrated approach:**
    - **to develop targets for priority areas (selected for instance by multi-criteria decision analysis), or**
    - **to develop a broad set of targets embracing all important areas of health.**
  - **A quantified or descriptive or mixed approach: examples abroad show that quantification of targets is not an absolute must.**
- **Targets developed by the platform should be further elaborated with:**
  - **recommended measures to reach the targets,**
  - **operational targets unfolded to macro, meso or micro level,**
  - **evidence-based information and recommendations related to the topic for healthcare professionals,**
  - **patient/consumer information.**
- **This project can be used as contributing element for further collaboration on target-setting with the WHO in the context of the Country Cooperation Strategy WHO-Belgium 2016-2022.**

REFERENCES

1. WHO Regional Office for Europe. Health 2020 A European policy framework and strategy for the 21st century. WHO Regional Office for Europe; 2013. Available from: http://www.euro.who.int/en/publications/policy-documents/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century-2013
2. Wismar M, McKee M, Ernst K, Srivastava D, Busse R. Health Targets in Europe Learning from experience. . European Observatory on Health Systems and Policies; 2008. Available from: http://www.euro.who.int/__data/assets/pdf_file/0008/98396/E91867.pdf
3. Wismar M, Ernst K, Srivastava D, Busse R. Health targets and (good) governance. Euro Observer - The Health Policy Bulletin of the European Observatory on Health Systems and Policies. 2006;Volume 8, Number 1.
4. WHO Regional Office for Europe. Qualitative indicators for monitoring Health 2020 policy targets. Denmark WHO Regional Office for Europe; 2014. Available from: http://www.euro.who.int/__data/assets/pdf_file/0004/259582/Qualitative-indicators-for-monitoring-Health-2020-policy-targets-Eng.pdf
5. Vrijens F, Renard F, Camberlin C, Desomer A, Dubois C, Jonckheer P, et al. Performance of the Belgian health system - Report 2015. 2015. (KCE Report 259C) Available from: https://kce.fgov.be/publication/report/performance-of-the-belgian-health-system-report-2015#.WRGp1dy_Opq
6. De Block M. Algemene Beleidsnota Gezondheidszorg - Note de Politique Générale Soins de santé. 2014 Available from: http://www.dekamer.be/FLWB/PDF/54/0588/54K0588007.pdf
7. WHO - Belgium. Country Cooperation Strategy WHO - Belgium 2016-2022. 2016. Available from: http://www.euro.who.int/en/countries/belgium/publications/country-cooperation-strategy-who-belgium-2016-2022

8. WHO. The World Health Report 2000. Health Systems: Improving Performance [Web page].Geneva, Switzerland;2000 [cited June 12, 2017]. Available from: http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1

9. De Block M. Persmededeling. Anti-rook beleidsplan met rookverbod in wagen met kinderen en accijnsverhoging. 2016 Available from: http://www.maggiedeblock.be/wp-content/uploads/2016/04/2016-04-09-NL-Anti-rook-beleidsplan-met-rookverbod-in-wagen-met-kinderen-en-accijnsverhoging.doc

10. WHO. Informal consultation with Member States and United Nations agencies on a proposed set of indicators for the Global Monitoring Framework for Maternal, Infant and Young Child Nutrition. Indicators for the Global Monitoring Framework on Maternal, Infant and Young Child Nutrition (30 March 2015). 2015. Available from: http://www.who.int/nutrition/events/2015_informal_consultation_monitoringframework_miycn_backgroundpaper_indicators.pdf

11. United Nations. Goal 3: Ensure healthy lives and promote well-being for all at all ages [Web page].2015 [cited 2017-05-08]. Available from: http://www.un.org/sustainabledevelopment/health/

12. WHO. Global action plan for the prevention and control of noncommunicable diseases 2013-2020. WHO; 2013. Available from: http://www.who.int/nmh/publications/ncd-action-plan/en/

13. WHO. Twelfth General Programme of Work 2014–2019 Not merely the absence of disease. WHO; 2014. Available from: http://www.who.int/about/resources_planning/twelfth-gpw/en/

14. WHO. Global health sector strategy on HIV 2016–2021 Towards ending AIDS. WHO; 2016. Available from: http://who.int/hiv/strategy2016-2021/ghss-hiv/en/

15. WHO. Global health sector strategy on viral hepatitis 2016-2021. WHO; 2016. Available from: http://who.int/hepatitis/strategy2016-2021/ghss-hep/en/

16. WHO Regional Office for Europe. Tuberculosis action plan for the WHO European Region 2016–2020. WHO Regional Office for Europe; 2015. Available from: http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/past-sessions/65th-session/documentation/working-documents/eurrc6517-rev.1-tuberculosis-action-plan-for-the-who-european-region-20162020

17. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on Action Against Cancer : European Partnership, 24 June 2009. Available from: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:52009DC0291

18. European Commission. European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) [Web page].2012 [cited 2017-05-09]. Available from: http://ec.europa.eu/health/ageing/innovation_en

19. 18 juli 2013. Koninklijk Besluit houdende vaststelling van de federale beleidsvisie op lange termijn inzake duurzame ontwikkeling,

20. WHO. Global health sector strategy on Sexually Transmitted Infections 2016–2021 Towards ending STIs. WHO; 2016. Available from: http://who.int/reproductivehealth/publications/rtis/ghss-stis/en/

21. RIZIV. Overeenkomst tussen het Verzekeringscomité van de Dienst Geneeskundige Verzorging van het RIZIV en erkende verplegingsinrichtingen voor de vergoeding van de totale uni- of bilaterale borstreconstructie 2016 Available from: http://www.riziv.fgov.be/SiteCollectionDocuments/overeenkomst_borstreconstructie.pdf

22. WHO Regional Office for Europe. Tuberculosis action plan for the WHO European Region 2016–2020 WHO Regional Office for Europe; 2015. Available from: http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/past-sessions/65th-

session/documentation/working-documents/eurrc6517-rev.1-tuberculosis-action-plan-for-the-who-european-region-20162020

23. Belgian Antibiotic Policy Coordination Committee. Beleidsnota legislatuur 2014-2019.

24. RIZIV. Kwaliteitsindicatoren met betrekking tot het geneesmiddelenvoorschrift resultaten per lok (gegevens 2013). 2015

25. INAMI-RIZIV. Objectifs chiffrés. Propositions pour une utilisation rationnelle de l'outil diagnostic et diminuer le risque d'exposition aux rayons ionisants d'origine médicale. 2009

26. RIZIV. Artsen en tandartsen: minimumpercentage goedkope geneesmiddelen voorschrijven [Web page]. Available from: http://www.riziv.fgov.be/nl/professionals/individuelezorgverleners/artsen/verzorging/Paginas/minimumpercentage-goedkope-geneesmiddelen-voorschrijven.aspx#.WRmPA-t96po

27. De vertegenwoordigers van de artsen en verzekeringsinstellingen. Nationaal Akkoord Artsen – Ziekenfondsen 2016-2017. 2015

28. Farfan-Portet M, Dubois C, Mistiaen P, Cordon A, Stordeur S, Van den Heede K. Towards an inclusive system for major trauma. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE); 2017 03/2017. (D/2017/10.273/04) Available from: https://kce.fgov.be/sites/default/files/page_documents/KCE_281_Trauma_Units_Report.pdf

29. European Commission. EU Action Plan on Childhood Obesity 2014-2020. 2014. Available from: https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/childhoodobesity_actionplan_2014_2020_en.pdf

30. WHO. Global Nutrition Targets 2025: Childhood overweight policy brief. WHO; 2014. Available from: http://www.who.int/nutrition/publications/globaltargets2025_policybrief_overweight/en/

31. WHO Regional Office for Europe. European Food and Nutrition Action Plan 2015–2020. WHO Regional Office for Europe; 2015. Available from: http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/publications/2015/european-food-and-nutrition-action-plan-20152020

32. WHO. Global Nutrition Targets 2025: Low birth weight policy brief. WHO; 2014. Available from: http://www.who.int/nutrition/publications/globaltargets2025_policybrief_lbw/en/

33. WHO. Guideline: Sugars intake for adults and children. Switzerland: WHO; 2015. Available from: http://apps.who.int/iris/bitstream/10665/149782/1/9789241549028_eng.pdf

34. WHO Regional Office for Europe. Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012−2016 Denmark: WHO Regional Office for Europe; 2012. Available from: http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf?ua=1

35. De Block M. Persbericht. Overheid en voedingssector gaan samen voor 5% minder calorieën en verbeterde voeding. In; 2016.

36. Hoge GezondheidsRaad - Conseil Supérieur de la Santé (HGR-CSS). [cited May 15 2017]. Available from: https://www.health.belgium.be/nl/hoge-gezondheidsraad

37. WHO. Mental health action plan 2013 - 2020. Switzerland: WHO; 2013. Available from: http://who.int/mental_health/publications/action_plan/en/

38. WHO. Universal eye health: a global action plan 2014–2019. WHO; 2013. Available from: http://who.int/blindness/actionplan/en/

39. WHO. The Partnership for Maternal, Newborn & Child Health in support of Every Woman Every Child - Strategic Plan 2016-2020. Switzerland: The Partnership for Maternal, Newborn & Child Health WHO; 2016. Available from: http://who.int/pmnch/knowledge/publications/pmnch_strategic_plan_2016_2020.pdf?ua=1

40. Vlaams Parlement (Commissie voor Welzijn - Volksgezondheid en Gezin). Commissievergadering. Commissie voor Welzijn, Volksgezondheid en Gezin. woensdag 23 november 2016, 9.30u.

Gedachtewisseling over de gezondheidsconferentie Gezonde levensstijl van 16 en 17 december 2016. Jo Vandeurzen (Vlaams minister van Welzijn, Volksgezondheid en Gezin) en Kim Oostvogels (managementconsultant Möbius). 2016 Available from: https://www.vlaamsparlement.be/commissies/commissievergaderingen/1094686/verslag/1095408

41. Smith PC, Mossialos E, Papanicolas I, Leatherman S. Performance Measurement for Health System Improvement Experiences, Challenges and Prospects. Part VI conclusions. European Observatory on Health Systems and Policies, WHO Europe, Cambridge. Available from: http://www.euro.who.int/__data/assets/pdf_file/0004/135976/E94887_Part_VI.pdf

42. van Herten LM, Gunning-Schepers LJ. Health targets: navigating in health policy. Health Policy. 2000;53:1-11.

43. WHO Regional Office for Europe. Targets and indicators for Health 2020 (Version 3). Denmark: WHO Regional Office for Europe; 2016. Available from: http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2016/targets-and-indicators-for-health-2020.-version-3-2016