CASE STUDY OF HEALTH GOALS DEVELOPMENT IN THE PROVINCE OF BRITISH COLUMBIA

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ABSTRACT

Health promotion research and practice reveal that goal setting and monitoring have gained increased acceptance at international, national, provincial/state, regional and local levels as a means to guide health planning, promote health-enhancing public policy, monitor reductions in health inequities, set health priorities, facilitate resource allocation, support accountability in health care, and track the health of populations. The global adoption of health goals as a strategy for population health promotion has occurred even though few protocols or guidelines to support the health goals development process have been published; and limited study has occurred on the variation in approach to health goals planning, or on the complex, multiple forces that influence the development process.

This is an exploratory and descriptive case study that endeavours to advance knowledge about the process and contribution of health goals development as a strategy for population health promotion. This study seeks to track the pathways to health goals in British Columbia (BC) and to uncover influential factors in rendering the final version of health goals adopted by the government of BC. Specifically, this study explores the forces that obstructed and facilitated the formulation and articulation of health goals. It considers also implications of health goals development for planning theory, research and health promotion planning. Data collection consisted of twenty-three semi-structured interviews with key participants and systematic review of BC source documents on health goals.

Data analysis uncovered nearly 100 factors that facilitated or obstructed the BC health goals initiative, organized around three phases of health goals development. Key factors influencing the premonitory phase included (a) government endorsement of health goals that
addressed the multiple influences on health, (b) expected benefits of health goals combined with mounting concern about return on dollars invested in health, and (c) effective leadership by a trusted champion of health goals. Key influencing factors in the formulation phase included (a) the positioning of the health goals as a government-wide initiative versus a ministry-specific initiative, (b) the “conditioning” of the health goals process through the use of pre-established health goals and “orchestrated” consultation sessions, and (c) the make-up and degree of autonomy of the health goals coordinating mechanism. The articulation phase of health goals development revealed several influencing factors in relation to two chief issues that characterized this phase: (a) the lack of specificity of the health goals, and (b) the variable portrayal of the “health care system” as a priority area in the BC health goals.

This study also revealed several concessions and trade-offs that characterized the BC health goals process. For example, the formulation of health goals that addressed the broader health determinants yielded health goals without the capacity for measurement, (b) the operational and bureaucratic autonomy of the health goals coordinating mechanism led to feelings of alienation from the health goals process and product among some branches of the Ministry of Health and some established health interests, and (c) the use of pre-determined health goals and the delivery of educative sessions based on the determinants of health generated claims of bias and a lack of trust and fairness in consultation processes and mechanisms.
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CHAPTER 1: INTRODUCTION

Goal setting and monitoring have gained increased acceptance as a strategy for population health promotion and disease prevention over the past two decades. Various jurisdictions have adopted health goals to promote health-enhancing public policy, guide health planning, set health priorities, monitor reduction in health inequities, focus attention on the broad determinants of health, track the health status of populations, or some combination of these purposes. Health goals provide an operational framework to support program and policy planning and to establish parameters for decision making about the health of people.

A complex, social-political process, setting health goals and targets strives to articulate expectations for health, quantify anticipated health-related outcomes, and delineate roles and responsibilities for improving the health of populations. As a strategy for population health promotion, setting goals for health usually precedes a series of steps that includes establishing objectives, identifying indicators, setting targets for improvement, and incorporating measurement and monitoring systems. Goal setting constitutes a hierarchy of action that begins with the articulation of broad, visionary statements which capture expectations for health gains, followed by increasingly specific actions of what must be accomplished in order to meet goals, as well as mechanisms to monitor and track progress toward goals.

This exploratory and descriptive case study examined the health goals initiative in the province of British Columbia (BC). While the health goals process typically comprises three

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1 The terms “goals”, “objectives”, “targets”, “indicators”, and “strategies” are often used interchangeably and carry different meaning in different jurisdictions that have adopted a health goals approach to population health promotion. Definitions of these terms and an explanation of how they are applied within the context of this study are provided in Chapter 2, in the section titled “Note on Terminology.”
stages -- the development stage, the implementation stage, and the monitoring stage -- this study focuses on the development stage only. The development stage considers the prevailing context for health goals, the processes undertaken to formulate health goals, and the final articulation (content) of health goals. In its simplest sense, this study addresses how health goals are formulated and what health goals come to say.

The aim of this study was to identify and describe those factors that have theoretical and practical import in the formulation of health goals and to examine how various factors influence the final articulation of health goals for a population. This study explores the forces that obstruct and facilitate the effective formulation and articulation of health goals and considers implications of health goals development for planning theory, research and planning practice in population health promotion. More specifically, this study tracks the pathway followed in the development of health goals for the province of British Columbia, and examines what factors were influential in rendering the final version of health goals that were adopted by the government of BC. The study aims to advance our understanding of the formulation and contribution of health goals as a strategy for the promotion of population health.

Statement of the Issue

Early indications of health goals as a strategy for population health promotion appeared in the late 1970's in the US. A comprehensive framework for health was outlined in Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (US Dept. Of Health, Education & Welfare, 1979a). This publication, inspired in part by the Lalonde report, A New Perspective in the Health of Canadians, disclosed a shift in emphasis from health care to health promotion and disease prevention and was led by the US Public Health Service. Their
work was detailed in the release of Promoting Health/Preventing Disease: Health Objectives for the Nation (US Department of Health and Human Services, 1980). This publication delineated 225 specific objectives and targets for improving the health of Americans for a ten-year period.

At about the same time, the international conference on primary health care, held at Alma Ata in 1978, established a policy framework of Health For All which called for all citizens of the world, by the Year 2000, to attain a level of health that would permit socially and economically productive lives. The Declaration of Alma Ata (WHO, 1978) defined the features of Health For All as a global strategy, formally adopted in 1981 by the Member States of the World Health Organization (WHO, 1981). In 1985, WHO’s European Regional Office published its first round of health goals in Targets for Health for All 2000 (World Health Organization Regional Office for Europe, 1985). This report was updated in 1991 based on broad consultation among European member states (WHO: Regional Office for Europe, 1991). Other countries and regions followed in the adoption of health goals and targets including Eastern Europe, Africa, South East Asia, the West Pacific, Australia, Sweden, Germany, and Mexico (McGinnis, 1984).

It is interesting to note that even though all Canadian provinces and territories have developed provincial health goals, health goals have not been established at the national level in Canada. Pinder (1994) notes that various calls for national health goals have been made over the past two decades. National goal setting was advocated as early as 1974 in A New Perspective on the Health of Canadians (Lalonde, 1974). Other calls for health goals came from the Ad Hoc Committee on National Health Strategies (Health Canada, 1982), the Canadian Public Health Association (1984, 1987, 1992), and the Canadian Journal of Public Health (Spasoff, 1987). Most recently, a report to Health Canada’s Population Health Promotion Division on the status and application of health impact assessment in Canada recommended the establishment of
national-level health goals as a prerequisite to health impact assessment (Frankish et al., 1996a).

Although many jurisdictions have adopted health goals as a national, state or regional strategy for population health, limited research and documentation has surfaced on the factors that influence the health goals development process. Several issues support the argument for a comprehensive examination of the health goals development process. These include (a) the broad acceptance of health goals as a planning and policy tool for population health promotion, (b) the complexity of health goals development, (c) the variations in approaches to health goals development, and (d) the role of theory in health goals development.

**Acceptance of Health Goals**

Beginning in the early 1980's, several OECD and other industrialized countries instituted a planning-by-objectives approach to health policy. Three factors influenced the broad-based appeal of health goals as a strategy for population health promotion worldwide: (a) an increasing emphasis on accountability in health, (b) reforming health systems by shifting the emphasis from resources to outcomes, and (c) the perceived contributions and underlying assumptions of health goals as a population health promotion tool.

**Accountability in Health**

The past decade has seen increased emphasis on accountability and evidence-based decision making in the clinical health care setting with the institutionalization of utilization review and clinical outcomes research (Chernichovsky, 1995; McKinlay et al., 1989). A similar

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2 The broad acceptance of health goals refers to the number of jurisdictions worldwide that have formulated health goals or that adopted a health goals approach; this does not include any judgment about health goals implementation or longevity within a given jurisdiction.
emphasis exists in the public health sector where a shift in focus from service provision to health outcomes has occurred (Eyles and Birch, 1993; Frankish et al., 1996a; Ratner et al., 1997). To attain political and financial support, health programs are expected to demonstrate a beneficial impact on health status, or on those factors that influence health. Expectations to demonstrate impact are largely a reflection of spending constraints at all levels of government, as allocation of resources for health and social goods compete with growing pressure to control government debt and deficit. Within this context, health goals offer a means by which health promotion and population health programs can demonstrate health gains, and thereby rally continued support.

**Health Reform**

The reforming of health systems around the globe has further contributed to the wide acceptance of the health goals approach. Health goals offer tangible strategic direction to reforming health systems that typically evolve within an environment of uncertainty as health services move from acute to community settings; as clinical care becomes more interdisciplinary; and as localized, democratic models of health decision making become institutionalized. Health goals, objectives and targets set out tangible parameters for change to support the reorientation of health systems in health reform. The wide acceptance of health goals as a strategy for population health promotion may also reflect a shift from *resource-based planning* which tends to rationalize and justify existing resources and activities in health, toward *population-based planning*, where planning is based on the needs of the population and strives to optimize resources for the improved health of people (Frankish et al., 1996a; Ratner et al., 1997).
Perceived Contributions and Assumptions of Health Goals

The potential contributions of health goals to health planning and policy making have increased their acceptance in jurisdictions around the world. The published literature and source documents from several jurisdictions highlight these multiple contributions. Health goals are viewed by some as a means for making service provision decisions and creating health system efficiencies by encouraging collaborative action and reducing fragmentation and duplication (Australian Department of Health, 1994). Others perceive health goals as an effective mechanism to support decision making about resource allocation, to enhance accountability, to promote quality information systems, and to reorient health systems from health services to health outcomes (Lyons, 1995). Health goals may also help to identify achievable improvements in health status and reducible inequities in health, and to provide a basis for setting priorities (British Columbia, 1995). Providing a framework for improving the health status of people and communities, allowing increased attention to the multiple influences on health, and setting guideposts for health-enhancing public policy are seen as additional contributions of health goals in some jurisdictions (Saskatchewan, 1994). Finally, health goals are viewed by some as a framework for health planning, as a road map for policy direction, and as a basis for health impact assessment of programs and policies (Frankish et al., 1996; Ratner et al, 1997).

The underlying assumption of health goals by jurisdictions that have adopted a health goals approach -- that health goals guide more efficient allocation of resources toward the improved health of populations -- has contributed also to their broad acceptance. Health goals, objectives and targets are envisioned as links in a “causal chain” where the ultimate end is to improve health and quality of life. Notable improvements in health and quality of life (or lack thereof) require tracking over time and across interventions, programs and policies to
demonstrate impact. Surveillance systems, with health goals and targets as cornerstones, offer means by which programs can be monitored for impact. Health goals support surveillance by clearly articulating the anticipated improvements in health and quality of life within a given jurisdiction over a set period of time. The utility of health goals in guiding effective surveillance further accounts for the world-wide acceptance of health goals as an effective strategy for population health promotion over the past two decades.

**Variations in Approach to Health Goals Development**

The World Health Organization’s Health For All policy encouraged a planning-by-objectives approach as a means to plan, evaluate and monitor the health of populations (World Health Organization, 1991). The global encouragement for health goals, however, came with few developed guidelines or protocols to support health goals planning. This led to significant variation in the health goals development process among jurisdictions that have adopted health goals. Variations occur in how health goals are developed, that is, in the processes and procedures drawn on to formulate health goals; as well as in health goals articulation, in relation to the number and kinds of issues addressed in health goals. Many of these variations might be necessary to fit the process to regional variations in political structures and traditions, resources, and levels of support. The lessons from these variations, however, need documentation and comparison.

Although variations in approach to health goals development occur along several dimensions, at least two deserve mention early on. (Chapter 2 provides a full discussion on these issues.) The first significant variation relates to the degree to which the proximal and distal determinants of health are considered in health goals. Any one health determinant may be
proximal or distal depending on: (a) the immediacy of the event to the health impact, (b) the
degree to which an individual may exert influence over the determinant, (c) the individual’s life
stage or circumstance, and (d) the singular or cumulative effect of risk factors for health
outcomes. The degree to which proximal and distal determinants of health are featured in health
goals varies across jurisdictions that have adopted the health goals approach. The variation may
be conceptualized along a continuum with one end representing what may be called a “health-
targeted” approach to health goals development, and the opposite end representing what may be
called a “health-determinants” approach to health goals development.

In the health-targeted approach; health goals, objectives, and targets focus on the more
proximal influences on health which include those factors that influence health that have
historically been viewed as under the individual’s control or relate to the more immediate
environmental influences on health of individuals or populations. Health goals in the health-
targeted approach tend to address issues related to preventable illness and injury, disability,
morbidity and mortality, risk factors, health protection, and health promotion and disease
prevention. In this approach, health goals development is concentrated in the health sector
(including a larger role for public health vis a vis medical care), although input is often sought
from multiple sectors; and issues and strategies associated with health goals fall most heavily
within the mandate of the health sector or health system. Interventions aimed at meeting goals for
improved health remain within the reach of public health and preventive health services. Finally,
the health-targeted approach to health goals relies principally upon established health status
indicators to track changes in health status and to monitor population health gains.

At the other end of the continuum, the health-determinants approach to health goals
extends beyond proximal influences on health to focus more on those factors commonly referred
to as the broader determinants of health. Generally, the broader determinants of health constitute those that are further removed in space or time from an individual and his or her immediate environment; and include global social, economic and environmental influences on health.

Within the health-determinants approach, the health sector coordinates health goals development, but the process relies more heavily on significant participation from other sectors. In the health-determinants approach, health goals tend to address issues that extend farther beyond the traditional health sector or health system and interventions to meet health goals require action from several sectors. In this approach, the development and articulation of health goals is a shared initiative between health and other sectors and the proposed advances in population health are the responsibility of multiple sectors. Finally, the health-determinants approach measures and monitors health status improvements by both traditional health status indicators, as well as by social, economic and environmental indicators. Although a distinction is drawn between a health-targeted approach and a health-determinants approach to health goals development, both approaches in real-life application settle for some middle range of comprehensive planning with targets and intermediate objectives scattered along the continuum.

Health goals development may vary also along a centralized - decentralized continuum. Planning processes can be placed on a continuum which spans the range of planning approaches from centralized to local, with many shades between. Typically, health goals planning combines these two approaches, where different aspects of the planning process relate more closely to one pole than the other. Elements of the planning process that influence its characterization as centralized or decentralized include the following: who participates in the process, who has control over resources, the level of buy-in from stakeholder groups, what kind of decision latitude is available to whom, who does the editing and report writing, and the level at which the
planning processes is coordinated and managed. The degree to which a health goals process is centralized or decentralized may influence the way in which the health goals development process proceeds; and, how the health goals are ultimately articulated. (Subsequent chapters discuss this issue in greater detail).

Variations in approach to health goals development may be beneficial by promoting creativity and flexibility and encouraging the adaptation of health goals to the unique characteristics and needs of each jurisdiction. Conversely, a limited availability of well-developed guidelines, protocols or modelling practices to support the development process may result in inefficiencies, promote disharmony and conceptual confusion, and further complicate an already challenging process.

Regardless of the approach taken to health goals -- whether it be a health-targeted or health determinants approach, or a centralized or decentralized approach -- implications arise for the articulation of health goals for a population. This study examines how the “pathway to health goals” in British Columbia influenced the articulation of the final version of goals that were adopted by the Cabinet of BC. Additionally, this study generates hypotheses about how a different approach or pathway may have led to a different rendition of health goals for BC. This study also draws conclusions about how other jurisdictions might improve upon the BC health goals experience.

**Complexity of the Health Goals Development Process**

Developing health goals is a complex process that attempts to accommodate various interests and expectations to reach agreement on priority health and health-related issues. Adopting a health goals approach may have significant implications for established health
interests by potentially shifting the focus of the health care system from health services to health outcomes; it may also lead to the redistribution of power and resources from special interests to broader purposes of population health promotion (Dimatteo et al., 1995; Hunter, 1996). One expectation of the health goals process is that through conciliatory and participatory mechanisms; health goals, objectives, targets and strategies will be established to prioritize health issues, reduce health inequities, improve accountability, and ultimately enhance the health of populations. But, getting there means working through a complex web of processes, procedures and mechanisms.

Formulating health goals is a demanding process even when health goals are focused solely on health issues which fall within the mandate of the health sector. The challenge becomes even greater when planners take on a larger-than-health focus by addressing social, economic and environmental influences on health. Health goals development that incorporates the broad determinants of health challenges traditional processes and players in the health sector, increases the mix of interests and orientations involved, and requires new collaborative and interdisciplinary approaches to health planning (Nutbeam et al., 1993).

Although some literature exists that surveys factors that influence the health goals exercise (Green et al., 1983; Lyons, 1995; Nutbeam & Wise, 1996; Nutbeam et al., 1993) less attention has been paid to examining the interplay between the various factors that characterize health goals development and the resultant effect on health goals articulation (or the content of health goals). This study offers a comprehensive, systematic analysis of those factors that contribute to health goals development. Specifically, this study examines and describes the multiple forces that facilitated or obstructed the development and articulation of health goals in the province of British Columbia.
Role of Theory in Health Goals Development

The role of planning theory in health goals development is often implied in jurisdictional source documents on health goals. Source documents typically include informational and public relations materials developed and disseminated by jurisdictions that have adopted a health goals agenda. The published academic literature on health goals offers more insight into the types of planning models and approaches that guide health goals planning. Some reference is made to goal-setting in the grand planning theories, such as the rational model of planning. The link between health goals planning and theory is more explicit, however, in those planning models that are more procedural in nature and that speak directly to the application of goals and targets. Examples of these models include, management-by-objectives (Lee, 1981; McConkey, 1975; McGinnis, 1984), the PRECEDE-PROCEED model (Green & Kreuter, 1991), the PERT model (American Public Health Association, 1966), the PATCH model (Nelson et al., 1986; Steckler et al., 1992), and others. (Chapter 2 provides a full discussion of these models.)

Understanding the role of theory in health goals development provides insight into the fit between empirical cases of health goals development and various established planning models or theories. By examining the health goals development process in British Columbia, this study helps to uncover those factors with theoretical importance to health goals planning. Further, this study examines the fit of the British Columbia health goals exercise against various established planning models. Specifically, it examines ways in which the British Columbia health goals exercise reflects or differs from various aspects of the established planning models; and suggests ways in which the established models may be enriched, adjusted or extended to guide goal setting in the health field.
Study Rationale and Purpose

As detailed in the section above, the following issues support a comprehensive examination of the health goals development process: (a) the wide acceptance of health goals at international, national, provincial/state, regional and local levels with minimal application of well-developed protocols or guidelines to support the health goals development process; (b) limited study of the variation in the approach to health goals development (other than at the national level) and the relationship between the pathway or approach to health goals and the articulation or content of health goals; (c) limited analysis of the complexity of the development process including factors that facilitate and obstruct health goals planning; and (d) limited efforts to assess the fit between real-life experiences of goal setting in the health field and the established or traditional models of planning.

The purpose of this study is to advance knowledge about the process and contribution of health goals development as a strategy for population health promotion. If health goals are to be an effective strategy for population health promotion, greater knowledge is required to support and inform the health goals development process. This means increasing our understanding of those factors that facilitate and challenge the health goals process. This study identifies the multiple forces that come into play in health goals planning and seeks to improve our understanding of how health goals planning can yield health goals that are both reflective of population needs and priorities, and achievable. Unless the health goals development process is guided by practices and procedures that are capable of sustaining and supporting the effort, and unless the process yields health goals that can be achieved; investments into health goals as a strategy for population health promotion cannot be justified.

Procedurally, a health goals (conceptual) framework guides the case study investigation
of the health goals development process in the province of British Columbia. The framework evolved from a review of the literature on various planning models, goal setting in the health field, and source documents from six national and state/provincial jurisdictions that have adopted a health goals approach. The health goals framework organizes and consolidates what is known about the health goals development process. It captures key practices, procedures and mechanisms and delineates the major themes and dimensions that characterize the health goals development process. The health goals framework is then applied to the British Columbia experience to guide observations and data collection as well as data analysis. Finally, the health goals framework offers an outline for the presentation and discussion of study findings.

**Research Questions**

This study is an exploratory and descriptive investigation of the health goals development process in the province of British Columbia that proposes to answer the following research questions:

*Implications of the Case for Theory:*

1. What factors, as perceived by participants in BC, obstructed or facilitated the formulation and articulation of health goals that were considered for submission, or adopted by, the Cabinet of the government of British Columbia?

*Implications for Modification of Planning Models:*

2. Which aspects of the BC health goals setting exercise fit best with the established planning models and what does the BC experience suggest for the application of existing models for goal setting in health?
Implications for Research:

3. What recommendations can be drawn from the goal-setting experience in British Columbia to guide and inform further study on the formulation and articulation of provincial health goals?

Implications for Practice:

4. What implications for planning practice can be drawn from this study for the formulation and articulation of health goals in other jurisdictions and at the regional or local level in British Columbia?

Potential Benefits of the Study

This study has the potential to influence key groups within the health sector. This study may benefit policy makers by encouraging them to apply health goals as a means to promote accountability and evidence-based decision making in government, and by offering a rationale for inter-ministerial and intersectoral approaches to policy planning. By making clear those factors that influence the health goals development process, this study provides jurisdictions contemplating health goals a framework for planning. Further, this study supports jurisdictions that have already adopted a health goals approach by providing a mechanism to refine existing health goals as well as a framework for the formulation of subsequent goals, objectives and targets for health. This study supports also the work of provincial health organizations in planning and setting organizational level priorities in areas of health that are of interest to them.

Although this study examines and describes the health goals development process at the provincial level, implications may be drawn also for the development of health goals at the regional and local levels in the province of BC and within other jurisdictions. This study may be
useful to health care practitioners by outlining the implications of adopting a determinants of health approach to health care practice and related implications for interdisciplinary and collaborative practice approaches. Finally, academics and researchers may benefit from this study by its advancing the theoretical foundation of health goals development, and identifying areas for theory, model, and instrument development for population health promotion, as well as generating research questions and hypotheses for testing in future research. Taken together, the intent of this study is to advance the knowledge and understanding of the health goals development process among those groups who plan for the improved health of populations.

Study Context

This section provides a summary overview of the British Columbia health goals process and discusses the initiation of the BC health goals process, the foundation of the BC health goals, and the various phases of the development process.

Initiating the BC Health Goals Process

The health goals development project in the province of British Columbia began in October 1994, three years after the release of the 1991 report of the BC Royal Commission on Health Care and Costs (BC Ministry of Health and Ministry Responsible for Seniors) which recommended that health goals be established for the health system. In a policy document entitled, New Directions for a Healthy British Columbia (BC Ministry of Health and Ministry Responsible for Seniors, 1993), the new government’s response to the Royal Commission extended the recommendation for health system goals to include the development of population health goals, with a focus on the broad determinants of health. In outlining priority actions that
focus on better health for British Columbians, the New Directions policy recommended the establishment of “a clear set of health goals for the province that reflect our understatements of how social, economic and environmental factors affect health, and provide a means of measuring our success over time” (p. 12). At about the same time, the government amended the Health Act (1996) to charge the Provincial Health Officer with the responsibility of reporting annually to the Legislative Assembly on the health of British Columbians “as measured against population health targets.” Initially, the BC government envisioned a Provincial Health Council to assume responsibility for the development of measurable health goals and objectives. In 1994, the Cabinet of the government of BC decided not to proceed with a Provincial Health Council following strong resistance from opposition political leaders to the proposed Health Council Act. The BC government then asked the Office of the Provincial Health Officer to undertake a wide consultative process to develop provincial health goals which began in the spring of 1995.

As referenced in several source documents from the Office of Provincial Health Officer, the expected contributions of provincial health goals and measurable objectives were: (a) to identify achievable improvements in health status and reductions in health status inequalities, (b) to focus attention on all the factors that influence health in addition to the health care system and broaden the agenda for action by all sectors concerned with the health of the population, (c) to provide a basis for setting priorities, linking public policy decisions and investments to desired health outcomes, and helping to ensure accountability for those investments and outcomes; and (d) to establish a framework for action by many different sectors inside and outside government.

By recognizing the many influences on health including social, environmental and economic factors, the health goals for BC were intended to serve as a tool to stimulate and encourage collaborative action by all ministries of the government of BC, as well as non-
government organizations from many sectors. The health goals were not to be considered the sole responsibility of the health services sector, nor of the government alone. Rather, the need for intersectoral collaboration within government and between government and non-government partners was recognized as a prerequisite to the effective formulation of health goals for BC.

The Foundation of the BC Health Goals

Three issues grounded the BC health goals initiative. First, the adoption by the BC government in *New Directions for a Healthy British Columbia* (1993) of the 1984 World Health Organization’s (European Region) definition of health which stated that:

Health is the extent to which an individual or group is able, on the one hand, to develop aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is seen as a positive concept emphasizing social and personal resources, as well as physical capacities.

Second, the articulation of an overall mission of the provincial health goals which aimed “to maintain and improve the health of British Columbians by enhancing quality of life and minimizing inequalities in health status” (British Columbia, OPHO, 1995). Finally, six key principles underlie the BC health goals and guided the health goals development process. They include: (a) collaborative action among individuals, communities, non-government organizations, communities, all levels of government, and Aboriginal peoples for the achievement of health goals; (b) public participation in decision making for implementation actions to achieve health goals, (c) respect for diversity of cultures, historical roots, and preferences and choices, and (d) equitable access to needed and appropriate health services and a balanced approach to government expenditure on health services and on other influences on health (British Columbia, OPHO, 1995).
The BC health goals development process reported here spanned nearly 3 years and yielded several versions of health goals. The six health goals that constitute the final version of health goals for BC are listed in Table 1 below. Please refer to Appendix Z for a full listing of the final version of health goals and associated objectives.

Table 1: Health Goals For British Columbia

<table>
<thead>
<tr>
<th>Goal 1:</th>
<th>Positive and supportive living and working conditions in all our communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 2:</td>
<td>Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life’s challenges and to make choices that enhance health.</td>
</tr>
<tr>
<td>Goal 3:</td>
<td>A diverse and sustainable physical environment with clean, healthy and safe, air, water and land.</td>
</tr>
<tr>
<td>Goal 4:</td>
<td>An effective and efficient health service system that provides equitable access to appropriate services.</td>
</tr>
<tr>
<td>Goal 5:</td>
<td>Improved health for aboriginal peoples.</td>
</tr>
<tr>
<td>Goal 6:</td>
<td>Reduction of preventable illness, injuries, disabilities and premature deaths.</td>
</tr>
</tbody>
</table>

Source: Health Goals For British Columbia, Ministry of Health and Ministry Responsible for Seniors, 1997

Phases of the BC Health Goals Development Process

Late in 1994, about 50 people from various organizations and sectors participated in the drafting of a preliminary set of health goals that was coordinated by the Office of the Provincial Health Officer. These goals served as the basis for wide consultation to reflect the interests and

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3 The various renditions of health goals and the genesis of each is referenced in greater detail in Chapter 4; and included in Appendices V through Z.
priorities of people and communities throughout the province. While the various phases of the health goals process are described in detail in later chapters, a summary of the six phases that comprise the development process is presented here:

Phase 1 involved *input from provincial government ministries* who provided comment on the preliminary health goals, identified areas within their sector where measurable objectives could be developed, and suggested data sources and advice on indicators for measuring progress.

Phase 2 included *input from provincial stakeholder organizations* who were suggested by the representatives of all provincial ministries. Over 100 representatives of provincial stakeholder organizations attended a series of half-day meetings conducted by the Office of the Provincial Health Officer, and about 50 organizations responded in writing on ways to improve health goals and made suggestions for objectives and methods to measure progress.

Phase 3 entailed *preparation of a public discussion paper* entitled, *Health Goals for British Columbia: Identifying Priorities for a Healthy Population* (1995) which included input from the first two phases on draft health goals, objectives and a preliminary set of measurement indicators. This paper also served as the source for public consultations in phase four.

Phase 4 involved *public consultations through regional health boards* which consisted of full day meetings in each of the 20 health regions and involved approximately 1,300 people including members of the public and representative of various government and non-government agencies in health and other sectors.

Phase 5 constituted *finalization of the proposed health goals and objectives* based on public consultation input and targeted discussion with ministries and sectors that proposed revisions. Development of measurement indicators and targets continued during this phase.
Phase 6 entailed *cabinet submission and adoption of the provincial health goals* and an expectation by the Office of the Provincial Health Officer for direction on how to proceed with the implementation of health goals.

At the time of writing of this thesis, provincial health goals have been adopted by the Cabinet of the government of British Columbia and the Office of the Provincial Health Officer is organizing to develop and implement actions to be undertaken by government and non-government partners from various sectors toward the attainment of the BC health goals.
CHAPTER 2: REVIEW OF THE LITERATURE

This chapter reviews the literature in two sections. Part A reviews the literature on planning theory that relates to the health goals development process. According to Cooper (1989), a theoretical literature review presents the theories offered to explain a particular phenomenon, compares them in relation to breadth and the nature of their assumptions, and makes assessments about which theory is most powerful and consistent with the issue under inquiry. Part B of this chapter attempts an integrative research review that summarizes and draws conclusions about the key, multiple factors known to characterize, influence or contribute to health goals development. The integrative research review synthesizes the past evidence on the issues; presents the state of knowledge concerning the issues, and highlights gaps in the literature and raises question about issues that remain unresolved (Cooper, 1989). Part B is structured around a set of propositional statements that organizes and summarizes the literature on the multiple factors that influence the health goals development process.

PART A: PLANNING THEORIES AND MODELS RELATED TO HEALTH GOALS DEVELOPMENT

This part of the literature review discusses the theoretical basis of health goals development. It provides: (a) an overview of four grand theories of planning relevant to health goals development, (b) a discussion of three key theoretical issues associated with health goals planning, and (c) a review of various procedural health planning models pertinent to health goals planning.
Grand Theories of Planning

This section reviews key assumptions and characteristics of four schools of planning thought: (a) the rational model, (b) the incremental model, (c) the mixed scanning model, and (d) Allison's models. An examination of the major schools of planning thought facilitates the understanding of the historical roots of goals-based planning in the health field. The intent of this section is to introduce the grand theories of planning that have guided the development of more procedural, practice-based health planning models (to be discussed later), which themselves can be considered progenitors of health goals planning.

The Rational Model

The rational planning model (also referred to as the rational-comprehensive model) is characterized by an orderly, logical progression from diagnosis of a condition or problem to actions taken to alleviate or improve it (Walt, 1994). The rational perspective views planning as an objective science that is based on cooperation among decision makers and takes place for the mutual benefit of those involved. The rational planning model assumes that planning advances through a rational series of steps to make the "best" possible choices for future action toward some vision of the "good life" for all concerned (Dror, 1973).

Rational planning provides a theory on the way policy makers ought to behave when making decisions and planning for the future (Walt, 1994). Decision makers go through a logical process to reach a decision that effectively achieves a given end, based on the examination and analysis of relevant facts, values and theories (Gilbert & Specht, 1977). Most often the problem or situation is thoroughly assessed and its scope, incidence and seriousness specified in great detail. Data collection is central to the planning initiative; typically, investigations are conducted
to collect information on what has been done regarding the problem within the planning jurisdiction as well as how other jurisdictions have addressed similar problems or situations.

Under the rational planning model, planners proceed through the following steps to reach the best possible decision:

1. Clear problem identification where the problem or issue under consideration is separated from other problems or compared with other problems.

2. Clear delineation of goals that aim for consistency across organizational or planning units. Planning groups clarify the goals and values that guide the planning process and rank them according to some measure or judgment of importance (for example, health equity goals may receive a higher ranking than health efficiency goals).

3. Generation of possible solution alternatives for addressing the issue or problem.

4. Comprehensive examination of each solution alternative including assessment of potential consequences in costs and benefits.

5. Comparison of each alternative and its consequences to other alternatives.

6. Choice of the solution alternative (and associated consequences) most aligned with expressed values and most likely to maximize goal attainment.

Some people question the usefulness of rational models and argue that the ability for decision makers or planners to act rationally is limited by various factors (Walt, 1994). For example, planners do not often face clearly defined problems or issues. Issue uncertainty jeopardizes the identification of alternatives and consequences and breaks down the logical flow of the rational planning process. Secondly, the practical considerations of time and access to information may impede planners in their attempt to make an exhaustive analysis of alternatives and consequences. Thirdly, planners or decision makers are not value free; they bring their
prejudices and preferences to the planning table, which may limit or screen the identification of solution alternatives (for example, the reluctance of a conservative to consider a “liberal” solution). Further, in many cases, past plans or policies dictate future plans or policies and movement on policy is especially constrained when past investments or commitments must be honoured, which may impede the otherwise rational process of working toward the best solution. Finally, the rational planning model does not fully consider social and political influences. Cervero and Wilson (1994), recent writers on planning, do not discount the role of rationality in planning, but believe that the greatest downfall of the rational approach is its lack of attention to political interests and power relations:

This is not to say that planners do not act rationally ... But it is to say that comprehensive notions of scientific rationality as underlying planning theory fundamentally fail to understand how planners act in the real world, for this mode of rationality lacks the crucial ethical, political, and structural dimensions that make sense of planners’ actions in a context of interests and power (p. 177).

Regardless of its limitations, the rational planning model has significantly influenced planning in the health field more than in some others (such as education, in which Cervero & Wilson were writing the foregoing quotation). It is traceable to several health planning models relevant to health goals planning. The management-by-objectives model is an example of rational planning that has been applied in several health goals initiatives world-wide.4

The Incremental Model

The incremental planning model (also referred to as the incrementalist model or the political model) is a response in part to the rational model (Walt, 1994). Unlike the rational

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4 Management-by-objectives characterizes the US Objectives for the Nation and Healthy People 2000 initiatives as well as other health goals initiatives that have been reviewed as part of this chapter. The management-by-objectives model is considered one of the progenitors of health goals planning and is discussed in detail later in this chapter.
planning model, the incremental model integrates the political dimensions of planning with the more technical aspects of planning. Incrementalism recognizes that planners and decision makers make decisions within a political context characterized by conflict and negotiation which introduces limitations and challenges to the planning process. Plans and policies therefore, are political outcomes, negotiated by interest groups with varying perspectives, aims and power.

An incrementalist perspective focusses planning on small changes to existing policy rather than large changes or consideration of major future policies which are more likely to be considered within the rational (comprehensive) planning perspective. Planning is envisioned as a continuous process where plans are revisited for ongoing adjustment. Few problems therefore are solved for all time or in any single attempt or program. Under incrementalism, policy planning proceeds with small serial steps, each similar to the one before, with ongoing “successive limited comparisons” (Walt, 1994). Each planning step is governed by the consideration of what actions can be taken to bring about the desired change with the least possible disruption to the status quo.

Goals may or may not be clearly delineated in the incremental model of planning. The reluctance to be clear on goals may reflect an awareness that goal definition precipitates conflict rather than agreement or consensus (Walt, 1994). In the incremental model, goal selection and the means of implementation are not distinct from one another; plan development and plan implementation occur in simultaneous cycles. This differs from the rational planning model where goals are clearly stated and the delineation of goals does not include evaluation or selection of means; that is, plan development is held separate from plan implementation. Also, unlike the rational model, formulating a coherent set of values to guide planning does not occur in incrementalist planning insofar as values, like plans, are fluid, and change with time and experience. Additional characteristics of the incremental planning model include (Gilbert &
Specht, 1979): (a) consideration of only a limited number of alternatives for addressing a problem where there is no optimal alternative, (b) choice of solution options that differ only marginally from existing policies, (c) consideration of only the most significant consequences for each alternative, and (d) striking consensus among decision makers about the option chosen is more important than ensuring the “best” decision, as is the case in the rational planning model.

Charles Lindblom (1959), likely the most recognizable incrementalist, in his classic work, *The Science of Muddling Through*, described the decision-making process as one of “disjointed incrementalism” or “muddling through.” To Lindblom, “partisan mutual adjustment” influences the policy process; it is a process of bargaining, negotiation, and adjustment between different interest groups to impact policy outcomes. What is feasible politically, Lindblom argued, is incremental or marginal changes to existing policies or programs. Incrementalism focuses the analysis of problems and issues on what is familiar and reduces the number of factors decision makers must consider. Lindblom’s beliefs on the nature of policy making remained constant over a twenty year span. In his later essay, *Still Muddling, Not Yet Through*, Lindblom (1979) argued that incrementalism had become orthodoxy; reaffirming that in policy making, only small, incremental steps are ordinarily possible: “It is more likely that decision makers get better at doing things incrementally than doing things in different ways, many ... believe that for complex problem solving it usually means practicing incrementalism more skillfully and turning away from it only rarely” (p. 517).

**The Mixed Scanning Model**

Etzioni (1967) introduced the mixed scanning approach to policy planning as an attempt to find a middle position between the rational and incremental approaches. Mixed scanning
combines the research and fact-gathering elements of the rational approach with the small-step, consensus-building elements of the incremental approach (Gilbert & Specht, 1977). First, "broad-angle scanning" provides an overview assessment of the situation or condition and relevant data are collected and analyzed (although not to the degree of the rational model). This is followed by an exercise in "narrow-scope scanning," which examines in detail only a limited number of alternatives or options available to address the situation or condition (representative of the incremental approach).

The mixed scanning model differentiates between fundamental decisions and incremental decisions. Planners make fundamental decisions by exploring the main alternatives available to them in view of their goals and values. An overview understanding is feasible, and details and specifications are not included. Incremental decisions are made but within the context provided by fundamental decisions and the overview. Thus, according to Etzioni:

"Each of the two elements in mixed scanning helps to reduce the effects of the particular shortcomings of the other; incrementalism reduces the unrealistic aspects of rationalism by limiting the details required in fundamental decisions, and contextualizing rationalism helps to overcome the conservative slant of incrementalism by exploring longer-run alternatives" (p. 93).

Etzioni developed the mixed scanning model as an effort to reconcile the imperfections of the rational and incremental approaches.

Henrik Blum (1983) advocated a similar planning approach which combines various planning styles into what he called developmental planning. In the developmental approach, normative planning, which focuses on goal attainment, is combined with guided and articulated planning, which centers on problem solving. Developmental planning attempts to bring short-term and long-term purposes together; it bases goal setting on society's value system and uses it to guide immediate and long-range planning initiatives. "In addition to defining major goals and
planning to reach them, [developmental planning] uses the same goals as a source of guidance for problems solving... thus, current problems are addressed by solutions that are designed to be compatible with desired large-goal directions” (p. 224). Developmental planning sets forth goals and strives to reach them both directly and incrementally, and the choice between these approaches is driven by the political outlook of the community and the nature of the situation being addressed. In this way, it combines efforts to be values-based and solution-generating within the existing political and planning context.

**Allison’s Models**

Graham Allison’s (1971) classic book, *Essence of Decision: Explaining the Cuban Missile Crisis*, provides a useful typology to assist in the study of decision making, planning and policy making. Model I and Model III of the Allison typology are similar to the models discussed above. Model I, the *Rational Actor* or “Classical” Model, similar to the rational school of thought, views planning and policy as a rational output where the decision maker or planner is considered to be a unitary purposeful actor. Model III, the *Governmental (Bureaucratic) Politics Model*, similar to the incremental model, views planning as a political resultant and addresses the interaction between various political groups and interests, and considers personalities, stakes, stands, influence and power of actors. Allison’s Model II, the focus of this discussion, views the planning process through an organizational lens. Referred to as the *Organizational Process Model*, Allison’s Model II considers planning as an organizational output whereby planning reflects conflicting organizational goals and the formal traditions and practices of participating agencies or organizations. Appendix A summarizes the three models that comprise Allison’s typology.
Within Allison's Model II, the "organization" is a bureaucratic unit of government which operates within its own standard operating procedures and deals with multiple interorganizational issues between itself and other bureaucratic units. Although the model acknowledges that organizations outside of government may be a part of the planning process, most planning and policy making takes place within government bureaucracies or agencies. For this reason, the governmental, bureaucratic organization is positioned at the nucleus of Allison's Model II.

Allison's Model II rests on organizational theory, and more precisely, that branch of organizational theory that takes as its focus the decision-making process. A distinguished figure in this area has been Herbert Simon (1960), whose work on "bounded rationality", has greatly influenced Allison's conceptualization of Model II. Allison's Model II, the Organizational Process Model, poses three major questions about the planning process:

1. What organizations are involved in the planning process?
2. Which organizations traditionally act on the problem or area of concern and with what relative influence?
3. What repertoire and standard practices, procedures and activities do these organizations have for generating alternatives to deal with problems and for implementing alternative courses of action?

Central to Allison's Model II is the view that planning is an output of organizational practices and procedures and inter-organizational accommodation; and organizational procedures and activities are largely a reflection of elected government officials whose preferred ways of seeing the world are incorporated into bureaucratic operations. Elected government leaders then

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3 Bounded rationality questions the ideal conditions assumed in the rational planning model and describes how decisions in real life planning situations are actually bounded (limited) by the complexity of the planning issues as well as by time and resource constraints.
define an organization’s capacity; and their influence sets organizational routines and practices. Within this context, planners represent organizational actors positioned within loosely allied organizations on top of which elected, government leaders sit. Planners work within organizational units (bureaucracies), each one perceiving problems, processing information, and performing activities relatively independent of the other. Being responsible for a defined, narrow set of problems relevant to one’s own organization encourages organizational parochialism. This slows organizational learning and change; encourages organization procedures, priorities and issues to remain constant; and leads to only marginal adaptation of existing programs, plans and activities.

Planning and decision making under Allison’s Model II is conducted within a set of constraints posed by organizational/bureaucratic units such as standard operating procedures, ongoing programs, and interorganizational relations. Allison’s Model II views goal setting as a mechanism to define acceptable performance for the organization or bureaucracy. The model acknowledges the importance of developing interorganizational or interagency goals to guard against role conflict between organizations and to facilitate organization-wide planning and decision making.

**Grand Theory Assumptions Relevant to Health Goals Planning**

The four major schools of planning thought discussed above rest on three assumptions that are particularly relevant to the process of health goals development: (a) assumptions about the achievement of consensus, (b) assumptions about the degree of centralized or decentralized planning (while this concept is introduced here, it is discussed in greater detail later in a later section), and (c) assumptions related to the role of the “public interest” in planning.
According to Gilbert and Specht (1979), the rational planning model assumes that a general consensus on means and ends that serves societal common good can be achieved. Development of the “best plan” is a matter of working through technical problems that will be solved by research and analysis of relevant data. A centralized planning mechanism that is able to address the “large picture” is more effective in accomplishing this kind of analysis than a group of decentralized units with more limited access and vision.

The incremental school of thought rejects the likelihood that consensus can be achieved around big or broad issues, but asserts that agreement is achievable on proposals for incremental change (Gilbert & Specht, 1979). A decentralized planning mechanism is best suited under this model by accommodating local decision making. The planning mechanisms must be flexible and versatile to allow input from different interest groups. This model accommodates the interests of many players and allows for opposing groups to protect their interests by putting forth their own plans as a means to compensate for the shortcomings of others.

The mixed scanning model allows for greater or lesser degrees of consensus around planning issues (Gilbert & Specht, 1979). This flexibility is translated into planning mechanisms. Consensus around specific or particular issues can take place at a decentralized level whereas more general policy directions, where a more moderate degree of consensus is acceptable, are best decided upon centrally. Gilbert and Specht (1979) share an example from urban planning whereby a city-wide master plan is set by New York City and serves as a framework for “mini-plans” to be developed by neighbourhood planning boards. This arrangement, according to Gilbert and Specht, “allows for flexible responses tailored to local needs and wishes, while continuing to keep the ‘big picture’ in view” (p. 75).

Gilbert and Specht (1977) argued that the “public interest” represents another
fundamental philosophical issue that distinguishes the various schools of planning thought. How the public interest is defined is a function of whether one adopts the individualistic or unitary conception of public interest or common welfare (Wootton, 1945). According to the individualistic view, there is no such thing as the public interest, “rather there are different publics with different interests, which makes the justification of planning on the basis of shared interests and mutual benefit a rather tenuous matter” (Gilbert & Specht, 1977, p. 20). From this perspective, public interest is transitory; it changes as new groups and interests enter to influence the planning process. The unitary view of the public interest holds that there are communal interests shared by the vast majority. “These interests are common ends that are more valuable in defining the public interest than the unshared ends of individuals and groups” (p. 20).

In terms of the planning theories highlighted here, the rational model of planning rests on a communal or unitary conception of the public interest; where planning is undertaken for the common good and more weight is attached to common ends than to unshared ends, even though the individuals who entertain the ends may themselves attach more importance to unshared ends (Banfield and Meyerson, 1955). The incremental model of planning adopts the individualistic view, where the public interest is a momentary compromise and is an outcome of competing positions and interests; it is negotiated among competing interests and is therefore fluid. The relevant ends that are sought in the incremental planning process are those of individuals, whether shared or unshared. “The ends of the plurality ‘as a whole’ are simply the aggregate of ends entertained by individuals, and decisions (for) the public interest are consistent with as large a part of the whole as possible” (Banfield and Meyerson, 1955, p. 323). The interest of the community, the public interest, equals the sum of the interests of the various members who comprise it.
Gilbert and Specht (1977) recognized the fundamental nature of the public interest in the planning process: “These different views of the public interest are not merely concepts upon which scholars ruminate; they are powerful ideas that influence the course of action in social planning” (p. 21). The various conceptualizations of the public interest pose significant implications for the planning process - who is involved, whose voice is heard, what priorities are identified, and what techniques and procedures are applied.

**Three Key Theoretical Issues in Health Goals Development**

The discussion above summarizes the broad schools of thought that influence health planning generally. Later, this chapter discusses those planning models more directly related to health goals planning that are typically more procedural in nature and give greater consideration to the application of goals and objectives. Before the discussion moves to specific health planning models, however, this chapter touches on a few key relevant issues to the health goals planning exercise. These include: (a) the evolution of health promotion theory in relation to the broad determinants of health; (b) the degree of centralization or decentralization that characterizes the planning exercise; and (c) the shifting focus from resource-based planning to population-based planning models.

**Health Determinants: From Health Education to Ecology to Population Health**

Our knowledge about the factors that influence health has evolved over the past two decades. Today, especially within the Canadian context, much of the discourse on health occurs under the rubric of “population health” which addresses the “broad determinants of health.” Typically, the broad determinants of health refer to the social, economic, and environmental
factors that influence health. Although significant evidence supports the relationship between the broad determinants of health and health status, less has been demonstrated to be causal in nature. It may be more accurate therefore, to use language that implies a correlation between these factors and health; rather than language which implies a deterministic or direct relationship. However, insofar as the term is widely accepted by public health practitioners in Canada and commonly incorporated in the health planning literature, “broad determinants of health,” will be used in this paper to refer to the social, economic and environmental influences on health.

Greater inclusion of the broad determinants of health in health planning and policy parallels the evolution of health promotion theory from health education to ecological models. Although the ecological view of health can be traced back to the earliest days of public health,\(^4\) it came into prominence as a result of the growing awareness of the limitations posed by those health education approaches restricted to changing the behaviour of individuals whose health was at risk.\(^5\) The central limitation of health education that encouraged the adoption of ecological models centred on a commitment to the guiding philosophy of an individual’s responsibility for health and an associated reliance on behaviour and lifestyle interventions; combined with limited consideration of the social, economic and environmental influences on health. According to Green (1996), although the intent of self responsibility for health may be positive by encouraging increased individual capacity to contend with factors affecting health, “initiatives to promote

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\(^4\) The historical roots of the ecological perspective in public health date back to the mid 1800’s with Dr. John Snow’s removal of the London Broad Street pump handle and the subsequent host-agent-environment epidemiological triad which informed effective ecological interventions for over a century. Further, Green (1996) tracks the intellectual roots of the ecological perspective and reveals its use in medical sociology, psychology, human and medical geography, and education.

\(^5\) Limitations were not associated with health education models alone, but as well with most models of medicine, nursing and patient care during this era. The limitations of health education pertained especially to patient education, school health education in adolescent problems, and media campaigns addressing only the knowledge, attitudes or beliefs of the individuals at risk.
health by placing the responsibility exclusively on the shoulders of the individual have the effect of blaming the victim of poor health and social conditions” (p. 19). Health, therefore should be a shared responsibility among individuals, their families, community, government, and corporate and volunteer sectors (Green, 1995).

A central assumption that defines the ecological model is that health is a product of the interdependence between the individual and the ecosystem subsystems that surround him or her including family, community, culture, physical and social environment (Blum, 1974; McLeroy et al., 1988). Within the ecological perspective, the principle of reciprocal determinism operates, whereby an individual’s functioning is mediated by behaviour-environment interactions (Green, 1996). The complex interdependencies of elements that influence health means that health promotion efforts must be directed at multiple levels and multiple sectors that comprise an individual’s or community’s environment (Green, 1996). Ecological approaches to health promotion and planning feature interventions directed at changing interpersonal, organizational, community and public policy factors which support or encourage healthful behaviours and conditions of living.

While the ecological model extends the action of health promotion, it does not discount the health education approach. Rather, the ecological perspective folds health education into its design and recognizes health education as a significant contributing influence to health and health promotion, alongside the social, economic and environmental determinants of health. Green and Kreuter (1991) defined health promotion in a way that clearly marries the two approaches to health promotion. Health promotion is “the combination of educational and environmental supports for actions and conditions of living conducive to health” (p. 14). This definition includes health education as one component of health promotion.
Today, discussion on the broad determinants of health occurs under the umbrella of “population health.” Discourse on “population health” began in the early 1990's, particularly in Canada and Australia. Similar dialogue is occurring in the United States and other countries under the rubric of “the new public health,” which, like population health, draws attention to the broad determinants of health and strategies to improve health at the aggregate or population level. Population health has been defined as “the epidemiological, social and environmental condition of a community that minimizes morbidity and mortality, enables the community to adapt to changing environmental circumstances, ensures equitable opportunity to contribute productively to the community, and achieves an optimal and sustainable quality of life within these bounds” (Green, 1996).

Generally, health determinants that serve as the foundation to the population health model include: (a) income and social status, (b) social support networks, (c) education, (d) employment and working conditions, (e) physical environment, (f) biology and genetic endowment, (g) personal health practices and coping skills, (h) healthy child development, and (i) health services (Minister of Supply and Services, 1994). (See Appendix B for a brief description of each of these nine health determinants.) Inclusion of the broad health determinants into population health planning models has resulted in models that are theoretically diverse (such as the PRECEDE-PROCEED model, Green & Krueter, 1991), informed by various social and behavioural science perspectives at the individual, interpersonal and community levels (Glanz & Rimer, 1995); as compared to health education models which draw largely upon individual level theories of health promotion such as the health belief model, the consumer information processing model, and the

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6 Others have defined population health as “a broad framework for studying the determinants of health, health outcomes and health interventions” (Rafuse, 1995). Finally, population health may be considered, “an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population” (Hamilton & Bhatti, 1996).
stages of change model. (See Appendix C for a listing and description of the multiple theories that characterize population health models).

The relationship between population health and health promotion has been vigorously debated over the past few years. Some people believe that the concepts and principles of population health and health promotion are fundamentally the same; others believe that population health represents a new paradigm for health. In his address to the Fourth Canadian Conference on Health Promotion in Montreal in June 1996, Dr. Lawrence Green commented on the unique characteristics of individual health promotion and population health promotion while acknowledging the likely contributions of each. Health promotion, for example, can offer population health various established strategies and interventions, and population health can offer health promotion a multiplicity of epidemiological and economic techniques. The contrasting characteristics of population health promotion and individual health promotion are summarized in Table 2 below, recognizing that in practice each depends on elements of the other.

<table>
<thead>
<tr>
<th>Table 2: Contrasting Population Health Promotion and Individual Health Promotion</th>
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<tbody>
<tr>
<td>Population Health Promotion</td>
</tr>
<tr>
<td>Defines population as unit of analysis</td>
</tr>
<tr>
<td>Focus is on distal determinants of health</td>
</tr>
<tr>
<td>Intersectoral action</td>
</tr>
<tr>
<td>Policy and organizational levers</td>
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<td>Societal conditions and health equities as the ultimate outcome</td>
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Source: Dr. Lawrence W. Green, Fourth Canadian Conference on Health Promotion, Montreal, June, 1996
It is generally accepted among scholars today that achieving a balance between population health promotion and individual health promotion that is appropriate to the circumstances is more important than engaging in discourse that attempts to dichotomize them. Clearly, a key issue of population health for health goals planning is the degree to which the multiple factors that influence health are incorporated into health goals and the opportunities and challenges this poses to health goals formulation, articulation and adoption.

**Expression of Ecological and Population Health Models in Health Policy**

Several national and international policies in health promotion over the past two decades have embraced an ecological perspective of health. The International Conference on Primary Health Care held in Alma-Ata, in 1978 adopted an ecological perspective in its declaration and recommendations for primary health care. The declaration put forth twenty-two specific recommendations that emphasized that health development is essential for social and economic development, that the means for attaining them are intimately linked, and that actions to improve the health and socioeconomic situation should be regarded as mutually supportive. The Declaration at Alma Ata (WHO, 1978) defined the features of the global Health For All strategy which called for all citizens of the world, by the Year 2000, to attain a level of health that would permit socially and economically productive lives. This strategy also set the foundation (as discussed in Chapter 1) for the health goals approach to population health planning that has been adopted by many countries around the world over the past three decades.

The classic Canadian document, *A New Perspective on the Health of Canadians* (Lalonde, 1974), explored how factors other than health care influenced and contributed to population health; and identified human biology, lifestyle, the environment, and the availability
of health services as key influencing factors. Two other documents, *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986) (also known as the Epp Framework) and the *Ottawa Charter on Health Promotion* (WHO, 1986), further developed the ecological perspective of health. The Epp Framework proposed three challenges to reaching the goal of *Health For All* in Canada including health inequities, methods for preventing injuries, illness, chronic conditions and related disabilities; and the ability of individuals to manage and cope with chronic conditions, disabilities and mental illnesses. Three mechanisms were proposed: mutual aid, self-care, and the creation of healthy (sic) environments; as were three implementation strategies including fostering public participation, strengthening community health services and coordinating healthy (sic) public policy.

Similarly, the *Ottawa Charter on Health Promotion* (WHO, 1986) referred to health determinants as pre-requisites for health and recognized that access to better health cannot be ensured by the health sector alone. The Ottawa Charter defined health promotion action as building “healthy public policy,” creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. Finally, the *Healthy Cities* initiative of the WHO’s European Region, built upon the principles of the Epp Framework and the Ottawa Charter and has been credited by some writers as fuelling the diffusion of the ecological approach in health promotion (Green, 1996).

Recently, a discussion paper entitled, *Strategies for Population Health: Investing in the Health of Canadians* (Minister of Supply and Services Canada, 1994), prepared by the Federal/Provincial/Territorial Advisory Committee on Population Health, set the stage for a national discussion on population health in Canada. It lays out broad population health strategies on which the provincial, territorial and federal governments could collaborate for the improved
health of Canadians. Further, the book, *Why Are Some People Healthy and Others Not* (Evans et al., 1994), has recently compiled current research on the multiplicity and interrelationship of factors that influence health. This work offered a comprehensive account of the available evidence on the key factors and conditions that influence health. Also, the Canadian Institute for Advanced Research, commonly associated with the “population health movement,” has received international recognition for the development of a population health model which recognizes the complex and interactive factors that determine health (Evans & Stoddard, 1990; Mustard & Frank, 1991). Finally, the report *Population Health Promotion: An Integrated Model of Population Health and Health Promotion* (Hamilton & Bhatti, 1996), traced and combined the various streams of health promotion over the past two decades and proposed a model to support planning for population health promotion at national and regional levels in Canada. These documents and authors provide only a sampling of those who have contributed to the ongoing evolution of population health promotion in Canada and other countries.

*Health Determinants and Health Goals*

Planning for health goals requires making decisions about which and how many factors known to influence health become incorporated into health goal statements. Variation in the approach to health goals planning may be conceptualized, as introduced in Chapter 1 (p. 8), along a health-targeted / health-determinants continuum.

The published and source document literature on health goals provides evidence of both kinds of approaches or pathways to health goals. (Part B\(^7\) of this chapter offers an extensive

\(^7\) Part B of this chapter offers a comprehensive review of the health goals initiatives of six exemplar jurisdictions with the aim to identify and describe the multiple factors that influence and contribute to the health goals development process. Health determinants is one of the areas covered as a part of this review.
discussion of the role of health determinants in health goals development.) For example, Health of the Nation, the health goals initiative of England, falls more to the health-targeted end of the continuum where health goals and objectives focus on health status issues and preventable illness including coronary heart disease and stroke, cancers, mental illness, sexual health, and accidents (England Department of Health, 1992). Alternatively, the health goals initiative in the province of Saskatchewan aligns more closely with a distal health-determinants approach to health goals development. In Population Health Goals for Saskatchewan (Saskatchewan, 1994) priorities addressed in health goals include the multiple factors that influence health such as supportive families and communities, healthy (sic) physical environment, health promotion, consideration of the broad determinants of health, social justice and equity, and shared responsibility for improved health (Saskatchewan, 1994).

Health goals, like the planning theories that underpin them, vary in the degree to which they incorporate the proximal and distal determinants of health, as represented in the health-targeted and health determinants approaches respectively. One point of interest centres on the challenges and opportunities presented by each approach and the resultant trade-offs and implications of choosing one pathway (to health goals) over another.

The Centralization - Decentralization Continuum and Health Goals Planning

The degree of centralization or decentralization of the planning process is a key issue in health goals development. Centralized planning, also known as controlled planning (Green & Frankish, 1995), is characterized as planning that takes place “at one central seat, presumably the key political centre of the given community, such as the city council for the city, or by the national government for all sectors of endeavour or all regions of the nation functioning under it”
Decentralized planning “occurs at many centres such as by sectors of endeavour or by regions or by segments within a given community or society” (Blum, 1974, p. 382).

Henrick Blum (1974) identified over sixty “modes of planning,” some of which have particular bearing on the centralization-decentralization question. For example, what he refers to as participative planning includes extensive involvement of all interested or potentially interested parties at various or all aspects of the planning process (Blum, 1974). Additionally, Blum refers to elitist planning (characterized by other writers as expert-driven planning) as planning carried out by people who are thought to have some specific attribute which qualifies them to direct the planning such as knowledge, social status, or some heavy investment in the planning issues. Finally, Blum identifies top-down planning where “concern with the broader societal or national level goal setting is done at high levels, from which more locally carried out planning stems for smaller or more local issues” (p. 386); and bottom-up planning where “planning and goal setting for specific or local issues are used as the basis on which broader or higher level goals and plans are built” (p 381). These various planning modes, as identified by Blum (1974), represent in many cases parallel and possibly confounded terms for what other writers may refer to as centralized and decentralized approaches to planning.

**Balancing Centralized and Decentralized Approaches in Health Planning**

Health promotion is inherently interdisciplinary and intersectoral and depends on the action of multiple forces including federal, state or provincial governments, local and multinational corporations, professional groups, communities and citizens (Green & Frankish, 1995). According to Green and Frankish (1995), effective health policy making and health
planning requires a “bifocal view of the world;” where many health promotion initiatives are legislated centrally and depend ultimately on individuals, families and local groups for their application (Green & Frankish, 1995; Green & Shoveller, 1996). This duality of central plans or policies and reliance on local implementation challenges health planning. Decentralization of the planning process is widely considered to be an effective means to address this challenge.

Decentralized planning in health promotion implies a preference for local rather than national control over priority actions for various population health concerns. The recent movement toward decentralization might be attributable in part to efforts by central governments to distance themselves from previous financial commitments to regional or local health initiatives. Favourable perceptions for decentralized approaches may reflect also the increasing demand for local autonomy over health decision making, elevated doubt among citizens about the role of governments, and increasing anti-government sentiment or loss of confidence among the public (Green & Frankish, 1995).

The health planning and health promotion literature documents several benefits of decentralized planning in health promotion. For example decentralized planning means that decision-making power rests closer to home, encourages partnerships and alliances at the local level, increases community and citizen empowerment, and promotes a sense of ownership of health goals and programs. These presumed advantages have led to commentaries in the health promotion literature (Bracht & Tsouros, 1990; Green & Raeburn, 1988; Tsouros, 1990) that favour local, decentralized planning approaches over central initiatives in health promotion planning (Green & Shoveller, 1996).

However, decentralized approaches to health promotion planning face several challenges and limitations. Decentralized planning places greater burdens of fiscal responsibility for health
on local governments; as demonstrated in Canada where provinces (which have jurisdiction over health) have received less federal transfer payments to support health systems, leaving fewer funds available for regional and local health promotion efforts (Green & Frankish, 1995; Green & Shoveller, 1996). Further, planning at the local level may involve individuals who lack the necessary training and skills to develop plans and to accommodate complex political and social dimensions into the planning process (Green et al., 1995; Siler-Wells, 1988). Also, decentralized planning at its theoretical best draws upon local citizens as volunteers for work that is often very labour-intensive and may lead to an over-representation of more affluent and retired people and professionals, challenging the goal of full community representation on planning committees and boards (Lomas & Veenstra, 1995; Wharf Higgins, 1997). Decentralized planning means also that lower planning levels are accountable to higher planning levels which leads to concerns among local planners of a loss of control over community programs and resources (Green & Frankish, 1995; Green & Shoveller, 1996). Finally, where local initiatives are successful, central agencies encourage them to be used as models and refer other groups to them for support or technical assistance, without providing the resources necessary to meet these added responsibilities (Green & Frankish, 1995; Green & Shoveller, 1996).

Movement toward decentralized planning approaches has led to a call in health promotion for balance between personal, organizational, community and centralized control in health promotion planning (Green & Frankish, 1995). The health promotion literature documents contributions of central governments. Hancock (1989) recognized that governments serve to promote understanding and recognition of perspectives on health and to set health goals and provide infrastructure and capacity; by providing funding, defining roles, providing training, and providing exemplars or centres of excellence that local constituencies can model. In this way,
central governments can strengthen local or community action in health promotion by improving the existing community health sector and by reinforcing community control over health planning decisions and resources. Green and Frankish (1995) acknowledged similar contributions of centralized governments to health promotion planning including (a) listening to the people and their concerns, (b) providing leadership and resources in disease prevention and health promotion initiatives, and (c) supporting infrastructure needs so that communities can maintain momentum and commitment in pursuit of population health gains. So while decentralized models have become popularized in health promotion planning, finding the right mix between personal, organizational, community and centralized controls remains a challenge to health planning and health promotion practice.

**Centralized-Decentralized Health Goals Development**

The literature on health goals points out that in most cases health goals planning in the early phases of the development process is situated within the government or political centre of the jurisdiction planning for health goals; this is usually followed by some moving out of the planning process to regional or local levels. Evidence to support this comes from the health goals experience of six sample jurisdictions reviewed in Part B of this chapter.

Notable is the health goals initiative in the United States which varied in the level of centralization between the first round of health goals to develop the 1990 Objectives and the second round of goal setting to formulate the Year 2000 Objectives. The first round of goal setting was centralized in the US Public Health Service followed by modelling and adaptation at the state and local level. The second round involved, to a much greater extent, starting the national effort through the involvement of states and regions. Similarly, the health goals
initiatives in Australia, England and the province of Saskatchewan were characteristically centralized — centred within an academic institution, a national department of health, and a provincial health council respectively.

Of interest is how the mode of planning may influence the processes undertaken to develop health goals as well as the outcome or products of the health goals planning effort. Of particular interest to this study, is the relationship between the centralization-decentralization continuum of health goals planning and the subsequent articulation of health goals in terms of their measurability, the kinds of health priorities they addressed, and the range of health determinants that are considered. Part B of this chapter further discusses these issues as well as other modes of health planning relevant to health goals development.

**Resource-Based and Population-Based Planning**

Planning for population health reflects a shift from *resource-based planning* which tends to rationalize and justify existing resources and activities in health, toward *population-based planning*, where planning is based on the needs of the population and strives to optimize resources for the improved health of populations (Frankish et al., 1996a). Resource-based planning aims to accommodate the demand for health services, procedures and resources in the most efficient manner possible. Resource-based planning starts with an assessment of health resources and attempts to match the supply of resources with the demand for health services. Resource-based planning revolves around the assets controlled by the health system, mainly hospitals, technology, and medical personnel, rather than the health needs of the population. According to Green (1996), the problem with the resource-based approach to health planning is that “it tends to perpetuate and expand resources whether they are needed or not” (p. 25). When
planning is based on allocating among providers resources that are distributed largely on the basis of past resource allocations, little consideration is given to the characteristics of the needs of the population being served or the outcomes achieved; the resources then become an end in themselves.

Population-based planning methodologies respond in part to the difficulties posed by resource-based planning models. Population-based planning endeavours to address effectively the health needs of the population, rather than to meet the ever-increasing demand for health services, procedures and technologies. Demand-based planning is especially distorted when the population’s demands are controlled in large part by providers or suppliers of resources (especially when health care is market-driven) such as physician’s control of referrals, prescriptions, lab tests, and high technology diagnostics (Herzlinger, 1997). Population-based planning can be described as “a process which determines health needs and establishes resource requirements based upon an assessment of the risk levels and the health status of a given population” (Tannen & Liebman, 1978). Population-based planning starts with the population and assesses what the population needs followed by an assessment of resources available and needed to meet those needs (Green, 1996). As with any attempt to differentiate between approaches, most real-life planning initiatives probably adopt some aspects of each of these approaches.

Certain phases characterize each planning model. Resource-based planning starts with the selection of the services to be studied or reviewed; selection is based on issues related to (over or under) utilization or to the deterioration of a service or facility (Tannen & Liebman, 1978). A review of current and past service utilization trends follows in order to forecast the future demand for the service. Then the projected demand is compared to the current capacity of the
service or facility. Finally, the projected demand is matched with the expected supply to
determine what kinds of adjustments to resource allocation are necessary to accommodate the
forecasted utilization.

Population-based planning proceeds through the following four phases (Green, 1996): (a) the
identification of a specific human population, (b) an assessment of causes of the health needs
including risk factors (such as alcohol, tobacco use, poor diet, or physical inactivity) and risk
conditions or determinants of health associated with risk factors (such as poor living and working
environments, inadequate housing, or secure incomes); (c) the strategic application of knowledge
and data about the causes identified in the second phase which leads to the identification of
policies or programs aimed at addressing the factors that influence health; and (d) the evaluation
of the programs planned to meet the population health needs and related adjustment to programs
or procedures to improve upon their construction or delivery.

While much of health planning is moving toward population-based planning models,
several challenges exist and most of them centre on data-related issues (Tannen & Liebman,
1978). Any assessment of a population's health status and risk conditions and factors requires
ongoing collection of accurate and adequate data in usable form. Without such data systems,
planning on an ad hoc basis can become costly and time-intensive. Further, population-based
planning tends to incorporate an analysis of the broad determinants of health which places greater
data needs in areas that fall beyond the traditional health sector, further compounding data
availability and access problems. Also, population-based approaches necessitate sophisticated
measurement strategies including the development of valid and reliable indicators of health status
to assess population health needs as well as indicators to serve as proxies for health-care or
health service needs (Eyles & Birch, 1993). Continued effort to improve data systems and
measurement strategies must parallel the increasing application of population-based planning methodologies in the health field.

**Resource-Based Planning and Health Goals**

The wide acceptance of health goals as a strategy for population health promotion may reflect a shift from resource-based planning toward population-based planning. Health goals and population-based planning share two important aims: (a) to consider the multiple factors that influence health in the planning exercise, and (b) to encourage a shift in focus from health services or resources to health outcomes.

Population-based planning lends itself to the consideration of the multiple factors that influence health and the full array of services, not just illness care. According to Tannen and Liebman (1978), resource-based planning tends to be drawn increasingly into the assumption that the purpose of the health system and health planning is to treat illness. Consequently, there is little attempt to link resources to the health status of the population or to the risk factors and conditions that influence health. In contrast, one objective of population-based planning is to detect and minimize risk to the health of a population. This goes well beyond a medical model of health, and necessitates a look at the social, environmental and economic characteristics of a population. Similarly, the literature on health goals acknowledges that most jurisdictions that have adopted a health goals approach incorporate the broad determinants of health into their health goal statements, although this tendency is more explicit in some jurisdictions than others. The health goals initiatives of the province of Saskatchewan and Australia for example, fully integrate the multiple factors that influence health. (Further discussion on health determinants in health goals follows in Part B of this chapter).
Encouraging a shift in focus from health services to health outcomes accounts for another shared objective of health goals planning and population-based methodologies. With the health of populations as its focus, population-based planning directs attention to health outcomes rather than health care. By defining groups in the population who share risks and targeting programs at the multiple factors that contribute to ill health, population-based planning “facilitates health maintenance by directing preventive health care programs directly at high-risk populations and can be used to orient the health system toward promotion, prevention and primary care activities” (Tannen & Liebman, 1978, p. 54). Health goals hold similar potential. In efforts to implement population-based planning in one of the Canadian provinces, proponents argued that “one of the guiding principles for achieving the vision of health in Ontario is that planning should be driven by health goals, that is, by health outcomes based on the health needs of the population (Eyles & Birch, 1993, p. 113). By focusing attention on the improved health status of populations, health goals encourage the creation of health promotion and prevention programs. Health goals thereby help to steer the emphasis away from health services to health gains, and importantly, to strike a balance between treatment, rehabilitation, and health promotion / disease and injury prevention services, programs, and policies.

By moving beyond the medical model of health, health goals and population-based planning encourage the consideration of the broad determinants of health in planning for the improved health of populations and facilitate a reorientation of the health system from health services to population health gains.

Health Planning Models

So far, this chapter has presented a discussion on the grand planning theories related to
health goals development including the rational, incremental, mixed scanning and Allison models; followed by a discussion on three key theoretical issues associated with health goals planning including the broad determinants of health, the degree of centralization of the planning exercise, and the shifting focus from resource-based to population-based planning models.

Moving from the general to the specific, we now enter into a discussion on planning models that are more procedural in nature - those that give greater consideration to the application of goals, objectives and targets. Some of these models may be regarded as progenitors of the health goals planning approach and include: (a) management-by-objectives, (b) the PERT model, (c) the PRECEDE-PROCEED model, (d) the PATCH model, (e) the MATCH model, and (f) the APEXPH and Model Standards models.

Management-By-Objectives

Management-by-objectives (MBO), a philosophy of scientific management and planning, emanates from the business and military/defence sectors and has been widely accepted in both private and public settings over the past twenty-five years. The central objective of management-by-objectives in business is to identify and meet organizational goals and objectives that ultimately impact productivity, profit, performance and positive outcomes. The underlying assumption of the management-by-objectives model is that "the best way to manage things is to involve people in setting objectives and then direct needed resources toward them in an organized manner" (Lee, 1981, p. 3). Further, the management-by-objectives model rests on the

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8 The concept of management-by-objectives was first introduced by Peter Drucker in 1954 in his classic book *The Practice of Management*. MBO was also linked to the defense sector in the US with the introduction of systems analysis by the then Secretary of the Department of Defense, Robert McNamara, in the 1960's followed by the adoption of the MBO philosophy throughout the federal government. MBO has been widely accepted as a management and planning methodology in the business sector since the early 1970's.
belief that individuals in the workplace are most effective when they understand the work they are doing, what they are working toward, and what the expected final results will be (Garrison & Raynes, 1980). The best way to meet these conditions is to set measurable goals and objectives and to hold parties accountable for their monitoring and attainment.

The management-by-objectives approach aligns with the rational model of planning. It is based on logical, systematic steps to solve problems and make decisions that provide managers with the tools to measure the effects of their management and planning efforts (Garrison & Raynes, 1980). Various alternative terms refer to the management-by-objectives approach and include, “administration-by-objectives,” “management-by-objectives and results,” “planning-programming-budgeting system (PPBS),” “zero-based budgeting,” and “management-by-objectives and priorities.” (Lee, 1981).

Management-by-objectives features goal setting (Benge, 1975; Lee, 1981; McConkey, 1975; Odiorne, 1965; Richards, 1986). Distinguishing characteristics of the management-by-objectives model relevant to goal setting include the following: (a) stating objectives in specific, measurable and attainable terms, and in ways relevant to managers and workers; (b) establishment of performance standards (targets) for assessing achievements of objectives, (c) goal consistency across organizational levels (horizontal consistency) and among organizational levels (vertical consistency); (d) involvement of all levels of the organization and the inclusion of technical expertise in goal development and attainment; (e) emphasising continuous feedback and recognition for successful performance and goal attainment where improved results are realized by comparing actual and expected performance results; (f) focusing attention on output and results versus activities; and (g) linking goal attainment to reward, reimbursement and gratitude.
Additionally, progress toward stated goals ordinarily occurs incrementally and intermediate steps are established to evaluate ongoing progress toward objectives. Further, the management-by-objectives approach continually asks questions as to whether proposed objectives are, in reality, achievable in light of other planning initiatives underway in interrelated parts of the system or organization (Richards, 1986). Finally, the most important predictor of success of the adoption and implementation of the management-by-objectives model is the level of commitment to the value and operations of MBO by top level managers who encourage the model’s application within a corporate culture of acceptance (Migliore & Martin, 1994)

Management-By-Objectives in the Health Field

The management-by-objectives model has been applied for different purposes in two distinct settings in the health field: (a) in hospitals and health care organizations where MBO has been used mainly as a management tool; and (b) in the areas of health promotion, disease prevention and population health where MBO is most commonly applied as a planning tool.

In health care settings, management-by-objectives has been widely accepted as a mechanism for results-oriented management among health managers and planners. Continuous quality improvement (CQI) and quality assurance (QA) are increasingly instituted at the organizational or acute care levels as a means of tracking progress toward improved quality of health care. Garrison and Raynes (1980) evaluated the ability of the MBO strategy to assist mental health managers in a community, mental-health outpatient clinic in Massachusetts in meeting administrative needs. The results of the study demonstrated that “management-by-objectives can be a potent administrative tool in increasing organizational effectiveness and staff productivity and has potential for use as a performance-based reimbursement system for staff” (p. 54)
Garrison and Raynes (1980) credited the MBO approach with secondary benefits as well: “Perhaps as important as achieving specific objectives was the process that had started in which staff at each level began to think in a much more disciplined manner about what had to be accomplished” (p. 128). Additional benefits attributed to the application of the MBO model in this study included increased understanding among staff of work expectations, more precise and useful planning initiatives, improved communications based on a common performance and progress framework, and improved problem identification and organizational priority-setting.

Management-by-objectives underpins long-term planning and the goal-setting approach in population health and health promotion. Parallelling the MBO methodology, many goals-based health promotion policies clearly state measurable expectations for improved health, encourage broad-based participation in goals development and attainment, set performance measurements or targets for health gain, incorporate means for tracking progress toward goal attainment, and institute accountability mechanisms for goal accomplishment. To a lesser extent, some health goals initiatives link goal attainment to resource allocation—a central characteristic of the MBO strategy in the private and business sectors.

In most health promotion programs and policies the management-by-objectives model is implied, in others it is made very explicit. The 1980 publication of Promoting Health/Preventing Disease: Objectives for the Nation, set forth 226 measurable objectives reflecting a conscious decision by the US Public Health Service to apply management-by-objectives as a mechanism to develop and then monitor progress on preventive health on a national level.

An expressed need for a high level of specificity and measurability of objectives that

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9 Goal attainment is linked to resource allocation in the US federal initiative whereby the annual budgets of the agencies of the US Public Health Service are allocated based upon their anticipated contributions toward the health objectives for the nation. (More on this in Part B.)
would allow for the tracking of the health of the American population over time represented a
driving force behind the US health goals initiative. A commitment to management-by-objectives
increased the likelihood that the US health objectives were not stated in ambiguous terms. The
Australian health goals initiative adopted a similar approach to goal setting where all goal
statements are quantified by setting specific targets for improved health status within set periods
of time. Reflecting on the Australian health goals and targets initiative, Nutbeam and Harris
(1995) noted that the Australian effort “reflected an approach to target setting which had been
established in other countries, notably the United States” (p. 53). Clearly the role of
management-by-objectives in goals-based health policies is undeniable.

PERT Model

Like management-by-objectives, the Program Evaluation and Review Technique (PERT),
is a management model introduced in the 1950's by the industry and defence sectors. PERT has
been applied chiefly in relation to program implementation in the health field, although it has
provided some support to program planning (American Public Health Association, 1966). PERT
is a form of graphic network analysis that provides a visual overview of a plan of action,
indicating the goals to be attained, the inter-relationships among activities necessary to meet
program goals, factors that may challenge goal accomplishment, and key completion points that
must be met. PERT’s greatest advantage reflects its ability to provide a “visual estimate of what
needs to be done in a program, how long it will take, and what kinds of activities must be carried
out, when and by whom” (p. 87). Most of the contemporary planning software packages available
commercially are patterned after a PERT approach to visualization of pathways to outcomes
desired.
PERT requires the clear identification of program goals and objectives, and then charts a course to their accomplishment. In her work with PERT in the health field, Arnold (APHA, 1966) acknowledged the role of objectives in this model: “The first step in [the PERT] network analysis requires that the end objective be defined precisely. Unless a specific objective can be precisely defined, it is impossible to plan adequately what needs to be done to meet this objective or to determine whether the program has been completed or successful” (p. 9). Under the PERT model, clear goals and objectives guide planners in their activities, directions and time lines. By making explicit the need to articulate specific, measurable objectives, PERT and MBO may be considered two of the earliest progenitors of the goal-setting approach in the health field.

**PRECEDE-PROCEED Model**

The two models discussed above originated outside the health field and were adapted for application to health planning. The discussion that follows reviews key planning models with a goal-setting dimension that have been developed specifically for planning in the health field. PRECEDE-PROCEED is a planning and evaluation model that has been widely applied in health promotion and disease prevention. The model is theoretically diverse and has evolved over the past thirty years from many bodies of research including family planning, geographic and demographic studies, sociomedical studies in health services research, epidemiology, social psychological research in health education, and research in the areas of patient education, self-care, mutual aid, and public health (Green & Kreuter, 1991). Over seven hundred applications of the PRECEDE-PROCEED model have been published in the academic and professional literature addressing a wide range of health issues including injury prevention, cancer, smoking AIDS, patient education, sex education, and worksite and school health promotion. The
PRECEDE-PROCEED model is diverse also in the variety of locations in which it has been applied such as clinical and health care settings, schools, workplace and occupational settings, and community settings (Green & Kreuter, 1991; Green & Kreuter, 1999 in press).

Two fundamental propositions underpin the PRECEDE-PROCEED framework: (a) health and health risks are caused by multiple factors; and (b) because multiple factors determine health, efforts to effect behavioural, environmental, and social change must be multidimensional or multisectoral (Green & Kreuter, 1991). Based on these assumptions, the PRECEDE-PROCEED model “provides systematic procedures, arrayed in a conceptual framework of causal relationships, to assess the determinants of health of the population” (Richard et al., 1996, p. 319). It begins with the identification of the ultimate social benefits or quality of life, and then works backward in the causal chain to health; assessing the behavioural, environmental, educational, organizational, administrative, and policy determinants of health (Green & Kreuter, 1991).

PRECEDE-PROCEED comprises six basic phases. The PRECEDE framework encompasses phases and steps which assist planners to work through the multiple factors that influence health status and to arrive “at a highly focused subset of those factors as targets for intervention” (Green & Kreuter, 1991, p. 22). The formulating of objectives also occurs in PRECEDE, as does the development of criteria for evaluation. The PROCEED framework is comprised of steps for developing policy and initiating the implementation and evaluation process. In this way, the PRECEDE and PROCEED frameworks “work in tandem....The identification of priorities and the setting of objectives in the Precede phases provide the objects and criteria for policy, implementation, and evaluation in the Proceed phases” (Green & Kreuter, 1991, p. 22).
More specifically, Phase 1 of the PRECEDE-PROCEED model, *Social Diagnoses*, entails a full assessment and disclosure of the social, economic, demographic and environmental conditions of a population and declares quality-of-life or social goals. Phase 2, *Epidemiological Diagnoses*, involves the identification and prioritization of specific health goals or problems that relate to the social goals of a population. Phase 3, *Behavioural and Environmental Diagnoses*, links health-related behavioural and environmental factors to priority health problems and specifies goals and targets for their change. Phase 4, *Educational and Organizational Diagnoses*, includes an analysis of factors predisposing, enabling and reinforcing specific health-related behaviours or lifespan development and lifestyles, and factors enabling environmental change; and specifies objectives for their attainment. Phase 5, *Administrative and Policy Diagnoses*, is an assessment of the strengths, challenges and barriers to successful intervention and program implementation and the identification of “available” versus “needed” resources; and the setting of objectives for change in organization policy, communications and practices of professionals or others influencing the predisposing, enabling and reinforcing factors. Phase 6, *Implementation*, the intervention is delivered and ongoing. Phase 7, 8 and 9, *Evaluation*, involves a systematic evaluation of the program or intervention including process, impact and outcome evaluation respectively.

**PRECEDE-PROCEED and Health Goals Planning**

Phase 2 of the PRECEDE-PROCEED model, the Epidemiological Diagnosis, is highly relevant to health goals planning at a national, provincial or state, and local level. (This section centres its discussion on Phase 2; other phases of the model are discussed in greater depth in relation to health goals planning in the final chapter.) The epidemiological diagnosis develops
health objectives based on an understanding of a population health issue or problem with the aim to prevent disease and promote health and well-being (Green & Kreuter, 1991; Frankish et al., 1996b). The epidemiological diagnosis builds from the Social Diagnosis phase which considers the demographic, social, economic and environmental costs of health problems and their consequent influence on the quality of life of a population.

The social diagnosis reminds planners that data examined in an epidemiological diagnosis must be viewed within the context of quality-of-life-concerns for their citizens. It must also consider the social, political, and environmental contexts and the living conditions of residents of a jurisdiction (Frankish et al., 1996b, p. 5).

In the epidemiological diagnosis the central question becomes, “What evidence exists that there is a need for change in the level or nature of specific health problems in a defined population” (Frankish et al., 1996b, p.5). Three purposes characterize the epidemiological diagnosis: (a) to provide empirical support for addressing a priority health problem; (b) to demonstrate the magnitude of particular health problems, and (c) to establish specific, measurable health objectives to address priority health issues. To meet these aims, the epidemiological diagnosis is comprised of the following three steps (Green & Kreuter, 1991):

Step 1 assesses and evaluates available prevalence and incidence data to determine which populations are in greatest need of programs or interventions. Three approaches may be used to gather necessary data in the epidemiological diagnosis: (a) the use of existing local data, if available, (b) the collection of new data through, for example, community surveys, and (c) the application of model-based or synthetic estimates through measures such as normative comparison (where data are compared from similar communities, or based on extrapolation from provincial or national data adjusted to the local demographics), or trend analysis (where a region uses existing statistics from previous years as a benchmark against which to project targets for improved health).
Step 2 compares identified health issues or public health problems which are rated on three dimensions: (a) the prevalence or incidence of health problems that may have an effect on quality of life issues for that region, (b) the causal importance in terms of their potential influence on quality of life issues, (c) and the potential for change, that is, their ability to influence population health.

Step 3 formulates health objectives which “allows for the conversion of epidemiological data into a reasonable direction and level of effort for a program or policy initiative to follow” (Frankish et al., 1996b, p. 14). Ideally, objectives are established for the highest priority health issues and problems that a population seeks to reduce. Health objectives must be relevant, specific, and measurable: “A health objective should state who (the target population) will change how much (% of target population) of what (health improvement) by when (e.g., year)” (p. 15).

The question of “how much” implies setting targets for improved health status; typically, this is the most difficult aspect of objective setting. Five approaches to target setting may be considered: (a) historical comparisons where targets are based on the extrapolation of levels on an indicator from past and present levels to future estimates, (b) normative comparisons where targets are set based on the level of performance on an indicator achieved by similar programs, interventions, or policies in comparable jurisdictions or settings (normative standards are often referred to as benchmarks); (c) theoretical standards where targets are based on what research and theoretical evidence would suggest is reasonably achievable; (d) ideal or absolute standards where targets aim for complete eradication of the problem or universal achievement of the health goal; and (e) compromise standards where targets are negotiated through some adjudication of the other four methods.
Health planners undertaking health goals face a challenging and complex process. The advantages of the PRECEDE-PROCEED model for health goals development is its ability to organize and focus health planners in the data collection and assessment stages of health goal formulation, to give full consideration of the multiple factors that influence health, and to set forth linked strategies for meeting goals and targets. The data examined in the epidemiological phase of PRECEDE-PROCEED provide the evidence on which to set goals and design population health programs and policies. The goals and objectives developed as a part of this phase establish expected levels or targets for improved health; they also frame the parameters for subsequent process and outcome evaluation of health promotion programs, policies and interventions.

By carefully working through the various stages of diagnosis and assessment, the PRECEDE-PROCEED model enhances the likelihood that health planners will formulate health goals that are relevant, appropriate, realistic, and measurable. By providing planners with a well-tested mechanism for formulating objectives, PRECEDE-PROCEED is a health promotion model deserving of consideration by jurisdictions contemplating a health goals approach to population health promotion.

PATCH Model

PATCH, an acronym for Planned Approach To Community Health, offers a practical step-by-step approach for facilitating collaborative, community-based health promotion planning. Based on the principles of health education program planning (Green et al., 1980), PATCH was developed by the US Centres for Disease Control (CDC) as a mechanism “through which state and local health agencies can involve local communities in diagnosing and solving their own
health promotion needs” (Steckler et al., 1992, p. 174). Grounded in the diagnostic planning principles of the PRECEDE model, PATCH is “designed to translate the complex methods of community intervention to communities via the state health agency” (Green & Kreuter, 1991).

By embracing the PATCH process, communities organize themselves for action, collect, analyse and interpret local data, set priorities and objectives, and implement and evaluate community health interventions. Specifically, the PATCH process consists of the following eight phases (Nelson et al., 1986; Green & Kreuter, 1991; Steckler et al., 1992):

1. Initiation of a community health promotion idea that involves the CDC, the state health department, the local health agency, and the community.

2. Selection of a community site, local coordinator, and creation of a core group or community coalition to guide and manage the community health promotion project.

3. CDC workshop training on health promotion needs and community diagnosis methods.

4. Data collection to assess health status of the community; data collection includes morbidity and mortality information, community opinion information, behaviour risk factor information, and other information as determined by the community. (Community data are typically compared against national and State data.)

5. Workshop training on data interpretation, data presentation, and program planning.

6. Identification of priority health problems, setting of goals related to priority problems, and writing of community-level objectives which capture the community’s intention to address health issues.

7. Generation of a work plan, including the identification of community resources necessary to address identified health problems; and the design and implementation of
intervention strategies to meet objectives which may include the application of health education, behavioural sciences, community mobilization, and mass media.

8. Evaluation of the intervention in terms of (a) health behaviour changes that lead to reductions in morbidity and mortality and improved quality of life, and (b) community and organizational changes such as the integration of a health promotion ideology into the organizational setting.

A formative evaluation to provide information on the PATCH process and its effects among twenty-seven PATCH sites was undertaken in 1987 (Steckler et al., 1992). In terms of skills development, many local PATCH participants felt they had learned useful new community organizing and data collection skills, although many found the various surveys (such as the Behaviour Risk Factor Survey) were more difficult to conduct than they had anticipated. Further, PATCH programs proved to cover a broad range of health promotion subject areas. It also increased a sense of program ownership among participating groups including local health departments, voluntary health agencies, community volunteers, the state health department, and universities. PATCH also increased cooperation between state agencies and communities and between local community agencies that had not previously worked together. Finally, the PATCH process increased awareness and interest in health promotion at the community level, and in many communities, resulted in health promotion programs and interventions that would not have occurred otherwise.

PATCH, as a planned system to encourage state and local partnerships, played a central role in implementing the national health goals prevention strategy in the US. The PATCH program supported the aims of the Healthy People 2000 initiative by providing a systematic mechanism to deliver community health promotion programs. This was considered to be a major
factor in achieving the national health objectives (Speers, 1992). Dr. James O. Mason, then Assistant Secretary for Health, US Department of Health and Human Services, recognized in 1990 the contribution of the PATCH model in achieving the 1990 objectives and made PATCH a more central part of his vision for the Year 2000 national health objectives:

States and communities must make their own decisions, based on assessments of health needs and resources at their own levels. Using the national objectives as a template, they can select priorities, objectives, and implementation plans to guide their efforts. CDC’s Planned Approach to Community Health (PATCH) program can be used to define and refine those priorities into community action and public health activities (Mason, 1990a, p. 28).

By offering a means for local communities to assess their priority health problems and to formulate and articulate goals and objectives at the community level, the PATCH model facilitated the institutionalization of goal-setting as a strategy for population health promotion at the local level in the United States. APEXPH and Model Standards, discussed later in this section, also supported the US health goals planning initiative.

MATCH Model

MATCH, an acronym for Multilevel Approach to Community Health, facilitates the planning, development, implementation and evaluation of health promotion programs, with an emphasis on intervention planning and implementation (Simons-Morton et. al., 1995). MATCH suggests a range of intervention approaches aimed at meeting targeted improvements in health status goals. MATCH is best applied when factors and conditions associated with poor health or injury have been determined and priority actions identified, “thus providing a convenient way to turn the corner from needs assessment and priority setting to the development of effective
programs” (Simons- Morton et. al., p. 155).\textsuperscript{10} MATCH assumes a bidimensional approach to health promotion interventions. It distinguishes between intervention targets which includes individuals, organizations, and governmental agencies; and practice settings which includes schools, work place, health care agencies, and communities (Simons-Morton, et. al, 1995; Richard, et. al., 1996). Formulating goals and objectives may be directed at any of the targets and applied to any practice setting. In this way, MATCH is viewed by some as a useful tool for formulating interventions that “have the greatest likelihood of achieving the intended impact on program goals” ( Simons-Morton et.al., p. 153).

MATCH offers a practical step-by-step guide to program planning that consists of five phases and several steps. These are summarized in Table 3 below.

<table>
<thead>
<tr>
<th>Table 3: MATCH Model</th>
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<tbody>
<tr>
<td><strong>Phase I: Goal Selection</strong></td>
</tr>
<tr>
<td>Select health status goals</td>
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<tr>
<td>Select high priority target groups</td>
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<tr>
<td>Identify health behaviour goals</td>
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<tr>
<td>Identify environmental factor goals</td>
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<tr>
<td><strong>Phase II: Intervention Planning</strong></td>
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<tr>
<td>Identify intervention targets</td>
</tr>
<tr>
<td>Select intervention objectives</td>
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<tr>
<td>Identify mediators of objectives</td>
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<tr>
<td>Select intervention approaches</td>
</tr>
<tr>
<td><strong>Phase III: Program Development</strong></td>
</tr>
<tr>
<td>Create program units</td>
</tr>
<tr>
<td>Develop curricula</td>
</tr>
<tr>
<td>Develop session plans</td>
</tr>
<tr>
<td>Create instructional materials</td>
</tr>
<tr>
<td><strong>Phase IV: Implementation Preparation</strong></td>
</tr>
<tr>
<td>Facilitate adoption, implementation, maintenance</td>
</tr>
<tr>
<td>Select, train implementors</td>
</tr>
<tr>
<td><strong>Phase V: Evaluation</strong></td>
</tr>
<tr>
<td>Conduct process evaluation</td>
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<tr>
<td>Measure impact and monitor outcomes</td>
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\textsuperscript{10} Match has been used in combination with PRECEDE model (planning component of PRECEDE-PROCEED) in several Centers for Disease Control intervention handbooks on smoking and alcohol abuse prevention and promotion of physical activity (Simons-Morton, 1995). Like PRECEDE-PROCEED, MATCH assumes a ecological perspective and suggests interventions that influence multiple environmental conditions as well as health behavior.
APEXPH and Model Standards

This section offers a brief discussion on the application of two health planning models that have guided health goals development at the state and local levels in the United States. The first model, APEXPH, the acronym for Assessment Protocol for Excellence in Public Health, was developed by a consortium of national public health organizations to help strengthen local health departments (Vaughn et al., 1994). This initiative paralleled concern over the future of public health at the national level in the US (Institute of Medicine, 1988). In its 1988 report *The Future of Public Health*, the Institute of Medicine described the US public health system as a “system in disarray.” At about the same time, *Healthy People 2000*, which established goals and targets for the improved health of Americans for the decade 1991-2000, included an objective (No. 8.14) that by the year 2000, the nation should “increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health” (USDHHS, 1996). The public health sector initiated APEXPH to meet local challenges associated with the core functions of public health which were defined as community assessment, policy development, and quality assurance (Handler & Turnock, 1993; Vaughn et al., 1994).

As a planning tool for local health departments, APEXPH was applied to: (a) assess and improve the local health department’s organizational capacity, (b) assess the health status of the community, and (c) involve the community in improving public health (Washington State Department of Health, 1994). APEXPH materials included worksheets to support communities in collecting and interpreting data about community health problems. Data were collected routinely on a community’s demographic, socioeconomic, and environmental characteristics; access to primary care; leading causes of mortality by age and population subgroup; estimated
prevalence of disease by age and population subgroups; leading causes of hospitalization by age and population subgroup; years of potential life lost (YPLL); and other health indices (Vaughn et al., 1994). APEXPH helped local health departments to set strategic directions for public health at the local level which included the setting of objectives for improved organizational capacity and community health.

Model Standards were also applied as a method to guide health goals development at the state and community level in the United States. The American Public Health Association and the Centres for Disease Control and Prevention developed Model Standards (American Public Health Association, 1985) to assist state and local agencies in determining their public health priorities and establishing objectives compatible with the objectives established at the national level in the US for the year 2000 (Green & Ottoson, 1999). The report Healthy Communities 2000: Model Standards (American Public Health Association, 1991) provided a blueprint for local communities to translate and implement the national objectives at the local level. In this way, Model Standards linked communities nationally in a shared vision of improved health through “a structured process to achieve identifiable local and national goals” (Green & Ottoson, 1994, p. 625).

A central feature of Model Standards is its adaptability for community use by encouraging the establishment of community level health objectives in relation to local needs, priorities, and resources:

[Model] standards must be significantly flexible to accommodate differences in the mix of preventable diseases and conditions facing communities...because of this variation in problems and service availability, it is neither useful or feasible to propose rigid, quantified national objectives for every community. Rather, a framework is presented that permits the quantification of objectives in every community irrespective of size, locale, nature of preventable problem, and present availability of preventive services (Model Standards, 1985, p.5).
Other defining features of the Model Standards planning approach include: (a) an emphasis on health outcomes, (b) recognition that disease prevention relies on a shared partnership between public and private sectors, (c) acknowledgment of the leadership role of government in supporting public health; (d) support for negotiation as a mechanism to define state and local responsibility for health and to determine levels of achievement, (d) inclusion of both standards (which implies uniform objectives) and guidelines (which emphasize local discretion for decision making) as integral components of the planning process, and (e) acknowledgment that access to community preventive health services is a major public health issue and services for people most in need must be assured.

Steps undertaken in Model Standards parallel those of other planning models. (See Table 4). Setting reasonable and achievable targets was accomplished through a fill-in-the-blank approach whereby community leaders, upon assessing relevant community data, could suggest levels of change or improvement in the form of outcome objectives for any or all of 34 prevention areas. Studies have shown that besides facilitating the establishment of quantifiable health objectives, Model Standards encouraged establishing and meeting organizational performance standards (Spain et al., 1989; Axnick et al., 1986). A study undertaken by Spain et al. (1989) which evaluated the impact of Model Standards on 18 local health departments in the state of California concluded that “the use of Model Standards appeared to contribute to establishing program priorities, emphasizing the measurement of outcomes, improving data management systems, and evaluating the current performance of programs” (p. 969). Studies demonstrated also that successful implementation of Model Standards at the community level was more likely when local health officers strongly committed to the Model Standards approach, when priority status was given to the program within the local health department, when data were
available and accessible, and when the Model Standards program was linked to existing planning practices and requirements (Spain et al., 1989).

Application of Model Standards facilitated the US health goals initiative in two important ways: (a) by ensuring the translation of health objectives from the national to the state and local levels, and (b) by mobilizing communities to determine their own health priorities and to set strategic directions (through outcome and process objectives) for improved community health. These activities helped to institutionalize health goals into US national health promotion and disease prevention policy over the past twenty-five years.

<table>
<thead>
<tr>
<th>Table 4: Steps for Model Standards</th>
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<tbody>
<tr>
<td>• Assess and determine the role of the public health agency within the community</td>
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<tr>
<td>• Assess the lead health agency’s organizational capacity (APEXPH can help here)</td>
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<tr>
<td>• Develop an agency plan to build the necessary organizational capacity</td>
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<tr>
<td>• Assess the community’s organizational and power structures</td>
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<tr>
<td>• Organize the community to build a stronger constituency for public health and establish a partnership for public health</td>
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<tr>
<td>• Assess the health needs and available community resources</td>
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<tr>
<td>• Determine local priorities and available resources</td>
</tr>
<tr>
<td>• Establish outcome and process objectives that are compatible with local priorities and Healthy People 2000 objectives</td>
</tr>
<tr>
<td>• Develop community-wide intervention strategies</td>
</tr>
<tr>
<td>• Develop and implement an action plan</td>
</tr>
<tr>
<td>• Monitor and evaluate the effort on a continuing basis</td>
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*Source: Healthy Communities 2000: Model Standards*

**Summary of Part A Review of the Literature**

Part A of the literature review provided an overview of the theoretical foundations of health goals development. It reviewed four classic models to help explain health goals planning.
Each grand model contributes to an understanding of health goals planning in important ways:
(a) The rational planning model highlights the orderly, logical and systematic nature of the planning process, (b) Lindblom’s incremental model accommodates the political dimensions of planning and illustrates the role of conflict and negotiation associated with varying interests and perspectives; (c) Etzioni’s mixed scanning model demonstrates how approaches can be combined by initially looking broadly at overview issues and then focussing more narrowly on specific solution alternatives, and (d) Allison’s Model #2 exemplifies the influence of organizational and bureaucratic pressures on the planning exercise.

Part A also discussed three key theoretical issues related to health goals planning. First, it traced the evolution of health promotion theory with particular attention paid to the role of the broad determinants of health in health goals planning. The discussion then focused on the degree of centralization of the planning process and the advantages and challenges decentralization poses to the health goals exercise. Finally, this section discussed health goals in relation to facilitating a shift in focus over the past few decades from resource-based to population-based planning approaches.

Part A then reviewed various procedural planning models that embody a goal-setting dimension. Two of these models originated outside the health field: management-by-objectives and the PERT model underpin health goals planning and offer a systematic, performance-based, results-oriented perspective to planning and management. Key planning models contributing to health goals development within the health field were then illustrated and included PRECEDE-PROCEED, PATCH, MATCH, and APEXPH and Model Standards. Each of these models have been widely applied in health promotion and population health and each has as part of its foundation the application of health goals, objectives and targets as a mechanism for population
health promotion. The PRECEDE framework and management-by-objectives predated the first round of the US health goals initiative and can be regarded progenitors of the health goals planning approach.

The review of the theoretical foundations of health goals planning sets the context for Part B of the literature review which aims to identify and describe the key factors and themes that characterize and influence the health goals development process.

**PART B: FACTORS AND THEMES OF HEALTH GOALS DEVELOPMENT**

This study aims to track the pathway followed in the development of health goals in the province of British Columbia and to identify and describe those factors that were most influential in producing the final rendition of health goals adopted by the government of BC. Additionally, this study endeavours to uncover those factors with theoretical and practical import to health goals planning and to judge what forces obstruct or facilitate the effective formulation of health goals. Before these aims could be addressed, it was necessary to identify and describe the universe of factors that come into play during the health goals development process. This section of the literature review draws on the international literature on health goals to describe the multiple factors that others have identified in characterizing goal setting in the health field.

In this section of the literature review, key themes and factors gleaned from the international literature on goals development are organized and summarized into a set of propositional statements. Each propositional statement is based on the research and evidence reviewed after the statement of the proposition, which is drawn from two sources: (a) published, peer-reviewed literature (henceforth, referred to as the published literature) in areas that relate to health goals such as goal setting in health policy, health planning, health promotion, population
health, community and public health, and planning theory; and (b) *jurisdictional literature* (henceforth, referred to as source documents) comprised of various government consultation and public relations materials and documents from six exemplar jurisdictions that have adopted a health goals approach.

Much of our current understanding of health goals development comes from national jurisdictions. Countries such as the United States, Australia and England offer rich sources to inform the health goals development process, and their experiences have been well documented. Over time, the health goals approach has been increasingly accepted as a strategy for population health at the state or provincial level. Both Australia and the United States, for example, have successfully translated national goals and targets into state policies, programs and plans. Both national and state/provincial health goals initiatives are considered here.

Source documents from three national and three state/provincial jurisdictions comprise this part of the literature review. Australia, England and the United States constitute the national sample jurisdictions; and Saskatchewan (Canada), Texas (US), and the Australian Capital Territory (or ACT, Australia) constitute the state level jurisdictions. (Appendix D provides a brief description of the six sample jurisdictions and their associated health goals policies.) The jurisdictions reviewed in this chapter represent similarly industrialized and developed countries and regions, although they differ in their approach to the organization, funding and management of health goals initiatives.

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11Evidence is cited more frequently from some sample jurisdictions than others. The health goals initiatives in some jurisdictions (such as Australia and the United States) are well documented and have a substantial amount of literature to draw upon and therefore figure more prominently in the discussion than those jurisdictions that are not so well documented. Further, the various factors that characterize and influence health goals development are emphasized to varying degrees in the source documents and published literature. This variation is reflected in the section below; for example, factors such as “consultation and participation” and “priorities addressed” are well documented in the literature and therefore receive greater commentary in this review than factors that are less well represented in the literature.
of health systems. Four criteria underpin the purposive sample: (a) an established, fully
developed approach to goal setting, (b) sufficient documentation of the health goals development
process, (c) availability of health goals related documents, and (d) the use of the English
language in source document materials.

By identifying, describing, and organizing the universe of factors that influence health
goals development, Part B of the literature review facilitates the construction of the conceptual
framework of this study. The conceptual framework for the examination of the health goals
development process in the province of British Columbia evolves out of the review of the
literature outlined in the following pages.

A Note on Terminology

Before a comprehensive discussion of the multiple factors that influence health goal
setting, some key terms are defined here. In this study, health goals development process refers
to the combined set of procedures, practices and mechanisms drawn on by planners to formulate
and articulate health goals for a given jurisdiction. When the term goal is used in a generic sense,
such as health goals or population health goals, it refers to a planning framework that typically
includes goals, objectives, indicators, targets and strategies. In its specific form, goals refer to
broad statements of desired conditions that are potentially attainable in the long term. Objectives
are specific, measurable statements of intent that state the direction of expected change and
clarify how the jurisdiction expects to achieve a particular goal. More concise than goals,
objectives strive to answer the questions of “who,” “how much,” “of what,” and, “by when.”
Indicators constitute measures or statistics that allow measurement of change or progress.
Targets, quantified statements of the amount and timing of desired change expected on an
indicator, are usually stated in rate form, and stipulate the date by which the jurisdiction expects to achieve the change. Strategies comprise the actions taken or methods employed to accomplish the stated goals and objectives. Finally, jurisdiction, within the context of this study, refers to geographical boundaries, usually also governed by constitutional or legal authority.

These definitions notwithstanding, these terms are used interchangeably and are jurisdiction-specific. Different jurisdictions apply different language for what is typically meant to include all the activities associated with health goals development; including the setting of goals, objectives, and targets, and the identification of indicators and strategies for goals accomplishment. For example, the Australia and ACT initiatives commonly use the language of “health goals and targets;” the United States and Texas characterize their initiatives as “objectives for the nation/ state;” the English initiative prefers the language of “targets and objectives,” and the language of choice in the province of Saskatchewan is “population health goals.” The preferred language of each jurisdiction is reflected in the pages of this paper.

Phases and Factors of Health Goals Development

Three naturally occurring phases comprise the health goals development process: the premonitory phase, the formulation phase, and the articulation phase. Each phase comprises multiple factors or themes; some that facilitate the health goals process, others that obstruct it.

Premonitory Phase of Health Goals Development

The premonitory phase of the health goals development process precedes any formal adoption or acceptance of health goals as an strategy for population health promotion in a given jurisdiction. By definition, the premonitory phase predates activities explicitly related to health
goals development; however, circumstances or conditions that support initiation of the health goals process are identifiable in the jurisdictional environment. Factors and precursors that establish the context for health goals and encourage or motivate their development comprise the premonitory phase. It is during the premonitory phase that health goals are contemplated as a mechanism to support accountability, guide health planning and evaluation, and set guideposts for health policy making. The premonitory phase sets the foundation for the subsequent health goals formulation phase, where health goals are formally adopted as a strategy for population health promotion.

**PROPOSITION 1:** FACTORS THAT CHARACTERIZE AND INFLUENCE THE FIRST PHASE OF HEALTH GOALS DEVELOPMENT, THE PREMONITORY PHASE, INCLUDE THE FOLLOWING: (A) PREVAILING DEMOGRAPHIC, SOCIAL, POLITICAL AND ECONOMIC CIRCUMSTANCES WITHIN AND BEYOND THE JURISDICTION CONTEMPLATING HEALTH GOALS; (B) THE EXISTING HEALTH SYSTEM ENVIRONMENT; (C) PROPONENTS AND SKEPTICS OF THE HEALTH GOALS DEVELOPMENT PROCESS; (D) PERCEIVED BENEFITS OF HEALTH GOALS AS A STRATEGY FOR POPULATION HEALTH; AND (E) TRIGGERS OR DECISIVE FORCES THAT CONFER LEGITIMIZATION OF A HEALTH GOALS AGENDA.

**Prevailing Circumstances**

Most of the published and source document literature on health goals acknowledge the role of *prevailing circumstances* as a contributing factor in health goals development. Prevailing circumstances are those factors at work, both within and outside a jurisdiction, that set the context for or motivate action toward health goals. Prevailing circumstances comprise influences in the larger environment including demographic, social, political, and economic conditions or characteristics. McGinnis (1984) summarized the various macro level influences that have motivated countries to adopt a health goals approach: "... As research has unveiled more opportunities, population growth and industrialization have created more problems, and the
exigencies of economic pressures have offered more constraints, many leaders have felt the need to clarify national directions in health.” (p. 387). Health goals offer a means by which directions in health can be established at a national, provincial or state, and local level.

Nutbeam and Wise (1996) recognized the appeal of health goals among political leaders and agendas when health goals are linked to a healthier population and a reduced need for health services. Commenting on the Australian health goals experience, Nutbeam and Wise drew attention to the significance of political interests in health goals planning: “The logic of improving the health of populations (and thereby reducing the need for services) clearly has political appeal....focussing the public debate on health, and diverting attention from the management of difficult issues of funding and access to expensive health services has had some obvious political appeal” (p. 11). In England, the framing and implementation of a new strategy for health, the Health of the Nation (England Department of Health, 1992), is attributed not only to the broad recognition of challenges to its population’s health, but also to a “political willingness” to come together to “further the span of healthy life of all the people of England” (p.5).

Economic considerations also influence the context and motivation for health goals in the premonitory phase of health goals development. Concerns in several countries about diminishing returns on health system investment account for increased attention to the effectiveness of interventions and health services. Health goals help to specify national or regional health priorities as well as focus attention of health outcomes, and are being used by some jurisdictions as a, “benchmark against which funding decisions may be examined.” (Nutbeam & Wise, 1996, p.10). Health goals support decision making on public sector spending as governments at all levels are under increasing pressure to demonstrate favourable return on health investments and
to be accountable for monies expended.

Conditions and influences that originate outside the boundaries of a given jurisdiction also contribute to the context for health goals planning. For example, the success of the World Health Organization’s smallpox eradication initiative generated interest for the first round of the US goal setting exercise, which then became an inspiration for other countries to move toward their own objective setting initiatives for health (Kickbusch, 1996). According to McGinnis et al. (1984, 1996), the WHO’s global smallpox eradication program, which formally began in 1967, and achieved eradication of the disease in 1977, “offers one of the more spectacular examples of successful targeting in health.” Henderson (1979) claimed that not only did the smallpox eradication program hearten the goal setting approach, it also motivated the World Health Organization and countries worldwide toward more far-reaching and aggressive programs in disease prevention. Another example of a successful targeting initiative that appears to have influenced the US health goals exercise was the childhood immunization initiative launched in the United States in 1977 to increase immunization levels for all children under 15 years to 90 per cent, and to establish mechanisms to ensure that all US newborns receive comprehensive immunization each year (McGinnis, 1984).

Finally, developments in international health policy have influenced health goals planning around the globe. Many countries attribute their decision to proceed with a health goals agenda to the World Health Organization’s global policy of Health For All (WHO, 1981) as a major influence. Not only does the national government of England acknowledge the important contributions of Health For All in the formulation of their goals-based health strategy; so to do the neighbouring countries of Scotland, Wales, and Northern Ireland (England Department of Health, 1992). In response to international initiatives under the global strategy of Health for All,
Australia established the Better Health Commission in 1986. The Commission’s report, *Looking Forward to Better Health* (Better Health Commission, 1988), set out the major challenges to the health of Australians. This led to the first round of health goal setting in *Health for All Australians* (Health Targets and Implementation Committee, 1988). The literature on goal setting in health clearly chronicles the influence of the WHO’s Health for All policy on goal setting around the world.

Ample evidence of the influence of prevailing circumstances on health goals development can be drawn from the published and source document literature on health goals (Kickbusch, 1996). The evidence provided here in relation to various social, political and economic factors provides a rationale for the inclusion of prevailing circumstances as a defining factor or theme of health goals development in the premonitory phase.

*Health System Environment*

Just as various characteristics of the social-political-economic environment establish a context for health goals in the premonitory phase, so do various features within the *health system environment*. Within this context, health system refers to health care organizations, public health organizations and other organizations and institutions having a health mandate. Published and source document literature reveals several characteristics of the health system that influence health goals development including population health status and discrepancies, health reform, health system efficiency and capacity, and health literacy of the population.

*Population Health Status*

The literature on health goals substantiates population health status as a motivating factor for health goals in the premonitory phase. For example, “formidable health challenges” facing the
people of England motivated the English health goals initiative (England Department of Health, 1992). These challenges included premature death and disability, variations in the quantity and quality of health care in different sections of the country, and significant variations in health status across geographic, ethnic and social and occupational boundaries. Recognition of these challenges and a readiness to act upon them set the stage for the framing and implementation of the *Health of the Nation* initiative.

It is worth noting however, that little has been said in the literature about the relationship between health goals and improved health status. Nutbeam and Wise (1996) noted that only the US has applied the health goals approach over an extended period of time, and “even here the evidence of effect is limited, although encouraging” (p. 1). In their midcourse reviews of progress in 1985 and 1995, the US assessed the progress on each objective and recommended shifts in allocation of resources to give greater attention to the lagging objectives.

**Health Reform, Health System Efficiency and Capacity**

Two of the six sample jurisdictions reviewed as a part of this chapter adopted a health goals approach within the context of health reform. In 1992, a new strategy for health was launched in England with release of the report, *Health of the Nation* (England Department of Health, 1992). *Health of the Nation* preceded a period of major reform and restructuring of both the National Department of Health and the National Health Service. Reforms focused on improved management of the National Health Service, changes to family and community health, reorganized hospital services, and expanded strategic roles for regional health authorities. The English health goals initiative clearly outlined the expectations for the improved health of the English people, as the structure and management of their health care system was undergoing significant change nationwide.
Adoption of health goals in the province of Saskatchewan paralleled provincial health reform initiatives that began in the early 1990s. Four major actions characterize health reform in Saskatchewan: the decentralization of health services to district health boards, the establishment of the Health Services Utilization and Research Commission, the reorganization of the Department of Health, and the creation of a Provincial Health Council (Saskatchewan Provincial Health Council, 1994). The Provincial Health Council was established to make recommendations on healthy public policies to the Saskatchewan government (Saskatchewan Provincial Health Council, 1994); in order to meet their mandate, the Provincial Health Council developed population health goals to serve as a foundation for proposed public policy initiatives.

Within the context of health reform, a drive towards health system efficiency also arises as a motivating factor for the adoption of health goals. Health goals are envisioned by some jurisdictions as a mechanism for supporting health system efficiencies at a time when there is an increasing demand for health services and technologies colliding with increasing pressure to justify health spending (Nutbeam et al., 1993).

Health Literacy

Similarly, the health literacy of a jurisdiction may contribute to decisions to adopt a health goals planning approach.\(^{12}\) In the US, notable scholars reflected on the potential of health promotion for the improved health of populations at the time of the release of the US health goals initiative. Green (1979) noted that, “the chief threats to health today can be ameliorated, controlled, or otherwise prevented. Experts now are convinced that the reduction of risk and the adoption of positive health practice hold the keys to better health in the years ahead” (p. 96). An

\(^{12}\) Health literacy refers to the experiences, values, attitudes, beliefs, assumptions, and knowledge of health issues by the people of a jurisdiction.
increasing understanding of health promotion and disease prevention as a means of better health influenced the first round of health objectives in the United States. In *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention* (US Department of Health Education and Welfare, 1979a) improved health was linked to policy action in health promotion: “... improvements in the health of the American people can and will be achieved, not alone through increased medical care and greater health expenditure, but through a renewed national commitment to efforts designed to prevent disease and to promote health (p. 9).

In commenting on the American health objectives initiative, McGinnis (1984) further linked health literacy -- a greater understanding of health and a growing faith in the ability to influence health -- with health goals planning:

In the US a number of factors have converged to foster the development and implementation of a [health] agenda setting process. Possibly the most significant of these was the development of a fuller understanding of the factors which affect health status and a sense of confidence with respect to our ability to control these factors (McGinnis, 1984, p. 389).

Finally, the realization that efforts to demonstrate health gains must reach beyond the health sector and be linked to initiatives aimed at improving economic and social conditions has been an “additional force compelling” health goals exercises in countries around the world (McGinnis, 1984). An increased understanding of health, the factors that influence it, and the role of health promotion and disease prevention in maintaining and improving health are important factors motivating health goals in the premonitory phase of health goals development.

**Proponents and Skeptics**

The literature on health goals recognizes the role proponents and skeptics play in health goals development. Generally, proponents of health goals are considered to be champions who
generate interest and excitement around health goals and provide leadership to move the
development process along. While proponents become engaged in health goals development in
the premonitory phase, they often remain involved throughout the formulation and articulation
phases of health goals development. In some jurisdictions, skeptics influence health goals
development by casting doubt on the benefits of health goals or by initiating actions aimed at
stalling or interfering with the health goals process. Proponents and skeptics of health goals can
originate within or beyond the jurisdiction, the government sector, or the health system or sector.

Of all the identifiable influencing factors in health goals development in the health goals
literature, proponents and skeptics receive less direct attention or recognition than others. In the
case of proponents, this can be attributed to the fact that those individuals who are writing and
commenting on health goals are themselves the greatest proponents of health goals. They are
unlikely to draw direct attention to their personal influence and efforts in health goals planning,
yet their role is undeniable. Two groups of individuals fall into this category: (a) scholars and
experts in the health goals field, as evidenced in the Australian case where a group of public
health academics at the University of Sydney championed the (second round of the) Australian
health goals and targets initiative; and (b) high-level government bureaucrats or politicians who
may be asked to write or sign the preface or the introductory remarks to the health goals
documents. For example, Dr. Julius B. Richmond, Assistant Secretary for Health and Surgeon
General, was the signator to the introductory letter of Healthy People: The Surgeon General’s
Report on Health Promotion and Disease Prevention (US Department of Health and Human
Services, 1979a) to the then Secretary of Health, Education, and Welfare, Joseph A. Califano, Jr.
In Healthy People 2000 (US Department of Health and Human Services, 1991), the forward was
over the signature of Dr. Louis W. Sullivan, the then Secretary of the US Department of Health

The literature on health goals makes limited reference to skeptics of health goals development. One interpretation may be that writers and commentators on health goals are reluctant to draw attention to dissenting parties on health goals (if they exist), since the aim is to demonstrate consensus in order to move the health goals agenda forward. It appears that where ambivalence about health goals exists, it is not so much a question of the utility of health goals as a population health strategy as it is a reluctance about the expressed potential of health goals to meet the sometimes lofty expectations associated with them (Lyons, 1995). Some of the skepticism arises from academic and bureaucratic circles concerned about the absence of baseline or historical data in some of the areas in which health goals and objectives are set.

Limited mention of proponents and skeptics in the health goals literature is somewhat perplexing. Commonsense (at least) tells us that the influence of certain individuals is key in either moving the health goals agenda forward or obstructing its advancement. Although some of the evidence is more indirect than direct, it is reasonable to include proponents and skeptics as a contributing theme in the premonitory phase.

**Perceived Benefits**

*Perceived benefits* of health goals account for an additional factor influencing health goals development in the premonitory phase. Several perceived benefits have been documented
in the published and source document literature and range from improvements in population health status to health system improvements (such as a reorientation of health systems) to improved health system accountability. Frankish et al. (1996a) summarize the major contributions of health goals as offering a framework for planning; providing a road map for policy direction; and encouraging the assessment of the impact of plans, programs, and policies on the health of the population. Additionally, health goals and targets have been adopted by several countries and regions to make explicit the achievements they expect from their investment in health, to guide policy development, and to assist in decisions about resource allocation (Lyons, 1995; Nutbeam & Harris, 1995; Nutbeam & Wise, 1996).

In Australia, the central expectation of health goals was to achieve more integrated, systematic actions by the health sector to improve the health status of the population (Nutbeam & Wise, 1996). Some of the motivation for the Australia national initiative came from the United States which, according to Nutbeam and Wise (1996), “demonstrated the usefulness of goals and targets as a means for achieving improved health” (p. 11). The Australian Health Ministers’ Advisory Council (AHMAC) established the Health Targets and Implementation Committee to develop national goals and targets that would support the reduction of inequalities in health status among population groups in Australia. The report entitled, *Health For All Australians* (Health Targets and Implementation Committee, 1988) identified strategies to improve the health status of all Australians and to minimize health inequities. Further, health goals were expected to support health service provision decisions and to create health system efficiencies by encouraging collaborative action and reducing service fragmentation and duplication (Australian Department of Health, 1994). Similarly, health goals in the Australian Capital Territory, which modelled the national health goals initiative, were expected to support resource allocation...
decision making, enhance accountability, promote quality information systems and provide a rationale to re-orient health systems from health services to health outcomes (Lyons, 1995).

In comparing the health goals initiatives of eight countries and regions, Nutbeam and Wise (1996) made reference to what they call, “second generation” health targets which confer additional benefits to the health goals approach. According to Kickbusch (1996), health goals initiatives of an earlier era (she cites the US Healthy People initiative as an example) constituted first generation health goals that aligned closely with the “confines of a medical agenda” (p. 4). Second generation objectives characterize more recent health goals initiatives that aim for a “classification based on key determinants of health,” and that propose integrated strategies from multiple sectors that “aim to tackle the problems closest to the root cause” (Kickbusch, 1996, p. 9). Second generation health goals and targets “are used more directly for health system planning, management, and funding, and greater emphasis is given to the need for all sectors of government to contribute to improving the health of the population” (Nutbeam and Wise, 1996, p. 1). A greater understanding that sectors other than health contribute to achievements proposed in health goals underpins second generation initiatives. In this way, second generation health goals and targets more fully support an interdisciplinary approach to health than do health goals developed during an earlier era, and provide a “platform for concerted intersectoral action” toward improved health of populations (Nutbeam & Wise, 1996). Intersectoral collaboration on health also motivated health goals development in the province of Saskatchewan where “shared responsibility” for improved health comprises both a stated goal and a mechanism for reaching the other goals. (Saskatchewan Provincial Health Council, 1994).

Similar to other jurisdictions, perceptions of the benefits of health goals in the United States varied. Proponents of the US initiative hoped that objectives would “serve as a catalyst for
change, as an energizer of various relevant sectors of public and private sectors, and as a framework for decision-making about fiscal resource allocation” (Mason, 1990b, p.6). Further, national objectives were envisioned as a management tool for systematic, monthly “progress reviews” required of responsible Public Health Service agencies to account for progress toward the achievement of health objectives (Mason, 1990b). Facilitating a shift from resource-based planning to population-based planning accounted for another ambition of the US objectives. Similar to the national health objectives initiative, the state of Texas goals initiative committed to three broad goals in Healthy Texans 2000: (a) to increase the span of healthy life for Texans, (b) to reduce health disparities among Texans, and (c) to achieve access to preventive services for all Texans.

The Saskatchewan health goals initiative linked health goals to the advancement of “healthy public policy.” The Saskatchewan Provincial Health Council was established in June 1993 with a mandate to identify and develop public policies conducive to health and to monitor their implementation (Saskatchewan Provincial Health Council, 1996). Population health goals were developed to provide a framework for the development of healthy (sic) public policies. The document, Population Health Goals for Saskatchewan (Saskatchewan Provincial Health Council, 1994), detailed other contributions of health goals: (a) health goals provide a framework for improving the health status of people and communities, (b) health goals allow for increased attention to the multiple determinants of health, (c) and health goals encourage shared responsibility for health.

As evidenced in the health goals literature, the potential contributions of health goals are wide and varied and include health status monitoring, program planning and evaluation, policy planning, health priority setting, population-based planning, reorientation of the health system,
and intersectoral collaboration (McGinnis, 1984; Green, 1994; Lyons, 1995; Nutbeam, 1996; Nutbeam & Wise, 1996). Whether these aims have actually been met is called into question by Nutbeam and Wise (1996) who believe that more time is needed to make assessments about impact. Regardless, expectations for health goals set the context and motivate action toward health goals in the premonitory phase.

**Triggers**

Numerous publications and source documents on health goals have acknowledged some precipitating event or phenomenon linked to the launching of the health goals process within a given jurisdiction. This “trigger” event, although often difficult to single out in a given jurisdiction, signals the progression of the health goals development process from the premonitory to the formulation phase, and connotes official legitimization of the health goals approach, usually by some political or decision making body. Triggers may take the form of a government announcement, endorsement, legislative act, consensus agreement among interested parties, or budgetary requirement.

The official endorsement of a health goals agenda by Australian state health ministers accounts for the precipitating event or trigger that motivated action toward national health goals in Australia. By supporting priorities for health set forth in the report *Health for all Australians* (Health Targets and Implementation Committee, 1988) the National Better Health Program was established to ensure achievement of priority targets. This, in turn, set the foundation for a second round of target setting in Australia that culminated with the publication of *Goals and Targets for Australia’s Health in the Year 2000 and Beyond* (Nutbeam et al., 1993).

Consensus agreement among key stakeholders was an important influencing factor in the
decision to proceed with health goals in the United States. In late 1979, a task force convened with representatives of all federal Health Education and Welfare agencies to take inventory of and assess federal programs in health promotion and disease prevention. The task force’s Report of the Departmental Task Force on Prevention (US Department of Health, Education and Welfare, 1979b) provided summary reports of existing programs and health risk factors and proposed a conceptual framework for prevention along with recommended strategies for action by the federal government. This report supported the development of the Surgeon General’s report, as did various background papers on health promotion and prevention by the National Academy of Sciences’ Institute of Medicine (1979), at the request of the Surgeon General (Green, 1979).

Evidence from the literature on health goals in the US and Australia, but not in Canada, shows that the trigger event that typically moves states or provinces toward action on health goals often emanates from a preceding national initiative. Both in the United States and Australia, the national initiative served as a framework to establish health goals and targets at the state level. With the release of the national health objectives in Healthy People 2000 (US Department of Health and Human Services, 1992b), Dr. Louis Sullivan, then US Secretary of Health and Human Services, challenged state health departments to participate in the goal setting effort. Texas developed the first set of state-wide health objectives in the early 1980's and went on to develop a second round of Year 2000 Objectives. The health goals and targets initiative in the Australian Capital Territory modelled the Australian national initiative and was completed in 1994.

Although parallel national and state initiatives characterize several goal-setting initiatives around the world, this precedent was not established in Canada. The goal-setting exercise in the province of Saskatchewan did not follow any national effort; rather, goal setting in Saskatchewan, as
within all Canadian provinces and territories, proceeded in the absence of any national leadership
on health goals as a strategy for population health promotion.

The contribution of several factors in the development of health goals in the premonitory
phase have been drawn from the published and source document literature on health goals and
presented in this section. Together, they comprise part of the conceptual framework that guides
the case study examination of health goals development in British Columbia. Table 5
summarizes the key factors and dimensions associated with health goals development in the
premonitory phase.

<table>
<thead>
<tr>
<th>Key Factors or Themes</th>
<th>Associated Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevailing circumstances</td>
<td>Demographic, social, political and economic factors</td>
</tr>
<tr>
<td>Health system environment</td>
<td>Health status, health system efficiency, capacity, satisfaction, orientation, health reform, health literacy</td>
</tr>
<tr>
<td>Proponents &amp; skeptics</td>
<td>Internal, external, government/non-government based, health/non-health sector, personal characteristics</td>
</tr>
<tr>
<td>Perceived benefits</td>
<td>Policy making, program planning and evaluation, health impact assessment, health inequity reduction, role and sector definition, health status monitoring, health priority setting, resource re-allocation, population-based planning, system reorientation, intersectoral collaboration</td>
</tr>
<tr>
<td>Triggers</td>
<td>Government endorsement, government legislation, consensus agreement, budgetary requirement, mass media</td>
</tr>
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**Formulation Phase of Health Goals Development**

The *formulation phase* of the health goals development process follows the formal
acknowledgment by jurisdictional officials that a health goals approach to health promotion and
disease prevention will be adopted. The formulation phase is typically the longest and most
challenging phase of the health goals development process, largely because of the numbers and mix of the parties involved. The formulation phase builds on the premonitory phase where health goals are considered as an option for action but no organization or activities related to health goals are initiated. During the formulation phase, health goals are constructed. The formulation phase constitutes the various processes, structures and resources required to support health goals formulation. Typically, the formulation phase yields a set of draft health goals.

**PROPOSITION 2:** FACTORS THAT CHARACTERIZE AND INFLUENCE THE SECOND PHASE OF HEALTH GOALS DEVELOPMENT, THE FORMULATION PHASE, INCLUDE THE FOLLOWING: (A) MIX OF PLAYERS FROM VARIOUS LEVELS AND SECTORS INVOLVED IN THE DEVELOPMENT PROCESS, (B) HEALTH GOALS COORDINATING MECHANISM, (C) STRATEGIC APPROACH, (D) CONSULTATION AND PARTICIPATION MECHANISMS AND STRATEGIES, (E) CORE CONTRIBUTIONS MADE BY VARIOUS PARTIES, (F) TIME AND BUDGET, AND (G) DATA.

**Levels & Sectors**

The mix of players involved in the health goals development process and the various *levels and sectors* they represent\(^{13}\) comprise a first set of factors in the formulation phase that has been thoroughly documented in the health goals literature. The range of interests and orientations that contribute to health goals formulation is wide and varied and includes representatives from government, non-government, health, and non-health sectors. Beyond discussions on the various levels and sectors involved in health goals formulation, the health goals literature chronicles the translation of health goals from the originating jurisdiction to subsidiary jurisdictions, most often

\(^{13}\) Some crossover of definition occurs between the “levels and sectors” theme and themes discussed later in this chapter. The “levels and sectors” theme addresses directly the types and levels of interests involved in health goals planning while the “consultation and participation” theme and the “coordinating mechanism” theme reference, in a more indirect way, the varying interests and parties involved in health goals. (See Appendix F for further differentiation).
from the national level to the provincial or state level.\(^\text{14}\)

The English goals-based strategy, *Health of the Nation* (England Department of Health, 1992), was based on a cooperative effort between the National Department of Health and the National Health Service. In collaboration with the National Health Service, the national government played a key role in articulating a plan for improved health for the people of England through efforts directed at legislation and regulation, information and education, departmental collaboration, facilitating and encouraging action, allocating resources, and monitoring and assessing changes in health status. Other participants with major roles in the English initiative were the Health Education Authority, various voluntary organizations, and local health authorities.

In the United States, the levels and sectors of government and non-government interests that participated in the goals initiatives varied between the first round of objectives (to establish the 1990 Objectives) and the second round of objectives (to establish the Year 2000 Objectives). The first round of objective setting was aimed at building consensus among experts, professionals, and national advocacy organizations. The second round of objectives involved broader participation, seeking input from 22 expert working groups, over 300 national organizations, the state health departments, and testimony from hundreds of individuals and organizations (US DHHS, 1980; Green, 1992).

The US Year 2000 Objectives undertook a conscious effort to initiate a *national* goal-setting exercise, involving all levels and sectors within and outside government; versus a *federal* approach, where health goals development could be perceived as an orchestration of the federal

\(^{14}\) The "diffusion" dimension will be discussed later in this chapter under the subtitle, *Late Stage Developments.*
government. Dr. James Mason, then Assistant Secretary of Health, US Department of Health and Human Services, captured this sentiment in his comments before the US Senate Subcommittee on Government Information and Regulation when he remarked that, “From the beginning, we in the Public Health Service made clear that any health promotion and disease prevention effort could only make real sense if it was a national effort, rather than just a Federal one” (Mason, 1990b, p. 2). Texas repeated this pattern. Texas Year 2000 objectives involved greater representation from the public, private and voluntary sectors than that which was sought in the formulation of the Texas 1990 Objectives, which was, like its national counterpart, represented largely by governmental and academic experts.

In Australia, the National Better Health Program of 1988 launched the health goals and targets initiative. This program however, was never really embraced by segments of the Australian health care system other than health promotion; and no government agencies responded to the program in any substantial way (Nutbeam & Harris, 1995). This put the health goals and targets and any serious efforts to address them in jeopardy. The downfall of the National Better Health Program spurred a renewed commitment to health goals and targets in 1993 when the Australian Federal Department of Health commissioned a revision of the national goals and targets by a group of public health academics at the University of Sydney. Extensive collaboration with national, state and territorial governments; medical colleges; professional associations; community groups; and health consumers characterized this round of target-setting. By reinforcing the need to expand the sectors traditionally involved in health and to involve them actively in the development and implementation of goals and targets, many more interests were involved and opinions solicited. The American and Australian experiences represent greater efforts to increase the diversity of levels and sectors in the second rounds of their goal-setting.
initiatives.

The extensive commentary dedicated to levels and sectors in the health goals literature substantiates this theme as a contributory factor to the formulation phase. Of interest is what the literature does not say in relation to this theme. Little mention is made, for example, of the challenges posed by inviting multiple interests to the health goals planning table. Typically, source documents on health goals list the parties involved without commentary on how various interests and perspectives were reconciled or accommodated, or on how multiple voices may effect the articulation of health goals in the number and types of priorities addressed. This raises interesting questions about the impact of multiple orientations on the health goals exercise.

**Coordinating Mechanism**

Most of the literature on health goals development acknowledges the role of a central coordinating mechanism in the formulation phase. By monitoring, leading and managing the health goals initiative, the coordinating mechanism is in many ways the hub of activity of the health goals process. Significant variation occurs across jurisdictions in the dimensions that define the coordinating mechanism in terms of where the coordinating mechanism is based, the mix of people and skills that comprise it, the degree of political and staff support it receives, and the level of autonomy it exercises.

The Ministerial Cabinet Committee on Health Strategy, an interministerial committee which comprised representatives from eleven government departments, coordinated the *Health of the Nation* initiative in England. The committee was established at the national level to coordinate Government action and to oversee the development of health policy. It was responsible for the overall coordination of the English *Health of the Nation* initiative in addition

At the national level in Australia, the location and makeup of the coordinating mechanism varied between the original effort and the revised targets for health. In Australia’s first round of health goals and targets, the Better Health Commission, established in 1986 in response to international initiatives under the Global Strategy for Health for All, outlined the major challenges to the health of Australians. Soon after, the Australian Health Ministers’ Advisory Council established the Health Targets and Implementation Committee whose central purpose was to coordinate the development of a set of national goals and targets.

The National Better Health Program marginalization, which led to a renewed effort for health goals in 1993 by a group of public health academics at the University of Sydney, produced a two-year consultation process and a report, *Goals and Targets for Australia’s Health in the Year 2000 and Beyond* (Nutbeam et al., 1993). This presented a new framework for the development of national health goals and targets. The coordinating mechanism for the second round of goal setting rested with the commissioned group of experts based outside the health sector, within an academic setting.

The US Public Health Service, under the direction of Dr. J. Michael McGinnis (Deputy Assistant Secretary of Health) coordinated the 1990 Objectives; with assistance from several federal agencies, state and local officials, and voluntary organization representatives. After a three-year consultation process, the Year 2000 Objectives led to greater community links and the establishment of a consortium of 350 organizations committed to the achievement of objectives relevant to their activities (US Department of Health and Human Services, 1992a). Further, specific public health agencies were designated by the Office of Health Promotion and Disease
Prevention as “lead agencies,” each responsible for “leading the Nation in achieving [one] of the [categories of] .....objectives” (US Department of Health and Human Services, 1992b, p.5). The Office of Disease Prevention and Health Promotion, on behalf of the US Public Health Service, had overall coordinating responsibility.

The coordinating mechanism in the US experience can be described as being diffuse, with coordinating points spanning across the nation and across the government; as compared to the Australian initiative for revised health targets which was centralized within academia. One additional defining characteristic of the US health goals coordinating mechanism has been its ability to sustain political support and remain intact in the face of several changes in the federal administration. Nutbeam (1996) attributed the sustainability of the US initiative to broad-based philosophical and technical support: “The US experience would seem to suggest that national health targets can survive changes in government provided they are based on good technical support, and that they build strong coalitions for action which are outside of government” (p. 12).

The US also vested responsibility for the objectives at a level of the bureaucracy where they originated, which was just below the level of political appointments. This ensured a staff with commitment to carrying the objectives forward to each new government.

Centrally-based intersectoral committees characterize the coordinating mechanisms for health goals development at the state or provincial level in most instances. In the Australian Capital Territory, a reference group comprising health practitioners and health planners from within and outside the health department, and representatives from various professional and community organizations coordinated the health goals process (Australian Department of Health, 1994). The coordinating mechanism in the Texas Year 2000 Objectives consisted of a steering committee comprised of the team leaders and facilitators of each of the twenty-one work groups.
assembled to draft health goals related to their expertise and knowledge. In the province of Saskatchewan, the Provincial Health Council, comprised of representatives of various interests including health, research, social services, education, agriculture, seniors issues, youth, recreation, and business and labour, coordinated the population health goals initiative (Saskatchewan Provincial Health Council, 1996). While the coordinating mechanisms for the ACT and Texas were positioned within state governments, the coordinating mechanism for the Saskatchewan health goals initiative, the Provincial Health Council, exercised a more autonomous, arms-length relationship with the provincial government.

**Strategic Approach**

Another central theme of the health goals formulation phase is the *strategic approach* that is adopted to guide the health goals development process. Strategic approach refers to the ways in which planning groups engage in the development process. Several strategic approaches to health goals formulation have been documented in the health goals literature; most can be described along a continuum with the ends of the continuum representing converse approaches.

One continuum that can be used to characterize the strategic approach assumed in health goals planning is a *top-down or expert-driven* approach as compared to a *bottom-up or grassroots* approach. Many viewed the first round of the US health objectives for the decade 1980-1990 as a top-down planning initiative. It was characterized as science-driven, governed by professional interests; and based on a process that supported technocratic and bureaucratic criteria, such as morbidity, mortality and cost containment (Green, 1992). The Year 2000 Objectives assumed a much more consciously bottom-up planning process that reached out to special populations, citizens, community leaders, and state and local areas and regions.
According to Green (1992), “the process of developing the Year 2000 Objectives has provided for a much more extensive and systematic pooling of perspectives from all segments of society” (p. vii).

Careful review of the health goals literature points also to another strategic approach that may be characterized along an original-derivative continuum. The Australian health goals and targets initiative builds on existing policies and programs that address key priority areas. The national initiative aimed to complement rather than compete with ongoing, related initiatives (Nutbeam et al., 1993). The derivative approach also characterizes the health goals initiative of the Australian Capital Territory which builds on the national goals by combining the health priorities identified in the national strategy with health issues of local significance (Australia Department of Health, 1994). Similarly, the state of Texas modelled its health goals after that US national initiative, first in the early 1980's to develop its 1990 Objectives, and again in the 1990's to establish health objectives in *Healthy Texans 2000* (Texas Department of Health, 1991).

The jurisdiction, in this review of the literature, that comes closest to assuming an original approach to health goals is the setting of the US objectives for the decade 1980-1990. It originated from an indigenous, broad-based inventory and review of ongoing federal health promotion programs that led to recommendations which supported the development of the Surgeon General’s report (US Department of Health, Education and Welfare, 1979a). This report set forth national health goals for a ten-year period for each of five age groups. The further specification then outlined the broad, life-span goals into 225 objectives in 15 priority areas (US Department of Health and Human Services, 1980).

*Incremental - comprehensive* is another dimension of strategic approach drawn from the literature on health goals. Both Australia and England employed an incremental approach to
health goals by identifying relatively few key areas for the articulation of goals and targets; both countries however, support the development of a comprehensive set of goals and targets over time. This is borne out in the English experience whereby, with the release of the *Health of the Nation* strategy, five initial key areas were introduced and remained as the focus until 1996, when a sixth key area, environment & health, was added to the strategy. In Australia, health goals and targets increased in number and scope in the revised version of the national goals as documented in *Goals and Targets for Australia’s Health in the Year 2000 and Beyond*. Expanded targets in the revised set of health goals and targets focused on health environments and health literacy and life skills. Conversely, the United States assumed a comprehensive approach from the start. The 225 health-related objectives comprised *Promoting Health/Preventing Disease: Objectives for the Nation* (US Department of Health and Human Services, 1980), and over 300 objectives were set forth in the report *Healthy People 2000* (US Department of Health and Human Services, 1992b).

Significant variation exists in the strategic approach assumed in the development of health goals. How planning groups organize and approach the planning process may vary along several dimensions including who is involved and who controls the project, the degree to which health goals build on existing initiatives, and the number and scope of issues addressed in health goals. Other possible dimensions include the degree to which the health goals initiative is politicized or associated with a particular political party, as well as the role and status of bureaucrats in the development process. As evidenced above, the published and source document literature on health goals corroborates “strategic approach” as a central factor characterizing and contributing to health goals development in the formulation phase.
Consultation & Participation

The literature on health goals extensively documents consultation and participation strategies. Discussion on this theme centres on the ways in which interests, priorities and opinions of various parties and constituencies are solicited and then incorporated into the health goals development process. Reference is made also to the methods by which individuals are chosen for participation and the variation in the level of participation at different stages in the health goals development process.

As mentioned above, based on the experience with the first round of the US health objectives for the decade 1980-1990, broader and more decentralized consultation was sought for the Year 2000 Objectives. The second round involved three years of consultation. During the first phase of goals planning a consortium of over 300 national membership organizations, state health departments, and the federal Office of Disease Prevention and Health Promotion worked in partnership with the US Public Health Service towards articulation of the Year 2000 Objectives (Green, 1992, Mason, 1990b). The second phase of the development process solicited public input and involved extensive public review and comment. Eight regional hearings were conducted by the Institute of Medicine of the National Academy of Sciences on behalf of the consortium and resulted in 750 submissions of professional and consumer testimony regarding the form and substance of Year 2000 Objectives. In total, these mechanisms allowed for input

15 In her classic article “A ladder of citizen participation,” Arnstein identifies eight levels of participation based on the extent of citizen’s power in “determining the end product.” The scale runs from nonparticipation (manipulation, therapy) to varying degrees of tokenism (informing, consultation, placation) to varying degrees of citizen power (partnership, delegated power & citizen power) (Arnstein, 1969). Generally, in this study, consultation takes on a meaning similar to Arnstein’s conceptualization (sharing views and being heard, with little follow-through or “muscle” or assurance on incorporating views) and relates to lay or citizen consultation; participation generally refers to how other sectors, professional groups, ministries /departments, etc were woven into the process. In this context participation refers to something more than sharing views, and includes some active involvement such as being part of a working group, submitting written testimony, or attending planning sessions/meetings.
from over 10,000 people including professionals, citizens and community leaders (Green, 1992, McGinnis, 1984). In his testimony before the Subcommittee on Government Information and Regulation Committee on Governmental Affairs of the United States Senate, Mason (1990b) captured the depth and breadth of consultation as follows:

I think those of us who have been deeply involved in this process feel that, in many ways, it may be the most extensive, comprehensive, and open experiment in democratic health policy-making undertaken to date in the US. Given the extensive memberships of the consortium organizations, the State health departments’ involvement, the many experts who have freely given their time and thought, and the devolved staff within the agencies of the PHS [Public Health Service], the final [health goals] strategy that is released next September will clearly be the result of a national effort (p. 5).

Consultation mechanisms in England revolved around the development of a health goals consultation document followed by its broad distribution to local authorities, health authorities, professional organizations, voluntary groups, and business and industry sectors. Feedback on the document was encouraged in the form of written submissions. Regional workshops were also conducted around the country to gather consumer and stakeholder feedback on the health goals. Finally, newspapers and local media invited debate on health issues related to the proposed health goals. In the end, more than 2,000 individuals and organizations commented on the health goals proposed in the Health of the Nation strategy for health in England (England Department of Health, 1992).

The Australian Capital Territory disseminated over one thousand copies of the health goals report, ACT Health Goals and Targets for the Year 2000 (1994) to individuals, organizations and health practitioners statewide. Input into the development of the health goals came from citizens through a consumer steering group and public meetings. The local newspaper media advertised health goals and targets for two weeks prior to the public consultation phase to facilitate the discussion sessions. Finally, a series of six special workshops and several meetings
with interested professional associations and various organizations solicited professional expertise on specific issues related to health goals.

Consultation strategies followed a similar pattern in Saskatchewan. First, the Saskatchewan Provincial Health Council drafted a set of health goals. Then public and special interest meetings, media presentations, conference participation, and written input from individuals and agencies throughout Saskatchewan yielded input from the citizens of Saskatchewan. Over 1,000 people attended a total of sixty-six Provincial Health Council’s Public Input Meetings which spanned nine geographical regions of Saskatchewan (Saskatchewan Provincial Health Council, 1996). Working groups were established also to develop measurable objectives for each of the six goal areas.

In the state of Texas, twenty-one working groups, totalling over 300 people, each representing a priority area; met over an eight month period to develop and refine the Year 2000 Objectives. Work groups consisted of representatives with expertise and knowledge drawn from private industry, voluntary organizations, academic institutions, consumer groups, government agencies, as well as advocacy groups related to each priority area (Texas Department of Health, 1989).

Although this literature review draws evidence on consultation and participation strategies from six independent jurisdictions, several common features emerge. Most jurisdictions sought feedback on draft health goals, usually in the form of a consultation document prepared by the health goals coordinating mechanism. They often requested written submissions and used public meetings or forums to solicit public and consumer input. They solicited opinion from experts and health professionals, typically in workshops or professional meetings. Finally, local media played a role in educating the public on health goals as well as
encouraging their attendance and participation at community and public meetings where health goals were discussed and refined.

(Core Contributions)

Most of the published and source document literature on health goals makes reference to the kinds of contributions made by participants in health goals development in the formulation phase. Core contributions comprise the various duties and responsibilities that typically take place to move the health goals process along. These include technical assistance, leadership, funding, promotion, organization, education, and communications. Typically, core contributions are linked to the expertise of the various individuals and interests involved in the health goals planning exercise.

Source documents commenting on the English health goals initiative outline the contributions of various parties in the health goals development process. The National Department of Health assumed the lead role and was instrumental in educating and informing the public, ensuring collaboration between government departments, allocating resources for health goals planning, and facilitating and encouraging action on health goals among professional groups. Another central player in the English goals initiative was the National Health Service. It aimed to organize work toward progress in target setting in the national key areas, and to identify and add local priorities to the national targets (England Department of Health, 1992).

In the United States, agencies of the Public Health Service took on a central role in the development of the 1990 Objectives. The Health Resources and Services Administration (HRSA) provided technical assistance in the development of preventive health services objectives; the National Institutes of Health provided research and prevention studies to support objective
setting; the Alcohol, Drug Abuse, and Mental Health Administration contributed to efforts aimed at health education of the public and professionals; the Centers for Disease Control contributed epidemiological research related to chronic disease and occupational safety and health; and the Office of Health Information, Health Promotion and Physical Fitness sponsored regional forums on community health promotion, provided technical assistance to community health promotion programs, and increased public awareness of disease prevention and health promotion through the National Health Information Clearinghouse and the National Health Promotion Media Campaign. (Green, 1979). The role of the federal government in the US initiative was to serve as a catalyst in the development of intervention methods and in the identification of target groups; and to stimulate participation and activities related to the health objectives around the country (McGinnis, 1984).

In Texas, the twenty-one working groups provided technical assistance; the Texas State Department of Health facilitated and managed the initiative; and the Texas State Centers for Disease Control provided training for work group facilitators (Texas Department of Health, 1989). Similarly, Saskatchewan’s working groups offered technical assistance, as was the case in the Australian Capital Territory. The Saskatchewan Provincial Health Council coordinated the health goals initiative and was responsible for public education and communications.

One theme that emerges from the jurisdictions in this review is that health goals planning was a shared responsibility, with contributions coming from citizen and consumer groups, governments, experts, and health specialists. The published and source document literature on health goals substantiates core contributions made by participating parties as a key factor contributing to health goals development in the formulation phase.
**Time & Budget**

Although planning theory and common knowledge suggest that time and budget are important factors in health goals development, little direct reference is made to these factors in the published and source document literature on health goals. Typically, they refer to time and budget considerations indirectly, as for example, in discussions regarding paid and voluntary personnel. Volunteer time played a major role in health goals development in the jurisdictions reviewed here. Volunteers constituted the advisory committees and working groups central to health goals development in both Texas and Saskatchewan. Further, most members of the US Consortium in support of the Year 2000 Objectives were volunteers who participated in the health goals initiative as part of their regular, paid employment. Paid support for Saskatchewan’s Provincial Health Council included the coordinating mechanism of the Saskatchewan health goals initiative. So too did the group of university scholars commissioned to coordinate the second round of the Australian health goals and targets, although at least one member’s salary was drawn from the university budget.

Little direct evidence exists in the health goals literature on the source and scope of health goals budgets. It is reasonable to speculate that health goals initiatives are funded by the governments that sponsor them. Although private sector interests clearly play a role in the health goals exercise (particularly in relation to providing expertise and technical assistance) there is no evidence that private sources have funded health goals initiatives.

One aspect of time and budget discussed openly in the literature on health goals is the overall amount of time dedicated to the development process. All six jurisdictions included as a part of this literature review required at least one year to develop their health goals, and a few required significantly more time. It is worthwhile to note that the elapsed time seldom means
full-time staff equivalents. It typically refers to time required for cooperating groups to confer with their constituencies, to gather data and complete background work, and to develop meeting schedules. The Australian initiative for revised health goals and targets progressed over a two-year period, while the development of the US Year 2000 Objectives spanned three years. Health goals development in the Australian Capital Territory stretched over a twelve-month period, as did the initiatives in the state of Texas and the province of Saskatchewan.

Although direct reference to time and budget in the health goals literature is scant, indirect evidence as well as inference based on planning theory, substantiates these factors as contributory to health goals development in the formulation phase.

Data

The literature on health goals devotes significant discussion to the role of data in health goals development. The most extensive coverage of data issues comes from the published and source document literature on the American health goals initiative. This is likely reflective of more than two decades that this jurisdiction has had to address the chief issues surrounding data in relation to national and state goals, such as data application, sources, quality, availability, and the development and management of data systems.

One of the contentious issues regarding data in health goals development is how data are applied; that is, whether health goals are formulated in only those areas where data are available or whether goal setting proceeds in areas where data do not exist or are unavailable. In both the US 1990 Objectives and the Year 2000 Objectives, measurable objectives were set even when data were unavailable or data systems were not in place to measure progress on the goals (Green, 1992). Developers of health objectives recognized that many of the more important issues for
health promotion and disease prevention had no national data. A decision had to be made on which was dominant, the principle of specificity and measurability or the principle of importance. They chose the later which served to drive the creation of data collection in those areas where there were previously no baseline data and no tracking systems in place. Reflecting upon the objective-setting exercises in the United States, Green (1992) commented on the benefits accrued from not ignoring areas for which data were inadequate, acknowledging the relationship between the identification of health priorities and data availability:

A larger proportion of the new [Year 2000] objectives are now more measurable than were the 1990 Objectives, thanks in part to the effect of publishing them as objectives in 1990 even though baseline measures were unavailable. Development of data should follow from what is considered important, not vice versa. If the only problems that qualified for objectives were those for which data were already available, the priorities would have been quite different, and to a large degree, trivialized” (p. viii).

The Australian health goals initiative restricted the first round of goals and targets to those indicators for which adequate data existed (Nutbeam & Wise, 1996). The revised goals and targets exercise, which added targets for two additional areas, were challenged by a “lack of relevant data to enable measurable targets for health literacy and skills, and for healthy environments ...” (p. 9). Although some acknowledged that data limitations can “severely inhibit the setting of goals and targets” (Nutbeam & Wise, 1996), the overall number of targets and measurability of goals increased between the original and revised set of health goals and targets for Australia.

Multiple data systems were accessed, and in many cases augmented, to support the formulation of US health objectives and to set in place mechanisms to track progress on the objectives. Data systems included (a) regulatory or quasi-regulatory systems such as the Food and Drug Administration, (b) surveillance and monitoring systems such as the Centers for Disease Control, (c) population-based surveys such as the National Health Interview Survey, and
(d) records-based data systems such as in the birth and death registration systems. The US experience considered the development of data systems along side goals planning (Green et al., 1983). Sometimes new data were required, especially in cases where no baseline data were available. To facilitate the collection of baseline data, either special surveys were undertaken to begin measurement toward goals attainment or additional items were added to existing surveys (Mason, 1990b).

The US health goals initiative judged monitoring, surveillance and periodic surveys as essential to track progress toward the national goals (Green et al., 1983). Notably, one set of objectives in the US initiative deals entirely with monitoring and surveillance as a way to ensure tracking, monitoring, and ongoing evaluation. Surveillance and data systems were also important considerations at the state level in the US where state objective-setting exercises were modelled after the national agenda (Texas Department of Health, 1991).

The international literature on health goals documents several issues related to data. This substantiates data as a key contributory factor to health goals development in the formulation phase. Table 6 summarizes the multiple themes and associated dimensions that comprise this phase.
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**Articulation Phase of Health Goals Development**

The *articulation phase* of the health goals development process is characterized by the formal proclamation of health goals, often a public announcement or press release, followed by release of the goals in published form, their dissemination, and any post-formulation adjustments or modifications to the health goal statements. Whereas the first two phases of health goals development - the premonitory phase and formulation phase - focus on *how* health goals are formulated, the articulation phase focuses on *what* the health goals come to say and to whom. Attention is paid to the content of health goals in terms of the types of priorities addressed, the relative emphasis on distal and proximal influences on health, and the level of operationalization of health goals into measurable objectives, quantifiable targets, strategies for action, and key institutions whose policies or actions need to change. During the articulation phase, health goals enter the public domain and are disseminated broadly to interested parties and the public.
PROPPOSITION 3: FACTORS THAT CHARACTERIZE AND INFLUENCE THE FINAL PHASE OF
HEALTH GOALS DEVELOPMENT, THE ARTICULATION PHASE, INCLUDE THE FOLLOWING: (A)
SPECIFICITY AND METHODS FOR ARTICULATING GOALS, OBJECTIVES AND TARGETS, (B)
PRIORITIES ADDRESSED IN THE HEALTH GOAL STATEMENTS, (C) THE RANGE OF HEALTH
DETERMINANTS ADDRESSED, AND (D) LATE-STAGE DEVELOPMENTS AND SPIN-OFFS THAT
OCCUR AS A RESULT OF THE HEALTH GOALS EXERCISE.

Specificity & Methods

The published and source document literature on health goal setting thoroughly
documents specificity, measurability, and the methods applied. Specificity of health goals, that is,
the degree to which goals are operationalized into measurable statements of health gain or risk
reduction, varies across jurisdictions. Some jurisdictions propose only broad health goals - stand­
alone statements of future desired states with little or no operationalization of health goals into
measurable objectives or quantifiable targets. Conversely, some jurisdictions assume a high level
of specificity in the goal setting exercise by identifying indicators for measurement, stipulating
targets for improvement within clearly delineated time frames, and delineating strategies for
goals attainment.

Methods for specifying targets vary also across jurisdictions. Methods were detailed
earlier in this chapter (p. 61) and include normative standards or benchmarks, theoretical
standards, historical standards, absolute standards and compromise standards (Green & Kreuter,

As indicated earlier, high measurability defined the US health goals initiative. Two
hundred and twenty six specific, measurable objectives were developed with endpoints to 1990
in the first round of goal setting and 300 to Year 2000 in the second round. Statements of
measurable objectives occur in one of three possible ways: (a) as an absolute reduction in a rate,
(b) as an absolute reduction in a number, or (c) as a complete elimination of a hazard (Green,
1992). Target setting depends on the particular objective. Targets were based on an assessment of recent historical trends, rates achieved by other countries that have resources similar to those of the US; combined with an estimate of what ought to be practically achievable within the time and resources available, barring any breakthroughs in science or technology or new interventions (Green, 1979, McGinnis, 1984). Very few of the US health objectives have not been quantified; only goals relating to improving data sources and those requiring further definition of specific or ambiguous terms have not been articulated to the level of measurability characteristic of the majority (Green, 1993). Dr. James Mason, then Assistant Secretary for Health, US Department of Health and Human Services, in his statement before the Senate Subcommittee on Government Information and Regulation made clear the commitment to measurability in the US initiative when he compared the setting of objectives for health to management-by-objectives in the business sector:

We are not engaged in a rhetorical exercise, stating only for purposes of motivation or encouragement a list of hopes or wishes for the future. In keeping with the basic philosophy of management-by-objectives, the quantified targets that are being set for attainment [of the health objectives] by [Year] 2000 are meant to be taken with the same kind of seriousness that business people take their production and sales targets... Without such definition - which means without measurements - objectives become an exercise in aspiration rather than an exercise in management to achieve improvements (p. 5).

In Australia, goals and targets for health increased in number and scope in the second version of the national goals as outlined in Goals and Targets For Australia's Health in the Year 2000 and Beyond (1993). Expanded targets focused on avoidable mortality and morbidity, "healthy lifestyles," risks to health, health skills and "healthy environments." As in the United States, goals and targets stated in specific and measurable terms were considered essential to track progress on goals effectively "by defining the direction, magnitude and timing of expected achievements in health" (Nutbeam & Wise, 1996, p. 11). Reflecting on the Australian health
goals and targets initiative, Nutbeam and Harris (1995) noted that “[the Australian effort] reflected an approach to target setting which had been established in other countries, notably the United States” (p. 53).

The *Health of the Nation* initiative in England selects five key areas for action, sets measurable objectives and targets in the key areas, outlines the actions needed to achieve the targets, proposes implementation strategies, and offers a framework for ongoing monitoring, development and review (England Department of Health, 1992). Wherever possible, targets in key areas are directed at actual improvements in health outcomes. Where this is not possible, targets relate to services that are known to be effective in improving health or preventing disease. Quantified national targets are established for most areas, however, in cases where opportunities for target setting are greatest at the local level, national targets are not set.

An outstanding feature of the *Health of the Nation* document is the degree of attention given to strategies for achieving projected targets for improved health. Specific roles are delineated for the major components of the health system including the national government, the National Health Service, local authorities, non-government agencies, and the voluntary sector. Further, special handbooks have been developed for each key area that outline specific actions to be taken by health sector partners, as well as within the workplace and schools. Implementation strategies emphasize the role of local alliances and intersectoral approaches as mechanisms for action (England Department of Health, 1992). Healthy Texans 2000 also features the delineation of responsibility for health goals whereby strategies for achieving the objectives include a listing of state organizations that may play a lead role and community resources necessary for success (Texas Department of Health, 1991).

Another feature of the *Health of the Nation* initiative is the clear articulation of guiding
principles that serve as its foundation. Six principles underpin the Health of the Nation initiative: (a) to identify the main health problems and focus on them; (b) to focus equally on the promotion of good health and the prevention of disease as on the treatment, care and rehabilitation of those who become ill or who need ongoing support; (c) to recognize that health is determined by a wide range of influences that include genetic inheritance, personal behaviour, family and social circumstances, and the physical and social environment; responsibilities for action to improve health are therefore widely distributed from individuals to governments; (d) to recognize that the strategy calls for greater cooperation between those involved, at national and local levels, within and beyond the National Health Service; (e) to strike a balance between central strategic direction and local and individual discretion and flexibility in policy implementation; and to ensure scrutiny of performance and outcomes where responsibilities for health are devolved; and (f) to ensure the best possible use of available resources, both money and people (England Department of Health, 1992).

Guiding principles also ground the Saskatchewan health goals initiative. Population Health Goals for Saskatchewan (1994) rests on a set of principles, values and beliefs that include notions related to health as a resource, the “whole” person, the importance of family, the value of children, community development, informed choice, respect for cultural diversity, and fairness. The intent of the Saskatchewan health goals initiative was to articulate broad health goals, considered to be ideals to strive toward; followed by the development of measurable objectives, and finally the creation of “healthy public policy” recommendations for each goal area. Very few objectives were developed in the Saskatchewan initiative, and of those, few were quantified. In several of the goal areas, recommendations for “healthy public policy” predated the definition of measurable objectives. In these instances, some targets were included within the public policy
recommendations but without any clear articulation of measurable objectives to support the goal statements.

Similar to the Australian and American national initiatives, the *ACT Health Goals and Targets for the Year 2000* (Australian Department of Health, 1994) strived for specificity and measurability of goals and targets. In the absence of baseline data in the ACT initiative, target setting was based on what health providers and researchers believed ought to be achievable, based on current research and practice. In some cases proxy baseline data have been used. One problem facing the ACT initiative was setting targets at the local level where smaller numbers are characteristic. ACT attempted to overcome this issue by using average rates over five years rather than annual rates, which helped to deal with the problem of wide variations between individual years when numbers were small (Lyons, 1995).

Similar to the health goals experience in England and Saskatchewan, the ACT initiative articulated a set of principles to guide and underpin their health goals and targets. They were as follows: (a) the goals and targets should attempt to strike a balance between process and outcome objectives (besides health status, include goals and targets for data collection, intersectoral collaboration, models of practice and building health services infrastructure); (b) target setting would not be constrained by existing data sources (some process targets focused on collecting data for areas where little was available); (c) targets and implementation strategies should involve the concerns and support of professionals, advocates, consumers, and local health and community agencies; (d) setting of health goals and targets should be an ongoing process of evaluation, review and refinement, to keep pace with the changing demographics and emerging priorities; (e) goals and targets should, where possible or appropriate, be compatible with those already adopted by other relevant organizations, and (f) targets must be appropriate for the
desired purpose, and the intent of the implementation strategies should match the targets (Australian Department of Health, 1994).

The published and source document literature on health goals dedicates a significant amount of discussion to the specificity and measurability of health goals and the methods used to set goals and targets. Interesting questions arise as to the influencing factors behind each approach; and the implications of assuming one approach over another. The centrality of the specificity issue to health goals planning supports its inclusion as a principal theme or factor of health goals development in the articulation phase.

Priorities Addressed

The published literature and source documents from sample jurisdictions reviewed for this chapter offer rich discussion on the priorities addressed in health goals as well as the methods employed for choosing among priority issues.

Healthy People: the Surgeon General's Report on Health Promotion and Disease Prevention (US Department of Health, Education and Welfare, 1979a), and Promoting Health/Preventing Disease: Objectives for the Nation (US Department of Health and Human Services, 1980) introduced five major goals designed to enhance the health of the US population at five major life stages (Green, 1979, McGinnis, 1984). The report emphasized two priority problems for each life phase goal as follows: (a) infancy, which addresses low-weight births and birth defects; (b) childhood, which focuses on childhood development and childhood accidents and injuries; (c) adolescence and young adulthood which addresses fatal motor vehicles accidents and misuse of drugs and alcohol; (d) adulthood which emphasizes heart attacks, stroke and cancer; and (e) elderly, which addresses functional independence and premature death from
influenza and pneumonia. Fifteen priority actions were identified as the focus for intervention programs. Considered critical to the achievement of the five major goals, the priority actions constituted three categories (Green, 1979; McGinnis, 1984):

1. Preventive health services which involves health providers and include actions toward high blood pressure control, family planning, pregnancy and infant care, immunizations, and sexually transmissible disease control.

2. Health protection measures which involves government, industry and other agencies to guard people from harm, including toxic agent control, occupational safety and health, accidental injury control, fluoridation of community water supplies, and infectious agent control.

3. Health promotion initiatives undertaken by individuals and communities to encourage changes in behaviour and to promote change in the social and economic environment to support improvements in health, including smoking prevention, reducing misuse of alcohol and drugs, improved nutrition, exercise and fitness, and stress management.

The second round or Year 2000 Objectives published under the title, Healthy People 2000 (US Department of Health and Human Services, 1992b), expanded the priorities addressed in the first round by giving more attention to disadvantaged groups and health inequities. The changes in the Year 2000 objectives were based on concerns of special populations, including ethnic and racial minorities and the elderly, that objectives masked the variation in mortality and health status between population subgroups (Green, 1992). Because advocacy groups for racial and ethnic populations were disappointed that separate categories for minority-specific objectives were not a part of the 1990 Objectives, the Year 2000 objectives targeted several high risk groups. Additional priority areas addressed in the Year 2000 Objectives included educational and community-based services, surveillance and data systems, and mental health services; increasing
priority areas from fifteen in the 1990 Objectives to twenty two in the Year 2000 Objectives.

Texas, the first state in the union to develop and publish state-specific health objectives for 1990, built the Texas Year 2000 objectives on the experience of the previous decade with greater focus on prevention. Like the national initiative, the Year 2000 objectives gave greater emphasis to improving the health of population subgroups such as minorities and elderly. A central claim in *Healthy Texans 2000* (Texas Department of Health, 1991) is that medical care alone cannot eliminate disease or improve quality of life, and that the public can no longer afford not to invest in health promotion and disease prevention. Prevention is acknowledged as an effective way to avoid human suffering and to reduce health system expenditure and the Healthy Texans 2000 initiative addresses the prevention of major chronic illnesses, injuries and infectious diseases. Similar to the national initiative, Texas groups its priority areas into health promotion objectives, health protection objectives, and preventive services objectives. In addition, Texas incorporates a set of health system improvement objectives, that include health education and preventive services as well as objectives for surveillance and data systems.

The English *Health of the Nation* strategy aimed to strike a balance between the promotion of good health and the prevention of disease; and the treatment, care and rehabilitation of those who become ill or who need ongoing support (England Department of Health, 1992). Five key areas represented the priorities for action in the English health initiative: (a) coronary heart disease and stroke, (b) cancers, (c) mental illness, (d) HIV/AIDS and sexual health, and (e) accidents. Within each key area, the health needs of specific groups of people are considered including children, women, elderly people, ethnic minority groups, and certain socio-economic groups. Success in key areas was defined in terms of improvement in life expectancy, decreased premature death, and improvements in quality of life. The English initiative based selection of
key priority areas on three criteria: (a) the area is a major cause of premature death or avoidable poor health, (b) effective interventions are possible and offer significant scope for health improvement, (c) and the area allows for the setting of objectives and targets.

One of the criticisms of the English health goals initiative in relation to priorities addressed centres on the lack of attention to health inequities. In a review of health goals initiatives in eight jurisdictions, Nutbeam and Wise (1996) pointed out that the Health of the Nation strategy emphasized individual behaviours, and paid less attention to population differentials than other countries or regions:

The English document paid relatively little attention to the need to reduce inequalities in health status within the English population. There is brief acknowledgment of differential patterns of disease among different population groups, but no targets are set for reducing modifiable differences, and no emphasis is given to these in the analysis of disease patterns in the community ... Targets in other countries such as Australia and the US focus more overtly on reductions in inequalities in health” (p.10)

The priorities addressed in the Australian health goals initiative vary between the first and second rounds of target setting. The first round of targets, captured in Health for All Australians (1986), set goals for improved health in five priority areas: (a) injury prevention, (b) health of the elderly, (c) preventable cancers, (d) high blood pressure, and (e) improved nutrition. The goals and targets increased in number and scope in the second version of the national goals as presented in Goals and Targets For Australia’s Health in the Year 2000 and Beyond (1993). The second round of targets built on the 1988 goals and targets and highlighted the need for a balanced approach to health promotion and disease prevention that included diagnostic, palliative, treatment and preventive services (Commonwealth Department of Human Services and Health, 1994).

The revised targets suggested also “much more precise definition of goals and targets for the achievement of equity in the health status of the population” (Nutbeam & Wise, p.9, 1996).
The health goals and targets articulated for the nation as a whole are complemented by the development of parallel health strategies for special population groups including Aboriginal and Torres Strait Islander Health Goals and Targets, Health Goals and Targets for Australian Children and Youth, Health Goals and Targets for Australian Women, and the National Non-English Speaking Background Women’s Health Strategy. Additionally, the revised health goals and targets considered the underlying determinants of health and focused attention more broadly on social, economic and environmental influences on health. Taken together, the health goals and targets for Australia comprise four groups (Nutbeam & Harris, 1995):

1. **Healthy lifestyles** sets targets for smoking, alcohol use, physical activity, diet and nutrition, cholesterol, obesity, and high blood pressure.

2. **Healthy environments** sets targets for clean air and water; safe, affordable housing; safe and healthy workplaces, social supports, environmental controls, and school policies.

3. **Health literacy and life skills** addresses coping skills, knowledge, motivation and community action.

4. **Mortality, Morbidity and Quality of Life** sets targets for cardiovascular health, cancer control, injury prevention and control, and mental health.

Three criteria guided the selection of priority areas in the development of the revised national goals and targets: (a) the condition must be of major concern to the health of Australians, (b) effective interventions to improve outcomes must be possible, and (c) ideally, it must be possible to measure progress. This standard is qualified by the recognition that this may create a bias in favour of setting targets for conditions with high mortality (Commonwealth Department of Human Services and Health, 1994).

The *ACT Health Goals and Targets for the Year 2000* (Australian Department of Health,
1994) expanded on the national health priorities to reflect priorities of significance at the state level. Beyond the national priority areas, goals and targets for the ACT include: (a) alcohol and other drugs, (b) food and nutrition, (c) communicable and sexually transmitted diseases, (d) people with disabilities or chronic conditions, (e) community access and participation, and (f) diabetes. Selection for priority areas were based on epidemiological, demographic and health service use information. As well, priorities were identified by the perceived ability to improve health outcomes in those areas attributable to the existence of prevention strategies or the potential for improved interventions.

Finally, with the long-term aim to improve the health status of the people and communities of Saskatchewan, six priority areas characterize the Saskatchewan health goals initiative. Health goals focus on the health of the population as a whole and the broad factors that determine or influence health that extend beyond the health service system. More specifically, the priorities set forth in *Population Health Goals for Saskatchewan* (1994) include: (a) consideration of the broad determinants of health, (b) social justice and equity, (c) supportive families and communities, (d) healthy (sic) physical environment, (e) health promotion, and (f) shared responsibility to improve health.

As evidenced above, jurisdictional health goals set forth several priority areas and include improved health status, health promotion, health practices, health equity, determinants of health, population subgroups, health care system, healthy public policy, and quality of life. The kinds and number of priorities as well as the criteria used to choose among priorities varies across jurisdictions that have adopted a health goals planning approach. The comprehensive coverage of the various priorities addressed in health goals justifies its inclusion as a dominant theme in the articulation phase.
Health Determinants Scope

The scope or range of health determinants incorporated into jurisdictional health goals is another defining feature of health goals articulation. Health goals can include proximal determinants of health, described earlier as those factors that influence health that have historically been viewed as under the individual’s control and relate to his or her immediate environment. Or, they may include the distal determinants of health, those influences on health that are further removed from an individual and his or her immediate environment, and include the social, economic and environmental influences on health, and health services. While the descriptions of the determinants of health are typically dichotomized, the differentiation is more accurately represented as a continuum where any one health determinant may be proximal or distal, depending on the individual’s life stage or circumstance, or the proximity of the health risk event.

The second rounds of health goals in both Australia and the United States paid greater attention to the broader factors that influence health. Goals and targets for Australia’s health in the year 2000 and Beyond (Nutbeam et al., 1993) considers the underlying determinants of health and focuses attention more broadly on social, economic and environmental influences on health. As a result, two new groups of targets were added to the revised targets: (a) health literacy and health skills, and (b) healthy (sic) environments. ACT aimed to incorporate the broader environmental and social perspectives on health. They accomplished this by asking why injury or illness was occurring, what factors contribute to the condition, what led to successful cases, and what barriers were at work to prevent progress toward positive health outcomes (Lyons, 1995). This kind of inquiry led to the inclusion of targets related to the broader determinants of health. According to Lyons (1995), while the ACT’s priority areas were generally risk factor and disease
focussed, the underlying goals, targets, strategies and supporting discussion focused predominantly on the local community and individuals within their social context.

A common criticism of the US 1990 and Year 2000 Objectives is that they focused almost exclusively on behaviour and on individual responsibility for change or improvement in health. A thorough reading of the American objectives however reveals a clear attempt to involve many parties in progress toward the goals including individuals, health practitioners, service providers, schools, communities, employers, food producers and distributors, insurance companies, mass media and other industries, and all levels of government. According to Green (1992), "the health promotion objectives give the impression of throwing the primary burden on individuals insofar as the risk factors for this set of objectives, more than the health protection and health services objectives, are behavioural." However, "the objectives themselves include these various levels of intervention, mostly under the rubric of 'services and protection objectives' within each chapter of the health promotion section." (p. ix). Further, insufficient provision for programs and budgets by the federal administration for various parties (schools, communities, industry, health providers, others) did not enable them to meet this challenge. This lack of support paved the way for significant criticisms that the American initiative had the appearance of blaming the victims for poor health.

*Healthy People: The Surgeon General’s report on health promotion and disease prevention* (1979a) substantiated the ecological foundations upon which the US efforts were based. Green (1996) defended the ecological framework of the *Objectives for the Nation* and offered an explanation for its misinterpretation:

The objective-setting process took pains to reflect a comprehensive and balanced approach, ecological in its conception, but bureaucratic in its execution, giving equal weight in the number of objectives to behavioural, environmental, and preventive health services as determinants of health. Unfortunately, in the effort to be
evenhanded, “health promotion” as a term came to be associated with the behavioural set of objectives whereas the term of “health protection” was attached to the objectives relating to the environment. This historical error of labelling has fed into an international stereotype by which writers in the rest of the world have characterized the American brand of health promotion to be exclusively concerned with individual behaviour and lifestyle determinants of health. A close examination of the structure and content of the objectives, however, reveal a rich array of ecologically oriented policy and environmental support objectives attached to each of the health promotion priorities ... In short, the policy documents provide an ecological framework for health promotion in the United States (p. 275).

The American initiative builds on the Lalonde Report (1974) and its health field concept gave significant consideration to the multiple factors that influence health.

Criticism has been directed also by some researchers toward the English Health of the Nation strategy especially in relation to a lack of attention to population subgroups, a reliance on individual behaviours, and little action on environmental conditions (Nutbeam & Wise, 1996). Nutbeam and Wise pointed out that the English initiative pays less attention to the determinants of health and the spirit of the global policy of Health For All than do other jurisdictions that have adopted a health goals planning approach. In comparing England to the US and Australia, Nutbeam and Wise commented that, “The goals and targets in these countries [US and Australia] offer greater recognition to structural determinants of health and illness, alongside individual lifestyles. This approach appears to be more in tune with the philosophy of the Health for All concept” (p.10).

This is inconsistent, however, with one of the defining principles of the Health of the Nation strategy which recognized that health is determined by a wide range of influences including genetic inheritance, personal behaviour, family and social circumstances, and the physical and social environment; and responsibilities for action to improve health are therefore widely distributed from individuals to governments (England Department of Health, 1992). This sentiment was captured in the introductory statement to the Health of the Nation document, when
the Secretary of State for Health remarked that “the need to focus on health as much as health care has long been the ambition” of the English health strategy (p. 2). Further, a new key area, environment and health, was launched in November, 1996 to recognize public concerns about the effect of the environment on health. The consultation document, *Environment and Health: Developing a Sixth Key Area* (England Department of Health, 1996) set forth preliminary ideas for suitable targets and objectives and partnerships to implement them.

The Saskatchewan health goals initiative focused broadly on the multiple factors that influence health including social environments, supportive families and communities, physical environment, and health promotion (*Population Health Goals For Saskatchewan, 1994*). Although the health system is not directly incorporated into the goal statements for Saskatchewan, it was recognized as one of the several influences on health: “a quality, accessible health service system is an essential component in achieving good health ... but it is not the only one” (Saskatchewan Provincial Health Council, 1994). The reach or scope of health determinants incorporated in the Saskatchewan health goals is reflective of the mission of the Saskatchewan Provincial Health Council, which developed the health goals, “... the Provincial Health Council deals with the broad determinants of health, or that wide variety of factors which impact on people’s health outside the health services sector, and is not responsible for making recommendations or dealing in areas of the health care system” (Saskatchewan Provincial Health Council, 1994, p. 1).

In the Saskatchewan initiative, the health care system and health services are effectively excluded from both the population health goals as well as the subsequent “healthy public policy” recommendations proposed as strategies to goals attainment. Rather priorities addressed in public policy recommendations emphasize the determinants of health, water quality, violence, pesticide
use, crop burning, range of health professionals, farm safety, rental properties, workplace wellness, hazardous wastes, health promotion, nutrition, toxic air pollutants, trucking, and clean air regulation (Saskatchewan Provincial Health Council, 1996). The level of attention paid to the broad determinants of health constitutes an outstanding feature of the Saskatchewan initiative.

_Late-Stage Developments_

Finally, the literature on health goals acknowledges what may be called “late stage developments” as a contributory factor to health goals development in the articulation phase. This includes post-consensus manipulation of health goal statements; as well as secondary or spin-off initiatives associated with the development process such as, institutionalization of health goals, diffusion of health goals, partnership and coalition building, and intersectoral collaboration.

Once health goals have been fully developed, some jurisdictions take actions to institutionalize the health goals by linking them to funding arrangements or requiring departments or ministries to set their budgets according to the anticipated contribution of their programs and policies toward the achievement of the health goals. In the United States, Public Health Service agencies were instructed in 1981 to prepare their 1982 budgets using the Objectives for the Nation as their justification (Green, 1992). This practice has continued over the past nearly two decades as the Public Health Service agencies are required to demonstrate how their activities or programs contribute to attaining one or more of the objectives in _Healthy People 2000_, as a part of their annual budget planning process.

In Australia, the Medicare Agreement links the funding and management of the public health system to the national health goals and targets. Under this agreement, the federal
government and states:

... Are committed to agree on priorities and program of implementation, and to progressively introduce changes in the management of health services to reflect the priority targets. This commitment is intended to ensure that the targets become more central in decision-making governing the funding and management of the mainstream health services (Nutbeam & Wise, 1996).

Additionally, the national health goals and targets set the foundation for the 1994 Australian National Health Policy. The National Health Policy (1994) is a shared policy framework for the Australian health system that focuses on improving the health of the population, reducing inequalities in health and making effective use of health resources.

The diffusion or translation of health goals from the originating jurisdiction to other jurisdictions may also occur in the late stages of health goals development. For example, the goals-based Health of the Nation policy in England spurred similar policy initiatives in neighbouring Scotland, Wales and Northern Ireland (England Department of Health, 1992). In Australia, all states have now developed or are in the process of developing their own goals and targets. Further, the Australian national initiative stimulated the development of complementary health goals and targets for several population subgroups including aboriginal people, children and youth, and women.

The diffusion of health goals from the national to state level characterizes also the American experience. To date, forty-seven states, the District of Columbia, and Guam have developed statewide plans that translate national Healthy People 2000 objectives to meet state priorities; and, 70% of local health departments are using Healthy People 2000 as a framework for health promotion and disease prevention (US Department of Health and Human Services, 1996). The Healthy Texans 2000 initiative, which is modelled after Healthy People 2000, has served as a model itself for several state and community level strategic plans including the Texas
Department of Health, Texas Rural Health Chartbook, and Travis County Healthy Partnership for the Year 2000. Finally, several large scale public health initiatives in the state of Texas have applied the Year 2000 objectives to evaluate program effectiveness by integrating them into their evaluation activities.

Developments of a more technical nature may also occur in the late stages of the health goals development process. Post-consensus edits refers to the adjustment of health goals after health goal statements have been agreed to by parties participating in their formulation. Green (1992) provided some examples of how the US objectives were adjusted by higher political operatives after consensus had been achieved through various review procedures. For example, one chapter of the Healthy People 2000 document, originally titled “Sexual Behaviour,” was retitled, “Family Planning,” and objectives relating to age-appropriate sex education in schools disappeared. The term “firearm-injury death” was substituted with a more general term, “weapon-related violent death,” likely to divert attention from the role of gun control. And in reference to tobacco, additional words were added to change the intent of the objective: “Eliminate or severely restrict ... tobacco advertising and promotion to which youth younger than 18 are likely to be exposed” (the added words are italicized). Manipulation of the health objectives in the American experience is attributable to high-level government clearing procedures.

While there are few studies on the long term impact of goals-based health policies in any jurisdiction, Nutbeam and Wise (1996) noted the significant impact of the National Health Goals and Targets initiative on health policy in Australia. The national health goals initiative is credited with shifting the focus of the health care system from health services to health outcomes, generating an information base to support the measurement of progress, uncovering the
difference in health status among various population groups, and encouraging broader ways of thinking about the factors that influence health. Other spin-offs of health goals planning include intersectoral collaboration on health issues; and the development of new coalitions and partnerships between levels of government, professional groups, and private and voluntary organizations (Frankish et al., 1996).

Ample examples of late stage developments can be drawn from the published and source document literature on health goals. The evidence provided here in relation to post-consensus edits, the diffusion of health goals, and the institutionalization of health goals provides a rationale for the inclusion of late stage developments as a defining factor or theme of health goals development in the articulation phase. Table 7 summarizes the principal themes and dimensions that characterize the articulation phase.

<table>
<thead>
<tr>
<th>Key Factors or Themes</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specificity and methods</td>
<td>Shared vision, statement of principles, goals, objectives, indicators, targets, strategies, language</td>
</tr>
<tr>
<td>Priorities addressed</td>
<td>Number and priority-setting criteria, health status, health promotion, health practices, health equity and social equity, determinants of health, population subgroups, health care system, health tools and supports, quality of life</td>
</tr>
<tr>
<td>Health Determinants Scope</td>
<td>Biology/individual genetics, personal health practice, coping skills, healthy child development, physical environment, income and social status, social support networks, education, employment and conditions, health system</td>
</tr>
<tr>
<td>Late-stage developments</td>
<td>Post-consensus edits, partnership and coalition building, intersectoral initiatives, community development, diffusion, policy extension, institutionalization</td>
</tr>
</tbody>
</table>
Summary of Part B Review of the Literature

Part B of the literature review identified, described and organized the factors that characterize and influence the health goals development process. It included a review of the published, peer-reviewed literature on health goals, and a review of source document literature from six exemplar jurisdictions that have adopted a health goals approach.

Sixteen major themes or factors that comprise the health goals development process have been identified and organized into three phases. The premonitory phase sets the context and motivation for health goals and is characterized by (a) prevailing circumstances, (b) health system environment, (c) proponents and skeptics, (d) perceived benefits, and (e) trigger events. The formulation phase constitutes the various processes, structures and resources required for health goals development. It is characterized and influenced by (a) the mix of players from various levels and sectors, (b) the health goals coordinating mechanism, (c) the strategic approach, (d) consultation and participation strategies, (e) core contributions from key players, (f) time and budget, and (g) data. Finally, the articulation phase of health goals development centers on efforts to define the content of health goals, or what health goals come to say, and is influenced and characterized by (a) the level of specificity and methods for articulating goals, objectives and targets; (b) the priorities addressed; (c) the range of health determinants addressed; and (d) late stage developments and spin-offs that occur as a result of the health goals exercise.

By identifying, describing and organizing the key factors in health goals development, Part B of the literature review has yielded the conceptual framework for this study. The conceptual framework guides the case study examination of the health goals development process in the province of British Columbia by serving as the foundation for the data collection
instrument, and as the organizing framework for data management, coding, and analysis. Sections of the conceptual framework that correspond to the three phases of the health goals development process have been presented in the previous pages. Appendix E presents the conceptual framework in its entirety.
CHAPTER 3: METHOD

This chapter outlines the methodological strategies and processes that guided the examination of the health goals development process in the province of British Columbia. It begins with a brief outline of the general methodological approach and then offers a full discussion on the methodological specifics that characterize this study including the construction of the conceptual framework, the procedures and techniques applied in data collection and data analysis, the criteria used to assess the quality of the research, and the limitations of the study design.

Characterizing the General Methodology

Case study is the central defining methodological feature of this research. Characterized as a case study analysis of the health goals development process in the province of British Columbia, this study applies both inductive and deductive approaches. The data drawn on are qualitative, derived from semi-structured interviews and source document materials. Interpretation of the data is accomplished through the application of various procedures and techniques associated with qualitative data analysis.

This case study can be characterized as a single (revelatory), descriptive, holistic case study (Yin, 1994). (See Appendix F for Yin’s (1994) case study classification scheme.) It involves one instance of the health goals experience and yields information that is revelatory in nature about how health goals are formulated and articulated. It is clearly descriptive, but demonstrates also some elements associated with exploratory case studies. The study is
descriptive in that it (a) presents a complete description of the “pathway” to health goals in BC, (b) identifies and examines the role of various key factors that characterize the health goals effort, including those elements that facilitate and obstruct health goals planning; and (c) applies a descriptive conceptual framework which is grounded in planning theory that helps to focus and guide the study. This study is exploratory in that it considers a phenomenon which has rarely been the topic of previous study and strives to generate hypotheses, particularly as it relates to how alternative factors or pathways to health goals may have led to a different rendition or articulation of health goals for BC. Finally, this case study applies a holistic design by focusing on a single unit of analysis, the health goals development process, and by considering the context and the global nature of the issue under examination.

The case study research strategy best serves the aims and fits the focus of this study. Yin (1994) suggests that case study is the preferred strategy among the five major strategies in social science research, when “how” or “why” questions are being asked about a contemporary set of events over which the investigator has little or no control. The case study strategy is also warranted when the aim is to gain an understanding of complex social phenomena, to reinterpret particular events and processes, to examine issues that are relatively unstudied, and to investigate phenomena within the context of real-life events (Paton, 1993; Skodol Wilson, 1993; Yin, 1994). Taken together, these conditions provide a rationale for application of the case study strategy to examine the health goals development process in BC. Table 8 summarizes the rationale for adopting a case study approach.

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16 Yin identifies five major social science research strategies: experiments, surveys, archival analysis, histories, and case studies. Each offers distinct advantages within some situations and under certain prevailing circumstances. Appendix G draws comparisons and describes conditions under which the five research strategies are applied.
This study draws on both inductive and deductive reasoning or logic models\textsuperscript{17} within a postpositivism research paradigm.\textsuperscript{18} The early stages apply an inductive logic model in the development of the study's conceptual framework. Evolving from a review of the international literature on health goals, the health goals framework identifies the multiplicity of factors that characterize and influence health goals planning. The inductive exercise yielded a framework comprised of generalized principles (themes and dimensions) based on the experience of particular instances (six sample jurisdictions). Later stages of the study relied on deductive reasoning when the conceptual framework was applied to the BC case. Semi-structured interview questions were generated from the framework to gather data from study participants. Finally, the analytic phase of the study applied inductive reasoning by generating hypotheses for future examination.

\textsuperscript{17} Inductive logic moves from particular instances to general principles, or from facts to theories (Beveridge, 1950). Babbie (1989) characterizes inductive reasoning as "the logic model in which general principles are developed from specific observations" (p. G4). In deductive reasoning one starts from some general law or principle and applies it to a particular instance; moving from the general to the particular (Beveridge, 1950).

\textsuperscript{18} Guba and Lincoln (1994) profile four alternative inquiry paradigms - positivism, post-positivism, critical theory and related ideological positions, and constructivism - and describe the basic assumptions that characterize each. See Appendix H for a summary of the ontological and epistemological assumptions that underlie this study.
Table 8: Rationale for Case Study Strategy

<table>
<thead>
<tr>
<th>Conditions Consistent with Case Study</th>
<th>BC Case Study of Health Goals Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>“How” or “why” questions</td>
<td>Focus is on how health goals are formulated (facilitating and obstructing factors), and why BC adopted its final rendition of health goals in the form that they did.</td>
</tr>
<tr>
<td>Contemporary events</td>
<td>Retrospective analysis of recent event in health sector in BC</td>
</tr>
<tr>
<td>Little investigator control</td>
<td>No manipulation of events or conditions</td>
</tr>
<tr>
<td>Need to understand complex social phenomenon</td>
<td>Nature of health goals process is social, political, and complex</td>
</tr>
<tr>
<td>Need to retain holistic and meaningful characteristics of real-life event</td>
<td>Holistic examination of a real instance of health goals development examined within its existing context</td>
</tr>
<tr>
<td>History of application in planning studies</td>
<td>Planning theory grounds and guides this study</td>
</tr>
</tbody>
</table>

Construction of the Conceptual Framework

The approach to the construction of this study’s conceptual framework, also referred to as the health goals framework, can be characterized as an in-depth review of the literature combined with the application of some tactics and procedures associated with content or documentary analysis. This section includes discussion on the conceptual framework in relation to the rationale behind it, sources drawn on and the process undertaken to construct it, its defining characteristics, and how it was applied in this study.

Rationale for a Conceptual Framework

Within the context of this study, a conceptual framework was adopted (Appendix E) to:
(a) summarize and synthesize the key themes or factors that characterize health goals
development, (b) set parameters and provide focus for the examination of the BC case, (c)
provide a basis for the development of the interview instrument, and, (d) offer a framework for
the analysis of qualitative data. This is consistent with the guidelines and rationale offered by
Miles and Huberman (1994) who attest that conceptual frameworks help to set parameters for
study, to consolidate and synthesize vast amounts of information, and to specify the phenomena
to be investigated by “explaining, either graphically or in narrative form, the main things to be
examined in the study -- the key factors, constructs or variables” (p. 18).

Sources in the Construction of the Conceptual Framework

Construction of the health goals framework drew on four sources: (a) the published
literature relating to health goals, including goal setting in health policy, health planning, health
promotion, health determinants, population health, and community and public health; (b) source
document materials from six sample jurisdictions; (c) planning theory; and (d) the experience of
the research team.

Source documents consisted of various government consultation, procedural and public
relations materials from six exemplar jurisdictions that adopted a health goals approach. Sample
jurisdictions included on a national level, Australia, England, and the United States; and on a
state or provincial level, ACT, Texas, and Saskatchewan. The selection of jurisdictions
represents a purposive sample, described by Babbie (1989) as “a type of non-probability
sampling method in which the researcher uses his or her own judgement in the selection of [the]
sample” (p. 207). It may also be characterized as criterion sampling where selection is based on
some set of pre-established criteria (Patton, 1990). Five criteria guided the selection of the
jurisdictions that were reviewed in this study: (a) an established, fully developed approach to health goal-setting, (b) sufficient documentation of the health goals development process, (c) availability of health goals related documents, (d) the use of the English language in source document materials, and (e) similarly industrialized and developed countries and regions.

Although explicit hypotheses are not articulated in this study, the conceptual framework, which is theoretically and empirically grounded in the literature on health goals, constitutes a set of implied hypotheses. In this study, planning theory helped to identify the issues to be considered for examination and to set the parameters of the investigation. This is consistent with the rationale for the application of theory in case study research offered by Yin (1993):

"Theoretical propositions (a) help to direct attention to issues that should be examined within the scope of the study, (b) offer guidance in making decisions about what data to collect and what data analysis strategies to apply, (c) compel the study to stay within feasible limits, and (d) become the "vehicle for generalizing the results of the case study" (p. 39).

Three-Step Process Undertaken in the Construction of the Conceptual Framework

This study's conceptual framework captures and consolidates the universe of factors that characterize and influence the health goals development process, as gleaned from planning

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19 The degree to which theory is applied varies among the different types of case studies. Exploratory studies are often undertaken when the existing knowledge base is poor and the literature provides little to support the development of a conceptual framework or to generate study hypotheses. Although exploratory approaches aim to generate hypotheses, they must clearly state their purpose and the criteria on which they will be judged successful. They otherwise run the risk of proceeding aimlessly (See Appendix I, Box 2). Theory helps to specify what is being explored in exploratory studies. Explanatory case studies rest firmly on theory where hypotheses are tested, and in some cases, rival theories are proposed and tested to clearly delineate causal relationships related to the issue under examination. In descriptive studies, theory guides decisions about important design issues such as (a) the purpose of the descriptive effort, (b) the full (yet realistic) range of topics to be considered for a complete description of the issue under examination, and (c) the likely topics that will be the "essence of the description" (Yin, 1994).
theory and the published and source document literature. Constructing the health goals framework entailed three steps: (a) identification of the major themes or factors associated with health goals development, (b) establishing operational definitions of framework themes, and (c) establishing face and consensual validity of the health goals framework. Each step was guided by and drew upon the expertise of senior members of the research team; comprised of individuals with experience and background in health goals development, health planning, health policy and health reform. The three steps undertaken in the construction of the conceptual framework are detailed below.

Step 1. Identification of Health Goals Development Themes or Factors -- Category Development

Construction of the conceptual framework began with a combing through of the literature on health goals with the aim to identify the major themes or factors associated with health goals development. This process is characterized differently by different writers on qualitative data and experts in content or documentary analysis. Some speak of reviewing materials for the purpose of “category development,” (Strauss, 1987; Babbie, 1989) or for “creating codes,” (Miles & Huberman, 1994), or for the “identification of 'bins' of intellectual variables” (Miles & Huberman, 1994). Although no easy way exists to describe the tactics involved, developing categories in documentary analysis should (a) be consistent with the research questions being asked, (b) be related to the properties of the phenomena under examination, and (c) be logically linked to or grounded in the materials being reviewed (Morgan, 1993; Miles & Huberman, 1994).

In this study, the researcher reviewed the literature to develop categories to reflect the multiple activities and processes that are undertaken as a part of health goals development.
Primarily, categories were developed through inductive techniques.\textsuperscript{20} Gathered materials were reviewed section by section. This study did not endeavour fine coding;\textsuperscript{21} in most cases, coding occurred paragraph by paragraph, and in some cases by larger sections. Each section was labelled with a word that best described it. The list of labels was reviewed. Typically, several labels were collapsed into more abstract categories, which grouped together similar incidents or observations. Each category received a code or tag to help organize “chunks” of descriptive information compiled during the documentary analysis (Miles & Huberman, 1994). In this study, applying tactics associated with documentary analysis yielded a final list of codes which reflect the major themes or factors that comprise the health goals framework; described, in most cases, in language associated with health planning concepts.

**Step 2: Operationally Defining Framework Themes**

Category development paralleled an exercise to define operationally each theme that comprised the health goals framework. Operationally defining themes meant setting the outside parameters for each theme while attempting to accommodate variations in themes across the six sample jurisdictions. Procedurally, operational definitions were developed through an iterative process of going back and forth from the literature to the framework to identify the multiple

\textsuperscript{20} Categories developed by researchers in documentary analysis can be determined inductively, deductively, or by some combination of both (Abrahamson, 1983; Strauss, 1987). An inductive approach begins with the researchers “immersing” themselves in the documents in order to identify the “dimensions or themes” that are meaningful to each piece or document (Abrahamson, 1983). A deductive approach typically uses some categorical scheme suggested by a theoretical perspective, and the documents provide a means for assessing the hypothesis. Some aspects of a deductive approach to category development entered into the category development process due to the researchers familiarity and knowledge of planning concepts and theories. This was particularly relevant to developing the operational definitions of the framework themes discussed below, where in many cases, themes were defined in relation to concepts associated with planning theory.

\textsuperscript{21} Approaches to category development vary in the level of coding. Identifying themes or categories may involve very fine coding where the researcher typically codes words, phrases or sentences, which is often the approach taken in grounded theory. The level of coding is less specific when the intent is to draw out larger conceptual issues related to the issue under examination.
attributes or dimensions related to each theme. Miles and Huberman (1994) capture the necessity of clearly defining themes: “Clear operational definitions are indispensable, so they can be applied consistently by a single researcher over time and multiple researchers will be thinking about the same phenomena as they code” (p. 63). This effort was particularly important to later stages of the research project where the operational definitions supported the coding of data and assisted in the interviews by providing a scaffolding for probing and follow-up questions.

Taken together, Step 1, the identification of major themes, and Step 2, operationally defining themes, resulted in a health goals framework that consisted of three phases, seven components, sixteen themes or factors, and over one-hundred dimensions or attributes. (Please note that the terms “factors” and “themes” are used interchangeably throughout this paper as are the terms “attributes” and “dimensions”). Please refer to Appendix E for a full display of the conceptual framework and to Appendix J for operational definitions of framework themes.

Step 3: Establishing Face and Consensual Validity of the Conceptual Framework

Ongoing debate and discussion of the health goals framework and operational definitions during project meetings (averaging four investigators, including the author) that spanned a four-month period established face validity of the health goals framework. As the framework evolved, the researcher would typically share draft iterations with colleagues to refine and reorganize the major categories (themes) and their definition and to reclassify subthemes. The project team then circulated the conceptual framework and operational definitions to a panel of experts for a second level of face validity and to establish consensual validity. Consensual validity refers to the degree to which the framework fits with the perception of multiple people who have experience with health goals planning. Three individuals, each representing one sample jurisdiction, and
each with direct knowledge and experience in health goals development, reviewed the health goals framework and the operational definitions. More particularly, the researcher asked them to consider the following question:

*Based on your experience and knowledge of health goals development, have we missed any key processes, mechanisms, structures, or factors of health goals development in our health goals framework; are there any gaps or deficiencies that we have overlooked that we need to fill or any misunderstandings that we need to correct?*

The researcher solicited feedback on the framework through one-hour, taped telephone conversations, then had these transcribed. Panel members agreed that the health goals framework was comprehensive and with a few modifications that it adequately captured the key themes or factors related to health goals development. Suggestions for revisions were directed mainly at the various dimensions or attributes associated with each theme. In most cases this meant an expanding of the definition to better capture the experience of the contributing experts in their respective jurisdictions. The project team considered and debated revisions or adjustments suggested by the panel which were then incorporated into the framework as deemed appropriate.

**Characterizing the Conceptual Framework**

Several descriptors can be used to characterize the health goals framework. Basically, the health goals framework is an organizing system that is informative, comprehensive, and representative; and is meant to be flexible and adaptable. The framework comprises various parts that (a) do not reflect sequential ordering, meaning the various parts of the framework do not necessarily play out in the order presented in the framework; (b) are not weighted; and (c) are not independent, and are not mutually exclusive, that is, some dimensions may fit into more than one theme category. Table 9 summarizes the defining characteristics of the conceptual framework.
Table 9: Characterizing the Health Goals Framework

<table>
<thead>
<tr>
<th>What it is</th>
<th>What it isn’t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informative</td>
<td>Prescriptive</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Sequential</td>
</tr>
<tr>
<td>Representative</td>
<td>Weighted</td>
</tr>
<tr>
<td>Flexible and adaptable</td>
<td>Mutually exclusive</td>
</tr>
</tbody>
</table>

Application of the Conceptual Framework

Within this case study, the health goals framework supported the following functions: (a) data collection, by providing a basis for the interview instrument; (b) data management, by providing an orderly way to organize and code the data; and (c) data analysis, by offering a systematic approach to the interpretation of the qualitative interview data and BC source documents. Subsequent sections of this chapter discuss in detail the application of the framework in relation to these functions.

Data Collection: Sample, Instrument and Methods

This section describes the various methods and procedures applied during the data collection phase of this study. It includes discussion on (a) preparing for data collection, (b) sampling strategy, (c) the data collection instrument, (d) approach to interviews, (e) conducting the interviews, (f) gathering source documents, and (g) securing the data.

Preparing for Data Collection

Before collecting any data, the researcher obtained support for the study from the Office of the Provincial Health Officer (OPHO) to maximize access to key individuals, information and
source documents; and to optimize participation in study interviews. Two individuals offered letters of support: (a) the Provincial Health Officer, whose office coordinated and managed all aspects of the health goals initiative and guided and directed its progress over time; and (b) a university professor with expertise in areas related to health goals seconded to support the health goals project. The research team sought and received ethical consent to proceed with the study from the Behavioural Research Ethics Board at the University of British Columbia. Refer to Appendix K for a copy of the UBC ethical consent form.

**Sampling Strategy**

As discussed in Chapter 1, individuals and groups who participated in the BC health goals development process represented four subgroups: (a) regional health boards, (b) provincial ministries, (c) provincial stakeholder organizations, and (d) the Office of the Provincial Health Officer. These subgroups comprised this study’s sample.

Identification of the study sample began with a meeting between the researcher and the university professor seconded to the health goals project. Although the professor offered some valuable information, he suggested that the researcher meet with the health goals project consultant hired by the OPHO to coordinate the health goals initiative. The project consultant helped to identify those individuals most involved in the health goals development process, those who could provide the richest description of the development process, and those who would be most open to an invitation to be interviewed.

A purposive sample characterized the study sample. “Those most involved and

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22 The “regional health boards” subgroup included individuals directly associated with the boards as well as the public at large. The regional health boards represented the mechanism for public consultation.
interested" represented the overarching criterion for inclusion. Additional criteria were applied to each of the four subgroups: selection of regional health boards was based on geographic representation; selection of provincial ministries included those most likely to influence the multiple determinants of health; and, selection of provincial stakeholder organizations sought to reflect a range of health-related interests and orientations. The last group, the Office of the Provincial Health Officer, comprised the key informants of the study and included regular paid staff as well as seconded and consultant support.

In total, the sample consisted of twenty-three individuals. Table 10 below displays the four subgroups involved, the total number participating in the health goals project from each subgroup, the total number interviewed from each subgroup, and the selection criteria applied to each subgroup.

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Total Number Participating in Health Goals Project</th>
<th>Total Number Interviewed</th>
<th>Selection Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Health Boards</td>
<td>20</td>
<td>5</td>
<td>- Most involved/interested</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Geographic mix</td>
</tr>
<tr>
<td>Provincial Ministries</td>
<td>18</td>
<td>5</td>
<td>- Most involved/interested</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Representative of health determinants</td>
</tr>
<tr>
<td>Provincial Stakeholder</td>
<td>100</td>
<td>8</td>
<td>-Most involved/interested</td>
</tr>
<tr>
<td>Organizations</td>
<td></td>
<td></td>
<td>- Range of health-related interests and orientations</td>
</tr>
<tr>
<td>Office of the Provincial</td>
<td>6</td>
<td>5</td>
<td>- Key informants (most involved in overall initiative)</td>
</tr>
<tr>
<td>Health Officer</td>
<td></td>
<td></td>
<td>- Included OPHO staff and seconded and consultant support</td>
</tr>
</tbody>
</table>
Data Collection Instrument

Data collection consisted of semi-structured interviews and source document collection. Semi-structured interviews were particularly suited to this inquiry by effectively guiding discussion framed by pre-established questions while allowing for some deviation from the interview agenda (Skodol Wilson, 1993). The study’s conceptual framework generated the semi-structured interview guide. Each of the sixteen major themes of the health goals framework constituted a main question while the various dimensions of the health goals framework provided the basis for follow-up questions.

Rubin and Rubin (1995) consider main questions to be focused, linked questions that provide direction to the interview; they cover an overall process, event or subject, and divide and organize the research topic in ways that make sense (such as phases in a process, or parts of a concept, or roles of actors). Main questions may be stimulated by observations, by literature, or by documents. They are generally worded broadly enough to encourage open answers from participants, yet narrowly enough to provide the necessary data (Rubin and Rubin, 1995). Follow-up questions are more specific and create a “scaffolding” for the interview (Rubin and Rubin, 1995). They help to keep the questioning on topic and to link what is asked in individual interviews to the overall interview design. Further, follow-up questions allow the researcher to get richer, more in-depth answers; to explore themes and concepts fully; and to clarify, test, and modify existing themes (Rubin and Rubin, 1995). The health goals framework offered a solid basis from which main and follow-up questions were generated to guide interviews with individuals who participated in the BC health goals process.
**Approach to Interviewing**

The approach to interviewing taken in this study parallels what Rubin and Rubin (1995) refer to as *topical interviewing*. These authors differentiate between two major types of qualitative interviewing. *Cultural* interviews are about how people see, understand and interpret their worlds. In cultural interviews, interviewers spend most of their time listening to what people say rather than asking detailed and focused questions. Researchers conducting cultural interviews ask about shared understandings, taken-for granted rules of behavior, and standards of value and mutual expectations. The aim is to examine what people have learned through experience and passed along to others. *Topical* interviews are focused on topics that the interviewer has chosen, involve more active questioning and rapid exchanges, and are more concerned with specific information than with eliciting meaning (Rubin and Rubin, 1995). Researchers use topical interviews to learn about particular events or processes and to explore what, when, how and why something happened.

Additionally, this study applies what can be called a *tree-and-branch* approach to interviewing (Rubin and Rubin, 1995). The *tree-and-branch* approach is most commonly used in combination with topical interviewing. In this method, the interview is “likened to a tree,” where the trunk represents the core topic; and the branches, the main questions. The main questions establish the overall sequence of what is asked and the researcher plans the questions to explore each branch with more or less the same degree of depth. A tree-and-branch model covers a topic as a whole and maintains its coherence because each question relates to a part of the broader topic. Typically, this approach is applied when a researcher “knows from previous interviews, observations, or background reading that certain main questions must be asked in order to cover the entire subject” (Rubin and Rubin, p. 159). This model is particularly helpful when the
interviewer has an overall topic worked out and wants to paint a complete picture by exploring the separate parts that go together. Within this model, the interviewer balances the time for follow-up questions (for depth and detail) with the goal of asking about each main question.

The river-and-channel interviewing style constitutes an alternative approach to the tree-and-branch model (Rubin and Rubin, 1995). It is most commonly used with cultural interviewing. The river-and-channel endeavours to explore one theme in depth and detail -- often at the exclusion of other themes. Because this study aimed for full coverage of framework themes, the river-and-channel approach was less compatible than the tree-and-branch approach.

Conducting the Interviews

The researcher administered twenty-three interviews between July 1997 and September 1997. Typically, two interviews were conducted each week, except when data collection took place on Vancouver Island. Island interviews took place on consecutive days to limit costs associated with travel. Once interviews were booked, a letter of introduction was faxed or mailed to the interviewee to confirm the date, time and place of the interview. It outlined also the broad topics to be covered during the interview and notified the interviewee that the interview would be taped. (See Appendix L for a copy of the letter of introduction.) Upon arriving at the interview site (at a location most convenient to the participant), the researcher offered some background information on the provincial health goals initiative and elaborated on the aims of the study. The interviewee then read and signed the interview consent form, the tape recorder was readied for taping, and the questioning began. (See Appendix M for a copy of the consent form.)

23 In the river-and-channel approach, the interview questions explore "one current within the main river" and follows it no matter where it goes. In this model a main question is asked and followed by many cascading probes or follow-up questions. Each follow-up question builds on the previous one within a single theme. This model is most helpful when the intent of the research is to explore one theme in detail and to understand it well.
Each interview commenced with an open-ended question for the purposes of (a) situating the participant in relation to the health goals initiative and (b) allowing the participant to speak openly for a few moments about his or her role in the health goals development process. Typically, each study participant was asked all sixteen main questions and thereby provided input on each of the major themes or factors that comprise the health goals framework. Appendix N provides a listing of the main questions that constituted the master interview guide. On a few occasions, main questions were skipped when, for example, it became obvious from answers to early questions that an interviewee would have little to contribute to later questions.

Follow-up questions, based on the various dimensions that comprise the health goals framework, showed greater variation across interviews. Follow-up questioning endeavoured to seek in-depth answers and to touch on (and, provide broader coverage of ) the multiplicity of dimensions that comprised the health goals framework. The level of follow-up questioning depended on the participant’s (a) level of involvement in the health goals process, (b) knowledge of issues related to health goals development, and (c) overall familiarity or experience with health planning. Typically, representatives from the OPHO received more follow-up questioning than representatives of the other subgroups, since they were most intimately involved with the development process and most knowledgeable about the issues at hand. This was reflected in the length of interviews. Interviews with representatives from regional health boards, provincial ministries and provincial stakeholder organizations routinely spanned ninety minutes; while interviews with representatives of the OPHO usually ran two hours, and in a few cases, up to two hours and thirty minutes.

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24 An open-ended question also concluded each interview, where participants were asked whether they felt the researcher (based on their experience) touched on all the key elements of health goals development; they were invited also to make additional comments or provide additional information.
At the completion of each interview, the researcher prepared interview-specific notations. Researcher notations commented on (a) the overall qualities of the interview such as the “mood” of the interview, the rapport that was established, and the willingness and eagerness of the interviewee to answer questions; (b) various methodological or procedural issues such as the coverage of the interview questions, the level of probing and follow-up questions, and reflection notes on how the interview was administered; and (c) the researcher’s perception of the interviewees overall contribution to the topic under examination and any unique contributions and insights provided by the interviewee. This kind of note writing allowed the researcher to reflect on each interview, to provide a sense of closure of each interview, and to contemplate how the next interview could be improved or adjusted.

Data Collection: BC Source Documents

Data collection included also the gathering of BC source documents. Early on in the data collection phase, source documents related to the health goals development process were gathered from the Office of the Provincial Health Officer. The OPHO granted access to project files and provided consent to copy relevant materials. Materials acquired included (a) various summary renditions of the BC health goals (and objectives, indicators, targets, and strategies), (b) several progress reports that traced the project over time, (c) various written submissions (feedback) from persons and groups who participated in the development process, (d) project time lines and schedules, and (e) some project meeting notes.

Securing the Data

All audio interview tapes, interview transcripts, signed consent forms, and computer
diskettes were filed and stored in a locked cabinet in the researcher's home-office. Interview transcripts and tapes were identified by a code name and subgroup label. Source documents also received a code (mainly for data input purposes, discussed later), and were similarly stored in safe-keeping. Consistent with standard practice at the University of British Columbia, copies of interview transcripts stripped of unique identifiers will be kept for three years following the completion of the researcher's doctoral program. Finally, the researcher adopted what Yin (1994) refers to as the "three principles of data collection in case study research," detailed later in this chapter, to ensure sound data management (as well as increase the overall reliability of the case study).

Data Analysis: Data Reduction, Display, and Analysis Procedures

This section outlines the various methods applied to analyse the qualitative data collected in this study. It includes discussion on (a) the overall analytic strategy, (b) transcription of taped interviews, (c) coding of interview transcripts and source documents, and (d) detailed data analysis and write-up.

Miles and Huberman (1994) view the analysis of qualitative data as a process that entails three concurrent activities: (a) data reduction, (b) data display, and (c) conclusion drawing and verification. *Data reduction* refers to the process of selecting, focusing, simplifying, and transforming the data. This step includes the researcher's choices of what data to code, which data to extract, and which segments of data yield patterns. *Data display* is a spatial representation of the data which helps to organize the data into understandable formats, view large amounts of

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25 Yin's (1994) three principles of data collection include: (a) creating a case study database, (b) maintaining a chain of evidence which is established as a part of the case study protocol; and (c) triangulation or multiple sources of data in order to demonstrate "converging lines of inquiry."
data, and establish the framework for drawing and verifying conclusions. Finally, conclusion drawing refers to the process of inferring substantive meaning from the data.

Yin (1994) claims that the analysis of case study data is especially difficult because strategies and techniques have not been well defined, making the “analysis of case study evidence one of the least developed and most difficult aspects of doing case studies” (p. 102). Without a clear approach to data analysis, investigators might become stalled during the data analysis stage and the study may falter. Yin (1994) suggests two strategies to facilitate and successfully complete the analytic phase of the research: (a) the establishment of an overall analytic strategy, and (b) the application of various analytic techniques and procedures.

Overall Analytic Strategy

The overall analytic strategy that guides this study, and the preferred strategy according to Yin (1994), relies on propositional statements. Linking data to propositional statements follows a pattern-matching logic (Campbell, 1975; Trochim, 1989; Yin, 1994), where an empirically-based pattern is compared to a predicted pattern of specific variables that were defined prior to data collection. This case study follows a pattern-matching approach whereby data from interviews and source documents were compared to a theoretical and empirically-based pattern that comprises the health goals framework. In this way, the researcher was able to assess the “fit” of the BC case (health goals experience) against the more generalized health goals framework (reflective of the experience of multiple jurisdictions). The health goals framework and propositional statements presented in Chapter 2 facilitated the analysis of the case study evidence.

While an overall analytic strategy sets the context for data analysis, various analytic...
tactics and techniques, which are more procedural in nature, facilitated the detailed analysis of qualitative data. These include noting patterns and themes, making contrasts and comparisons, clustering, counting, making metaphors, factoring, subsuming particulars into the general, and noting relations between variables (Yin, 1994; Miles & Huberman, 1994). A later section of this chapter presents discussion on the specific tactics used to support data analysis in this inquiry.

Transcription of Taped Interviews

Twenty-three interviews that comprised this study generated approximately fifty hours of tape. A professional transcriber required between 3.5 to 4.5 hours transcribing for every one hour of tape recorded interview. Transcription time increased in those instances complicated by background noise; or when the interviewee spoke with a faint voice or where words were muttered or garbled.

Several steps characterized efforts to promote quality and consistency of transcription in this study. First, the researcher worked with the transcriber to develop a set of transcription guidelines. Guidelines specified that testimony be recorded verbatim, that pauses and incomplete sentences be indicated with standard notations, that indiscernible words be blocked in brackets, and that loud or emphasized words or phrases be capitalized. Second, the researcher undertook spot-check reviews of a total of six of the transcripts (25%). Transcripts were reviewed while the tape was running; and errors were noted, corrected, and discussed with the transcriber. Finally, the researcher, transcriber, and software consultant discussed transcription techniques in advance of any transcription to ensure that transcripts were produced in a format consistent with the software package chosen to support analytic functions.
Coding of Interviews and Source Documents

Coding represents one form of *data reduction* which is defined by Miles and Huberman (1994) as “the process of selecting, focusing, simplifying, abstracting, and transforming the data” that appear in transcriptions, field notes and documents (p. 10). The health goals framework (and associated operational definitions of framework themes) guided the coding of interview transcripts and source documents. A computer software program called NUD*IST 4.0, an acronym for Nonnumerical Unstructured Data Indexing, Searching and Theorizing, supported the data analysis. NUD*IST is a multifunctional software system for the development, support and management of qualitative data analysis projects. NUD*IST has the ability to both document and index data which supports the creation and effective manipulation of concepts, themes and categories. NUD*IST allows the researcher to stay close to the data and to preserve context, to maintain a documentation trail, to process high volumes of data, to test hypotheses and counter hypotheses, and to pursue rigorous examination of data with depth and breadth. For these reasons, NUD*IST has quickly become one of the preferred software packages for the analysis of qualitative data (Weitzman and Miles, 1994), and was the software of choice for the analysis of interview and source document data in this study.

Several steps characterized the coding process undertaken in this study. First, the health goals framework was incorporated into NUD*IST and all themes and dimensions that comprise the framework were assigned a numerical address or code. This generated a coding scheme comprised of 116 numerical codes organized under 16 major code categories. (See Appendix O for coding scheme.) With a coding scheme in place, a copy of the interview transcript was generated where transcript text was organized into text units (paragraphs) so that NUD*IST generated numerical codes could be attached. The researcher carefully reviewed each transcript
and made judgements as to which NUD*IST generated numerical codes (representing the various themes and dimensions) would be assigned to which chunks of data (text units). Check-coding (Miles & Huberman, 1994) was applied across two data analysts. The researcher and project coordinator coded some of the same data sets, discussed difficulties that arose, and established levels of agreement for subsequent data analysis and categorization. This practice is consistent with tips suggested by Miles and Huberman (1994) for improving reliability and establishing definitional clarity. Finally, operational definitions which clearly defined and set the parameters for each theme and dimension of the health goals framework, guided the coding process.

Reliance on the operational definitions further enhanced coding consistency across transcripts.

Text units were copied to more than one NUD*IST address when a particular chunk of data related to multiple framework themes or dimensions. Further, chunks of data considered by the researcher to be important, but that did not “fit” into any of the established codes (based on the operational definitions); were grouped into new categories, assigned new codes, and tallied on a separate coding sheet titled “New and Emerging Themes/Dimensions.” In this way, revelatory or important data that did not match with the original framework was not lost or ignored; rather it was integrated into the coding scheme for consideration during detailed analysis to take place at a later time. Computer entry of codes from each transcript signalled the end of the coding process for that particular transcript.

Source document coding underwent a similar process whereby the health goals

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26 For example, the NUD*IST assigned numerical code for “data sources” was (2 5 12 3); any paragraph in the transcript that was related to data sources was coded (2 5 12 3) and copied to that address in the NUD*IST indexing system. When the coding was complete, texts units relating to data sources from all 23 transcripts were stored at that particular address in NUD*IST. Having all text units relating to each theme/dimension at one location allowed the in-depth analysis to proceed in an orderly and efficient manner.
framework guided the coding effort. Source documents, however, were not integrated into the NUD*IST document system (as were the interview transcripts). Rather, each source document in its entirety received a NUD*IST address code where notations were made as to (a) its title, (b) how it related to the themes and dimensions of the health goals framework, (c) the page numbers where relevant data could be located, and (d) whether it included any “new and emerging themes.”

The coding process was labour-intensive. Generally, transcript coding ranged 3 to 7 hours (depending on length), and data entry of transcript codes extended over 1 to 2.5 hours. Time dedicated to source document coding varied widely, based on length and type of material. The entire coding process spanned a three-month period.

**Detailed Data Analysis and Write-Up**

The themes and dimensions of the health goals framework guided the detailed data analysis and write-up of study findings. The data analysis technique can be characterised broadly as thematic analysis, which involved a systematic review of the data, theme-by-theme. The data was combed through several times; the first time for familiarity. During subsequent readings, the researcher checked for consistencies, similarities, and contradiction of participant responses; summarized key testimony related to each theme; and flagged potential quotes that exemplified certain perceptions, phenomena, or ways of thinking. Specifically, thematic analysis allowed the researcher to: (a) comprehensively review the data associated with each theme of the health goals development process; (b) assess participant perceptions on which factors were the most influential and which factors challenged and facilitated health goals planning; (c) consider the “fit” between the BC health goals exercise, the health goals framework, and established planning.
models; and (d) generate hypotheses related to future research and practice.

The researcher relied on a number of established analytic tactics and techniques (Miles & Huberman, 1994) to make sense of the data, including (a) noting patterns in participant responses while remaining open to evidence that may disconfirm the pattern, (b) clustering which involved aggregating and sorting similar and dissimilar concepts or characteristics (and possibly themes and dimensions), (c) counting to determine "the number of times" in order to establish representativeness of participant perceptions (i.e. most, many, several, some, few, etc; See Appendix S) and to make judgements about consistency; (d) making contrasts and comparisons between sets of issues or entities that differ in various respects, and (e) noting relationships between various variables.

Write-up of study findings flowed from the research questions and involved writing descriptively about how each theme played out in the BC case and providing examples of each theme with quotations from the data. Thematic writing was supplemented by the use of data displays. Marsh (1990) describes data display as a "spatial representation [of data] that allows the researcher to organize data into a compact form and that establishes the framework for conclusion drawing and verification" (p.55). Data displays support in-depth data analysis by presenting data in an orderly and succinct manner through the use of tables, matrices, graphs, and charts (Miles & Huberman, 1994). Further, data displays simplify the analysis process by condensing large amounts of data into understandable formats, by easily communicating findings, and by stimulating the researcher to look at data in new ways (Marsh, 1990; Miles & Huberman, 1994). This study applied two types of descriptive data matrices: (a) conceptually clustered matrices which "order the display by concepts or variables [and] bring together items that 'belong together'" (Miles & Huberman, 1994, p. 127); and (b) event listing matrix, a type of
time-ordered display that arranges specific events of a process or phenomena either by some arbitrary standard (such as month or year) or by empirically-derived phases or stages.

Not only did descriptive data displays simplify the analytic function in this study, they helped also to establish quality of findings (Marsh, 1990, Miles & Huberman, 1994). Within the framework of Guba and Lincoln’s (1985) four criteria for assessing trustworthiness of findings from qualitative data, matrices help to establish (a) credibility by presenting data in a physical form that can be shared with other members of the research team or experts in the field to test the various categories that comprise the matrix and the conclusions that were drawn; (b) transferability in single case studies (where analytic generalizability can be established by using matrices to compare findings against theoretical constructs), and in multiple case studies (where matrices support the comparison of findings across sites); (c) dependability by using matrices to display and make transparent the processes, procedures and tactics used by the researcher (which can then be duplicated by others); and (d) confirmability by helping the researcher to account for decisions that are made and to thereby establish and follow practices that promote relative neutrality and freedom from biases in interpretation of study findings.

Assessing the Quality of Case Study Research

If case study is considered to be one of the five major social science research strategies, then tests to establish the quality of empirical social research must also be applied to case studies,

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27 Alternative terms are used by other researchers to refer to the four criteria established by Guba and Lincoln (1985): for credibility, authenticity and internal validity; for transferability, fittingness, external validity; for dependability, reliability and auditability; and for confirmability, objectivity.
particularly in relation to the study’s validity and reliability (Kidder & Judd, 1986; Yin, 1994).\textsuperscript{28} External validity is concerned with “establishing the domain to which a study’s findings can be generalized” (Yin, 1994, p. 33) and has presented the greatest challenges to case study researchers. Consistent with Yin’s approach to case study quality issues, external validity has been addressed in this study by generalizing study findings not to other cases or jurisdictions; rather, findings have been generalized to theory. Yin (1994) acknowledges that while critics of case study typically state that “single cases offer a poor basis for generalizing,” this challenge can be met by understanding that the aim of case studies is to strive for “analytic generalization,” where the goal is to generalize from the case to a set of a priori theoretical propositions or to expand and generalize theory; versus “statistical generalization,” characteristic of experimental strategies, which aim to generalize from a “sample” to a universe or to enumerate frequencies of variables (Yin, 1994)

Reliability, another significant test for the quality of case study research, endeavours to minimize the errors and biases in a study by demonstrating that study operations and procedures can be repeated, with the same results (Kidder & Judd, 1986; Yin, 1993; Yin, 1994). Full and accurate documentation of study procedures is required to allow the study to be repeated by the original investigator or another investigator. Neglecting careful documentation of case study research procedures has added to the criticism of the case study method and led “external reviewers [to be] suspicious of the reliability of the case study” (Yin, p. 37).

Two techniques, as suggested by Yin (1994), have been applied in this case study to meet

\textsuperscript{28} Generally, the notions of external validity and reliability are most important to descriptive case studies. Internal validity is relevant to explanatory studies concerned with establishing a causal relationship, “whereby certain conditions are shown to lead to other conditions, as distinguished from spurious relationships” (Yin, 1994, p.33).
the tests of reliability: (a) the development and application of a case study protocol, and (b) the development of a case study database. The case study protocol is “a major tactic in increasing the reliability of case study research and is intended to guide the investigator in carrying out the case study” (Yin, 1994, p. 63). The case study protocol includes the data collection instrument as well as the procedures and general rules that guide the use of the instrument. Depending on the purpose of the case study and the phenomenon under examination, the case study protocol typically consists of: (a) a succinct overview of the case study project that includes project objectives, case study issues, and relevant literature about the topic being investigated, (b) field procedures for obtaining access to case study sites, general sources of information, case study key contact persons, and procedural reminders, (c) case study questions such as interview questions that the case study investigator follows in collecting data and potential sources of information for answering each question, and (d) a guide to support the writing of the case study report, taking into consideration the audience of the report and including any bibliographical information and other documentation. Appendix P presents the case study protocol that guided this case study.

Development of a case study database further increases the reliability of this case study by providing a way to organize and document the data that is collected. The central aim of the case study database is to ensure that documentation consists of two separate collections: (a) the data or evidentiary base, and (b) the report of the investigator, whether in article, report, thesis, or book format (Yin, 1994). Secondary data analysis accounts for the principal reason for separating these two collections. Only if the case study data is held separate from the case study report, can the database be “the subject of a separate, secondary analysis, independent of any reports by the original investigator” (Yin, 1994, p. 95). Several types of data typically constitute a case study
database such as investigator case study notes, case study documents, various tabular materials to organize data, researcher narratives, and case study interview tapes and transcripts (Yin, 1994). Appendix Q details the development and management of the case study database in this study.

Limitations of the Study

Earlier sections of this chapter referenced some limitations associated with this study. Several challenges applicable to this study rest on the case study design, including (a) the difficulty in generalizing patterns and trends from a single incident to other situations or jurisdictions; (b) the amount of time required to conduct the study and a reliance on lengthy narrative write-ups, and (c) poorly developed data collection and analysis methods, leading some to view the case study method as lacking in rigour. As noted above, techniques to overcome problems related to data collection and analysis within a case study design include establishment of a case study protocol, development of a case study database, use of propositional statements, and application of data displays. Yin suggests also a set of commonly desired skills that may be learned and practiced by case study researchers to facilitate effective case study research. (See Appendix R.)

Consequences of a purposive sample posed another study limitation. "Those individuals most involved and interested" constituted the overarching criteria for inclusion into the sample which comprised representatives from regional health boards, provincial ministries, provincial stakeholder organizations, and the Office of the Provincial Officer. Interviewees were chosen based on their ability and willingness to provide the richest description of the health goals development process. This may have biased the study findings by excluding individuals or groups who did not support the health goals or who were skeptical of the development process.
Even though this study did not collect data from parties with cynical views of the BC health goals initiative, some data relating to their perspectives emerged from individuals who participated in this study.

Semi-structured interviews present additional challenges. Interviews based on a semi-structured design are time-consuming for both data collection and data analysis, and interview findings are limited to the perspectives of those who participated in the study. Although study interviews endeavoured to have participants speak openly about their perceptions of the BC health goals process, respondents could have inadvertently or intentionally withheld comments they would normally share, conscious of being taped; or conversely, in their enthusiasm to share their experience, portrayed themselves and the process in the most favorable light. Finally, the potential exists for recall bias to have influenced data integrity since interviews took place about two years after interviewee participation in the health goals process. Despite its limitations, the study design adopted for this inquiry is compatible with the its purpose and objectives.

Chapter Summary

This chapter has outlined the various methodological strategies and processes that guided the examination of health goals development in BC. It began with a brief discussion on the general study methodology; characterizing this study as a single, descriptive, holistic case study that draws upon both inductive and deductive reasoning within a postpositivist research paradigm. It established also the rationale for the adoption of the case study approach. The

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29 Semi-structured interviews are also advantageous by (a) allowing for the introduction of thoughts and observations particularly relevant to a respondent’s personal perspective on the issue under examination, and (b) offering the interviewer more flexibility in moving between content areas, to follow-up on cues, and to spend differing amounts of time interviewing various participants (Skodol-Wilson, 1993).
chapter then moved to a discussion on methodological specifics concerning the construction and application of the study's conceptual framework. Highlights of data collection methods and strategies followed and included discussion on: the purposive sampling strategy, the development of the semi-structured interview guide, the topical and tree-and-branch interviewing approach, conducting the interviews, collection of BC source document materials, and methods applied to secure the data. The chapter then detailed the various data analysis procedures applied, including transcription of taped interviews, data reduction techniques related to coding, and tactics for detailed data analysis including thematic analysis and data displays. The chapter closes with comments on the criteria for assessing the quality of case study research and some observations on study limitations.
CHAPTER 4: FINDINGS

This presentation of findings mirrors the health goals framework that underpins this study. The main headings of this chapter (in bold font) represent the sixteen major themes that constitute the health goals framework; the subheadings (in block font) represent the various dimensions that are associated with each theme and for which data are reported on in this study.

This chapter presents a considerable amount of interview and source document data related to framework themes and associated dimensions. The reader will benefit by referring to Appendix J: Operational Definition of Framework Themes to follow along with the presentation of findings. Appendix J provides detailed definitions of the 16 themes and over 100 dimensions that comprise the health goals framework and provides an outline for the report on findings presented below. This chapter also reports on dimensions that arose from the data apart from the health goals framework (referred to as “emergent dimensions” here). Tables at the end of each of the three phases that subdivide this chapter summarize factors that facilitated or obstructed the BC health goals development process, as perceived by study participants.

The findings seek to answer the following four research questions:

1. What factors, as perceived by participants in BC, obstructed or facilitated the formulation and articulation of health goals that were considered for submission, or adopted by,

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30 Because the presentation of findings follows the health goals framework, some data reporting may be redundant across dimensions. Chapter 5 deals with the redundancy issue by proposing suggestions for modification and refinement of the health goals framework that include the collapse and integration of some themes and dimensions.

31 Please refer to Appendix J to facilitate the reading of this chapter, and to support clarity and understanding of study findings.
the Cabinet of the government of British Columbia?

2. Which aspects of the BC health goals setting exercise fit best with the established planning models and what does the BC experience suggest for the application of existing models for goal setting in health?

3. What recommendations can be drawn from the goal-setting experience in British Columbia to guide and inform further study on the formulation and articulation of provincial health goals?

4. What implications for planning practice can be drawn from this study for the formulation and articulation of health goals in other jurisdictions and at the regional or local level in BC?

Findings are presented in narrative supplemented by data displays. The report on findings related to each of the sixteen themes and associated dimensions of the health goals framework are presented below.

PART A: FACTORS INFLUENCING HEALTH GOALS DEVELOPMENT IN THE PREMONITORY PHASE

By definition, the premonitory phase of the health goals development process predates activities explicitly intended to develop health goals, but circumstances and conditions that

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32 Consistent with the narrative format, comments from study participants are identified and referenced by the study subgroup they represent: (a) comments from interviewees representing the Office of the Provincial Health Officer, which includes the contracted consultants, are referenced as “OPHO;” (b) comments from interviewees representing the regional health boards are reference by the abbreviation “RHB;” (c) comments from interviewees representing the various provincial stakeholder organizations are referenced by “PSO,” followed by the sector they represent (including health, public health, hospital, member health associations, special needs, business, forestry); and (d) comments from representatives of provincial government Ministries are referenced by either “health” or “non-health.” Further, terms to capture (quantify) the number of interviewees who subscribe to an opinion or share an understanding include “one,” “a few,” “some,” “several,” “many,” “most,” and “all.” Please refer to Appendix S for definition of these terms within the context of this study.
support initiation of the health goals process are identifiable in the jurisdictional environment. Factors associated with the premonitory phase set the context for health goals and motivate action toward a health goals agenda. Typically, health goals are contemplated during this phase which precedes any formal adoption or acceptance of health goals as a strategy for population health promotion.

This section describes findings associated with each of the themes of the premonitory phase in of the health goals development process in BC.

**Theme 1: Prevailing Circumstances**

Based on the experience in other jurisdictions, and captured in the health goals framework; demographic, social, political and economic conditions comprise prevailing circumstances that set the context for health goals.

**POLITICAL FACTORS**

In British Columbia, the ideological and philosophical stance of the government of the day was considered by some participants to be a key factor in setting the context for health goals in British Columbia. One study participant believed that a health goals approach "supported the general principles of the government of BC" and that interest in health goals was linked to the New Democratic Party (NDP) government's "broad philosophical and ideological overtones" (OPHO). A representative of the Ministry of Health supported this view and remarked that the NDP's "social kind of philosophy" was more conducive to the idea of health goals than would be "governments more conservatively inclined." Another interviewee agreed and linked the interest in broad population health goals to the governing political ideology: "Ideologically, I suppose... there are certain implications from a population-based perspective on health that are more..."
consistent with certain ideologies and less consistent with others” (OPHO).

One respondent considered political will and support for health goals at the executive level of the Ministry of Health to be a contributing factor to health goals in BC:

I think the Deputy at the time... was interested in [health goals] and supported them. You know, it takes that kind of support, at the level of the bureaucracy for these things to work, right? And at a high level... unless the executive is interested and on-side with it, those sorts of things tend not to take off (OPHO).

Finally, a representative of a regional health board believed that pressures placed on governments to demonstrate outcome achievement and performance monitoring at a systems level established a supportive context for health goals in BC:

A general movement in the public services sector towards outcome-based types of approaches and to monitoring performance and service quality... was one sort of an overriding thing, outside of the health care system, that probably facilitated goals being developed” (RHB).

ECONOMIC FACTORS

A few participants recognized the role of economic factors in establishing the context for health goals in BC. One interviewee suggested that the government “knew darn well that remedying [health problems] is very expensive” and that government’s interest in health goals was stimulated by the belief that health goals may lead to a greater focus on disease prevention and in the long run, cost savings. In the view of another interviewee, reduced transfer payments from the federal government to the province of BC and the development of the Canada Health and Social Transfer Fund “forced the provincial government to look at the balance between health, education and income assistance... and how [governments] should be re-directing... funds with reduced capacity” (Ministry, Non-health). Health goals, according to this interviewee, were envisioned as one possible mechanism to deal with reduced provincial fiscal capability.
Theme 2: Health System Environment

HEALTH REFORM

Just as various characteristics of the larger social-political-economic environment establish a context for health goals, so do the prevailing circumstances and conditions of the health system environment. Most participants viewed the BC health reform process as a significant factor in setting the context for health goals in BC. Closer to Home, the report of the 1991 Royal Commission on Health Care and Costs, and the force behind BC health reform; recommended the establishment of health system goals. In its response to the Royal Commission, the Ministry of Health expanded its own mandate and proposed the setting of broad population health goals. According to one participant, “in the absence of that mandate... I’m not sure if the government of the day would have said, ‘we need health goals’” (OPHO).

Several source documents that comment on the BC health goals initiative summarize health reform events that set the context for health goals in BC:

The 1991 BC Royal Commission on Health Care and Costs recommended that goals be established for the health system. As a result, the document New Directions for a Healthy British Columbia included a commitment to developing health goals, with a broad focus on all health influences, not just health care services (Interim Report on the Project to Develop Health Goals for British Columbia, June 10, 1996, Draft 2, p. 6).

Within the context of health reform, three factors influenced the context for health goals:

(a) the regionalization of health services, (b) the reorganization of the Ministry of Health, and (c) the expanded mandate of the Provincial Health Officer.

Several respondents believed that regionalization of health services contributed to a positive environment for health goals. As one respondent reported, “with all that change going on, there [were] opportunities to do new things... to bring the idea of the health goals forward”
A representative of a regional health board agreed and hypothesized that the health reform initiative motivated interest in health goals.

*Without the reform process there would be even less likelihood that the health goals would have been able to get very far because the reform process has actually opened up the opportunity for all sorts of questioning of how the health system works and what it's trying to achieve and where it is going... and so people have been receptive to the idea that maybe there should be some goals.*

Conversely, one interviewee suggested that the health reform process hampered the enthusiasm of some for health goals in the premonitory phase. This interviewee reasoned that regionalization was disruptive and distrusted by some, and that it discouraged discussion on health goals. In her view, “[regionalization] created an environment where people [were] less comfortable talking and less comfortable putting forth their ideas.” In turn, people in health agencies became “very defensive” and were more likely to react “in a closed manner” to new ideas such as health goals (PSO, Health).

A few participants attributed the reorganization of the Ministry of Health to a supportive context for health goals. A representative of the Ministry of Health suggested that the “demise of [the] Health Promotion [Branch]” and the creation of the Population Health Resource Branch helped to “institutionalize the determinants of health agenda,” paving the way for a population health goals “down the road”.

Finally, some study participants believed that an expansion of the mandate of the Provincial Health Officer, as a part of the provincial health reforms, contributed to a supportive environment for health goals in BC. According to a representative of the OPHO, one of the major contributing factors for consideration of health goals in British Columbia was “requiring the health officer to report annually to the Minister of Health on [the health of British Columbians]...against measurable targets.” The 1996 BC Health Act confirms this requirement.
and stipulates that:

Each year the Provincial health officer must give the minister a report on the health of the people of British Columbia including, if appropriate, information about the health of the people as measured against population health targets, and the minister must lay the report before the Legislative Assembly as soon as practical (Health Act, 1996, RS Chap. 179, p. 6).

HEALTH SYSTEM EFFICIENCY AND HEALTH STATUS

Two study participants viewed health system efficiency as a contributing factor to health goals in the premonitory phase. A representative of a regional health board believed that the interest in health goals in his community was due to an increased understanding by community members of the escalating costs of supporting the community hospital: “you know when people found out that [our hospital] cost $110 million dollars a year to run ... that sort of data ... generated interest [in health goals].” A high level government Ministry representative linked concerns about efficiency and effectiveness of the health system to health status and to interest in health goals: “Spending has being going up enormously without making a big difference in health status... we have had high spending and high technology and low results.” This respondent believed that health goals were viewed by some as a means to improve return on investment (in terms of health status) on resources invested in health.

HEALTH SYSTEM CAPACITY AND HEALTH SYSTEM SATISFACTION

In reflecting upon the early discussions of health goals in a northern community, one study participant believed that a low level of services contributed to a positive context for health goals in rural and northern regions. Claiming that “we don’t get the health care that’s available if [we] were living in Vancouver,” health goals were envisioned as a mechanism for increasing health system capacity in the north, as well as enhancing overall community satisfaction with the health system.
HEALTH SYSTEM REORIENTATION

Other participants spoke of an increased interest in reorienting the health system as a contributing factor to a positive environment for health goals. In the perception of interviewees, reorientation involves a shift in focus from illness and medical care to health promotion, disease prevention and a better understanding of the determinants of health that lay beyond the health system or sector. A representative of the Office of the Provincial Health Officer commented that “part of the context for health goals in BC was a focus on the broad determinants of health and getting people to recognize that there are other factors apart from... the health care system, which make populations healthy.” Another interviewee challenged this view and contended that a preoccupation with health care and health services characterized the health system environment in BC:

In truth, I think that in British Columbia, like a lot of provinces in Canada and Canada as a nation... is so focused on having the best health care system... I don’t think there has been a climate around health promotion or health goals or preventive health (RHB).

HEALTH LITERACY

Some study participants cited a general understanding of public and preventive health as a motivating factor towards health goals in the early days. Discussions centred on the role of public health nurses and their level of understanding (health literacy) about primary care practices and determinants of health and their tradition of working in preventive health care:

“Public health nurses, I think have been an unrecognized, unsung group of health promoters...when you gather them together and get them to talking, they talk about preventive health care. ... So I think they have a [health goals] orientation” (RHB). A policy analyst with the large member health association in the province concurred and credited his agency with
“doing a lot of ground work with nurses throughout the province to help them understand the
importance of primary health care, the social determinants of health and health goals as a part
of that.”

Emergent Dimensions

Study participants identified two additional factors that influenced the context for health
goals in the premonitory phase that were not a part of the health goals framework that guided this
study. They are: (a) peer pressure, and (b) research and academic precedence.

Peer Pressure

Interviewees believed that peer pressure -- the realization that all Canadian provinces as
well as many jurisdictions around the world had already developed health goals -- facilitated an
agenda for health goals in BC: “Every other province and territory had done [health goals]... so
that, you know, becomes kind of a reason even in itself sometimes (OPHO). Some interviewees
spoke of “being embarrassed” that BC was the only province without health goals: “So, yeah. I
think there was a sense that BC really was kind of backwards in being just about the only place
in the western world that wasn’t doing [health goals] (OPHO). Other interviewees saw the
lessons learned by others as a reason for BC to move forward with a health goals agenda.

In terms of facilitating things [in BC] is the fact that there had been health goals
developed in a number of other jurisdictions and [across] Canada... The fact that
there were lots of examples to look at, I think should be recognized as something that
paved the way for the development of health goals in BC” (RHB).

Research and Academic Precedence

Several interviewees cited the state of knowledge about the multiple influences on health
and the evidence that was mounting in academic circles around health determinants as a factor
generating interest in health goals in BC. “I think another reason [for health goals] was the
changes in attitude and understanding that people, particularly in the health professions... have attained over the past few years on the nature of the determinants of health” (PSO, Public health). Most interviewees believed that research and dissemination of information on the multiple influences on health by various research centres across Canada, such as the Canadian Institute of Advanced Research and McMaster University, helped to establish a supportive context for health goals. A representative of the OPHO remarked that once a “critical mass” of evidence on health determinants was generated, interest in health goals increased, because health goals would “provide a means to address the determinants.”

Theme 3: Proponents and Skeptics

As defined within the health goals framework, proponents comprise supporters of health goals. They typically initiate interest in health goals, provide leadership, and undertake actions to sustain the health goals development process. Skeptics comprise individuals antagonistic to a health goals agenda who typically take actions aimed at interfering with the initiative or defusing enthusiasm over the prospect of developing health goals during the premonitory phase. Proponents and skeptics may originate within or beyond the jurisdiction, the government sector, or the health system or sector.

Proponents of the BC health goals process emanate from (a) inside the jurisdiction, that is, within BC; (b) inside the government, that is from various Ministries, divisions and branches, both health and non-health; and (c) outside the government in the form of provincial stakeholder organizations, both health and non-health.

INTERNAL AND PERSONAL CHARACTERISTICS

Overwhelmingly, study participants identified the Provincial Health Officer as the chief
proponent of health goals in BC. Most respondents attributed the advancement of health goals in BC to the vision, fortitude, and personal qualities of the Provincial Health Officer. Some of their sentiments are captured below.

"Well, the champion of the health goals... was clearly [the Provincial Health Officer] (RHB).

I think we should recognize that the Provincial Health Officer has been a very key player in this, in terms of taking the [Royal Commission] recommendation and then really putting some enthusiasm and interest into it and really charging forward with it, so basically... championing that cause... so I think that's been one of the key facilitators in BC... (RHB).

Interviewees perceived the Provincial Health Officer as some one who was knowledgeable, credible, highly respected, and trustworthy.

I think [the Provincial health officer] is a person with incredible integrity (OPHO).

[The Provincial health officer]... is very well respected by the people of British Columbia. I certainly pay heed when he says, 'Go out and get flu shots' or 'Don't eat raw shellfish' or whatever... and I trust him... and I think most British Columbians do (PSO, Forestry).

One study participant extended his comments beyond personal characteristics and reputation of the Provincial health officer and attributed the advancement of the health goals agenda in the premonitory phase to the “non-partisan stance” assumed by Office of the Provincial Health Officer. He contended that the Provincial Health Officer legitimized the health goals initiative by “managing to maintain [his] independence” and to remain “independent.” He said, “you know, if I thought, in any way, that [the Provincial Health Officer] was politically motivated I wouldn't have wasted by time... yeah, I mean, if the draft [goals]... came under the signature of the Health Minister, I probably would have been less inclined to respond.” (PSO, Forestry).
Study respondents expressed mixed sentiments about the role of the Ministry of Health as a proponent of health goals. Several respondents acknowledged the supportive role of individual branches and divisions within the Ministry, but did not view the Ministry of Health overall as a proponent of health goals in the early days. Several participants viewed the Population Health Resource Branch (previously called the Office of Health Promotion) as the chief supportive force within the Ministry; characterizing it as “very keen and very supportive” (OPHO), and the “strongest supporters I think, within the Ministry” (PSO, Public health).

Study participants perceived the Ministry of Health - the bureaucracy as a whole - to be less than supportive. Some respondents characterized the Ministry’s role as being ambivalent: “it was like, ‘well... this might be a good thing or it might not... let’s see how it turns out’” (OPHO). Others portrayed the Ministry as being reluctant: “I did hear that there was some sort of foot dragging around the [health goals] process” (RHB). Interviewees offered two reasons as to why the Ministry of Health was reluctant to support health goals in the early days. Issues centred on (a) accountability and (b) mandate.33

I do recall that there was some suggestion that some people in the Ministry of Health had some concerns about... if they were to formally accept or approve these goals, would there be some potential repercussions if they couldn’t achieve objectives that were actually laid down - would they leave themselves open to criticisms or even open to liability issues, if they actually formally approved an objective and then didn’t deliver on the objective... I gather it was a real concern within the Ministry of Health, anyway (RHB).

[Health goals] didn’t really fit with the Ministry’s mandate... because it’s much broader. Like the mandate of the Ministry of Health is really to provide health services... like to set health policies and standards and to fund the provision of health services for British Columbians... well health goals extended beyond that... a lot of

33 The issues of accountability and mandate are discussed in greater detail in later sections of this chapter, especially in relation to Themes 6 and 13.
the things weren't within the control of the Ministry of Health. From information that I've received is that there was a bit of a tug-of-war as... is the Ministry of Health responsible for the development of goals, which really impact or which other Ministries are responsible for? (Ministry, Health).

Although none of the participants reported that the Ministry of Health was fully supportive of health goals in the premonitory phase, one respondent claimed that support seemed to increase with time: “I think initially, probably the group that had the most difficulty with [the health goals] was the Ministry of Health, itself... Over time, I think the support began to widen” (PSO, Public health). Several other respondents, while acknowledging the hesitancy of the Ministry of Health at the level of the bureaucracy, spoke of early and sustained support for health goals from the Minister and Deputy Minister of the day: “I think that [the Deputy Minister], and through him..., the Minster of the day... they were all effective lobbyists and ... you know, supported the process and so forth and, in that sense were champions of the idea” (OPHO).

Study participants reported other government-based groups as proponents of health goals in the premonitory phase, including medical officers of health and various representatives of the public health sector:

[Health goals] were certainly supported by people like the medical health officers and public health people and people who did health planning, generally... I think, you know... and anybody who had management... managerial training, program evaluation training... so, I think it's fair to say, it was probably supported by the public health sector (OPHO).

Another participant agreed that medical health officers were proponents of the BC health goals initiative in the early days and attributed this to their training and professional perspective:

They have always had that bent... because of their training... medical health officers and epidemiologist are the only physicians there are that are not individual patient focused, you know, they have the population health perspective, rather than the individual [perspective]... I am sure those are the key champions (PSO, Health Association).
In response to questions about how government Ministries, beyond the Ministry of Health, responded to plans to initiate a health goals agenda, study participants shared mixed accounts. A representative of the OPHO commented that, “[After] presentations to all Deputy Ministers and one-on-one briefings with every government Minister... some were really enthusiastic... many were... thought it was interesting and supportive... and one was quite negative.” Another respondent with the OPHO reported that the proximity of Ministries to health-related issues was not necessarily an indicator of whether that Ministry would be a proponent of health goals or not: “Ministries that might seem to be far removed from health, in fact, were quick to get on board and understood what the implications were and so forth... and other people, even those who might be seen to be closer to the health issues, were still... sometimes had difficulty because they were equating health and health care and so forth.” This interviewee went on to say that “no one Ministry was steadfast in either its opposition or [support]... it was [rather] kind of fluid.” Another interviewee challenged this view believing that those Ministries farthest removed from health, what she referred to as “industry Ministries,” did not support a health goals initiative because of mandate considerations: “But I think the industry side of government is less supportive of [health goals]” and are likely to ask, “‘why is this a government thing, this is a health thing” (PSO, Health).

Some participants noted support for health goals from various non-government agencies including the Registered Nurses Association of British Columbia and various health-related organizations such as the Heart and Stroke Foundation and BC People with Disabilities. Additionally, one individual noted that local “CIAR folks,” that is, members of the Canadian
Institute for Advanced Research, “were in BC and readily available” to support the health goals initiative. In reflecting upon the interest of non-government groups in the health goals initiative, one representative of the OPHO portrayed them as being “very enthusiastic” and offered a reason why: “And the health NGOs, the health stakeholders were very, very keen for a variety of reasons. Some of them saw it as a chance to, you know, you’ve got to keep your oar in the water. All the health professions group, they showed [interest] in order to advocate for their place in the sun.”

Generally, participants had more to say about proponents than skeptics of health goals in the premonitory phase, although several respondents recognized parties less enthusiastic.

Not everybody was a convert or on-side with what we were doing. But, mercifully, there were very few people who were really opposed to it, who didn’t think it was a good idea. And so... and I didn’t really see any main [distractors] in the sense of people who were coming forward in the press or writing to the Premier or Minister saying, ‘Hey, stop this process - what’s going on here.’

Some participants linked skepticism about health goals to health groups that support the status quo and who may perceive health goals as “[threatening] budgets and control and power and so forth” (OPHO). An interviewee with the Ministry of Health singled out one non-government group, the BC Medical Association: “You know, there were certain organizations that weren’t so keen... BCMA, for example - initially gave its blessing and then... late in the process became quite concerned of... what they saw as the lack of visibility of health care concerns and so forth.” Similarly, several participants believed that service providers resisted the idea of a health goals agenda because it related in no direct manner to patient care:

People responsible for service provision, in large institutions, for example, might have some skepticism about this... they may have thought no matter what else goes on in terms of broader health goals or population health goals, we still have basic service provision to provide to patients coming into emergency or in for surgical
operations or whatever... so, I would expect that there would probably be some skepticism there (PSO, Public health).

I think you’ll find that people who have to deal every day with real sick people may be a bit sceptical about [health goals] because they will say, ‘Well, is it really going to make any difference to what we have to do [to] treat accidents or people with heart attacks or cancer?’ (OPHO).

One participant equated the skeptics of health goals with the skeptics of health reform more broadly: “I think, in fact, that... the groups that didn’t support [health goals] are still the main deterents to real health reform - doctors and administrators... hospitals” (PSO, Health association). Health goals, in this interviewee’s view, implied change to the status quo and this; as noted by others, proved threatening to existing power structures and agendas.

Theme 4: Perceived Benefits

The data on “perceived benefits” captures the perception of study participants on the anticipated contributions of health goals in British Columbia. Several benefits of health goals for various players in the health sector were uncovered and are discussed below.

POLICY MAKING AND PLANNING

While only one participant viewed health goals as a mechanism to support policy making, several interviewees reported that health goals were expected to benefit program planning and evaluation. The chair of a regional health board shared his view on how provincial health goals would contribute to regional program planning: “[Health goals] provide a framework under which you can now place other goals and objectives...they... provide a planning umbrella.” One interviewee identified population-based planning as a related benefit of health goals, postulating that health goals may help to “reduce this inexorable growth in demand ... for more and more and more service,” and to focus planning on the needs of the population (OPHO).
PROGRAM EVALUATION AND HEALTH IMPACT ASSESSMENT

One interviewee believed in the potential of health goals to facilitate program evaluation: "Health goals allow you to evaluate what you're doing against some criteria" (PSO, Health Association). This was extended by another respondent who believed that health goals had the potential to support health impact assessment, that is, health goals could be used to evaluate the effect of various government policies and programs on the health of the population. Linking health impact assessment to environmental impact assessment, he claimed that "[health goals] could do the same thing around health impact where [there would be] automatic review of legislation and regulations from the perspective of healthful public policy" (RHB).

HEALTH STATUS MONITORING

Some participants considered improved health status as the chief motivating factor for health goals in the premonitory phase. One interviewee shared a personal thought on the commitment of the representatives of the OPHO to this purpose: "I would have to say that the motive... the perceived benefit among the people involved in the [health goals] process... was very much to improve the health status of British Columbians, as opposed to improving one's CV or you know, sort of getting some sort of personal advantage or something" (OPHO). Most respondents believed that health goals would facilitate the monitoring of population health status over time. This in turn would help to focus attention on health inequities and stimulate actions to reduce inequities, which, as stated by one respondent, is what "I think people want to see... across the board" (OPHO).

PRIORITY SETTING AND RESOURCE REALLOCATION

Priority-setting, particularly "setting of priorities for funding" was identified by a few participants as a likely contribution of health goals and several participants reported that health
goals would support the reallocation of resources. They deemed that health goals (with a population health perspective) would “lead to a climate” where there may be a “shifting of pies... putting resources into different pots, in the name of health” (OPHO). One respondent spoke of “shifting money into other sectors [which] would probably have more of an impact on health than just improving services” (OPHO).

HEALTH SYSTEM REORIENTATION

Resource allocation relates to another perceived benefit of health goals by study participants -- health system reorientation. Several respondents viewed the health goals as a mechanism to facilitate a shift from health services to a “clear focus on the broad determinants of health... [Health goals] are one way to get people off of this ‘more health care is the only answer’ and to get people thinking more broadly about health” (OPHO). Another interviewee supported this sentiment and declared “I guess the primary reason [for health goals]... is that our system needs to be redirected to where the larger health issues are,” which he went on to explain, “are embedded in the broad determinants of health” (PSO, Public health). A representative of a regional health board challenged this view by perceiving health goals as a way to “bring in the services.” Increasing health services rather than reorienting the health system was a central concern to people in northern BC. Finally, one participant believed that health goals would decrease the need for provincial funding cut-backs, and in the long run, steady the health care system. In his view, health goals, with a focus on prevention, would lead to “healthy British Columbians,” and subsequently decrease the need for “government cutbacks of health budgets;” which, in his view, “is how we save health care!” (RHB).

INTERSECTORAL COLLABORATION

Intersectoral collaboration was identified as yet another benefit of health goals that
motivated interest in a health goals agenda in the premonitory phase. Many viewed health goals as a way to “galvanize [action] from many sectors to assist and basically improve health and quality of life” (RHB). Another respondent perceived health goals as a way to “break down the stovepipes between sectors;” which was important in his view because “health [is] everyone’s business” (OPHO). A representative of a health association put it simply, “[Health goals] have [presented] an opportunity for different people from different jurisdictions to better understand their joint efforts to improve health,” and to “create a joint vision... in a way that moves people forward” (PSO, Health association). In this way, several participants viewed health goals as a way to both encourage and define intersectoral action toward health.

Various source documents on health goals in BC identified benefits of health goals and corroborated interview data on contributions of health goals. They revealed that health goals were expected to: (a) establish priorities, (b) guide actions to improve population health status and reduce health inequalities, (c) guide policies and investments in health (and link public policies and investment to positive health outcomes), (d) ensure accountability for investments and outcomes, (e) provide a basis for planning within regional health authorities and provincial organizations, (f) serve as a framework for joint actions across sectors and between government and non-government organizations, and (g) increase public understanding about the multiple determinants of health.

**Emergent Dimensions**

Study participants identified two “perceived benefits” that influenced the motivation for health goals in the premonitory phase that were not a part of the health goals framework: (a) public education, and (b) health system accountability.
PUBLIC EDUCATION

Several participants identified public education as a benefit of health goals. Health goals were believed to increase the understanding of the “public and public bodies” about the “notion... of what it is that makes people healthy” (OPHO). A representative of a member health association in BC stated that health goals “act as an educational focus for people around the social determinants of health” (PSO, Health association). A representative of the hospital sector supported this view by characterizing health goals as a “public educative mechanism by which you can move public understanding” about health and the factors that influence health. Another interviewee stated that even if the BC health goals were not, in the end, endorsed by the government of the day, his efforts around health goals would not be wasted if public education occurred: “Certainly, my decision to sign onto this project was that even if the health goals were not adopted, it would be worth doing for the sake of public education (OPHO).

HEALTH SYSTEM ACCOUNTABILITY

Study participants identified health system accountability as a second emergent benefit of health goals. One interviewee remarked that health goals would help to “set the stage for some genuine accountability” (PSO, Public health). A representative of the Ministry of Health reported that health goals would provide a framework “to report on health to the public.” This sentiment was shared by an interviewee who linked health goals and targets to the assessment of the overall health system:

It was also recognized that in the process of setting goals, the next logical step is the setting of objectives, which often include, you know, targets and measurable indicators.... and that would provide a way of measuring the accountability of the [health] system, to see that actual gains were being achieved with the effort and the money that was being put into the initiatives (RHB).
This interviewee perceived measurable objectives as a means to increase accountability for health spending towards the improved health of British Columbians.

**Theme 5: Triggers**

Within the health goals framework, triggers refers to the precipitating event or phenomenon that leads to the launching of health goals and connotes official legitimization of the health goals approach usually by some political or decision-making body.

**COMMISSION RECOMMENDATION AND GOVERNMENT ENDORSEMENT**

Most study participants identified the trigger event for health goals development in BC as the commission recommendation from the *Royal Commission on Health Care and Costs* (BC Ministry of Health and Ministry Responsible for Seniors, 1991) that advised the establishment of health system goals. This was followed by an endorsement from the government of the day in *New Directions for a Healthy British Columbia* (BC Ministry of Health and Ministry Responsible for Seniors, 1993) that recommended the development of population health goals. A representative of the public health sector characterized the trigger event for health goals in BC as follows:

*I guess the single most precipitating event would be the one back in the early '90's which was the release of the [Royal] Commission Report... After that, I don't think you could point to any one major event by itself... I think it was just the gradual development of some momentum and the momentum refusing to be dissipated. I would probably point to the [Royal Commission] report more than anything else.*

One respondent, while acknowledging the role of the commission recommendation as the legitimizing force of the BC health goals process, noted also that the project really “kicked-off when [the Provincial Health Officer] went to the cabinet to get money” (Ministry, Health). This interviewee felt that until funding was in-hand there was no real assurance that health goals
would proceed to the formulation phase. Securing funds further signalled government endorsement of the health goals agenda and meant that "there was a clear commitment to it."

Various source documents on the BC health goals initiative commented also on the government endorsement of health goals. In a November, 1995 update report on the BC health goals project to the Minister of Health, the Provincial Health Officer reported that "The British Columbia government has made the development of health goals and measurable objectives one of its priorities" (p.5). This phrase appears in several reports and documents produced by the OPHO.

Table 11:
Factors that Facilitated and Obstructed the BC Health Goals Development Process:
The Premonitory Phase

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<th>Theme 1: Prevailing Circumstances</th>
<th>Facilitating</th>
<th>Obstructing</th>
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<tr>
<td>- Ideological &amp; philosophical stance of the government of the day</td>
<td>- Perception that health goals may yield cost savings</td>
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<td>- Political will and executive-level support for health goals</td>
<td>- Reduced transfer payments from federal to provincial government</td>
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<td>- Increasing pressure for government demonstration of outcome achievement &amp; performance monitoring</td>
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<td>Theme 2: Health System Environment</td>
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<td><strong>Facilitating</strong></td>
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<td>- Regionalization of health services</td>
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<td>- Reorganization of the Ministry of Health</td>
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<td>- Expanded mandate of the Provincial Health Officer</td>
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<td>- Escalating health services costs</td>
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<td>- Low level of health services in some areas</td>
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<td>- Shift of health system to health promotion / disease prevention focus</td>
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<td>- General understanding of public &amp; preventive health</td>
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<td>- Peer pressure - all other Canadian provinces and many jurisdictions around the world had health goals</td>
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<td>- Increasing understanding and evidence about the multiple factors that influence health</td>
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<td><strong>Obstructing</strong></td>
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<td>- Perception that health reform was disruptive and distrusted by some</td>
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<td>- Orientation to health services by some</td>
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<th>Theme 3: Proponents and Skeptics</th>
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<td><strong>Facilitating</strong></td>
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<tr>
<td>- Provincial Health Officer - vision, leadership, fortitude, personal qualities</td>
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<td>- Non-partisan stance of OPHO</td>
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<td>- Branches of Ministry of Health most associated to population health issues such as the Population Health Resource Branch</td>
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<td>- Minster and Deputy Minister of Health of the day</td>
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<td>- Some government Ministries (other than health)</td>
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<td>- Medical officers of health</td>
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<td>- Non-government agencies such as CIAR, and health related groups and associations</td>
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<td>- Public health sector</td>
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<td><strong>Obstructing</strong></td>
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<td>- Ministry of Health bureaucracy</td>
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<td>- Entities representing the status quo -- service providers, doctors, hospitals, administrators</td>
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<td>- Some government Ministries (other than health) that saw health goals as part of Ministry of Health mandate</td>
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### Theme 4: Perceived Benefits

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<th>Facilitating</th>
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| - Health goals were perceived to support, enhance or contribute to:  
  - Regional program planning  
  - Population-based planning  
  - Program evaluation  
  - Health impact assessment  
  - Monitoring of health status  
  - Actions toward reducing health inequities  
  - Priority setting  
  - Re-allocation of resources  
  - Reorientation of health system  
  - Increasing health services (in the north)  
  - Intersectoral action toward health | - Health goals increase health services  
(Although viewed as a facilitating factor in a northern community, some interviewees view this as obstructing to health goals -- rather, health goals in their view should be used to support a reorientation of the health system away from health services to the social and environmental factors that influence health) |

### Theme 5: Triggers

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| - Government-appointed commission recommendation for health (system) goals  
- Government response and recommendation for (population) health goals  
- Budget to proceed |  

### PART B: FACTORS INFLUENCING HEALTH GOALS DEVELOPMENT IN THE FORMULATION PHASE

The formulation phase of the health goals development process builds on the premonitory phase where health goals are contemplated as a strategy for population health promotion. During
the formulation phase, health goals are constructed. This phase constitutes the various processes, structures, and resources required to support health goals formulation. This section reports on the interview and source document data for each theme that comprises the formulation phase the health goals development process.

**Theme 6: Levels and Sectors**

Most of the data on this theme are drawn from source documents, supplemented by data from participant interviews. This theme summarizes the data on the range and mix of parties and interests involved in the BC health goals development process. Theme 9 (Consultation and Participation) below, reports the data on methods used to consult parties during the formulation phase.

**GOVERNMENT SECTOR**

In early 1994, the Deputy Minister (Ministry of Health) notified all eighteen Ministries that comprised the provincial government that the OPHO “*is now proceeding with the development of provincial health goals*” and asked Ministries to “*fully cooperate in this very important initiative for the health of British Columbians.*” A listing of the eighteen government Ministries and associated contact persons who participated in health goals development follows:

- **Ministry of Forests:** Manager, Occupational Health and Accident Prevention
- **Ministry of Women’s Equality:** Senior Policy Analyst, Policy and Planning Branch
- **Ministry of Aboriginal Affairs:** Policy Analyst, Social Economic Unit
- **Ministry of Social Services:** Executive Director, Policy, Planning and Research Division
- **Ministry of Environment, Lands and Parks:** Manager, State of Environmental Reporting
- **Ministry of Energy, Mines and Petroleum Resources:** Director, Financial Services Branch
- **Ministry of Employment and Investment:** Senior Policy Advisor, Policy Development Branch
- **Ministry of Agriculture, Fisheries and Food:** Executive Director, Policy and Legislative Services
- **Ministry of Municipal Affairs:** Senior Policy Analyst, Policy and Research Branch
Most study participants were aware that all Ministries were consulted in the BC health goals process and supportive of their involvement because “clearly... [the Ministries] had a role, in terms of setting policy which influenced health” (Ministry, Health). Several interviewees attributed the involvement of all eighteen Ministries to “the broad perspective” adopted by the health goals team and their aim to incorporate the multiple influences on health into the BC health goals. Representation from all government Ministries was perceived to be important particularly by representatives of the OPHO, one of whom stated, “because it was realized that what the health goals were all about... was the broad determinants of health... not just the health care system”.

LEVEL OF GOVERNMENT

In terms of levels of governments involved, both interview and source document data confirmed the provincial level of government as most involved in the health goals process. Study participants made no reference to representation by regional governments and no attributions to national bodies. A few participants however, shared that, in some areas, “mayors and city councillors” participated in the health goals process as representatives of municipal governments.
NON-GOVERNMENT LEVEL AND SECTOR

Source documents indicated that representation from the non-government sector came from over one-hundred provincial agencies and organizations (referred to as provincial stakeholder organizations) as well as from the public at large. The various types of stakeholder organizations involved and examples of each are listed below. Refer to Appendix T for a full listing of provincial stakeholder organizations that participated in the BC health goals process.

- **Voluntary and non-profit (health) agencies** such as the BC Lung Association, BC Psychological Association, Canadian Cancer Society, Canadian Diabetes Society, Pacific AIDS Resource Centre
- **Voluntary and non-profit (other-than-health) agencies** including the BC Association of Chiefs of Police, BC Council for the Family, BC Teachers’ Federation, Tenants Rights Action Coalition
- **Business and industry sector** such as the BC Federation of Labour, Business Council of BC, BC Council on Forest Industries, Construction Labour Relations Association of BC
- **Professional associations** including the BC Council of Licensed Practical Nurses, Physiotherapy Association of BC, Canadian Institute of Public Health Inspectors, BC Pharmacy Association

When asked to reflect on participation by non-government agencies or sectors, many interviewees identified several of the organizations included in the BC source documents. Participant perceptions on the level of input from non-governmental groups ranged from “a reasonable sampling” to an “expansive representation.”

Interviewees shared mixed accounts on participation by the public at large. One interviewee stated that the public was well represented since every attempt was made to “involve the public,” by, for example, “conducting [health goals] sessions at convenient times and locations... and putting notices in newspapers” (OPHO). Another interviewee challenged this view stating that the BC health goals process did not sufficiently involve the public; rather, “it [involved] a very elite group of people” (PSO, Hospital). In this participant’s view, the “average Joe on the street” was not represented.
QUASI-GOVERNMENT SECTOR AND DIFFUSION

Both interview and source document data mentioned the role of regional health boards and community health councils in the health goals process. All of the then twenty regional health boards participated in the formulation process. (See appendix U for a listing of participating regional health boards). Both sets of data recognized contributions to the goals process from cultural groups, in particular, groups representing the BC aboriginal population.

Within the “levels and sectors” theme, data were also drawn on the “diffusion” dimension of the health goals framework. Diffusion refers to the adoption or translation of provincial health goals by regional health authorities and provincial stakeholder organizations.

During the early days of the formulation phase, the BC regional health boards were in the process of developing regional health plans. Several source documents comment on the expectations for health goals at the regional level. They set forth OPHO intentions that regional health boards use the provincial health goals as a framework to guide planning and decision making at the regional level. The provincial health goals offered a model for regions to define regional expectations for population health in relation to local conditions and characteristics.

The expectation is not that regional health boards will directly adopt the provincial goals and objectives. Each region has a unique situation to which its own goals and objectives must respond. However, the provincial health goals and objectives can provide a framework or model for regional goals and objectives related to population health. (Internal correspondence, Health Goals Project Team, September 20, 1995).

Many study participants affirmed an implied expectation by the OPHO that provincial health goals be adopted or translated at the regional level. One interviewee, when asked if the regions were expected to adopt the health goals, stated:

“Not in any directive sort of way... they generally were put forward as one way of thinking about [planning]... and I think there was sort of an unstated hope... that the regional health boards and community health councils would consider adopting
variations of the provincial health goals and using those... to help guide their activities” (RHB).

This view was shared by another interviewee:

I would expect that there be some - maybe not a requirement - but some kind of expectation, I guess, from the provincial government that the various regions are going to somehow be working towards these health goals... overall, I think that was the intent” (PSO, Public Health).

Source documents on the BC health goals initiative suggested also that the provincial health goals be used to guide planning by both government Ministries and various health-related provincial organizations.

Once adopted by Cabinet, the health goals and objectives will become a basis for planning and action by the Ministries of government. They will also provide a framework for collaboration among Ministries, and between Ministries and their partners at the provincial, regional and local levels. As well, it is hoped that the organizations in many sectors, particularly those which participated in the goals development process, will integrate relevant parts of the goals and objectives into their ongoing planning and work (Internal correspondence, Health Goals Project Team, September 20, 1995).

Interview data showed that provincial stakeholder organizations appeared less likely than regional health boards to adopt or translate the provincial health goals. Several interviewees did not believe that adoption of health goals at an organization or agency level was an aim of the health goals initiative. One participant, while acknowledging that stakeholders needed to be involved in the development process “to effectively set health goals,” did not see a role for his organization in addressing them: “But I don’t really get a sense that anybody was expecting us to do very much with them... from our organization’s perspective (PSO, Health association).

Similarly, a representative of the provincial stakeholder organization claimed that although she hoped that the provincial health goals “would align with what we were doing as an organization,” was quick to add, “but at no time [would] we consider changing what we were
“doing as an organization to be aligned with the health goals” (PSO, Health).

Emergent Dimensions

MANDATE FIT

Although discussions with study participants, both within and outside government, on the various parties and interests (levels and sectors) involved in the BC health goals process centred mainly on who was involved and the expectation by various parties on how the goals would be applied at regional and organizational levels, the issue of “mandate” came up repeatedly. More specifically, “mandate fit” may be the term used to refer to interviewee’s perceptions of and concerns over the “fit” of the BC health goals with the mandate and responsibilities of the various parties and interests that were consulted as a part of development process. There were two schools of thought on this issue: (a) that the health goals were the responsibility of, and fell within, the mandate of the Ministry of Health, and (b) that health goals were a shared responsibility among health and non-health Ministries and sectors.

Several interviewees shared their belief that the BC health goals should be associated with the government-at-large rather than the Ministry of Health. In this way the health goals would be perceived as provincial versus Ministry-specific health goals. This would help to reinforce the emphasis on the multiple determinants of health and would reflect the intent of the architects of the health goals that “health is more than health care.”

One of the strengths of the [health goals] project ... was that it didn’t get bogged down in sort of, internal Ministry of Health machinations... [This] helped to reinforce the intent that they be provincial health goals not Ministry of Health [health] goals... certainly the [Provincial health officer] tried to get that message across... and I think this has helped to preserve that broader perspective of the health goals (RHB).

Positioning the health goals as a government-wide initiative and framing them within the determinants-of-health perspective helped also to rally action on the health goals from sectors
By acknowledging the importance of the broad determinants of health the health goals were seen to be not just the Ministry of Health's responsibility... It was going to leave some obvious overlap to other Ministries (PSO, Public health).

The expectation that Ministries or sectors outside of health would be responsible in some way for the provincial health goals, while favoured by some, was unsettling to others and led to some interviewees to make charges of "imperialism" by the health sector. 

Some of the Ministries saw [the health goals] as sort of the great takeover by health... that health becomes the Ministry of EVERYTHING and you know, that sort of health imperialism, reaching ever forward trying to gobble up different Ministries and so forth...So I think there was that kind of fear that was circulating (OPHO).

I think that the fact that health is now seen as being affected by a lot more than just health services has probably created some scepticism among people outside of health who say, 'Look at health trying to steal some of the other areas over which we have responsibility and trying to make it all fit under health for some reason' (PSO, Public health).

The other parts of government, initially, were a little suspicious of it as being... 'Christ, isn't the Ministry of Health big enough? Do they want to take over everything now?' (Ministry, Non-health).

Ironically, while some interviewees, usually those outside the Ministry of Health, expressed feelings of encroachment from the health sector, other interviewees believed that the Ministry of Health (except for some units of the Ministry like the Population Health Branch) was largely uninterested. This was explained in large part by a perception that the mandate of the Ministry of Health was not reflected in the health goals: "That's why there wasn't a great deal of support within the Ministry of Health... because [the health goals] didn't address their mandate... which they believed to be the provision and funding of health services." (Ministry of Health). This led to a "natural tension" between the Ministry and the OPHO who was coordinating the health goals process.
Some study participants went beyond suggesting the Ministry was uninterested for reasons of mandate fit. They suggested some antagonism by health workers toward the scope of the health goals, and expressed that the health goals were asking more of health workers and professionals than they were prepared to do or trained to do. One interviewee summed it up this way: “so now they want [health workers] to talk about road safety... that’s a health issue and... how clean our parks are - that’s a health issue, and how effective our schools are - now that’s a health issue, and....” (Ministry, Non-health). A feeling of being overwhelmed by new responsibilities and not having the resources to deal with such was reflected also by some interviewees in relation to the work of the regional health boards:

Also there was a reaction in terms of some of the regions and boards and you know, ‘you’re not giving us the money to do education, to increase, you know, opportunities for employment and better income, so we can achieve better health... so, what do you expect us to do?’ Like, this doesn’t fit (Ministry of Health).

A representative of a non-health Ministry rebutted this sentiment. When asked if he felt the health sector had over-stepped its mandate in the health goals, he replied, “no, not at all.”

During the health goals development process, this particular Ministry was undertaking the development of a new curriculum called, “career and personal planning,” which included issues related to health and lifestyle. With this as the backdrop, this interviewee believed that:

We were working towards very much the same type of goals... we saw a great deal of complementarity between what we were doing internally... and with what the health goals were trying to do... I mean, we looked at this very much as something the Ministry of Health should take, or could take a lead on, but that certainly a lot of stakeholders should have a part of (Ministry, Non-health).

Theme 7: Coordinating Mechanism

The health goals framework recognizes the coordinating mechanism as the body
responsible for coordinating, leading and managing the formulation of health goals. It typically represents the hub of activity during the health goals formulation phase. Participant’s perception of the coordinating mechanism in the BC health goals initiative centred on where the coordinating mechanism was based, the mix of people and skills that comprised it, the degree of political and staff support it received, and the level of autonomy it exercised.

BASE

Most study participants identified the Office of the Provincial Health Officer as the coordinating mechanism in the BC health goals process. A representative of the public health sector captured what most participants believed: “The [Office of the Provincial Health Officer] was vested with that particular responsibility.” Regardless of the majority opinion, a few participants considered the coordinating mechanism to rest with the contracted project consultant. One interviewee was uncertain where responsibility for coordinating the health goals process rested. This participant shared questions that arose in her own mind as the health goals process was underway: “Who’s coordinating this, who’s filtering... Where do [we] go for further information?” (PSO, Health).

Two study participants reflected on the original conceptualization of the health goals coordinating mechanism. They recounted that the government of the day, in their response to the recommendations by the 1991 Royal Commission on Health Care and Costs, proposed the creation of a Provincial Health Council that would assume responsibility for the health goals. The government of BC decided not to proceed with a Provincial Health Council following strong resistance from opposition political leaders who labelled the initiative as partisan and who disapproved that Council members would be government appointed. The Office of the Provincial Health Officer was then asked to coordinate the health goals development process.
And, in the [government's] response [to the Royal Commission], they undertook to have a Provincial Health Council... [but] that didn't fly. It was criticized because it was a government-appointed thing... you know, considered partisan... So then there was no mechanism to develop health goals. So that is when [the Provincial Health Officer] was asked to do it by cabinet (OPHO).

BC health goals source documents confirm plans to establish a Provincial Health Council. In its response to the recommendations by the Royal Commission, the government identified one of its priority actions in *New Directions for A Healthy British Columbia* (1993) as follows:

[To] set up a Provincial Health Council to promote public awareness and knowledge about health issues, to review and report publicly issues affecting health and to establish provincial health goals (p. 12).

With the Provincial Health Council never getting off the ground, the OPHO assumed the task of coordinating the health goals development process.

**MAKE UP, CAPACITY AND STAFF SUPPORT**

Four core members constituted the health goals coordinating mechanism: (a) the Provincial Health Officer (b) the Deputy Provincial Health Officer, (c) a project consultant experienced with health goals-related work in other jurisdictions, and (d) a seconded university professor with a background in medical geography. This group was supported in the early days by a steering committee to increase its capacity to address the multiple demands of the project. The steering committee comprised the core members plus staff from select branches and divisions of the Ministry of Health. The Population Health Resource branch, for example, assigned six members to assist with the health goals initiative; other staff came from the Communications and Public Affairs Branch, and the Policy, Planning and Evaluation Division.

Once the health goals process was underway, key individuals and groups were consulted by the health goals coordinating mechanism on an ‘as needed” basis for advice or comment. A representative of the OPHO reflected:
There were people that we contacted to get their spins on things or advice on certain things and so forth... we called together a few meetings of select individuals from time to time to try to strategies how we would think about certain issues."

On occasion, medical health officers from around the province took on an advisory role by reviewing draft health goals materials, at the request of the Provincial Health Officer.

Drawing on support from various groups and bureaucracies increased the capacity of the health goals coordinating mechanism. In the view of one interviewee, this kind of collaborative effort increased the likelihood that the job would get done:

*In terms of their capacity?... they had the capacity to do it, not [from] within the Provincial Health Officer’s office, but with the collaboration and cooperation of other areas [of the Ministry of Health], which I think was most appropriate (Ministry, Health).*

**POLITICAL SUPPORT**

Political support for the health goals coordinating mechanism, and the health goals initiative more broadly, came from government Ministers and Deputy Ministers. The health goals coordinating mechanism endeavoured to rally for broad-based support from all Ministries “because it was realized that the health goals were about the very... the broad determinants of health,” which would require the support of all government sectors (OPHO).

Several study participants attributed the progression of the health goals process to support from political leaders and high-level bureaucrats. Attempts to win political support took the form of actions by the Provincial Health Officer who met on various occasion with Deputy Ministers and Ministers to rally their support and to ensure “buy-in [from] quite high levels.” (RHB). One interviewee reflected on the Provincial Health Officer’s ability to secure the support of all Ministers:

*You know, the fact that [the Provincial Health Officer] was able to get all of the Ministers of the government at that time - eighteen of them - to agree to the process...*
it seems to me is pretty important... pretty major... So he had access to cabinet and so forth and he went to the Ministers and said, ‘This is what I’m trying to do and I’m seeking your support and the support of your Ministry’ (OPHO).

Political support for the health goals initiative trickled down from the Ministers through the various Ministries by Ministers “making it clear to their staff that, you know... this is important” (Ministry, Health). Political support for health goals extended beyond the Ministries to the regional health boards. One study participant remarked that the perception of support from provincial political leaders stimulated interest in health goals regionally:

People were sensing, that, yes, this is something that the government has decided to do. There is political support for it and so it would be a good game for us to play (OPHO).

In the opinion of one interviewee political support for the health goals varied over time; but in the end, was sustained. Differing levels of political support, in his view, resulted in large part from the turnover of political leaders and upper-level bureaucrats: “I think the level [of support] varied... and a lot of players have changed, but the Provincial Health Officer has not...

And I think that’s made a difference” (PSO, Public health). One interviewee commented on the reluctance of political leaders to support the health goals: “they aren’t something that the cabinet has even been particularly enthusiastic about” (Ministry, Non-health).

AUTONOMY

Most participants characterized the coordinating mechanism as functioning autonomously or independently: “Well, it was sort of like [the Provincial Health Officer’s] project, wasn’t it?” (RHB); although, a few believed there was occasional outside influence that came to bear on the OPHO.

Two interviewees attributed the autonomy of the health goals coordinating mechanism to the (bureaucratic) proximity of the OPHO to the Minister of Health:
The fact that [the Provincial Health Officer] had, I believe, a reporting mechanism to the Minister... that gave him the ability to do [the health goals] without having to go through all the hierarchy and bureaucracy... there was a sense that structurally he could bypass the bureaucracy (PSO, Health association).

A second interviewee concurred:

The fact that the Provincial Health Officer reports directly to the Minister is an extremely important strength [to this] process... so, it couldn't be muzzled, couldn't be diverted, it couldn't be side-tracked by the Ministry bureaucracy” (PSO, Public health).

Conversely, one interviewee expressed that the direct-line relationship between the OPHO and the Minister posed a threat to the autonomy of the health goals coordinating mechanism. In her view, the fact that the health goals initiative was funded by the Ministry of Health meant that the coordinating mechanism was more accountable to “who's paying the cheque,” than to the “citizenry” who were consulted as a part of the health goals process. This interviewee would have preferred if the health goals initiative could have been more of an “arm's-length process (PSO, Special needs).

A representative of a provincial organization, although believing that the coordinating mechanism operated autonomously, doubted whether such an initiative could occur without any influence or pressure from the outside: “Were they autonomous? - Yes... Was there political influence? - I'm sure there was because... as soon as you want everybody to agree and bless something that you're doing... some influence occurs” (PSO, Health).

One representative of the OPHO expressed that the health goals process came under some bureaucratic pressure in their consultations with the Ministry of Aboriginal Affairs:

Now, in some instances there were... situations where I felt that what we said was very much conditioned by a bureaucratic influence... and I had referenced the Aboriginal Affairs Ministry as an example... that there were just certain things that we couldn't say.
This interviewee went on to explain that the pressure “wasn’t so acute that [the Aboriginal health goal] was written by some sort of ghost writers in the bureaucracy that, you know, for which we were just puppets or something.” Rather, the OPHO undertook several rounds of negotiations and made several revisions in the hope that the goal related to Aboriginal health “would be embraced” (OPHO).

Theme 8: Strategic Approach

The data on “strategic approach” capture the perceptions of study participants on the overall strategy employed by the OPHO to guide the health goals development process and the ways in which it became engaged as a planning group to formulate health goals.

EXPERT DRIVEN

Most study participants perceived the BC health goals process as expert-driven. Their rationale was based not so much on the belief that expert advice was sought from knowledgeable individuals, but that the BC health goals process was evidence-driven or based on a certain body of knowledge.

[The health goals] were driven very much by evidence... but we didn’t send it off to a number of academics or experts, the way other [health goals] processes unfolded (OPHO).

It seemed to me to be kind of an expert approach... and to be based on certain published documents in the literature that have become popularized... and certain types of published reports (PSO, Health Association).

With further probing, these interviewees revealed that the evidence used in the BC health goals initiative consisted of “various materials that focused on the multiple determinants of health.” Materials produced by the Canadian Institute for Advanced Research (CIAR) were offered as an example. Source documents revealed also that CIAR formed the basis of much of
the material produced by OPHO relating to evidence on the broad health determinants.

One interviewee, while acknowledging the role of evidence in the BC health goals process, questioned the mix of experts that contributed to the initiative which, in the view of this interviewee, led to an unfavourable perception:

Yeah, and it's which experts you include as well? Like.. I'm not opposed to using experts... but I feel that there are experts in women's health, in immigrant and refugee health, and First Nations' health that should have been part of developing those goals and instead it came from white males... that's the perception (PSO, Hospital).

BUREAUCRATIC-POLITICAL

Interviewees offered mixed responses on questions relating to whether they believed the health goals process was more politically-driven (by political officials and/or interest groups) than bureaucratically-driven (by the civil servants or bureaucratic leadership). One interviewee recognized that the health goals project “required the commitment of Cabinet... to see it as a positive initiative... and then, to get the commitment of each Ministry.” This led him to conclude that the BC health goals process was “very much... politically driven” (Ministry, Non-health). Another interviewee remarked that the initiative was not only politically driven at the provincial level, but also at the local and regional level, since regional health boards were comprised “at that time [of] political people, in effect... who were appointees,[or] elected” (OPHO).

One interviewee, who was responsible for coordinating a health goals workshop within northern BC, characterized the approach to health goals as bureaucratic. This interviewee based her view on her reflection that nearly all of communications and planning related to the workshop involved individuals from the Ministry of Health. Another regional health board representative described the health goals process as somewhat political and somewhat bureaucratic. It was political because “[the Provincial Health Officer] had to get legislative
backing and the mandate to do this;” it was bureaucratic insofar as regional health boards “were encouraged by the Ministry to be involved... so there was also that bureaucratic push from the Ministry of Health” (RHB).

INCREMENTAL-COMPREHENSIVE

All interviewees characterized the strategic approach of the BC health goals process as comprehensive in nature; no one described it as incremental, where only a few health-priority areas would be addressed. There was consensus that the BC health goals initiative attempted to cover all key priority areas in relation to the health of British Columbians:

There was never... a sense of, you know, let’s start small - let’s choose a few key priorities and get people understanding and then build... It was, let’s get this right,... let’s be the jurisdiction that went for the maximum, comprehensiveness, the full ‘schtick’ of the determinants of health, the works. And it is. BC’s health goals are the most comprehensive and wide-ranging in the world (OPHO).

Everything has been addressed (RHB)

One interviewee, while recognizing the comprehensiveness of the BC health goals, also raised questions about this approach: “It was comprehensive, I thought... well, we’re going to see if they tried [to] cover too much territory... but it was pretty comprehensive (PSO, Health association). Another interviewee commented on the comprehensive approach and attributed it to the acceptance of health goals among people who were consulted:

This has been comprehensive, I’d say, definitely... [they] tried to... cover the map and I think that’s part of why its generally been fairly well-accepted and bought into... is because people can see that their issues... their concerns are being covered in some area within the whole [health goals] framework (RHB).

Overall there was a sense of rightness and pride about the comprehensiveness of the BC health goals; although, as noted later in this chapter, some interviewees expressed concerns on the breadth of the health goals for purposes of galvanizing action toward health goals.
Most interviewees were of the opinion that the BC health goals development process was non-partisan in nature; that is, that it was not attached to any political agenda, party or ideology. A representative of the business sector took exception to this characterization and believed the preliminary BC health goals were grounded in a far left ideology: “there were concerns among [our group] that there was a political agenda at play” (PSO, Business). This interviewee based his perceptions on his participation in a health goals stakeholder meeting where, in his view, the presentation focused on economic and equity issues more than health issues. He shared his surprise that “they never talked about lifestyle [issues]!” This interviewee summarized his point of view by saying, “it was all [about] economics... all philosophical, all ideological.” Another interviewee reflected that during one community meeting on health goals, although meeting planners were careful to portray this as a “non-partisan approach” a few members of the public “actually walked out because they thought it was very political” (Ministry, Health).

Another interviewee reflected on the role of political ideology in the BC health goals and compared the BC experience to jurisdictions that held different ideological positions:

There was ideology at work here. I mean, we mustn’t forget that the kind of political ideology of BC... and [the Provincial Health Officer’s] profound beliefs about the importance of the [social and economic] determinants of health... Really, [in] Ontario... who also had a NDP government... when they finished their health goals there was a very similar flavour to the 'social justice,' the 'equity,' and those kinds of things. Whereas when we did [health goals] in Alberta... that wasn’t a big part of the agenda... [In that report] the word 'equity' could never be [used]. There was... a different political ideology (OPHO).

This interviewee went on to explain that although the BC health goals were based in ideology, that the health goals development process wasn’t: Yeah, the ideology was support of a
particular way of doing [the health goals], but... there was nothing politically partisan about the process (OPHO). This respondent went on to say that “in fact, we tried very hard to keep it, you know... neutral from any kinds of alliances.”

This interviewee also commented on the sustainability of the BC health goals (if adopted) through future changes of government; hypothesizing that the survival of the health goals was linked to the mandate of the Provincial Health Officer: “The Provincial Health Officer set the stage... to say that... regardless of what happened politically, he needed these goals as the framework for his reporting on the health of British Columbians (OPHO).

Overall, most interviewees perceived the health goals development process as non-partisan; and most of this group attributed this perception to the non-partisan stance of the Office of the Provincial Health Officer:

*I haven’t seen any indication of sort of partisan elements to [the health goals development process]... because of the independent nature of the Provincial Health Officer... I would characterize it as non-partisan (RHB).*

*There were no [political] agendas... [the Provincial Health Officer] is interested in health and the health goals, and ‘let’s forget the politics’ (RHB).*

Finally, one interviewee attributed perceptions of the non-partisan nature of the health goals initiative to the fact that the Provincial Health Officer met with members of the official opposition party (the Liberal Party of BC) to explain the health goals initiative and to seek their support:

*Well, I mean he spoke to... you know, to the Liberal health critic and... he went to see Gordon Campbell to say, ‘Look, you know, this is what we’re doing and I hope you’ll support our process’” (OPHO).*

In the opinion of this interviewee, the Provincial Health Officer undertook these meetings, “Because I think he wanted [the health goals process] to be perceived, not to be something that was cooked up by the NDP for any particular partisan purpose... [but,
On questions relating to the derivative-original continuum, all study participants characterized the BC health goals as derivative; that is, that they were based on various initiatives and programs that pre-dated the health goals initiative. Interviewees described the BC health goals as being derivative of:

(a) Work done in other jurisdictions:

"I gather there was quite a bit of commonality between the [BC] health goals... and those developed in other jurisdictions (RHB).

(b) A growing understanding of multiple health determinants:

"[The health goals] are clearly derivative... in a sense they are sort of a culmination of this growing understanding and growing conceptualization around the determinants of health... the BC [health goals] were able to just, kind of, culminate all of the development (OPHO).

(c) Plans of other Ministries that incorporated goals that aligned with the health goals.

Goals embedded in programs of other Ministries were considered in the articulation of the preliminary BC health goals: "like the Ministry of Environment, for example, had a whole set of sustainability goals that they were very anxious to share with us... so we would just work on those as a basis for the [health] goals (OPHO).

Several interviewees commented on the link between the BC health goals and the 1996 Provincial Health Officer’s Annual Report. Source documents reveal that the 1996 Provincial Health Officer’s Annual Report was developed shortly after consultation on the preliminary health goals. The OPHO coordinated both these initiatives. The Provincial Health Officer’s Annual Report presents six “health challenges” that precisely mirror the BC health goals. One
interviewee, who worked on both these initiatives noted, “And so, eventually the ["health challenges” in the Annual Report] began to dove-tail with [what] you see in the goals document... by the time you come to the ’96 Report... basically the [BC health] goals, objectives and indicators are in [the Annual Report], in disguise.” Another interviewee remarked: “The health challenges that were in the most recent Provincial Health Officer’s report... my understanding is [that] the health goals are going to be quite similar to those” (RHB).

Source documents support interviewees’ perceptions on the derivative nature of the BC health goals. A 1996 progress report on the health goals states: “As well, as being an important tool on their own, the provincial health goals and objectives will complement other major initiatives being undertaken to improve and sustain quality of life for British Columbians” (Interim Report on the Project to Develop Health Goals for British Columbia, p. 8). Several ongoing initiatives with links to the proposed health goals were identified. They included: (a) the 1995 Sustainability Strategy, developed by the BC Commission on Resources and Environmental; (b) the 1995 BC Growth Strategies Act; (c) reports from the Premier’s Forum on new Opportunities for Working and Living, the Gove and Cain Commissions, and various Minister’s Advisory Committees; and (d) the 1996 Accountability Framework, published by the Auditor General.

BOTTOM UP - TOP DOWN

On questions relating to the bottom up - top down approaches, interviewees distinguished between (a) how persons were consulted as a part of the health goals development process and (b) how the goal statements were derived.

In terms of the approach to consultation, some participants characterized the health goals development process as bottom-up: “When it came to the goals... it was bottom-up to the extent
that they did allow for a lot of input from a lot of different sectors (PSO, Public health). A representative of the OPHO did not feel that a bottom-up approach was applied because “we didn’t get any genuine great public participation.” Another interviewee characterized the approach to the BC health goals as mixed: “I think it took the top-down leadership from [the Provincial Health Officer], combined with the grassroots responding [to the health goals]... and I think we met in the middle” (RHB).

In terms of how the health goal statements were derived, most study participants characterized the health goals development process as top-down. This perception was due in large part to the recognition by interviewees that the key issues in the health goals were pre­determined and that the health goals were crafted in advance.

[The Provincial Health Officer] set the context... [we were] invited to come forward... to respond to things that he set out as issues (RHB).

I would say it was more on the top-down than bottom-up side. My impression was certainly that there were some ideas... some things that were, you know, pretty much fixed...(PSO, Health).

One interviewee, while acknowledging that pre-established health goals represented a top-down approach, believed this was a sensible way to proceed:

I never heard any criticism of the first [pre-determined] set of goals... people thought they were generally quite good... rather than saying, ’Oh, forget this - it’s not good... go back to square #1’... So I think that was an indicator that starting from an already... sort of distilled set [of goals] really did make sense (RHB).

A member of the health goals team who participated in meetings with provincial stakeholder organizations and regional health boards reflected on how the public education component of the presentation (which initiated each session and focused on the determinants of health) set the context for the discussion on the health goals that followed:
We asked lots of different people about what they thought the issues were... and partly they were reflecting on what we told them, because we gave them the story of the determinants of health... and then said, 'Now here are the goals... what do you think?' So, in a way, we kind of SET them up... so clearly we conditioned the process and I think we can never pretend otherwise (OPHO).

This interviewee went on to qualify the above remarks in the following way:

At the same time, I think we are honourable people who weren't lying and we weren't fabricating this stuff, you know... we were sort of representing what we believed to be 'truth' or an accurate representation of reality, and so forth. And consequently, it wasn't a matter of trying to mislead people in anyway... I think we were being open and honest about what the major [health goals] issues were.

Another interviewee shared this sentiment and remarked that the health goals project team recognized “right off the bat” that this process was not “simply about health care” (PSO, Public health). Rather, the health goals process aimed to educate and interest people in the broad determinants of health: “So I think they already knew that before they started the [health goals] process.” This interviewee suggested that the manner in which the health goals project team structured the consultation sessions enabled them to achieve the result they hoped for -- health goals that reflected the broad determinants of health.

I think the way they framed the workshops... the way they framed the day-long events... allowed or facilitated... made it easy for people to recognize the broader approach to health goals ... They created a context for the development of the goals that would, in fact... lead to... that kind of result.

An interviewee representing a provincial organization in the business sector criticized this approach. This participant agreed that the consultation sessions were best described as top-down and that they were structured in a manner consistent with the expected result, but was critical of this approach because it did not allow for a “full representation of views” (PSO, Business).

Theme 9: Consultation and Participation

While Theme 6, Levels and Sectors, reported on the various interests and parties that
were involved in the BC health goals development process, this theme presents the data on the selection strategies applied, the breadth and depth of representation, and consultation mechanisms.

SELECTION STRATEGIES

Study participants reported on several selection strategies that were applied by the OPHO to solicit involvement in the health goals development process. The overarching selection criteria for government Ministries was to “involve all of them” (OPHO). Buy-in from all Ministries was considered important if the health goals were to be seen as a government-wide initiative rather than solely as a health sector or Ministry of Health initiative.

Interview and source document data reveal that the OPHO asked each government Ministry to select or recommend up to ten provincial stakeholder organizations that they believed should be consulted on the health goals: “we hit each Ministry [and] asked them to identify stakeholder groups that they felt were important... from their perspective” (OPHO). A member of the health goals project team, reported on several criteria that were applied in the selection of stakeholder groups: “[They were] chosen because we wanted to educate or influence them.. they were also selected because they had already been working closely with us... we saw them as ... key sort of players who could influence their peers in seeing the [determinants of health] linkages... and who would keep things moving” (Ministry, Health).

Representatives of provincial stakeholder organizations offered a variety of responses when asked why they were chosen to participate in the health goals process. A representative of a provincial organization of the forestry sector, which represents over one-hundred forestry-related companies in BC, believed his group was selected because it could offer a majority opinion: “Government bureaucrats tend to deal through trade associations rather than going to
[individual] companies... to get a collective opinion.” Similarly, a representative of a provincial stakeholder organization of the business sector, which represents over 155 of the largest employers in BC, claimed that they were chosen to participate because “our [organization] is unique in what we are and who we represent...[our aim is to] encourage people to think of BC as a place to come and live and work and invest their money.” Another interviewee believed his agency’s involvement was solicited because, “our organization has a long history of advocating for health reform and health goals... and because we are considered to be a large stakeholder organization (PSO, Health association).

At the regional level, selection of people for consultation took place through the regional health boards. The regional health boards strove for broad-based participation “representing the key Ministries and the key sectors” (OPHO). The OPHO encouraged also RHBs to “try and involve the people who [were] traditionally more marginalized... so women’s groups, Aboriginal groups, poverty groups, cultural minorities, [and] that sort of thing” In the view of one member of the health goals project team, the involvement of the members of the regional health board in each of the then twenty health regions was important to encourage and promote the health goals agenda: “[Health boards] would be responsible for carrying the message in the field... We also wanted to position them as messengers and leaders and champions for this.”

REPRESENTATION

Several study participants offered comment on their perceptions of the breadth and depth of representation in the health goals development process. By and large, most interviewees portrayed the health goals development process as inclusive and representative of varied interests.
[They consulted] pretty much... everybody they could think of...there was very much a
sort of a philosophy of inclusiveness and that kind of thing... (PSO, Health
Association).

I... recall thinking, 'Oh, he’s talking to EVERYBODY about it!' (PSO, Health).

So, I feel pretty comfortable that we got a reasonably good representation of people’s
views and so forth because we didn’t knowingly, at least, exclude specific sectors...
Well, you know, we didn’t make it our business to try to go out and enlist the support
of Neo-Nazi groups and so forth, I suppose... but, you know what I mean, in terms of
mainstream. I think we were pretty inclusive” (OPHO).

A few study participants rebutted this position and claimed that the process was not
representative in their view. One interviewee, who helped to organize a health goals public
consultation meeting in northern BC, believed that more effort could have been made to include
a greater mix of people; in particular, greater representation from sectors other than health.

We had a really good turnout, but it was limited, I think, to mostly health people, and
... I think it should have been a bit broader... It should have included more of the...
big businesses that we have in town, as well as different Ministries... its always the
same health people. And you don’t want to say that their ideas aren’t just as good as
anybody else’s but you need... we needed some fresh ideas” (RHB).

A second participant reflected on how consultations have been conducted in other
jurisdictions and shared her dissatisfaction with the BC approach:

[The BC process] was mostly professional groups and associations [and] service
providers. So... um... it’s not at all like the Oregon process where there was some
active debate and discussion... [here] it was more about groups looking at [the health
goals] and saying, ‘Well, let’s see if I am in there?” (RHB).

A representative of the business sector was similarly dissatisfied with the breadth of
consultation. This interviewee asserted that because only one business group had been consulted
on the health goals, business interests were basically outnumbered by all the “social” groups that
were consulted. This participant expressed also displeasure with the “consultation tactics”
applied:
[Health goals] consultation was not really that broad ranging thing that it was purported to be... My guess would be that those [parties] consulted would largely be supportive of whatever [the Provincial health officer] cared to present...
See, I could do the same think if I wanted to get a particular point of view across... I could invite twelve people, two of which I would know would have an opposing point of view... but... the other ten that I picked would certainly carry the day -- ten to two... I picked them because I know that's the way they would come across. So, the other two, we can just kind of ignore them because... you know, they must be out of step when... when so many others feel that this is the way it should be. And that's not hard to do. That's an OLD trick (PSO, Business).

This interviewee was displeased with what he characterized as “stacking the deck,” under the guise of broad-based consultation.

CONSULTATION MECHANISMS

The OPHO consulted various groups and interests about the content and form of the BC health goals through a multiplicity of consultation mechanisms and methods. These included workshops, group meetings, one-on-one briefings, and written submissions. For ease of presentation, the data on consultation mechanisms is organized by the six (consultation) steps undertaken by the OPHO below. Source document data provide the basis of this presentation, supplemented by interview data on interviewee perceptions of the consultation strategies applied.

The consultation strategy undertaken by the OPHO entailed the following steps:

Step 1: Health Goals Drafting Workshop

In October 1994, the Provincial Health Officer convened a meeting in the BC government Cabinet offices in Vancouver with about 50 people from various sectors, Ministries and organizations to develop a preliminary set of health goals. The meeting began with a presentation by the Provincial Health Officer on the multiple influences on health. A professional facilitator conducted the session and encouraged participants to “brainstorm” about what they would like to see in the health goals. The aim of the meeting was to “talk about, you know, what would... our
first crack at these goals look like" and to “scope out the issues” (OPHO).

Step 2: Reworking Draft Health Goals

Representatives of the OPHO developed a set of draft health goals based on (a) the issues identified in Step 1 and (b) a review of health goals in other jurisdictions. This rendition of the health goals (referred to as Version I in the context of this study) consisted of seven health goals. Version I health goals are presented in Appendix V.

Step 3: Consultation with Deputy Ministers and Ministers

The OPHO used the draft health goals as the basis for a presentation to a group meeting for Deputy Ministers representing all eighteen government Ministries. The Provincial Health Officer also conducted “one-on-one meetings with every Minister” (OPHO). The meetings endeavoured to rally support for the health goals from the multiple sectors that comprise government. The intent was that “[The Deputy Ministers and Ministers] would then send the word down through their ranks... you know, so that we would get a favourable response when we came knocking to get some advice on... content issues around the goals” (OPHO).

Step 4: Input From Provincial Ministries

Individuals within each government Ministry were identified as contact persons for the health goals initiative, following a letter from the Deputy Minister of Health to the Deputy Ministers of all other Ministries asking for their “full cooperation” with the health goals process. From June to August, 1995, members of the OPHO met with contact persons in each Ministry, informed them of the health goals project, provided background on the factors that influence health, and asked them to comment on the draft health goals.

Source documents further reveal that each provincial government Ministry provided comment on the draft health goals. They also identified areas within their sector where
measurable objectives could be established, forwarded policies and plans that were consistent with the BC health goals, and provided advice on indicators for measuring progress and possible sources of data.

**Step 5: Input From Provincial Stakeholder Organizations**

The OPHO invited about 170 provincial organizations from the health and other sectors to participate in the health goals project. Invited organizations were suggested by representatives of the eighteen provincial Ministries. During August and September 1995, representatives of more than one hundred provincial organizations attended a series of half-day meetings (See Appendix T for a list of participating organizations). Meetings included a briefing on the health goals project, a presentation by the Provincial Health Officer on the key influences on health, and discussion on the draft health goals. Additionally, participating organizations were invited to provide written submissions on ways in which the draft health goals could be improved, and to make suggestions about measurable objectives, targets and ways of measuring progress.

**Step 6: Preparation of a Public Discussion Paper for Regional Consultations**

Based on the input from government Ministries and provincial organizations, the OPHO developed a public discussion paper in November, 1995 which formed the basis for one-day public consultation meetings held in each of the then 20 health regions in BC. (This represented Version II of the health goals and consisted of 6 goals. See Appendix W.) The public consultation document, *Health Goals for British Columbia: Identifying priorities for a healthy Population, A Draft for Discussion* (British Columbia, November, 1995), included information on the determinants of health and the health goals development process. Otherwise known as the “blue document,” this paper proposed also a set of draft health goals and suggested measurable objectives and examples of possible measurement indicators.
The stated purposes of the regional meetings were “to increase public understanding about what makes and keeps people healthy and to obtain multi-sectoral comment on the draft goals and objectives” (Progress report, June 1996). A total of 1,130 people attended the regional meetings including interested members of the public and representatives from government and non-government organizations in health and other sectors. Regional public consultation meetings attracted between 40-100 people in each region. Through the regional meetings, about 4800 copies of the consultation document were circulated.

The OPHO sent each of the over 170 provincial organizations that participated in Step 5 a copy of the discussion paper and asked for their “reaction and advice.” Over fifty organizations and individuals provided input by (a) returning a response form that was included at the end of the discussion paper, or (b) by making a more in-depth submission. Several of these organizations also offered their assistance to refine measurement indicators and develop strategies to address the health goals and objectives.

While most participants judged the consultation mechanisms and strategies employed by the OPHO as satisfactory, some interviewees expressed displeasure and offered suggestions for alternative mechanisms. Several interviewees representing provincial stakeholder organizations (who took part in the half-day meetings) expressed that consultations should have been organized by groups with similar interests and perspectives, rather than by a single large group comprised of varying interests. In their view, one-on-one meetings with the health goals project team would have yielded more in-depth and meaningful discussion and a better exchange of views on the draft provincial health goals.

One interviewee suggested that “reference groups” could have been established around each of the key areas of the health goals. Each reference group would have been provided with
background information on health goals and then asked to report back with their recommendations in their key area (BC Public Health Association). A related suggestion came from a representative of the Ministry of Health who suggested a "stratified random sample of different groups;" consultation strategies would then be custom designed for each group, "appropriate to their culture, sector, [and] education."

The proposal to consult groups separately was supported by a representative of the business sector. This interviewee stated "if you want to talk to the business community, TALK to the business community." In the view of this participant, large meetings with representation from multiple groups and sectors makes it difficult for any one group to get their perspective across. This interviewee expressed also his dissatisfaction with the manner in which the context for the consultation meeting was "pre-set." He complained that starting the session with a "presentation of studies, as chosen by [the Provincial Heath Officer]" biased the discussion. In his view, the presentation by the health goals team contained evidence in support of their own position. This "did not provide balance" to the discussion; rather it set the context for the OPHO to acquire confirmation on what they considered to be the important issues. As someone who felt that health goals should deal more directly with "lifestyle and individual choices and personal responsibility and so on," rather than equity and social issues, he concluded that "a forum like that is not giving discussion a chance. It's not giving other opinions a chance to emerge."

**Emergent Dimensions**

**PREVIOUS CONSULTATION EXPERIENCE**

An issue that emerged from the interview data, that is not a part of the health goals framework, was how one's experience with previous government consultation processes influenced one's perception of the BC health goals process. Two interviewees remarked that
their involvement with the BC health reform (regionalization) initiative left them cynical of the health goals project. One interviewee admitted that she did not hold out a lot of hope that her views (that is, the views she represented) would be appropriately reflected in the BC health goals. She based her comments on her experience with “this whole regionalization process and how we were not properly consulted” (PSO, Special needs). This sentiment was shared with a representative of the non-health Ministry who believed that consultation on the BC health goals “will be very much like the New Directions [consultation]...[where] the provincial government hasn’t seen [it] important to allow us opportunity for full consultation.”

Other interviewees shared their reluctance about government consultation generally. A representative of the business sector remarked, “The government’s discussion of issues with the business community has been either non-existent or reluctant at best. And... I think that maybe colours... MY thinking and... my attitude [about health goals] a little bit” (PSO, Business). Another study participant believed strongly in consultation practices where people are involved “from the outset,” but was wary of consultation practices “where the job is done and then you are asked to review it.” This interviewee claimed she would wait to see the final version of the health goals before making any judgement in this regard about the BC health goals consultation process.

Theme 10: Core Contributions

Several groups contributed to the BC health goals development process. Core contributions included technical assistance, funding, organization, education and communications, leadership, and promotion.
TECHNICAL ASSISTANCE

Technical Assistance, which entailed contributions of knowledge, skills and information related to the development of health goals, was provided by all four subgroups in this study: representatives of the OPHO, provincial stakeholder organizations, regional health boards, and government Ministries. The summary below offers examples of technical assistance and associated quotations from subgroup representatives.

Technical assistance provided by the Office of the Provincial Health Officer included the following:

- Development of progress reports and preparation of documents related to health goals.
- Liaison with the provincial Ministries to collect information to support the articulation of health goals: "So, [an OPHO representative] ran around and talked to the Ministries and got them to send him... in their areas of expertise... what they could to help out with [goal setting]."
- Research on health goals from jurisdictions around the world
- Briefing meetings with Deputy Ministers on the health goals development process
- Development of an indicator database and collecting baseline data on various indicators
- Articulating objectives and identification of targets: "And then, I suppose technically, you know, I was meant to be responsible for pulling the targets together and so forth... and you know, specifying what the objectives were and all that sort of stuff... which I spent a lot of time doing."
- Making clear the message that "health is more than health care" and affirming OPHO’s focus on the multiple determinants of health

Technical assistance provided by the Ministry of Health included the following:

- Delineation of the deliverables that comprised the consulting contract for the development of health goals (Population Health Promotion Branch)
- Recruitment of facilitators for small-group working sessions at regional health board workshops and development and delivery of a facilitator training program: "We developed a training package... and [when] we would go out to participate in the community workshops, we would spend about an hour with the facilitators... prior to the public coming in... and we would train them" (Population Health Promotion Branch)
- Review and provide input on early drafts of health goals and suggest goals and objectives related to Ministry of Health interests: "We did have an opportunity... to provide our input and response to the first or second round of draft goals and to submit some indicators and suggested goals that the Ministry of Health would like to see included" (Population Health Promotion Branch)
• Assist in design of consultation processes for government Ministries, provincial stakeholder organizations and regional health board workshops (Population Health Promotion Branch)

• Support with data analysis and research (Policy, Planning and Economics Division)

• Source documents further demonstrate the contributions of the Ministry of Health: "Ministry of Health staff provide some logistical support and program assistance" (Briefing on the Project to Develop Health Goals for BC, October 16, 1995).

Technical assistance provided by other provincial Ministries included:

• Provide feedback on preliminary health goals as well as indicators, targets and strategies: "When we received the first communications from [the OPHO], our request was to... comment on the draft goals themselves, but also, more specifically, to look at how [our Ministry] could contribute to those [goals] in terms of specific outcomes, strategies, targets, data indicators... that type of thing.”

• Some Ministries sought input on the health goals from branches and divisions that comprised it. For example, the representative of one non-health Ministry, “So what I did, as having the lead role on this was... invite people from a number of different branches within the Ministry that might have something to say on this... I summarized the results of that... and wrote [it] up and forwarded a submission [to the OPHO].”

• To contribute expertise related to each Ministry toward content of health goals. A high level bureaucrat with another non-health Ministry remarked that her contribution included “helping [the OPHO] to consider some of the contributions to health status in Canada and particularly, in British Columbia, and the effects of economic indicators on health... and various issues relating to income adequacy and effect on health.”

Technical assistance provided by provincial stakeholder organizations included:

• Formal input on health goals at half-day meetings, followed by, written submissions on content and form of health goals (by some stakeholder organizations)

• Informal consultation on health goals on an ad hoc basis with representatives of some provincial stakeholder organizations: “On a less formal, unofficial basis... I would occasionally come into contact with [the OPHO] and they would try out the draft version of what seemed to be emerging... and say, ‘So, take a look at this... how do you think this sounds.”

• Advice on data sources

• Some provincial organizations encouraged their membership to write letters commenting on the preliminary health goals

Regional Health Boards provided technical assistance to the regional workshop / public consultation sessions in the following ways:

• Taking primary responsibility for organizing regional workshops: “The [regional health board] staff you know, got involved in setting up the meetings, recording,... technical
support stuff, for sure.”

- Generating invitation lists (based on suggestions from the OPHO) and mailing out invitations
- Booking a suitable location; making lunch and coffee arrangements
- Recording and taking minutes at regional workshops
- Recruiting local facilitators for small-group sessions at regional workshops

FUNDING

Study participants identified funding as another core contribution. Funding of the health goals development process came primarily from the Ministry of Health, which covered contract costs for the consultant and the seconded university professor. The OPHO covered costs associated with travel. The regional health boards met some incidental costs: “And sometimes [the regional health boards] were able to contribute and pay for a facility or get sandwiches in and that sort of thing” (OPHO).

ORGANIZATION

Organization of the health goals initiative was a function of the OPHO, with responsibilities chiefly assumed by the contracted consultant. Source documents include work plans developed by the consultant that outline the health goals project; including tasks to be completed, parties responsibilities, and projected time lines. The regional health boards, in partnership with the OPHO, were instrumental in organizing the one-day regional workshops. Typically, one individual in each region accepted responsibility for workshop planning.

COMMUNICATIONS AND EDUCATION

Interviewees commented on their contributions around education and communications. Most study participants identified public education as a chief role of the OPHO in the health goals development process. A representative of the OPHO, while acknowledging the role of health goals in “improving health, reducing health inequities, [and] controlling costs,” believed
that public education was the central aim of the BC health goals development process: “But beyond [those things] was the notion of more broadly getting the knowledge out there around, you know, what it is that makes people healthy. These beliefs guided each presentation by the OPHO which typically began with an educative session that included “a whole lot of overheads talking about what really makes populations healthy, particularly [related to] the social determinants of health” (OPHO).

The OPHO worked with the Communications and Public Affairs Branch (Ministry, Health) on health goals communications; with the project consultant handling much of the day-to-day communications between the OPHO and the provincial stakeholder organizations and government Ministries. Source documents confirm the role of the Communications and Public Affairs Branch; memos from the Branch to the OPHO refer to issues relating to communications, media, and advertising. Communications was a shared function regionally, where the OPHO and regional health boards worked together on the community workshops. One interviewee judged their efforts at communications as mostly unsuccessful and believed that greater use of local media may have led to greater interest: “There certainly wasn’t a sufficient communications plan... I think there [should have] been better media presence so that... the public were [made] aware that the [Provincial Health Officer] was embarking on this important project” (RHB).

Another interviewee, who undertook some of the public speaking on the health goals, believed the aim of communications on health goals was to “try to inspire people... not only the community folk, but people in government and so forth” to think more broadly about health. This interviewee viewed the health goals as a “cultural... phenomenon... not a technical one,” and hoped that they would bring people to understand the “ideas about the multiple dimensions of health... in a spirit of nurturing... rather than as [something] technical... that can be fixed by this
or that program” (OPHO). This interviewee hoped the health goals process would contribute to a “shift in public attitudes” and to increased understanding about the determinants of health and how they are “vital to our long term well-being.”

PROMOTION AND LEADERSHIP

One interviewee twinned the promotion of the health goals with advocacy for health goals by the Provincial Medical Officers of Health:

As a group... working with the medical health officers, one of the things we did was support the Provincial Health Officer’s initiative and advocate to the Minister about the importance of provincial health goals being developed (RHB).

Finally, in terms of leadership of the BC health goals development process, a simple statement by one interviewee captures the perception of all persons interviewed in this study:

“[The Provincial Health Officer] has been the leader of this” [OPHO].34

Theme 11: Time and Budget

Questions on time and budget generated some interesting data about the resources required in the BC health goals development process.

SET-ASIDE TIME

Most interviewees commented that they had specifically allocated or “set-aside” time available to them to participate in the health goals process. Some representatives of the OPHO, especially the contracted consultant and policy coordinator (seconded university professor), spent their time exclusively on the health goals initiative. Other representatives of the OPHO dedicated time on an as-needed-basis. Regional health boards allocated time for (typically) one person to

34 Additional evidence to support this claim has been included in earlier sections of this chapter, especially in relation to Theme 3: Proponents and Skeptics.
coordinate the health goals workshop. One regional health board representative claimed that she spent about half of her workday over a three-month period planning for the health goals workshop in her region: “I think I put in about 50% of my work day into... getting the invitations out, doing the phone calls to arrange the facilitators and talking to the [OPHO]” (RHB).

Provincial ministries did not allocate time specifically for health goals; work spent on health goals-related activities such as meetings with the OPHO and preparation of written submissions was typically integrated into the regular work day. A representative of one non-health Ministry estimated his time commitment to the health goals process: “I suppose over the entire length of time I worked on it... maybe the equivalent of a week or so.” Provincial stakeholder organizations characteristically set aside one-half day for agency representatives to participate in meetings hosted by the OPHO where they offered feedback on preliminary health goals.

TIME FRAME

Interviewees had mixed responses to questions on time frame. A few remarked that an overall time frame was established, that is, that there was some designation of the total amount of time available for health goals development. One member of the OPHO recalled that the health goals process was to be completed within one year (as stipulated by the Ministry of Health in the request for proposal for consulting services) and that certain milestone dates were suggested within that time frame: “Yeah, the [time] was all pre-set. The end point had been set... it... we had to sort of start at that point and work backwards and figure out then, how to schedule activity.” This interviewee believed that an insufficient amount of time was delegated for the complex undertaking of heath goals: “The time frame was done, I think, in a certain absence of understanding of what a complex thing it was that was being asked for” (OPHO). Another representative of the OPHO could not recall if an overall time frame had been established for
health goals development, “I can’t remember, you know... whether there was something imposed on us or not... in any case, we had it done long before [the time] was ever used [up].” Another representative of the OPHO shared a similar perception on time frame: “there was plenty of time to get the health goals done, because there hasn’t been any external pressure to get it done at a particular time.” Additional comment on time frame came from a regional health board representative who believed that sufficient time was not allowed for the planning of the regional workshop which resulted a session that was not as representative as she would have liked:

_The original [workshop] request didn’t come to me until November and we needed to set something up by February... and then, of course, we had Christmas and New Year’s and vacation time... so the time frame was too short. If we would of had [more time]... I could have done a lot more follow up and making sure that there was a bit more diversity in the participants (RHB)._

**SET-ASIDE BUDGET, SHARED BUDGET AND VOLUNTEER TIME**

The BC health goals development process drew on a specifically-allocated budget. This budget, funded by the Ministry of Health, covered some personnel costs, including the contracted project consultant and policy coordinator. However, contributions made by others -- staff of provincial ministries, provincial stakeholder organizations, and regional health boards -- were largely in-kind, and were not reimbursed by the health goals budget. Rather, representatives of these groups contributed “borrowed time;” they volunteered their time to the health goals project while remaining in their regular paid employment. Time was also volunteered, in most cases, by facilitators of the regional health goals workshops who, in return, hoped to benefit from the experience: “The community developers... volunteered their services to be facilitators... mind you they are always looking to hone their skills... and so... yes, it was all volunteer.”(RHB). Several interviewees remarked that the BC health goals process would not have been adequately represented if individuals were unable to volunteer their time in this way.
One interviewee questioned the amount of budget allocated to health goals and the use of contracted personnel. This interviewee asserted that the health goals project may have been just as well served by in-house (Ministry of Health) staff; he also implied that reliance of Ministry staff would have likely, in the end, resulted in cost savings.

*I'm not sure that this is something that needed the amount of money spent on it to produce the identical result... I think the Ministry [of Health] has an ample supply of very, very capable people who could have moved this forward without incurring the costs... Maybe [Ministry staff] kind of sell themselves short a little bit of their own capabilities... And, the financial incentives for things to take a long time aren't present when you use direct employees [that] are there when you use contracted staff (Ministry, Non-health).

Several interviewees challenged this view by recognizing the benefits of using (full time) contracted personnel to organize and coordinate the health goals development process and to provide technical assistance.\(^{35}\)

One interviewee estimated the overall budget set aside for the BC health goals development process at "about a quarter of a million [dollars]" (OPHO). Besides coverage of contracted personnel, this budget supported travel-related expenses incurred as a part of the province-wide consultations meetings and workshops. On occasion, various branches of the Ministry of Health, especially the Population Health Resource Branch, accompanied representatives of the OPHO to consultation meetings; for this, "they contributed their [own] resources...and travel costs" (OPHO).

**INDIRECT COSTS**

Indirect costs were also incurred and included things such as meeting rooms or facilities and lunch costs. The OPHO and the host group typically shared these costs. Where possible,

\(^{35}\) Evidence supporting this statement is included in earlier sections of this chapter. See (especially) Theme 10: Core Contributions.
public facilities were used such as Ministry offices (for consultation with Ministry representatives) and public health units (often, the site of regional health goals workshops): "We didn't have a lot of money for renting [facilities] so we usually tried to use health unit buildings or whatever" (OPHO). In relation to lunch costs at (full-day) regional workshops, the OPHO contributed $5.00 per person; the regional health boards met any expenditures above this and often relied on "local caterers or... hospital kitchens" (OPHO) to keep costs as low as possible.

Theme 12: Data

DATA REQUIREMENT

"Data requirement" refers to how data were applied in the development of health goals; that is, whether health goals and objectives were formulated only in areas where data were available or whether goal setting proceeded in areas where data did not exist or were unavailable. Most of the interviewees agreed that goal setting in the BC experience did occur in the absence of data related to some issues. One interviewee claimed that the representatives of the OPHO had several discussions on this and came to conclude the following: "Yes, it was a very delicate decision to at least set some objectives... in the absence of any capacity to measure. Because the sense was, if you set an objective, at least it provided an impetus to start thinking about it... and about measurement" (OPHO). Another interviewee, in response to a question on whether (some) BC health goals were formulated in the absence of data replied, "definitely" (RHB).

One interviewee gave a passionate rationale for setting health goals where data were unavailable or did not exist. In this interviewee's view, goal setting should be based on some theoretical understanding of "what we think is going on," and on things that are "culturally significant."
Now... sometimes, we put forward objectives that were not based in evidence, but [were] derived from a theory of what we think is going on... that needs to be stated... [where] there are no data available... But we believe these things to be true because they resonate with a theoretical understanding that we have about these processes and so forth... even though there’s no hard data to support them (OPHO).

This interviewee believed that setting goals and objectives in the absence of data was particularly relevant to the BC experience since little data existed in relation to the several of the broader determinants of health which comprise the BC health goals. This “new approach” to health goals which includes recognition of the distal determinants of health should not, in the view of this interviewee, be based on what data are typically applied, but rather, on “what matters.”

If [we] are saying, ‘Look we need a new approach here,’ then it doesn’t make sense philosophically to keep measuring the same things that you have always [measured]... Now, okay, we’re talking about living and working conditions... we’re talking about housing... we’re talking about social support... There is no necessary evidence tied to [these]... Those sorts of things are based on attitude... So we put them in because we just BELIEVE in them (OPHO).

DATA TYPES, SOURCES AND QUALITY

Study participants spoke about data types, sources, quality and access in very general terms. Related to data types, a representative of the OPHO remarked that they applied epidemiological data in the formulation process. Study participants provided a bit more detail in relation to data sources. One interviewee, a member of the OPHO, linked data sources for the health goals to sources used in the development of the Provincial Health Officer’s annual reports. These included: (a) Vital Statistics, (b) National Population Health Survey, (c) hospital morbidity databases, and (d) individual databases maintained by various programs throughout the health system. CIAR materials, as mentioned earlier, was identified also as a data source. A few interviewees related that the “source for numbers” for the health goals and objectives was, very often, the provincial government Ministries: If we were [setting objectives] in the area of the
environment, then we would rely on sources [at the Ministry of Environment]... If we were looking at, you know, things like economic indicators, we’d go into that area... just whatever” (OPHO). This is confirmed by memos that comprise the source documents on the BC initiative which include requests to Ministries for information related to goals and objectives in their area.

In relation to data quality, a representative of the hospital sector characterized the data used in the goals process as out-dated; this interviewee shared her concern that reliance on “old” data would perpetuate what she considered to be a lack of attention to women’s health issues: “At least in my mind, the kind of data they [were] using was antiquated... It’s just using data that’s going to take them to an old place.” Another interviewee commented that data quality is typically suspect: “Numbers are problematic... the are often are cooked or... you know, come... or fall out of the sky... they are always partial, they never necessarily connect to what you’re trying to accomplish and so, you know, you can get into real difficulties” (OPHO). Other comments related to the quality of data were made in relation to the Provincial Health Officer’s annual reports (these two initiatives were commonly confounded in the minds of some interviewees since both were coordinated by the OPHO).

DATA ACCESS AND AVAILABILITY

Access to data was not a problem in the BC experience. Government Ministries provided most of the data and the OPHO had full access to Ministry personnel (due to earlier communications from the Deputy Minster of Health encouraging the deputies of all Ministries to support the health goals initiative). Access was enhanced by personal, informal relationships that were forged between members of the OPHO and various Ministry personnel. One interviewee reflected on Ministry support: “There was always someone [ready] to help out... It might be a research officer in this Ministry... or a policy person in another Ministry” (OPHO). Knowing

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whom to contact in each Ministry enhanced efforts by the OPHO to secure data related to health goals in the formulation phase.

DATA MANAGEMENT

Finally, a few study participants believed that the BC health goals initiative led to the augmentation of existing data management systems. Once again, several interviewees linked the health goals initiative to other OPHO projects. When asked if the health goals were linked to the data management system for the Provincial Health Officer’s annual reports, a representative of the OPHO remarked, “They’re identical.” Another interviewee perceived the health goals as a stimulus for better data management systems. In her view, once the health goals were adopted, “the pressure would be there to start building better data systems or tying together existing data systems” (OPHO).

Emergent Dimensions

ROLE OF EVIDENCE

Study participants brought to light an additional issue related to the data theme -- the perception of study participants on the role of evidence in goal setting. Interviewees at large, and within the OPHO, offered mixed responses on evidence. One representative of the OPHO stated firmly, “we were committed to using the best evidence that was available.” Another member of the OPHO concurred that evidence did play a role in the process, especially in relation to the multiple determinants of health and the links between them: “[Evidence] played a role just in terms of being able to identify... some of the... influencing factors or determinants with certain health conditions or health behaviour.

Another member of the OPHO was less clear about the role of evidence in the BC health goals exercise. On the one hand, this interviewee portrayed the BC initiative as evidence-driven,
based on the following: (a) the application of literature on the determinants of health including materials produced by CIAR: "What we in essence did was...work from the evidence of 'Why Some People are Healthy and Others are Not,' and the whole CIAR framework... and that was our evidence base; (b) a review of the international literature on health goals: "[We] combed through everybody's health goals in the world;" and (c) efforts by the OPHO to involve Ministries in suggesting baselines and indicators for measurable objectives. On the other hand, this interviewee ascribed a minimalist role for evidence in the BC health goals by describing the development process as "pretty 'loosey goosey'" (OPHO).

Several interviewees representing provincial stakeholder organizations and regional health boards believed that evidence played a significant role in the development of the BC health goals. The use of regionally-specific data in OPHO presentations to regional health boards was considered by most as representative of an evidence-based approach. A representative of a provincial health organization believed that the people most involved with the health goals process "were keeping at least one eye on any available evidence." This interviewee went on to say: "The [OPHO] were certainly aware of the work of the CIAR or other groups that were working in the health determinants... So, in that sense, I think, data and evidence were important." However, this interviewee commented that because BC was dealing with goals that were "broader than... most or some other types of health goals in other jurisdictions... [the] actual need for specific data sets... I don't think, was quite as critical." Like others, this interviewee had mixed feelings on the role of evidence in formulating health goals that addressed the broad health determinants.
Table 12: Factors that Facilitated and Obstructed the BC Health Goals Development Process
Phase Two: The Formulation Phase

<table>
<thead>
<tr>
<th>Theme 6: Levels and Sectors</th>
<th>Facilitating</th>
<th>Obstructing</th>
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<tbody>
<tr>
<td></td>
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<td>- Perception among provincial stakeholder organizations that they were not expected to adopt or translate provincial health goals</td>
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<td>- Perception by some that health sector was overstepping its mandate, “health imperialism”</td>
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<td></td>
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<td>- Lack of fit between Ministry of Health mandate and health goals</td>
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<tr>
<th>Theme 7: Coordinating Mechanism</th>
<th>Facilitating</th>
<th>Obstructing</th>
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<tr>
<td></td>
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<td>- Uncertainty of where responsibility for health goals rested (coordinating mechanism)</td>
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<td>- Turn-over of political leaders and upper-level bureaucrats</td>
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<td>- Proximity of the OPHO to the Minister of Health (accountability to Minister versus citizenry)</td>
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<td>- Bureaucratic influence from Ministry of Aboriginal Affairs</td>
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- Letter from Deputy Minister of Health to Deputy Ministers of all government Ministries requesting their “full cooperation”
- Health goals “packaged” as government versus Ministry-specific health goals
- Linking provincial health goals to developing regional health plans
- Perception among provincial stakeholder organizations that they were not expected to adopt or translate provincial health goals
- Perception by some that health sector was overstepping its mandate, “health imperialism”
- Lack of fit between Ministry of Health mandate and health goals

- Support to coordinating mechanism from health goals steering committee which included staff from various Ministry of Health branches and divisions
- Support to coordinating mechanism from key individuals and groups on an ad hoc basis (e.g. medical health officers)
- Support to coordinating mechanism from political leaders and high level bureaucrats
- Trickling down of support from Ministerial level through the layers of Ministerial bureaucracies
- Perception of support from political leaders stimulated interest in health goals in the health regions
- Proximity of the OPHO to the Minister of Health (direct-line reporting relationship)
### Theme 8: Strategic Direction

<table>
<thead>
<tr>
<th>Facilitating</th>
<th>Obstructing</th>
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</table>
| - Effective use of evidence and published materials (on the multiple determinants of health)  
- Comprehensive approach, addressing most priority areas contributed to acceptance of health goals  
- Non-partisan stance of OPHO  
- Seeking support from members of the official opposition party  
- Linking health goals with Provincial Health Officer’s Annual Report and with several ongoing government initiatives  
- Use of pre-established health goals  
- Structuring consultation sessions in order to achieve expected result or conditioning the process | - Insufficient mix of (contributing) experts  
- Perception that health goals were driven by political agenda  
- Structure and process of consultation sessions (pre-established goals, choice of evidence/studies) did not allow for full disclosure of views |

### Theme 9: Consultation and Participation

<table>
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<th>Facilitating</th>
<th>Obstructing</th>
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</table>
| - Broad based consultation to bring on-side all parties with potential to influence aspects of health goals  
- Early on consultation and buy-in from all (18) Ministries  
- Participation by all (20) regional health boards to carry the message at the regional level | - Consultation dominated by health sector representation in some RHB workshops and some meetings with provincial stakeholder organizations  
- Large group discussion sessions that did not allow for full disclosure of views from multiple interests and sectors  
- Introduction to consultation sessions with stakeholder organizations was pre-set -- focused on the multiple determinants of health, biasing the discussion on draft health goals |
## Theme 10: Core Contributions

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<th>Facilitating</th>
<th>Obstructing</th>
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<tbody>
<tr>
<td>- All core contributions made by various parties facilitated the health goals development process including: technical assistance, funding, organization, education and communications, promotion of health goals, and leadership</td>
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## Theme 11: Time and Budget

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<tr>
<th>Facilitating</th>
<th>Obstructing</th>
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<tbody>
<tr>
<td>- Specially allocated time was set aside for health goals development</td>
<td>- Overall time frame for health goals development was insufficient</td>
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<tr>
<td>- Allocation of specific budget</td>
<td>- Mixed perceptions among the health goals coordinating team (OPHO) on whether an overall time frame was established</td>
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<td>- Ability and willingness of individuals to volunteer their time to assist in the health goals process</td>
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<td>- Use of full time contracted personnel to organize and monitor the initiative and to provide ongoing technical assistance</td>
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<td>- Use of public facilities to cost save for health goals presentations / consultation sessions</td>
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## Theme 12: Data

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<th>Facilitating</th>
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<td>- Goal setting proceeded in the absence of data related to particular issues</td>
<td>- Data used was outdated; data quality was questionable</td>
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<td>- Provincial Ministries helped to assemble and forward “numbers” for health goals and objectives;</td>
<td>- Mixed perceptions on the role of evidence in health goals planning</td>
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<tr>
<td>- Favourable personal (and informal) relationships between OPHO and Ministry personnel; OPHO had full access to Ministry personnel</td>
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<tr>
<td>- Health goals perceived by some to be effective way to augment and improve existing data management systems</td>
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PART C: FACTORS INFLUENCING HEALTH GOALS DEVELOPMENT
IN THE ARTICULATION PHASE

Whereas the first two phases of the health goals development process - the premonitory and formulation phases - focused on how health goals are developed, the articulation phase focuses on what the health goals come to say. Attention is paid to the level of operationalization of health goals into measurable objectives, quantifiable targets and strategies for action; the content of health goals in terms of the types of priorities addressed; the emphasis on distal and proximal influences on health; and developments that may occur late in the health goals development process. Interview and source document data for each theme that characterizes the articulation phase are presented below.

Theme 13: Specificity and Methods

“Specificity” of health goals refers to the degree to which the health goals were operationalized into measurable statements of health gain or risk reduction. This section groups the data on “specificity and methods” into six key areas. These areas reflect study participants’ perceptions of (a) the vision and principles of the health goals, (b) the intent for specificity of health goals (c) the need (requirement) for measurable health goals, (d) methods to establish specificity of health goals, (e) the level of measurability of health goals for Cabinet submission, and (f) the role of language in the BC health goals. Source document data is also presented.

• PERCEPTIONS ON SHARED VISION AND PRINCIPLES

Only a few study participants commented on the underlying shared vision of the BC health goals. A representative of the public health sector shared his belief that the health goals helped to “provide a focus for action” for improved health. Similarly, a representative of a
provincial stakeholder organization (health sector) envisioned that the BC health goals would help to facilitate joint action and to move the health agenda forward:

*I think first [the health goals] create sort of a joint vision... [to] work above the individual silos... [The health goals are] a recognition that we are inter-connected... a recognition that if we work together we an move things forward* (PSO, Health).

Source documents on the BC health goals establish an “overarching purpose” for the health goals:

*To maintain and improve the health of British Columbians by enhancing quality of life and minimizing inequalities in health* (British Columbia, 1995).

Source documents offer also a preamble to the health goals that reinforces the health determinants approach; additionally, they set forth a set of principles that underlie the health goals:

*The BC health goals and objectives are based on knowledge about the broad and interrelated factors that determine and influence health over the human life-course. They provide a framework to help us better understand the relationship between the health outcomes we want and our efforts to achieve them. The following principles and assumptions underlie all of the goals: collaborative action, public participation, equitable access to health care, and respect for diversity* (British Columbia, 1995).

- **PERCEPTIONS ON INTENT FOR MEASURABILITY**

Study participants demonstrated mixed perceptions on the intent for specificity of the BC health goals. Some interviewees believed that the BC health goals intended to be operationalized into measurable statements of health gain or risk reduction from the start:

*The intention is that [the health goals] would translate into measurable objectives... into setting very clear specific objectives* (Ministry, Health)

*My impression from early on was that the goals were only a step to getting to the objectives with ‘measurables’... that really the ‘measurables’ were the key component of the whole thing* (RHB).

Others believed that specificity was not the intent of the BC health goals:
The health goals were really seen as... sort of the guiding statements... providing strategic direction (Ministry, Health).

One participant, while believing that measurability was intended, commented on the challenge of operationalizing the health goals in specific terms:

_We had a hell of a time getting off the general, you know, the big, wide vision stuff... Getting down to targets was very hard (OPHO)._  

• PERCEPTIONS ON MEASURABILITY REQUIREMENT - FAVOURABLE

Mixed perceptions occurred also on the need for measurability of the BC health goals; and individual interviewees expressed strong feelings on both sides of this issue. Many interviewees believed that the BC health goals needed to be highly measurable and offered reasons why.

One interviewee claimed the BC health goals initiative would not have been worthwhile if it resulted in health goals that were not specific or measurable:

_If the health goals are just airy-fairy... then [this process] hasn’t been useful (BC Health Association)_

Several interviewees believed that the health goals needed to be stated in specific, measurable terms in order to generate concerted actions toward improved health:

_I think that [targets] are an ultimate thing to get to... that’s what’s going to galvanize action... when we actually start to look at hard numbers and trends over time (RHB)_

_Having clear targets to work with is very important. If you don’t have a good sense of what you’re trying to achieve - how can you ever hope to get there?... so [targets] would certainly be very important to us... (PSO, Health)._  

Similarly, some interviewees claimed that unless goals were stated in specific terms, they would be more “statements of good will” than stimulators of action:

_Unless ultimately you push it down to, ‘What does this mean in terms of measurable goals we can achieve?’ all you are doing is getting people to agree on platitudes (PSO, Health)._
If the process had just stopped at setting broad health goals and didn’t try to get down to the level of setting objectives with indicators and targets, than it really would have been more motherhood than action-oriented. So, I think that was recognized and that’s why... I certainly supported it (RHB).

One interviewee, while supporting the need to be specific in goal setting, recognized the challenges of getting to the level of targets for improved health within her own organization:

Setting targets... it’s, you know, something we believe in, something that we continue to work towards but... its hard and its time consuming... and you know, they change all the time, so its not something that you sort of carve in stone and then... you’re finished with (PSO, Health).

Statements from study participants demonstrate that mixed feelings existed among members of the health goals coordinating mechanism (OPHO) about the requirement for specificity of the health goals. Some individuals believed that it was important to get to the level of targets, others did not. One interviewee, when asked whether consensus existed among the OPHO to set measurable objectives with targets for improved health, replied: “It went back and forth” (OPHO). Another member reflected on the measurability issue:

Initially, it was yeah, targets, go, go, go... And although I was never swayed that way myself... but that was sort of what [others were] interested in doing... Through time, I think, [they] began to appreciate the peril of targets (OPHO).

Besides commenting on the operationalization of health goals into measurable objectives and quantifiable targets, some interviewees noted an absence of action strategies in the BC health goals. One interviewee said, “No one talks about how to do these things.” (PSO, Health Association). A representative of the OPHO explained that the identification of action strategies was not a part of the health goals development process: “No, strategies weren’t a part of”[this] (OPHO); and strategies to meet goals would be defined once the health goals were endorsed by the Cabinet of the government of BC.
PERCEPTIONS ON MEASURABILITY REQUIREMENT -- NOT FAVOURABLE

While some interviewees made strong arguments in favour of specificity of the BC health goals, others expressed their reluctance to this approach and offered their reasons why.

One interviewee was not convinced that a highly specific approach would suit the BC health goals, especially since, in this interviewee’s view, the intent of the BC health goals was to move "beyond diseases" to address the various factors that influence health:

I suppose there was a bit of a reluctance to take a functionalist stand, measuring this thing to go down by that much, because I just... I personally don’t believe that’s the way to go... that leads us to count the things that we can count well and back into the ‘Okay, how many cases of this disease or that disease’ (OPHO).

A representative of the OPHO who was largely responsible for the identification of targets and indicators characterized personal efforts as “largely unsuccessful” and attributed this to a personal reluctance to measurability:

I suppose, technically, you know, I was meant to be responsible for pulling the targets together and so forth and you know, specifying what the objectives were and all that sort of stuff... which I spent a lot of time doing. But I don’t think I was terribly successful in articulating good targets and good indicators, partly because... there’s a lack of information, partly because I’m not sure how inspired I was, given my reluctance [to this] personally... philosophically.

In this interviewee’s view, health goals were better conceived as a cultural value, as something to be “believed and understood,” than as a measurement mechanism:

I think that these things, if they are just BELIEVED and held as a cultural value, then the need to [measure]... and to track them and so forth, will fall away... (OPHO).

Another interviewee agreed that the health goals exercise was more about broadening understanding than about numbers or measurement:

Specific targets like that are never achieved... Many of us were somewhat sceptical [of targets]... pie in the sky... we were [more interested] in developing an understanding and recognition, philosophically, that if we all work together, [health] is achievable (Ministry, Aboriginal Affairs).
Reluctance regarding the measurability of health goals came also from the regional level. A representative of a regional health board shared her hesitancy to support high measurability in the health goals because doing so may turn people away.

Just talking about health goals is so new to some people... Maybe, we can get to those specifics after awhile... my feeling is that if you were terribly specific right off the bat, people would yawn and walk away from the table... I think the bigger net catches more interest (RHB).

• PERCEPTIONS ON METHODS TO ESTABLISHED SPECIFICITY

Study participants identified several methods to establish measurable goals and objectives in the BC health goals exercise. Applying normative standards or benchmarks from other jurisdictions established some targets:

A number of different [baselines] were taken - whether a WHO [World Health Organization] standard, or the best region in the province, or the best region in the world (OPHO).

Interviewees shared also that setting targets involved “borrowing targets” from Ministry branches and divisions that had previously established goals as a part of their programs and policies:

The Ministry of Environment... had a number of targets that [we used] (OPHO)

[We used] public health nursing targets on breastfeeding (OPHO).

Still other targets represented “best guesses” by representatives of the OPHO.

• ROLE OF LANGUAGE IN THE BC HEALTH GOALS

Study participants shared their perceptions on the role of language in the BC health goals in terms of the choice and application of words to portray meaning or tone. Several interviewees commented on the use of clear language in the BC health goals and believed that this increased understandability and accessibility of the health goals among many people:
As far as I am concerned, the language is clear and succinct (OPHO).

I think they were making an effort to make the goals understandable... accessible (PSO, Hospital).

We tried to use that kind of language and you know... the 'living and working conditions' as opposed to 'social-economic environment'... and make it accessible and make it about daily life (OPHO).

One interviewee, in reflecting upon the health goals exercise, remarked that the health goals initiative may have been better served if health goals were referred to as something other than “health goals.” This interviewee surmised that the use of the term “health goals” focused public attention on “health care” rather than on the multiple influences on health. Further, the term “health goals” may become associated solely with the Ministry of Health which ran counter to the expectation that the goals be seen as a government-wide initiative. This interviewee contemplated other terms that may have been used in BC and reflected on the use of terms in other jurisdictions:

*I could be convinced now that we would be better off not calling them health goals... 'quality of life goals' or even, like the Oregon thing where you just call them 'benchmarks,'...[That way] you get away from the health thing... because so many of the public think you are talking about health care, no matter what you do to try to move it away from that, it becomes the association, just by word... Then it becomes Ministry of Health and that’s not appropriate” (OPHO).

Finally, one interviewee representing the executive level of a non-health Ministry, claimed that the term “health goals” would not be used, but rather, would be substituted by the term “health challenges.” According to this respondent, the change in terms would yield a product less politically charged: “The political problems [with health goals] mean that we will not see health goals in British Columbia... that we will have health challenges.” This interviewee went on to explain that the change in language would make it easier for the government of the day to manage the issue:
You know, they’ve been published as ‘health challenges,’ so ‘health goals’ are gone, period... And that’s about issues management, and health goals is an issue and so health challenges are, you know, more easily managed.”

In the view of this interviewee, the adoption of the health goals may have been threatened without the change of language: “It may have died if it had gone inside [Cabinet] and so, you know, getting it on the ground as health challenges, I think is a great success.”

As source documents reveal, “health challenges” were not, in the end, substituted for “health goals;” the final version of health goals adopted by Cabinet and published in December 1997 is entitled, simply, Health Goals For British Columbia (BC Ministry of Health and Ministry Responsible for Seniors).

• MEASURABILITY AND CABINET SUBMISSION OF HEALTH GOALS

Only a few study participants were able to comment on the final version of the health goals that were submitted to Cabinet for official endorsement. This was due in large part to the activities during the period just before the submission that were privy to only a few individuals within the OPHO. Those who commented on the health goals that constituted the Cabinet submission agreed that the goals demonstrated low specificity or measurability:

 Well, anyway, in the final documents that went to cabinet there weren’t any targets in there anyway (OPHO).

There won’t be [targets or] stated levels within any periods of time in the [cabinet] submission... those have disappeared... We are looking at trends here... not targets (Ministry, Non-health).

Last I heard... all that was going to Cabinet was, the big, broad, squishy stuff... goals and some objectives... to give them a flavour for what we were talking about (OPHO).

Several interviewees offered reasons as to why the health goals submitted to Cabinet were not stated in measurable or specific terms:

One interviewee hypothesized that highly specific health goals would set the government
up for potentially embarrassing situations:

The reality is that commitment to those health goals... by the government... may ultimately wind up putting them in embarrassing situations. Embarrassing situations in terms of the politics... so the opposition suddenly goes after their hide. OR, embarrassing in terms of being able to deliver or make available the appropriate level of resources in order to accomplish [the goals]. And those are big risks for politicians (PSO, Public health).

Related to this, a representative of the OPHO suggested that measurable health goals would not be appealing to government leaders because they were too politically sensitive:

I can understand why [the cabinet] didn’t want [targets]... You know, there is a lot of political exposure potential there. So it didn’t’ surprise me too much that they didn’t want to go for that. You know, this is not rocket science... this is political science!

This interviewee went on to say that the inclusion of targets in the cabinet submission may have led to the demise of the BC health goals. In this participant’s view, less measurable health goals were less intimidating to government leaders and therefore increased the likelihood that they would be officially endorsed by Cabinet:

I’m not disappointed of the fact that [targets] weren’t a part of it... it could have been so complicated nothing would have happened. It would have died. And so this is not a bad trade off. At least... they are now out there in kind of a non-threatening way (OPHO).

The aim, according to another OPHO representative, was to get the health goals adopted by Cabinet so that the Provincial Health Officer could deliver on his mandate to report annually to the BC legislature on the health of British Columbians “against measurable targets.” This meant taking steps to win the support of Cabinet leaders without hostility or confrontation.

The [Provincial Health Officer’s] position has always been, “Look, I’ve got this mandate... it’s my responsibility, so I am going to do this come hell or high water... but, I’d rather do it with their blessing and so I’m going to do whatever I can to engage them... rather than to create hostility and just end run them” (OPHO).

Study participants offered additional related reasons for low specificity of health goals.
One participant surmised that it came down to accountability. The concern was that government leaders would be held accountable for the goals, even though they did not “control the processes” that would work toward their achievement.

_We [debated] whether or not we should in fact emphasize targets because people had said, ‘Look, if you set specific targets you are going to lose support for this because we can’t control these processes... but you’ve put a target date down, down there and we haven’t made the target and now we’re responsible...’ So, we wanted to be a little bit soft on targets (OPHO)._

Another interviewee agreed. When informed that the final version of health goals were not stated in measurable terms, he remarked:

_I wouldn’t be surprised... And, the reason of course, is that... once it’s approved by Cabinet they are really tied to it and they don’t want to tie themselves down with something so specific that it may not be achievable...so I understand that (Ministry, Non-health)._

A representative of the Ministry of Health concurred and suggested that this has resulted in greater expectations for accountability at the program level:

_There is a reluctance... by the government to set targets. Because, then as elected officials... they can then be held accountable for them, especially in the short term... As a result of that there’s been a greater push for greater accountability within programs, for setting targets, for setting measurable targets and for being accountable for them (Ministry of Health)._

While several study participants expressed that they would be disappointed if the BC health goals were not highly specific (with targets), they believed that the potential for specificity still existed as a part of the Provincial Health Officer’s mandate:

_The [Provincial Health Officer’s annual] report allows targets to be developed without the government being hung out to dry on them... it can still be done... (OPHO)._

_We’ve built in a mechanism [in the annual report]... where there is a requirement for regular reporting on targets (OPHO)._
[The Provincial Health Officer] can pick them up in his report... and in fact he’s mandated to do that (Ministry, Health)

• LEVEL OF SPECIFICITY AS REFLECTED IN SOURCE DOCUMENTS

Source documents reveal a clear intent for specificity of the BC health goals; however the commitment to measurability waned with each subsequent version of health goals. In an article on health goals in the Health Network Newsletter, October 1996, the Provincial Officer of Health shared his vision for the BC health goals. He asserted his intentions for measurability and claims that the BC approach was unique among the Canadian provinces in its aim for a high level of specificity of health goals:

_Virtually every province in recent years has been developing health goals, but these... largely have been broad, statements of intent. Where BC has tried to be innovative is in closely tying targets, indicators and benchmarks to measure the province’s progress... the BC process of having targets, indicators and benchmarks, we hope, takes it to a much different level than other provinces (p. 7)._  

Meeting notes generated from a June 1995 health goals meetings, hosted by the OPHO, made clear the intent for specificity; they outlined tasks for government Ministries relating to the health goals. Ministries were asked to (a) identify goals to which they think they can contribute, (b) identify concrete, measurable objectives for their Ministry to address those goals, (c) provide related data, information on existing or planned measurement indicators, measurement and tracking capacity, and (d) establish an internal process to do the above. The notes go on to explain that “to be measurable, there has to be the potential to set targets and develop measurement indicators and tracking systems.” The notes further advised that, “where possible, targets could be set now, but the intent is that once the objectives are established, Ministries will then work on targets and then implementation measures to address the objectives/targets.”

Briefing notes on the progress of the health goals project, dated October 16, 1995,
demonstrated early signs of resistance to targets from government Ministries, but reassert the intention to go forward with a measurable approach:

*Although many priority areas for objectives were suggested by Ministries, little was provided in the way of quantitative objectives and targets... Advice from several Ministries is to avoid setting numerical targets.*

Feedback on health goals from provincial stakeholder organizations illustrated similar hesitancy toward measurability:

*Written input [from stakeholder groups] focuses primarily on advice about goal statements and suggestions about priorities and strategies for change rather than concrete measurable objectives.*

Feedback on health goals from the Ministries and stakeholder groups formed the basis of the public consultation document, *Health Goals for a Healthy British Columbia: Identify Priorities for a Healthy Population, A Draft for Discussion,* to guide regional workshops and public consultations. A briefing note from the OPHO (November, 1995) recognized the hesitancy towards specificity from Ministries and stakeholder groups and explained: "*it seems unlikely that numerical targets for most objectives can be proposed in the consultation document... However, the intent is still to work toward quantitative objectives for the Cabinet submission.*"

Materials that comprised the Cabinet submission disclosed that the original hope and expectation for highly specific health goals would not be realized. Source document materials related to the Cabinet submission of the health goals spoke more cautiously about aims for high measurability and predicted that, "*the document that will be presented to Cabinet...will contain proposed goals and objectives with indicators and targets where possible*" (Update on Development of Health Goals for BC, November 16, 1995). The version of health goals that was submitted to the Cabinet of the government of BC in June 1997 included goals, objectives, indicators, targets and lead sectors; but was accompanied by a request to Cabinet that it consider
only the health goals and objectives, and not the indicators, targets and lead sectors. The final version of health goals published in December 1997 included goals, objectives and examples of indicators only.

The BC source documents reviewed in this study reveal five versions of health goals developed during the period October 1994 to December 1997. (See Appendices V to Z for versions of goals and the genesis of each). Versions I through III represent draft iterations of health goals. Version IV portrays the version of health goals adopted by Cabinet in June, 1997. Version V represents the version of health goals published in December 1997. Table 13 presents the various versions of the BC health goals in relation to specificity. It highlights the following:

1. Goals: The number of goals varied between 6 and 7 across the five versions (the next section will address the variation in the content of goals across versions).

2. Objectives: All but the first version included objectives. The number of objectives varied across versions; the final version having the lowest number. The goal addressing Aboriginal health in Versions IV and V did not include any objectives.

3. Indicators: All but the first version included indicators. (Although indicators were included with Version IV, the version that went to Cabinet; Cabinet was asked to consider only the goals and objectives).

4. Targets: Two versions of the health goals - Versions III and IV - included targets. Most of the targets were associated with the health goal that addressed reduction of preventable illness, injuries, disabilities and premature deaths (Goal 7 in Version III, and Goal 6 in Version IV). (Again, although targets were included with Version IV, Cabinet was asked to consider goals and objectives only.) No targets were included in the final, published version of health goals (Version V).
5. Action strategies: Action strategies were not proposed. However, Versions III and IV identified lead sectors which comprised those government Ministries responsible for progress toward specific goal areas. The final published version of health goals did not include lead sectors.

<table>
<thead>
<tr>
<th>Version</th>
<th>Goals</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Targets</th>
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<th>L.S.*</th>
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<td>#</td>
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<td>6</td>
<td>Y</td>
<td>50</td>
<td>Y</td>
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</tr>
<tr>
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<td>64</td>
<td>Y</td>
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<td>6</td>
<td>Y</td>
<td>46</td>
<td>Y</td>
<td>152</td>
</tr>
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<td>V Dec/97</td>
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<td>6</td>
<td>Y</td>
<td>44</td>
<td>Y</td>
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</table>

* L.S. stands for “lead sector”
- Versions I, II, and III were pre-Cabinet submission renditions
- Version IV was submitted to and adopted by Cabinet (* Cabinet was asked to consider the health goals and objectives only; and not targets, indicators or lead sectors
- Version V was the version published for public dissemination (December, 1997)

**Emergent Dimensions**

**SPECIFICITY RESPONSIBILITY**

An additional issue related to “specificity and methods” arises from the interviews with
study participants. This may be called “specificity responsibility,” and it relates to the perception of study participants on where targets should be set. All interviewees who commented on this issue believed that target setting should occur at both provincial and regional levels.

Interviewees believed that target setting at both levels would facilitate the development of action steps toward goals, the delineation of roles and responsibilities for goals accomplishment, and the monitoring of progress toward health goals over time.

Only one interviewee, while believing that targets should be set at both levels, doubted the likelihood of this occurring regionally due to a lack of availability of regional data:

*Actually, I think [targets]... definitely should be set at the provincial level because of the provincial mandate for health... I don’t think the province... should opt out of having some kind of provincial sense of what it would like to set as [measurable] objectives... As far as the regional level, setting specific targets there is going to depend quite a bit on the ability to actually measure them... It may not be possible to actually get the data at the regional level (RHB).*

A representative of a regional health board believed that not only should targets be set at the regional level but that regions should be held accountable for progress toward them:

*The Minister [should] hold these regional health authorities accountable for demonstrating how they intend to move on the health goals. .. And part of that... addressing the health goals, would require the establishment of specific targets at the regional or local area.*

Another interviewee took an even broader view and claimed that the health goals should guide target setting not only at the regional level, but also at municipal and organizational levels.

*Yeah, I think that the role that the health goals can play is to provide an umbrella where all the targets feed into one process... I don’t think it’s particularly meaningful... to have provincial health goals without saying, ‘Okay, what are the goals at a regional level, both within regional health boards and also for municipal governments, and for organizations like ours’ (PSO, Health).*

This interviewee drew a comparison between target setting at the provincial level and at the level of her own organization:
For me, it’s no different than if you were working in an organization, you wouldn’t have an organizational goal without having individual departmental goals and then, individual, personal, professional goals, within the department... so you can say... you are all trying to move in one direction (PSO, Health).

Several interviewees agreed that the provincial targets can be used as a model for regional goal-setting, but that regions needed to have autonomy over establishing their own targets. This would allow them to address local priorities and conditions and to acquire a sense of ownership over the goals:

*I would almost see the provincial target as being sort of the gold standard... and I think that what the regions need to do ... is to set targets that they believe they can achieve... Because if, you know, someone else imposes a target on you... that you don’t think you’ll be able to meet... there’s nothing empowering about that at all*(PSO, Health).

Similarly, an interviewee with the OPHO claimed that regional target setting would “be a way of bringing people into the process... and showing that these goals aren’t ours, as it were... they belong to the body politic... and that, you know, everybody... made some contribution that way.” Another interviewee believed target-setting at both regional and provincial levels would help everyone in the system to “know what their business is.” Further, “it would assist [regions] in... writing their own report cards, in a sense... to have a better sense of what it is that they, in their region, are charged with accomplishing” (PSO, Health Association).

**Theme 14: Priorities Addressed**

Discussion on this theme begins with a review of interviewee perceptions on the number of priorities addressed and the kinds of criteria used to choose among health-related issues in the development of health goals. This is followed by a report on the data related to nine priority areas that comprise the health goals framework. Those priority areas less referenced by interviewees
are summarized first and compared to priority area references in source document materials. This is presented in summary form. This section proceeds with a more comprehensive presentation of data on two priority areas most mentioned by interviewees: (a) health care system, and (b) population subgroups. This discussion not only reports on interviewee perceptions but traces the evolution of these two priority areas across the multiple versions of the health goals.

LIMITED OR MOST PRIORITIES ADDRESSED

Theme 8 above summarized the data on the "strategic approach" to health goals in BC, characterized by most interviewees as comprehensive in nature. Questions related to the number of priorities addressed (as a part of this theme) uncovered similar perceptions. Interviewees believed that most priority health-related issues were addressed in the BC health goals. A representative of the OPHO who reviewed health goals in various jurisdictions around the world commented on the range of priorities addressed: "[The BC goals] are SO massive.... you know, it's like this might as well be about what is the meaning of life... it's sort of a statement of social policy for wonderfulness" (OPHO). This interviewee goes on to explain that based on the increasing evidence and understanding about the multiple determinants of health, "I don't think anything but a broad comprehensive approach that looked at all the determinants of health would have been... well, [it] just wasn't the thing to do [in BC]."

PRIORITY-SETTING CRITERIA

On the issue of priority-setting criteria, study participants agreed that no pre-established criteria were applied to guide the selection of health-related priorities for goals development. However, individuals turned to evidence on the determinants of health, epidemiological data, and health status indicators to assist in priority identification. A representative of the OPHO remarked:
There were not specified, pre-determined sets of criteria... But there were some defacto ones, drawn from epidemiological knowledge... and the evidence based around the determinants of health.

One criteria would be the whole determinants of health philosophy (PSO, Health).

Two criteria guided the decision to include a goal on Aboriginal health: historical legacy and health status. In response to questions as to why a health goal was articulated for Aboriginal populations, one interviewee commented, “[Because] of poor health status indicators and just sort of, the historical experience, if you will, of Aboriginal groups.” (This issue is addressed in detail in the section titled “Population Subgroups” below.)

The section that follows presents interviewee and source document data on the various priorities that were addressed in the BC health goals. Interviewee perceptions of priority areas are presented either as summary statements or as direct quotations. The source document material referenced here is the final version of health goals and related objectives (Version V) that were published in December 1997.

• HEALTH STATUS

**Interviews:** Health status was perceived as a priority issue in relation to the health goal on Aboriginal health.

**Source document (Version V):** Two goals address health status: (a) Goal #5 “Improved health for Aboriginal peoples.” No objectives were articulated for this goal in the final version. Overall indicators were included: life expectancy, infant mortality, and age standardized mortality rates (of Aboriginal peoples compared to total population of BC); (b) Goal #6 “Reduction of preventable illness, injuries, disabilities and premature deaths.” Related objectives include the reduction of cardiovascular disease; breast cancer, cervical cancer, lung cancer and melanoma skin cancer; respiratory disease, vaccine preventable disease; tuberculosis;
HIV infection; sexually transmitted diseases; chronic disabling conditions; unintentional injuries and premature deaths; injuries from interpersonal violence and abuse; use of illegal drugs; water-borne and food-borne diseases; neural tube defects; negative impact of mental illness; suicides; and, infectious diseases.

• HEALTH PROMOTION

Interviews: Interviewees made few direct references to health promotion or disease prevention; the language of population health was commonly used to refer to health promotion concepts.

Source document: Goals #2 depicts health promotion issues and states: “Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and to meet life’s challenges and to make choices that enhance health.” Related objectives focus on the improvement and maintenance of supports for young children; skills needed to participate fully in social, cultural and economic life of the province; skills and capacities to find productive employment in a competitive labour market; individual capacity and supports for making healthy lifestyle choices; and, capacity for independent living of persons with disabilities or limitations.

Health promotion is referenced also in Goal #1 in reference to “access to self-help and mutual support” activities and resources for social networks and families. Goal #6 makes additional references to health promotion and disease prevention including; mammography and cervical cancer screening, immunizations, reduction in injuries and premature death.

• HEALTH PRACTICES

Interviews: One interviewee commented on the lack of attention paid to lifestyle in the BC health goals: “One thing lacking... that stuck in my mind from these meetings was... they did not want to talk about lifestyle... we didn’t talk about lifestyle... I raised it but it was... ‘No, that
was not what we are talking about...” (PSO, Business).

Source document: Goal #2, as noted above, addresses health practices (referring to individual choices, lifestyle and behaviour). Goal #6 makes some reference to health practices in relation to decreased use of illegal drugs.

• HEALTH EQUITY AND SOCIAL EQUITY

Interviews: Interviewees shared mixed perceptions on the need for a goal on Aboriginal health in order to reduce health inequities between Aboriginal and non-Aboriginal populations (this is discussed in greater detail below). Only one interviewee commented on social (and economic) equity as a priority focus in the health goals. This interviewee spoke out strongly against what he perceived to be too much emphasis in the BC health goals on the relationship between income and health:

The object I would hope of [the health goals]... is for the health of people... If you just say... well, those that don’t earn this much, are not at fault if they are sick... Is it that the less you earn the more you have a right to be sick?... I mean... am I going to get sick because I earn a certain amount of money or is it because I live a certain way? (PSO, Business).

This interviewee perceived the health goals as a mechanism for wealth redistribution:

To attempt to use health care... as the vehicle to distribute wealth... seems to me, blatantly dishonest... If you want to re-distribute wealth - then you get on with it - and, do it... upfront and do it honestly. If you want to improve the health of the people of BC, then do that... Don’t use distributing wealth as the way for people to live longer, live healthier... I don’t believe that is the answer... it, in some small way probably has some impact, but when it’s sold as the ONLY thing, then it becomes nonsense.

Source document: Goal #5 references health equity: “Improved health for Aboriginal peoples,” where one of the overall indicators for the goal is “age standardized mortality rates of Aboriginal (or Status Indian) peoples compared to total population of British Columbia.” Goal #1 makes reference to social (and economic) equity: “Positive and supportive living and working
conditions in all our communities." Related objectives focus on: equitable opportunities for employment; reduction of marginalized and disadvantaged groups in lower paying and lower status jobs, and increased social recognition and valuing of jobs at all levels; reduction in the gap between British Columbians at the lowest and highest levels to achieve a more equitable income distribution; and increased range of housing options for people who are homeless or at risk of homelessness.

• DETERMINANTS OF HEALTH

Interviews: By and large, most study participants supported the approach taken in BC to incorporate the multiple health determinants as priority issues in the BC health goals. Examples of statements in favour included: "I think there is quite a good correlation between the goals and [the] determinants framework... I think they... are quite consistent with each other... and I'm quite comfortable with this framework" (RHB).

Some interviewees considered the health determinants focus in the BC goals as consistent with earlier frameworks: "The thing I like about it too is it [is] quite consistent with the frameworks we've been using ever since the, you know, the Lalonde Report... that [have] served us well.” (RHB). Another interviewee noted, “BC [health goals]... are built very much on the social determinants theory” (PSO, Health Association). One interviewee commented on the efforts of the OPHO to link specific objectives (associated with each of the goals) to the various health determinants: “We tried to have an objective for each of the [determining] factors that the evidence seemed to suggest... would have an impact on population health” (OPHO). A few interviewees did not agree with the health determinants framework. Some believed the health

31 Interviewee perceptions on the determinants of health are included in various themes throughout this chapter (only a few are included here). See especially, Themes 2, 3, 4, 6, 9, 12, and 13.

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determinants approach "was overdone;" "was almost like a religion in some circles;" "was very one-sided," "neglected health care," and "pooh-poohed the role of organized medicine and health care providers" (PSO, Health association).

Source document: The final version of BC health goals confirm that the BC health goals and associated objectives cover the range of health determinants including biology and individual genetics, personal health practices, coping skills, healthy child development, physical environment, income and social status, social support networks, education, employment and working conditions, and the health system.

• HEALTH TOOLS AND SUPPORTS

Interviews: No reference was made to information, research or public policy as a priority issue in health goals.

Source document: Objectives associated with Goal #1 make some reference to public policy, including: "family friendly policies to help balance work and family responsibilities;" and "policies for workers with disabilities, chronic illnesses or other special needs." [Reference to public policy was more explicit in Version #2 of the health goal; Goal #4 of this version stated: "Ensure that our public policies and investments recognize all the important influences on our health, and result in the best possible health outcomes." The final version of health goals did not include this goal.]

• QUALITY OF LIFE

Interviews: No reference was made to quality of life.

Source document: Quality of life is included in the overall mission of the BC health goals: "To maintain and improve the health of British Columbians by enhancing quality of life and minimizing inequalities in health status." Quality of life is referenced also in Goal #1 in
relation to "improving and maintaining the quality of life in the workplace;" and "improving and maintaining the design of communities to ensure quality of life for residents."

Of the nine priority areas that comprise the health goals framework, study participants had the most to say about "health care system" and "population subgroups."

- HEALTH CARE SYSTEM

Source documents reveal that "the health care system" was both included and excluded as a priority issue in the various versions of the BC health goals. Version I of the health goals called for a balance between investments in health care services and other influences on health. Version II made no reference to health services; this version did however, include a goal calling for the recognition of "all the important influences on health" in public policies and investments (Goal #4). Version III, like Version I, made reference to a balanced approach to health care and other health determinants. Version IV and Version V included a clearly-stated goal on the health service system (the language changed from "health care" and "health care services" to "health service system" in the last 2 versions of health goals). Table 14 outlines how "health system" was handled across the multiple versions of health goals.32

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32 The generic term “health system” will be used in this section to include what is alternatively referred to as “health care system” or “health service system.”
Table 14: "Health Care System" Across Multiple Versions of BC Health Goals

<table>
<thead>
<tr>
<th>Version</th>
<th>Priority: Health Care System</th>
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<tr>
<td>I Oct/94</td>
<td>&quot;Ensure effective use of societal resources to improve population health, including an appropriate balance between investment in cost-effective health care services and investment in other determinants of health&quot; (Goal #6).</td>
</tr>
<tr>
<td>II Nov/95</td>
<td>No reference to health care or health care services.</td>
</tr>
<tr>
<td>III June/96</td>
<td>&quot;Balanced investment of resources between health care and other important influences on our health, based on the evidence about what makes and keeps people healthy&quot; (Goal #5).</td>
</tr>
<tr>
<td>IV June/97</td>
<td>&quot;An effective and efficient health service system that provides equitable access to appropriate services&quot; (Goal #4).</td>
</tr>
<tr>
<td>V Dec/97</td>
<td>&quot;An effective and efficient health service system that provides equitable access to appropriate services&quot; (Goal #4).</td>
</tr>
</tbody>
</table>

- Versions I, II, and III were pre-Cabinet submission renditions
- Version IV was submitted to and adopted by Cabinet (* Cabinet was asked to consider the health goals and objectives only; and not targets, indicators or lead sectors
- Version V was the version published for public dissemination (December, 1997)

* Please refer to Appendices V through Z for the genesis of the various versions of health goals.

Study participants shared interesting and varied comments on the health system priority issue in the BC health goals. Variation in opinion was evident not only among the interviewees-at-large, but also among the members of the health goals coordinating mechanism (or the OPHO).

Most interviewees believed that the BC health goals should include a goal on the health system. Several believed that a health system goal was important since a large amount of annual provincial budget is allocated toward it; also a goal on the health system would help to ensure "buy-in" and a "sense of ownership" of the health goals from the various components of the health system:
There wasn’t the health care system in the original [version of health goals]... I think [some of us] woke up one day and said ‘Hey... we better put it in... after all the Ministry now spends seven billion dollars a year on health care and shouldn’t we put something in there about the performance of the health care system?’... Otherwise, [people in] the system won’t feel any ownership of this (OPHO).

So in terms of the health system, if you don’t recognize that, it’s going to be much more difficult to get buy-in from kind of the traditional, medical environment, because they will recognize [that] ‘it’s clearly not for me’ (PSO, Health).

Some interviewees believed that the health system goal should be a separate, stand-alone goal; others believed that the health system issue should be combined or “buried” within other goals. Those in favour of a separate goal had this to say:

I think the [health system] goal is important to keep there ... to bury [it] within another goal is... just becomes a way of sort of muddying the issue... so might as well have it up front and separate... so you can talk about service separately from the other issues rather than having them buried within one [goal] or scattered across all of them... I think there is an important role in people’s minds for health services (PSO, Health).

The [health system] goal should be separate and equal (PSO, Health Association).

Other interviewees preferred a blended approach where the health system goal would be a part of another goal(s): “I do think the health care system needs... [to] fit in... [as] a subset of the overall health goals... to serve as a guide for the health care sector (PSO, Health Association).

Others were opposed. One interviewee believed it was important to bury the health system goal into other goals to demonstrate clear support for the principle that “health is not health care.” Combining the health system goal into other goals would help to redirect focus and resources from “diseases and services” to other factors known to influence health:

I argued that we should bury it.... If we are going to change people’s attitudes about what these [health determinants] relations are... we should take on a global whole and... what we should be saying is that we want to deploy our resources [in order] to enhance the health and well-being of British Columbians to the best of our ability. That gives us a lever to say, ‘Well, let’s shift money out of health care into early childhood development’... in the name of health... like all of this would be in the
service of improving health... Let's disappear the health care or disease [goals] and let's embed them into other [goals] (OPHO).

This interviewee went on to say that because "we were getting some flack" over not including a health system goal, the decision was made to include it. But, it was important, in this respondent's view, to order the health goals according to "relative importance." Goals relating to the social, economic and environmental health determinants should come first, followed by goals relating to the health system or to illness-related issues. This kind of ordering would portray what he believed to be true -- if the broader determinants of health were addressed, reduced illness and a reduced need for health care services would result:

*We should move [the health system and disease goal] to the end of the queue because that says they are important but relatively speaking -- they are less important than the other [goals]. I argued that we should put [these] last and say that we believe that these goals and objectives are right, are appropriate and good things to do AND if we do [goal] one through [goal] five, then [goal] six will take care of itself* (OPHO).

A representative of the Ministry of Health believed that exclusion of the health system from early versions of the health goals led people within the Ministry and traditional health care practitioners to judge the health goals as "not relevant." The emphasis on health determinants created a backlash response from the Ministry and from health practitioners because "there wasn't enough in terms of health services."

*[The health goals] were too [focused] on all the factors that may influence and contribute to health, but they didn't take care of those who were sick... [they] didn't address who didn't have good health... and they did not recognize the contribution of the health care system" (Ministry, Health).

*If you fail to acknowledge physicians as part of the health [goals], we've got a problem because what you get is a reaction... you just further entrench their thinking and their need to protect their turf and their need to be recognized...* (Ministry, Health).

This interviewee shared her disappointment on the first published version of health goals (Version II), which focused on the broader determinants of health and excluded the health
system, and hypothesized about the effect on the Ministry of Health:

*That was a great disappointment for me because to me, it’s almost like the pendulum swing... there was so much emphasis on health care and health care services for so long that here’s the new kid on the block -- [the health determinants] were the hot item and we went COMPLETELY to it... [to] the other far end of the pendulum. What we needed was balance to recognize that you need both things to play together, to achieve what you want. That’s why there wasn’t a great deal of support within the Ministry of Health (Ministry, Health).*

This interviewee agreed with reports by others that representatives of the Ministry of Health and health practitioners pressured the OPHO to include a health system goal. A representative of the OPHO commented on pressure from health interests and the general public alike: “*And we just had to [include a health system goal] politically because there were lots of pressures on us... not just from entrenched interests groups but from the general public saying: ‘We don’t understand this.’*” Calls for a health system goal came also during regional health board workshops which typically included representatives of various health care interests:

*I understand as to why [the health system goal] got included was that when [the OPHO] went around [the province], there was a lot of health providers who went to the workshops... and the lack of a specific health system [goal] was raised... and input was listened to and that’s why [it] was included*” (RHB).

**POPULATION SUBGROUPS**

Like “health system” above, the “population subgroups” priority area, in relation to Aboriginal health, has been variously represented in the health goals source documents. The articulation of the goal on Aboriginal health moved from a broad representation that included “*cooperation between governments*” in the early versions of health goals to a narrower focus on “*improved health*” in the later versions. Additionally, the number and content of objectives varied across versions of health goals. Version II had 3 objectives which focused on control and access to health services as well as jurisdictional issues and the ongoing provincial treaty process. Version III, in addition to these issues, included issues on self-government and traditional
Aboriginal health practices. Versions IV and V focused nearly exclusively on health status issues as overall indicators and did not articulate any specific objectives. Handling of the Aboriginal health issues across the various versions of BC health goals is outlined in Table 15 below.
## Table 15: “Population Subgroups” Across Multiple Versions of BC Health Goals

<table>
<thead>
<tr>
<th>Version</th>
<th>Priority: Population Subgroups</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Oct/94</td>
<td>GOAL: “Foster cooperation between all levels of governments to resolve issues impacting the health of First Nations.”</td>
</tr>
<tr>
<td>II Nov/95</td>
<td>GOAL: “Foster joint action to improve the health of Aboriginal peoples.”</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVES (3):</td>
</tr>
<tr>
<td></td>
<td>- “Increase the degree of control of Aboriginal communities over programs, services and resources for health.”</td>
</tr>
<tr>
<td></td>
<td>- “Decrease jurisdictional issues that cause gaps/overlaps in access to health-related services for First Nations peoples”</td>
</tr>
<tr>
<td></td>
<td>- “Ensure a managed and inclusive treaty negotiation process which concentrates on local and regional negotiations and achieves results with First Nations”</td>
</tr>
<tr>
<td>III June/96</td>
<td>GOAL: “Improved health for Aboriginal peoples, to achieve comparable health status between Aboriginal peoples and the general population.”</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVES (4):</td>
</tr>
<tr>
<td></td>
<td>- “Conclude treaties with Aboriginal peoples so their communities can be more self-determining, which will lead to improved health status.”</td>
</tr>
<tr>
<td></td>
<td>- “Resolve cost-sharing responsibilities between the federal and provincial governments regarding Aboriginal health services.”</td>
</tr>
<tr>
<td></td>
<td>- “Increase the involvement of Aboriginal peoples in the planning, management and decision-making on programs, services and resources for health; and ensure that health services specifically targeted to the Aboriginal community are controlled by Aboriginal peoples.”</td>
</tr>
<tr>
<td></td>
<td>- “Increase awareness, knowledge and valuing of traditional Aboriginal healing practices that take a holistic approach to health.”</td>
</tr>
<tr>
<td>IV June/97</td>
<td>GOAL: “Improved health for Aboriginal peoples.”</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVES: None, rather, “overall indicators for the goal” were presented and include life expectancy, infant mortality, and age standardized mortality rates of Aboriginal people compared to BC total population.</td>
</tr>
<tr>
<td>V Dec/97</td>
<td>GOAL: “Improved health for Aboriginal peoples.”</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVES: None, rather “overall indicators for the goal” are included as above (Version IV). Additionally, four socio-economic indicators are offered: education, unemployment rate, low income, and lone parent families</td>
</tr>
</tbody>
</table>

- Versions I, II, and III were pre-Cabinet submission renditions
- Version IV was submitted to and adopted by Cabinet (* Cabinet was asked to consider the health goals and objectives only; and not targets, indicators or lead sectors
- Version V was the version published for public dissemination (December, 1997)
Most study participants favoured a separate health goal for the Aboriginal population. Those who were supportive cited two reasons: health status and historical legacy. Members of the health goals coordinating mechanism varied in their opinion as to which reason was most compelling. Most believed that the primary justification for a separate health goal was the poor health status of Aboriginal people as compared to non-Aboriginal population: "The health of the Aboriginal population in BC is awful and we have to do something to address it" (OPHO).

Several interviewees cited particular health issues as justification for a health goal on Aboriginal health including high rates of diabetes, infant mortality, and fetal alcohol syndrome, as well as a shorter life span for Aboriginal people.

One representative of the health goals coordinating team felt strongly that a separate goal on Aboriginal health should be tied to historical legacy rather than to health status (OPHO). This interviewee highlights the difference in viewpoint among members of the health goals team:

> I always was for [Aboriginal health] to be a separate goal, and a goal that was tied to historical legacy. And again, that was something that [we] differed on. [Some] felt that [the Aboriginal health goal] should be there because their health status is so poor... For me, I was keen to see [the Aboriginal health goal] stand alone not for issues of health status but for issues of historical relationship... between [Aboriginal] people with the government of British Columbia and the government of Canada (OPHO).

The motivation behind a separate health goal for this interviewee was to enhance social and economic equality between Aboriginal and non-Aboriginal populations and to promote "identity, "autonomy," and "dignity." In this respondent's view, "we wanted to create greater equality both in the material and non-material resources of society." This would, in the end, improve health status, "because we believed from the evidence on the health determinants that [economic factors] are key in reducing health inequities and improving overall levels of health."

Another issue underlying the decision to articulate a separate goal for Aboriginal health
was related to jurisdiction, that is, the level of government responsible for the health of Aboriginal people. Several interviewees spoke of the jurisdictional responsibilities of the provincial and federal governments and the factors that made this a complex issue including (a) Aboriginal status, (b) whether Aboriginal individuals live on or off-reserve, (c) and variations in access to different kinds of health services.

[Aboriginal health] is not a responsibility of the federal government alone... The federal government Medical Health Services provides health services to Aboriginal people living on reserve [only]. They do not provide services to Aboriginal people living off reserve... And, their mandate provides only certain services... like home care services are not provided to Aboriginals on reserve (Ministry, Health).

So if you’re off reserve or... you don’t have status, and are Metis... or are living in the city... you don’t qualify for federal health services (Ministry, Non-health).

According to a representative of the Ministry of Health, discussion related to jurisdiction “revolved around the barriers to health that those jurisdiction issues created;” and dealt specifically with gaps and overlap in service and programing and ways to facilitate Aboriginal participation in and management of health services, as a part of self-government.

According to some interviewees, although a health goal for the Aboriginal people was generally accepted in principle, the process of “hammering out the details” was “fraught with difficulty.” Controversy arose in the wording or language of the goal and over the proposed objectives. One interviewee reflected that even though the BC Union of Chiefs “supported a separate goal on Aboriginal health... at least in spirit,” the issues become very contentious when attempts were made to get specific:

The devil is in the details... and then that meant fighting it out with... well, that’s too hard... negotiating with [the Ministry of] Aboriginal Affairs to hammer out the specific wording... And consequently the draft went through revisions and revisions and revisions and revisions... (OPHO).

The difficulty encountered in the articulation of the health goal and objectives for
Aboriginal health was borne out in the source documents. While earlier renditions dealt comprehensively with the Aboriginal health issue, the final version of the BC health goals was both narrower in focus (addressed health status issues only) and did not include any specific objectives aimed at progress toward the goal. A rationale for the exclusion of objectives related to this goal is offered as a footnote in the final versions of health goals for BC:

*Although considerable work toward developing objectives and indicators for this goal has occurred, more discussions are still needed. A process to finalize specific objectives and indicators must include the extensive involvement of Aboriginal peoples, and must complement the other processes and negotiations that are underway concerning Aboriginal health, First Nations self-government and other key issues. Therefore, no objectives or indicators are being presented at this time.* (British Columbia, 1997, p. 25).

Source documents indicate that further articulation of a health goal for Aboriginal people will occur in liaison with other Aboriginal-related initiatives in the future.

**Theme 15: Health Determinants Scope**

Much of what study participants had to say about health determinants has already been reported on in previous themes. This section reports the data on four of the ten health determinants that comprise the health goals framework which have not received much comment so far. Interviewee perception’s and source document data are presented below in summary form. Similar to Theme 14 above, the source document that was considered in relation to “health determinants scope” is the last version or Version V of the BC health goals. This section concludes with a summary of interviewee perceptions on the overall range or scope of health determinants in the health goals for BC.

- **BIOLOGY AND INDIVIDUAL GENETICS**

  Interviews: Two references were made to genetics. One interviewee, who favoured a
health determinants approach to health goals, remarked: “I think they provided a little too much emphasis on genetics and lifestyle... but overall, I am quite pleased” (PSO, Public health).

Another interviewee, who characterized “gender” as a health determinant, expressed her dissatisfaction with what she perceived to be too little attention dedicated to women’s health issues in the BC health goals (PSO, Hospital).

Source document (Version V): Goal #2 refers to biology and genetics indirectly in Objective #5, where persons with “disabilities or limitations in their physical, mental, social or emotional functioning,” will receive assistance with daily living. Goal #6, “Reduction of preventable illness, injuries, disabilities and premature deaths,” pays some attention to genetic-related conditions such as cardiovascular disease, breast cancer, cervical cancer, neural tube defects and congenital anomalies.

- **HEALTHY CHILDHOOD DEVELOPMENT**

  Interviews: No reference was made to this issue.

  Source document: Goal #2 makes direct reference to healthy childhood development in Objective #1: “Improve and maintain supports to ensure all young children receive the best possible start in life, including: appropriate pre- and post-natal care, effective early childhood nurturing and parenting, and appropriate early childhood stimulation, socialization and education.”

- **PHYSICAL ENVIRONMENT**

  Interviews: One interviewee cautioned that decisions affecting the physical environment be based “in science” rather than driven by “political or emotional interests.” (PSO, Forestry).

  Source documents: Goal #3 deals directly with the physical environment: “A diverse and sustainable physical environment with clean, healthy and safe air, water and land.” Related
objectives include: improve and maintain air quality; quality and safety of water; sustainable, safe and nutritious food supply; quality of land and soil; decrease damage to the global atmosphere; and minimize the negative impact of human settlement and activity on the long term sustainability of natural ecosystems.

- EDUCATION

Interviews: One interviewee believed it was important that “life-long learning” be incorporated into the health goals (OPHO).

Source documents: Education, both in relation to formal education to promote employment opportunities as well as informal education to acquire skills for daily living, was referenced as follows: (a) Goal #1 alludes to “re-training initiatives” for people who experience job loss, “education and supports for effective parenting,” and “access to self-help and mutual support activities.” (b) Goal #2 refers to “improving skills for acquiring knowledge, thinking critically, solving problems, making informed decisions, and communicating effectively;” it calls also for “a commitment to life-long learning,” a “flexible, accessible formal education system” and “access to education and training opportunities throughout adult life.”

PERCEPTIONS ON SCOPE OF HEALTH DETERMINANTS

Most interviewees expressed satisfaction with the range or scope of health determinants addressed in the BC health goals. One interviewee stated simply: “I am comfortable with our range of health goals” (PSO, Public health). Another interviewee believed that the BC health goals ended up being “far-reaching in scope” because the “working group” on health goals adopted a broad definition of health from the beginning by conceiving health as “more than physical health,” and by paying attention to all the factors known to influence health (Ministry, Non-health). An interviewee with a regional health board expressed her pleasure with the range
of the health goals, and believed it was important to address broad issues like housing and
poverty early on and “up-front,” and that issues of implementation could be handled at a later
time:

*I mean, when a group identifies housing and poverty as health issues, you go, ‘Yes!’
Now, okay, they are huge and I wonder what could anybody ever do about them?
We’ll get around to deciding how we’re going to chop those big [pieces] up into
digestible pieces later. But that they would even think that they could be put down
[in the health goals]... is a huge step forward* (RHB).

One interviewee with the OPHO supported the broad scope of the BC health goals, but
recognized that they may be difficult to implement and suggested that priority areas be set early
on: “This is so huge, its intimidating and it’s really overwhelming... it’s going to take us a long
time and we’re going to need in the end, some little inroads, some... priorities where we could
start.” A representative of a member health association of BC agreed. In this participant’s view,
the health determinants model was a good one, but he worried about the breadth of the health
goals in relation to implementation. This interviewee acknowledged the need to set priorities:

*Well, I think... that the conceptual model is good and that, in it’s range, it obviously
covers everything. But the problem occurs... if you cover everything, you can’t
address everything... with the resources that we have, so you have to set priorities...
If you have a set of health goals that is so global that it is everything to everyone,
then it’s not helpful to anybody... So what you need to do is make sure that if you are
going to have a framework which is so all encompassing, is that you have a way of
divvying that out somehow... and then helping people to set priorities around it.*

Another interviewee cautioned that although she agreed with a broad approach to health
goals, they may prove difficult to act on: “There’s a danger there because if they are too broad,
there’s a possibility that... they are wide open for interpretation and nothing concrete happens”
(PSO, Special needs).

Only one interviewee believed that the health goals were insufficient in their scope or
range. This interviewee felt that the final version of the BC health goals did not sufficiently
address equity issues and matters of class, race and gender:

*If* [the health goals] *don't include race, class, gender -- then they are not going to be very useful to the people I work with or who I think the system needs to readjust to... I have a lot of problems with [the health goals] because they don't really address inequities in the way that I would address them... Anyway, it just doesn't cut it* (PSO, Hospital).

**Theme 16: Late Stage Developments**

The health goals framework defines late-stage developments as processes, initiatives or spin-offs that come about as a result of the health goals process that are not necessarily expected or anticipated, and may confer secondary benefits or conditions.

**POST-CONSENSUS EDITS**

This chapter dealt with the evolving iterations of health goals in two ways. First, the various renditions of the BC health goals were traced in relation to two themes above: (a) Theme 13, “Specificity and Methods,” which uncovered the changes in the specificity of health goals across iterations; and (b) Theme 14, “Priorities Addressed,” which traced the adjustment to health goals relative to priority issues addressed. Second, Appendices V through Z track the genesis of each of the five versions of health goals. They (a) outline the evolution of the health goals over time, (b) delineate the groups that were consulted as a part of each version, and (c) point out the changes to the goal statements associated with each version or iteration. 33

Post-consensus edits refers more narrowly to the adjustment of health goals by bureaucratic or political interests late in the health goals development process, after all groups or parties have been consulted and consensus has been reached. One interviewee reflected on

33 Related findings are not repeated here. Please refer to Themes 13 and 14 and to Appendices V through Z for a report on data relevant to these issues.
adjustments to the goals and the influence that was applied in the weeks before the health goals were forwarded to Cabinet:

_There’s been some tinkering with them... Was there influence?... I think that there was during the last period, between the end [of the consultation process] and the time that the final draft was adopted... This was when there was probably the MOST influence from a bureaucratic perspective... because that was the period of most intense lobbying by [the Provincial Health Officer] (OPHO)._

Another interviewee confirmed this view and commented on efforts by the OPHO to get buy-in from political leaders in the late stages of the development process: “[The Provincial Health Officer] went around to the ministers once again and tried to make [the health goals] a little more politically appetizing” (OPHO). This interviewee was referencing the period of time that preceded Cabinet submission of the health goals (between the third and fourth version of health goals) when the Provincial Health Officer undertook a final round of one-on-one briefings with government ministers and deputy ministers to consult on the health goals and to build support for them.

When asked to think prospectively about the final version of health goals (Version V), most interviewees believed that they would not differ significantly from the versions that they were consulted on (typically, Version I and II). One Ministry representative put it this way:

_I wouldn’t really expect any [surprises]... I can’t see that [the OPHO] would publicly announce something different [from] what’s been approved basically by all the Ministries, because then [they] really, sort of runs the risk of... rebuke by the Ministries, saying, ‘Sorry we didn’t support this... This is not what we said.’_ (Ministry, Non-health).

A representative of a provincial stakeholder (health sector) organization agreed:

_I would be surprised if the health goals were radically different, because I think that would be a real betrayal of the whole consensus-building process, and I don’t think that [the OPHO] would do that._
The most notable change between the health goals that were submitted to Cabinet and the version that was published for dissemination was in relation to the decreased specificity or measurability of the health goals. Although the package forwarded to Cabinet in June, 1997, included goals, objectives, targets, indicators, and lead sectors; Cabinet was asked to consider only the goals and objectives. Source documents reveal that the goals and objectives that were considered by Cabinet comprised the published version of health goals. Further, the final published version included also examples of indicators, but did not include any targets or lead sectors.

INTERSECTORAL COLLABORATION

Study participants suggested a few early spin-offs or secondary benefits of the health goals process. Some interviewees cited intersectoral collaboration. One interviewee believed that the health goals process provided a good example of how Ministries across governments could work together: “[Health goals] promoted an understanding by the different Ministries that they can work collectively towards meeting major objectives like this” (Ministry, Non-health). In the view of a representative of a member health association, the health goals process encouraged people to work together in “untraditional areas” which may, in turn, lead to alternative ways of allocating resources.

I think you might be a little more likely to find a community health council looking at getting together with the Ministry of Transportation and Highways to fix a road rather than buying a new machine for their [hospital] emergency ward... now, than you would have in the past (PSO, Health association).

DIFFUSION

Some study participants commented on the diffusion and translation of the health goals from provincial to regional levels as a late-stage development of the health goals process. In their
view the provincial health goals facilitated health planning at the regional level: "The [provincial] health goals provided a framework under which you can now place other goals and objectives... they provide a broad base where things, in fact, can be anchored" (PSO, Public health). A few interviewees pointed to the experience of the Vancouver Regional Health Board:

*When the Vancouver Richmond Health Board went through its process of developing its inaugural health plan [we] identified six basic health goals... and that work was very much driven by what were the initial draft version of the provincial health goals... They certainly have served to provide an umbrella for planning (BC Public Health Association).*

A representative of this regional health board agreed and commented that the provincial health goals helped to facilitate and organize their work: "The [provincial health] goals helped to us to focus... and to inform... and organize our discussions about health issues... So to have the [provincial health goals] that you can sort of hang on to, like a ship in the storm, was helpful" (RHB).

**INSTITUTIONALIZATION**

When asked if the government may attempt to institutionalize the BC health goals by linking them to health care budgets, most interviewees believed that this would not occur. One interviewee, while acknowledging that this would be highly unlikely at the provincial level, felt that it may occur regionally, especially in relation to the goal on health services: "[Health goals] may be linked [to funding] at the regional level for Goal #4... but not at the provincial level" (OPHO).

**POLICY EXTENSION**

Finally, "policy extension," which refers to the incorporation of health goals into broader health or public policy initiatives, may be considered a late-stage development or spin-off of the BC health goals development process. Source documents revealed that the BC health goals form
the basis of revised tools for health impact assessment currently being developed by the BC Ministry of Health. The health impact assessment tool, which is grounded in the broad determinants of health, as reflected in the BC health goals; provides a mechanism to assess the impact of proposed government-wide programs and policies on the health of the British Columbians.

**Emergent Dimensions**

**HEALTH DETERMINANTS AWARENESS**

Study participants identified one additional dimension as a late-stage development of the BC health goals process: “health determinants awareness.” Several interviewees commented that the health goals process increased public awareness and understanding of the multiple factors that influence health. A representative of the OPHO who facilitated many of the regional health goals workshops remarked: “I mean, there is now, who knows, how many hundreds of people in the province who have learned the determinants of health themes and have had them presented in kind of coherent and logical way.” Another interviewee mentioned that the health goals process yielded a greater understanding of “what makes and keeps people healthy” among groups responsible for the delivery and management of services within regional health boards:

*Certainly, [there has been] more discussion at the governance tables about the determinants of health and the importance of focussing on the ... the broad concept of health and being sure that, you know, other things beside health care interventions are considered as ways of improving health*” (RHB).

A representative of the OPHO attributed the BC health goals process to an increased awareness and application of the multiple factors that influence health in the formal education system. This interviewee was surprised to learn that the draft health goals (Version II) were “so quickly picked up” by several educational institutions:
Several other study participants confirmed “health determinants awareness” as a late-stage development or spin-off of the BC health goals process.

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**Table 16:**

Factors that Facilitated and Obstructed the BC Health Goals Development Process

**Phase Three: The Articulation Phase**

<table>
<thead>
<tr>
<th>Theme 13: Specificity and Methods</th>
<th>Facilitating</th>
<th>Obstructing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Availability (“borrowing”) of indicators and targets from some Ministry programs</td>
<td>- Mixed perceptions on the (original) intent for specificity of BC health goals</td>
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<tr>
<td>- Use of clear language in health goals to increase comprehedability and accessibility</td>
<td>- Challenges associated with operationalizing health goals (getting people to think) in specific terms</td>
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<tr>
<td>- Less-specified health goals perceived as less intimidating to government leaders</td>
<td>- Mixed perceptions among groups consulted (on health goals) regarding the need / requirement for measurability</td>
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</tr>
<tr>
<td>- Steps taken to ensure movement on health goals without hostility or confrontation of government leaders</td>
<td>- Mixed feelings among health goals coordinating mechanism (OPHO) on need for measurability</td>
<td></td>
</tr>
<tr>
<td>- Perceptions that target setting is a shared responsibility by province, regions, and organizations</td>
<td>- Personal reluctance to measurability on the part of the individual most responsible for identification of targets and indicators (specificity), and this interviewee’s conception of health goals as a cultural value versus a measurement mechanism</td>
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<tr>
<td></td>
<td>- Highly-specified health goals perceived to be potentially politically sensitive or embarrassing to government leaders; and concern that government leaders would be held accountable for (measurable) health goals without control over processes and programs aimed at achieving them</td>
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</tr>
<tr>
<td></td>
<td>- Resistance / hesitancy toward targets from some government Ministries and stakeholder groups</td>
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</tr>
</tbody>
</table>

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## Theme 14: Priorities Addressed

<table>
<thead>
<tr>
<th>Facilitating</th>
<th>Obstructing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Exclusion of the health system (as a priority area) from early versions of the health goals led people within the Ministry of Health and health care practitioners to judge the health goals as irrelevant and stifled their enthusiasm to support the health goals.</td>
<td></td>
</tr>
<tr>
<td>- Mixed perceptions among members of the health goals coordinating mechanism (OPHO) about whether or not to include the health system as a priority area in the BC health goals.</td>
<td></td>
</tr>
<tr>
<td>- Mixed perceptions among members of the health coordinating mechanism (OPHO) over the rationale for an Aboriginal health goal and whether it should be linked to health status or historical legacy.</td>
<td></td>
</tr>
<tr>
<td>- Controversy over the specific wording and language of the goal.</td>
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<td>- Ambiguity over jurisdiction for Aboriginal health.</td>
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## Theme 15: Health Determinants Scope

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<td>- Overall consensus on the scope or range of the health determinants addressed in the health goals.</td>
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<td>- Possible problems with implementation.</td>
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## Theme 16: Late-Stage Developments

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<th>Facilitating</th>
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<td>- Second round one-on-one briefings by the Provincial Health Officer with government ministers to win support for health goals.</td>
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CHAPTER 5: CONCLUSIONS AND IMPLICATIONS

This case study examined the health goals development process in the province of British Columbia. It sought to track the pathways to health goals in BC and to uncover influential factors in rendering the final version of health goals adopted by the Cabinet of the government of BC. Analysis of interview and source document data focused on the factors that facilitated and obstructed health goals planning. This chapter begins with a discussion of the key findings of the study. The chapter then deliberates critical questions that arise from the study and considers implications of the study for planning theory, future research, and health promotion practice.

Discussion of Key Findings: Influential Factors

Data analysis uncovered nearly 100 factors that facilitated or obstructed the BC health goals initiative. Although, not all can be discussed here; this discussion weaves those influencing factors framed by the following: (a) the research questions that guided this study, (b) key issues identified in earlier chapters that indicated theoretical relevance to health goals planning, (c) issues relevant to health goals development in other jurisdictions, and (d) the overall influence of factors on the final rendition of health goals that were adopted by the Cabinet of the government of BC.

Key Influencing Factors in the Premonitory Phase

Findings of this study highlight three factors in the premonitory phase: (a) government endorsement of health goals that addressed the broad determinants of health; (b) expected
benefits of health goals paralleled with a concern about return on dollars invested in health, and
c) effective leadership by a trusted champion of health goals.

**Government Endorsement of Broad-Based Health Goals**

Findings of this study demonstrate that soon after the recommendation for *health system goals* by the 1991 Royal Commission on Health Care and Costs; the government of the day, in its policy document, *New Directions for a Healthy British Columbia* (1993), extended the recommendation to include the development of *health goals*, with a focus on the broad determinants of health.\(^{34}\) The New Directions policy called for the establishment of "a clear set of health goals for the province that reflect our understanding of how social, economic and environmental factors affect health." The call for broad-based health goals was driven by an earlier government decision to adopt the 1984 World Health Organization’s (European Region) definition of health\(^{35}\) to guide provincial health reforms. This study demonstrates that the deliberate decision of the government of BC (as a part of the larger health reform initiative) to develop health goals that addressed the broad determinants of health influenced profoundly not only how the health goals development process unfolded; but also, the

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\(^{34}\) As noted in Chapter 2, the "broad determinants of health" (or "broad health determinants") typically refer to the distal influences on health and comprise the social, economic, and environmental factors. Since the term is widely accepted by scholars in the field and commonly incorporated in the health planning literature, "broad determinants of health," will be used in this paper to refer to the distal influences on health. Further, within the context of this study, the term "broad-based health goals" reflects the inclusion of the broad health determinants into the BC health goals.

\(^{35}\) The 1984 World Health Organization’s (European Region) definition defines health as, “The extent to which an individual or group is able on the one hand to develop aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday living, not the objective of living; it is seen as a positive concept emphasizing social and personal resources, as well as physical capacities.”
way in which the health goals were ultimately articulated.

*Expectations for Health Goals*

Findings of this case study corroborate previous research (Lyons, 1995; Nutbeam & Harris, 1995; Nutbeam & Wise, 1996; Frankish et al, 1996a) that positive expectations (perceived benefits) of health goals motivated interest and action towards health goals in BC. Similar to the experience of other jurisdictions, source documents reveal that health goals in BC were expected to support, encourage or improve the following: regional program planning, population-based planning, program evaluation and health impact assessment, monitoring of health status and reduction in health inequities, priority setting and resource reallocation, intersectoral action toward improved health, public awareness of the multiple determinants of health, and health system accountability.

Study findings further suggest that economic factors set the context for health goals in the early phase. Nutbeam and Wise (1996), in their review of health goals planning in eight jurisdictions around the world, found that concern about diminishing returns on investments in health motivated several jurisdictions to adopt a health goals approach. In BC, health goals were envisioned as a way to demonstrate positive outcomes for government investments in health; and as a mechanism to support decisions on spending priorities, especially in light of reduced transfer payments for health from the federal government to provincial coffers.

*Leadership by a Trusted Champion of Health Goals*

Likely, the most compelling force for moving the health goals agenda forward in the premonitory phase was the leadership and commitment by the Provincial Health Officer. Asked
by the government of the day to “coordinate the health goals development process,” after initial plans for a Provincial Health Council did not materialize; the Provincial Health Officer took on the initiative with energy and enthusiasm, and soon became identified as the champion of the health goals cause. Findings from this study suggest that the personal qualities and widely-respected reputation of the Provincial Health Officer, as well the perceived non-political stance of his office, established him as a trusted and capable leader.

Charged with the responsibility of coordinating the BC health goals development process, the Provincial Health Officer followed the parameters set forth in *New Directions for a Healthy British Columbia* (1993). He adopted what has been referred to in earlier chapters as a “health-determinants approach”\(^{36}\) to health goals development. Under this approach, the broad determinants of health became the overarching philosophy that guided and directed the BC health goals process. The Provincial Health Officer’s personal commitment to the health-determinants approach was driven by several issues: the mounting scientific evidence that factors that reside outside the health system or health sector influence health; a commitment to educate

\(^{36}\) The “health determinants” approach to health goals was introduced in Chapter 1, under the subtitle, “Variations in Approach to Health Goals Development;” and expanded upon in Chapter 2, under the subtitle, “Health Determinants: From Health Education to Ecology to Population Health.” To refresh the reader’s memory, health goals development may vary by the amount of consideration given to the proximal and distal determinants of health. At one end of the continuum is the “health-targeted” approach where health goals focus on the more proximal influences on health which include those factors that influence health that have historically been viewed as under the individual’s control or relate to the more immediate environmental influences on health of individuals or populations. Within the health-targeted approach, health goals typically address issues related to preventable illness and injury, disability, morbidity and mortality, risk factors, health protection, and health promotion and disease prevention. At the other end of the continuum, the “health determinants” approach, extends beyond proximal influences on health to focus more on those factors commonly referred to as the *broader* determinants of health which constitute those influences further removed in space or time from an individual and his or her immediate environment; and include the global social, economic and environmental influences on health.

Characterizing the BC approach as a health-determinants approach reflects the fact that the distal health determinants constitute distinct *ends* (main goals) that are being sought. This differs from the health-targeted approach that characterizes the health goals initiatives of other jurisdictions reviewed in this study (US, England, Australia, Texas); where the more distal health determinants that comprise health goals constitute *means* (to more specific health endpoints), rather than ends in themselves. In these initiatives, the broader or more distal health determinants typically comprise sub-goals under health-specific main goals.
the public that "health is more than health care;" the belief that good health outcomes required more than tinkering with the health care system; and a desire not to follow what many considered to be the narrow focus of health goals developed by other jurisdictions.

While the literature on health goals, both published and source documents, makes some reference to the concept of proponents and skeptics in a general sense, little has been suggested about the role of what might be called a "health goals champion." Findings from this study appear to add to the literature by contributing to a greater understanding of the role of champion as a key facilitating factor in the health goals process. Moreover, this study suggests that both personal qualities and the personal philosophy of the health goals champion influence the formulation and articulation of health goals for a population.

**Key Influencing Factors in the Formulation Phase**

Based on the criteria that guide the discussion on findings, this section considers three influential factors in the BC health goals process during the formulation phase: (a) the positioning of the health goals as a government-wide initiative versus a ministry-specific initiative, (b) the "conditioning" of the health goals process through the use of pre-established health goals and "orchestrated" consultation sessions, and (c) the make-up and degree of autonomy of the health goals coordinating mechanism.

"*Government*" Health Goals Versus "*Ministry of Health*" Health Goals

Study findings illustrate that early in the formulation phase, the OPHO positioned the

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37 Phrases and words presented in quotation marks and italics represent direct quotations from study participants presented in the previous chapter (following the pattern consistent with the previous chapter that reported on study findings).
health goals as a government-wide initiative rather than a Ministry-of-Health initiative. This was both a practical and strategic decision. The strategy adopted by the OPHO to align the health goals purposefully with the wider government reinforced the guiding philosophy that “health is more than health care,” and helped to galvanize support for health goals from all sectors of government. The OPHO recognized that all government ministries must participate in the development process to successfully meet its mandate to develop health goals based on the broad determinants of health. Subject expertise in each government ministry or sector would be required; especially in relation to identifying measurement indicators, projecting targets, and securing data sources. After several meetings and one-on-one briefings with government ministers and deputy ministers, all eighteen government ministries endorsed the health goals initiative. Each ministry then assigned a person from its bureaucracy as liaison for matters related to health goals.

Although government ministries at the level of the executive were quick to endorse the health goals agenda, significant ambivalence and resistance existed at the level of the bureaucracy; both within the Ministry of Health and in other ministries. Study findings indicate the chief issue was one of mandate. The expectation that ministries or sectors outside of the health ministry would be responsible in some ways for the provincial health goals was unsettling to some ministries, and led to charges of “imperialism” directed at the Ministry of Health. The feeling that “health was now taking over everything” was expressed by several study participants who questioned the motives of the Ministry of Health. They wondered why the Ministry of Health was entering into the business of their ministries. In the view of representatives of some ministries outside of health, the health ministry was overstepping its mandate and involving itself in matters that extended beyond its purview. These perceptions persisted; even though the health
goals project was purposefully "packaged" as a government-wide initiative, and the OPHO worked arduously to have it perceived both within government and non-government circles as a multi-sectoral effort.

Ironically, while some ministries outside of health experienced a sense of encroachment by the health ministry; several branches and divisions of the Ministry of Health felt far removed from the health goals initiative, and believed that their mandate was not adequately reflected in the BC health goals. Study findings indicate that concern centred on a lack of attention to health services and a lack of representation of health provider interests. This led to variable representation of issues of relevance to the Ministry of Health in the articulation of health goals across various renditions (this is discussed in greater detail later in this chapter). It resulted also in "a natural tension" between the Ministry of Health and the OPHO, in its role as the health goals coordinating mechanism.

Study findings point out that regardless of the reluctance by several constituencies within the Ministry of Health to embrace the health goals, notable exceptions existed. First, the then health minister and deputy minister supported the health goals initiative. Similarly, the Population Health Resource Branch backed the initiative from its inception. Members of this branch participated on the health goals steering committee, assisted with health goals consultation sessions, reviewed draft health goals statements, and provided ongoing technical support over the span of the project. One might surmise that the close relationship between the OPHO and the Population Health Resource Branch was due in part to a commitment by both parties to health goals aimed at addressing the broad determinants of health.

While the literature on health goals describes intergovernmental partnerships in other jurisdictions in relation to the implementation of health goals, less reference is made to
government-wide positioning of health goals or multi-sectoral lobbying as a part of the
development process. This might, once again, be an effect of adopting a health-determinants
approach to health goals planning. In the BC case, it was incumbent upon the OPHO to rally the
support of all ministers in the development process to achieve Cabinet endorsement of a set of
broad-based health goals that had the potential to "touch upon the business of all government
ministries."

Conditioning The Health Goals Process

Study findings suggest that the BC health goals process was organized and structured in a
manner that ensured the outcome sought by the Office of the Provincial Health Officer and
prescribed by the New Directions health reform policy; namely, a comprehensive set of
measurable health goals which addressed the social, economic and environmental influences on
health. Study participants, both within and outside the OPHO, believed that the health goals
process was "conditioned" by the kinds of activities and procedures undertaken by the OPHO in
pursuit of its aim. Study findings indicate that this manifested itself in two ways.

First, feedback on health goals sought from participating parties was based on a set of
predetermined heath goals. Several study participants characterized this as a top-down approach
to health goals development\(^{38}\) and some suggested that this approach biased the discussion and
did not allow for a full and open exchange of views. Study findings suggest further that the
health goals process was conditioned by the manner in which the health goals consultation
sessions were conducted. Consultation sessions with various ministry representatives, provincial

\(^{38}\) While some study participants characterized the health goals process as top-down in relation to how the
health goal statements were derived, most described it as bottom-up in that it allowed for input from many sectors
and levels.

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stakeholder organizations, and regional health boards (which was also the vehicle for public consultation) revolved around the determinants of health theme. Typically, representatives of the OPHO summarized the evidence on the multiple determinants of health and then encouraged feedback from participants on the information presented.

The "orchestrating" of the consultation sessions around the health determinants theme and the use of pre-determined health goals set the context, in the perception of some study participants, for the OPHO to acquire confirmation on what it considered to be the important issues; leading some participants to characterize the process as "conditioned." This sentiment is captured in the words of one individual who reflected on the health goals consultation sessions:

_We asked lots of different people about what they thought the issues were... and partly they were reflecting on what we told them, because we gave them the story of the determinants of health... and then said, 'Now here are the goals... what do you think?' So, in a way, we kind of SET them up... so clearly we conditioned the process and I think we can never pretend otherwise (OPHO)._ 

One wonders how the health goals might have turned out differently if pre-determined health goals were not used and if health goals consultation sessions were not framed by issues related to the broad determinants of health. What would have transpired, for example, if the health goals were generated from the ground up, without pre-established issues or priorities to guide their development? To date, the published and source document literature on health goals provides little insight into these issues. Even though the approach taken by the OPHO raises some questions, it seems entirely plausible and reasonable. Adopting a health-determinants approach to health goals development meant that the activities and procedures undertaken by the OPHO, as well as the goal statements themselves would flow naturally from that perspective to reflect the health determinants. Moreover, study findings suggest that anything but a health-determinants approach to health goals would not have been an option for the OPHO, which faced
increasing pressure and expectations from some groups to recognize the broad health determinants in the BC health goals.

Make-Up and Autonomy of the Health Goals Coordinating Mechanism

Within the context of this study, the health goals coordinating mechanism equates with the OPHO. Two dimensions of the OPHO were especially salient in the BC health goals development process: (a) commitment by all members of the OPHO to the health-determinants approach to health goals; and (b) the level of autonomy of the OPHO, relative to the Ministry of Health.

All members of the OPHO were committed to the development of a set of health goals that reflected the broad determinants of health. They varied in opinion however, on other issues related to the articulation of health goals, such as the desired level of specificity of health goals, and the range of priority areas to be included in the health goals. (Both of these issues will be discussed in later sections.) Study findings indicate further that the OPHO routinely drew upon individuals from the larger community to provide overall guidance to the health goals initiative and to review draft health goals; thereby increasing its capacity to deal with the complex job at hand. Assistance typically came from individuals of “like mind” including representatives of the BC Public Health Association, the medical officers of health, and the Population Health Resource Branch of the Ministry of Health. These findings suggest that a shared philosophy among architects of health goals advanced health goals planning in BC.

The other aspect of the health goals coordinating mechanism that study findings suggest influenced the health goals process across phases is the level of autonomy it exercised relative to the Ministry of Health. Several study participants suggested that the arm’s length relationship
between the OPHO and the Ministry of Health, and the direct reporting relationship of the
Provincial Health Officer to the Minister of Health, had two effects. First, the autonomous nature
of the OPHO meant that the it could operate independently and could bypass, in the words of one
interviewee, the "bureaucratic machinations" of the Ministry of Health. This essentially allowed
the OPHO to chart its own course to health goals. Second, study findings reveal that the
autonomous nature of the OPHO reinforced and contributed to perceptions by various branches
and divisions within the Ministry of Health that the health goals "weren't about them." The
bureaucratic separateness and operational autonomy of the OPHO appeared to alienate further the
various constituencies of the Ministry of Health; fuelled also by issues of mandate discussed
earlier.

This case study is not unique in uncovering issues related to the make-up and autonomy
of health goals coordinating mechanisms. Source documents reveal that health goals coordination
in the province of Saskatchewan resided with the Provincial Health Council which constituted a
entity distinct in location and operations from the Ministry of Health. The US Office of Disease
Prevention and Health Promotion, on behalf of the US Public Health Service, had overall
coordinating responsibility for both rounds of goal setting in the United States (McGinnis, 1984;
Green, 1979, 1992). This office constituted a staff office in the policy arm of the department, not
a line office in the bureaucracy. Nutbeam et al (1993) point out that the coordinating mechanism
for the second round of goal setting in Australia rested with a commissioned group of scholars
who were based within an academic setting, far removed from the health bureaucracy. The
OPHO in BC, typically characterized as having an arm’s-length relationship with the Ministry of
Health, constituted a part of the larger health bureaucracy.
Key Influencing Factors in the Articulation Phase

This section discusses the key influencing factors related to two central issues that characterized the articulation phase of the BC health goals process. The two issues are (a) the lack of specificity or measurability of the health goals, and (b) the variable portrayal of the “health care system” as a priority area in the multiple versions of health goals.

Lack of Specificity of BC Health Goals

Findings of this case study uncover several factors that help to explain the low specificity or measurability of the BC health goals, including the operationalization of a health determinants perspective, the reluctance from government ministries and provincial health organizations to support targets, and the potential for political exposure of highly-specific health goals.

The deliberate decision by the OPHO to adopt a health-determinants approach to health goals planning set up challenges for it to meet its stated intention of developing health goals with measurable objectives (and quantified targets and measurement indicators). Study findings confirm measurability was in large part accomplished in goals and objectives relating to the health sector. Measurability proved particularly challenging however, for those goals that addressed the broad determinants of health and were under the mandate of ministries outside

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39 Although phrases used in this section such as “measurability of health goals” or “measurable/specific health goals” are technically incorrect (because goals by definition are broadly stated and do not aim for high specificity), they are used here to reflect the hierarchy of goal setting that typifies health goals development; where goals are stated in broad terms followed by increasing levels of specificity in objectives, targets and measurement indicators.

40 Version III and IV of the health goals included specific targets. Most targets addressed health gain or risk reduction and aligned most closely with the goal that addressed “the reduction of preventable illness, injuries, disabilities and premature deaths.”
health. In essence, the specificity of the health-specific goals suffered because all the goals were “put in the same basket.”

Evidence of low specificity of goals that addressed the broad health determinants came in the level and quality of response from government ministries to requests from the OPHO for “concrete, measurable objectives” relevant to each sector. Rather than forwarding information to support specificity of health goals, most government ministries provided suggestions for priority areas and strategies for change; and offered only broad advice on goal statements. Study respondents suggested that this was because of concerns by ministries that failure to meet projected targets may jeopardize ministry programs and budgets. Additionally, the evidence suggests that ministries did not have well defined, program-specific goals and objectives to draw upon that would be useful to the OPHO.

Participating provincial stakeholder organizations were asked also for suggestions on measurable objectives and data to support target setting. Most responded, like the government ministries, with comments on broad goal statements and priorities they would like to see included; but offered little to assist the OPHO in meeting its aim to establish a set of measurable health goals, objectives and targets.

Study findings identify how the potential for political exposure further challenged the measurability of the BC health goals. The chief concern among political leaders was that they would be held responsible for projected targets; which stipulated in quantifiable terms, government’s expectation for the improved health of British Colombians. Concerns arose also over the ability of government leaders to secure funding to support the attainment of the health

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41 Targets relating to the natural environment which were previously established by the Ministry of Environment, Lands and Parks were one notable exception to this.
goals. Study participants speculated that failure to meet projected targets or to provide the necessary budget could embarrass the government, could provide justification for criticism from political opposition parties, and ultimately could threaten government leadership.

Findings from this study suggest that hesitancy about targets by government ministries and provincial stakeholder organizations, combined with concerns by government leaders over the potential for political embarrassment, account for the form and content of the health goals that were submitted to Cabinet of the government of BC. The multiple pressures placed on the OPHO in advance of its submission of health goals to Cabinet placed it in a precarious position. Study findings show the OPHO carefully weighed its options. The OPHO knew, on the one hand, that a Cabinet submission that included highly specific health goals would not be acceptable to political leaders and may lead to the demise of the health goals. On the other hand, submitting health goals without specificity amounted to a failed attempt by the OPHO to meet its original intention for measurability. Moreover, health goals with low specificity jeopardized the expected contributions of health goals in BC, for example, to monitor the health status of British Columbians, to track reductions in health inequities, to provide an accountability mechanism for investments in health, and to support decision making on resource allocation.

In the end, the OPHO took the decision to submit a package to Cabinet that would meet the OPHO's original intention of developing measurable health goals; the package would include goals, objectives, targets, indicators, and lead sectors. This was accompanied however, with a request to Cabinet to consider only the goals and objectives. So, a compromise was made: Cabinet endorsement for health goals without specificity. The final version of health goals, published in December, 1997 included broad health goals and objectives which were not stated in measurable terms; it also offered examples of measurement indicators, but did not include any
targets and did not assign lead sectors to take responsibility for action on goals. Study findings suggest that the annual reports produced by the OPHO on the health of the BC population might offer a measurability mechanism, outside the health goals initiative, to track and monitor the health status of British Columbians over time.

A Glance at Other Jurisdictions

Unlike British Columbia, five of the six jurisdictions reviewed as a part of this study achieved high specificity of health goals including Australia, ACT, England, US, and Texas. It is worthwhile also to note that these jurisdictions took a decidedly more health-targeted approach to health goals; where health goals typically addressed issues related to preventable illness and injury, disability, morbidity and mortality, risk factors, health protection, health promotion, and disease prevention. These jurisdictions both set specific health goals and addressed the social and environmental influences on health; albeit to a lesser extent than BC (McGinnis, 1984; England Department of Health, 1992; Nutbeam and Wise, 1992; Green, 1992, 1993; Lyons, 1995).

Typically, inclusion of the broader health determinants in these jurisdictions did not occur at the level of broad goals; but were woven into lower levels of the goal-setting hierarchy and reflected in objectives, strategies, and supporting discussions on how goals would be accomplished.

Study findings demonstrate that BC tried to have it both ways: to develop a set of goals with measurable objectives that addressed the multiple factors that influence health. In so doing, BC may have set a trap for itself. Attempts by the OPHO to get specific about the business of ministries outside of health; that is, to set targets in areas under the mandate of other ministries,

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42 The Saskatchewan health goals initiative focussed on the articulation of broad health goals that addressed the determinants of health and did not reach the level of measurability characteristic of the other jurisdictions reviewed in this study.
proved largely unsuccessful. On the other hand, the OPHO succeeded at getting very specific about the health-targeted goal that aligned with the health sector and addressed issues of preventable illness, injuries, disabilities and premature deaths.

One interpretation of the BC “lesson” or experience could be: “You can’t have it both ways.” Health goals can either be broad in scope, addressing the global social, economic and environmental influences on health, and not be specific or measurable; or they can be limited in scope, focusing on contemporary health-specific issues, and be very specific. Given the evidence on the multiple factors that influence health, a balanced approach to health goals that includes the broad determinants as well as health-specific issues, is likely the “best” approach. Findings of this study suggest however, that the adoption and operationalization of a health-determinants approach challenges the likelihood of formulating measurable health goals. Suggestions on how to meet the twin aims of addressing the larger-than-health sector issues along with health-specific issues, while meeting the standard of measurability, are discussed later in this chapter.

**Health Services as a Priority Focus in the BC Health Goals**

The portrayal of health services as a priority issue in the BC health goals accounts for another principal issue in the articulation phase. While the first version of health goals included health services as a priority area; Version II excluded them, and Version III referenced them indirectly. Health services received equal attention to other priority issues in Versions IV and V. Forces that called for the exclusion of health services were greater in “voice” than in number. The argument against the inclusion of health services came from one representative (especially) of the OPHO; and some representatives of the public health sector. Their position was driven by the belief that health goals that included health services would reinforce the traditional
prominence of health services as a health determinant; and undermine efforts to shift public understanding and resources away from the health sector toward the social, economic and environmental factors that influence health more indirectly. Study findings show that some members within the OPHO and representatives of various parties consulted on the health goals challenged this position. They argued that health services should receive equal prominence in the BC health goals and based their position on the following:

• Expressed feelings of alienation by many branches and divisions of the Ministry of Health and their reluctance to support the health goals if health services, which was the focus of their mandate, were not included.

• Expressed dissatisfaction from the “status quo” or representatives of the traditional health sector such as health care providers, hospitals and professional health associations that their interests would not be adequately reflected in health goals that excluded health services.

• Queries from and confusion among the public-at-large (voiced mainly at RHBs health goals workshops) about the absence of health services in the health goals.

• A need to acknowledge and justify the expenditure of over $7 billion annually on the health care system in the province of BC.

The evidence of this study aligns with the experience of other jurisdictions that have adopted a health goals approach to population health promotion. Of the jurisdictions reviewed in this study, only Saskatchewan did not include health services in its health goals; although it referenced the contribution of the health system in supporting documentation. Other jurisdictions, such as the US and Texas, established a comprehensive set of objectives for preventive health services (Green, 1979; US Department of Health and Human Services, 1980;
McGinnis, 1984; Texas Department of Health, 1991); while Australia, England and ACT set out clear expectations for health services in some combination of goals, objectives and strategies (Lyons, 1995; Nutbeam et al, 1993; England Department of Health, 1992). The Australian and US experiences also illustrate ways in which inclusion of health services in health goals helped to garner some of the considerable share of resources in the service of goals for disease prevention and health promotion.

The literature on health goals and the real-life experience of several jurisdictions around the world demonstrate that traditional interests related to health services can be effectively combined with matters relating to the broad determinants of health in health goals. Health goals that include both health services and those influences on health that reside outside the health system hold the greatest potential for appeal and acceptance across sectors. The BC experience revealed that the decision to exclude health services in the early versions of the health goals alienated a chief component of the health care system. This challenged the BC health goals process in ways that could have been avoided, had health services been included as a priority issue in the health goals from the beginning.

**Trade-Offs and Health Goals Planning in BC**

Several accomplishments and concessions characterized the BC health goals development process. The OPHO met its original intent to establish a set of goals that addressed the social, economic and environmental influences on health. This was accomplished, however, at the cost of health-goal specificity or measurability. Although the OPHO made every effort to formulate specific objectives for the broader determinants of health, it was largely unsuccessful. The OPHO was most successful in meeting the measurability standard in relation to the health goal that
addressed health-specific issues related to preventable illness, injury, disability, and premature death. This has significant implications for the future of the BC health goals. Health goals stated in immeasurable or unspecific terms are less likely to galvanize action toward successful implementation than health goals stated in clear and specific terms. Further, health goals without the capacity for measurement decrease the likelihood of yielding the benefits or positive contributions attributed to them, such as fostering health system accountability, supporting health impact assessment and health status monitoring, and facilitating population-based planning. Only time will tell whether the commendable breadth of the BC health goals will survive the problems associated with their lack of specificity and measurability.

Additional trade-offs in the BC health goals exercise were reflected in relation to the role of the health goals coordinating mechanism and the handling of health services as a priority issue. Study findings show that although the operational and bureaucratic autonomy of the OPHO facilitated the health goals process by allowing it to side-step the health bureaucracy and “chart its own course to health goals,” these conditions generated also feelings of alienation from the health goals process and product among some branches of the Ministry of Health. A decision to exclude health services from an early version of health goals further estranged the Ministry of Health and some established health interests. The OPHOs drive to focus the health goals on the social, economic and environmental health determinants, led established health interests to question the relevance of the health goals and further distanced them from the health goals planning process.

Intersectoral relations reflect additional challenges and accomplishments of the health goals process. The BC health goals initiative successfully rallied the support of all government sectors and received the endorsement of every government minister. Some study participants
believed that this (alone) amounted to a significant achievement. However, the intersectoral partnerships forged as a part of the health goals process did not effectively translate into action plans aimed at the attainment of the goals. Although early versions of the BC health goals assigned lead sectors responsible for goal accomplishment, the final version did not. Failure to designate responsibility for health goals to the various sectors and ministries that comprise government may further jeopardize the implementation of the BC health goals and their institutionalization into provincial health policy.

Efforts to articulate a goal on Aboriginal health reflect additional challenges and trade-offs in the BC health goals initiative. Most study participants believed it reasonable to link the goal on Aboriginal health to historical legacy rather than to health status. While this helped to reflect the renowned challenges faced by the Aboriginal people in relation to self-government and First Nations’ treaty negotiations, it also encumbered the health goals process and made it difficult to get specific about objectives. The final version of health goals failed to articulate objectives for the goal on aboriginal health; rather, it stipulated a few overall indicators. One can speculate that measurable objectives may have been achieved, if the goal on Aboriginal health was linked to health status, early on. This reasoning is based on the notable success of the OPHO in formulating measurable health objectives (in early versions) associated with the health-specific goal which addressed issues relating to preventable illness, injury, disability, and premature death.

Finally, trade-offs and concessions characterized various procedural aspects of the health goals development process. By carefully orchestrating the consultation sessions through the use of pre-determined health goals and basing educative sessions on the broader health determinants, the development process followed an orderly path and unfolded in a systematic fashion. Having
the final result clearly in mind, the OPHO set forth procedures to reach that result in the most efficient manner possible. This, however, led some to judge the health goals consultation process as biased. Some participants claimed that consultation sessions were designed not to identify priority health concerns, but to confirm priorities previously deemed salient to the OPHO. Others declared that consultation mechanisms did not allow for a full and open disclosure of views. While decisions to expedite health goals planning, by structuring aspects of the process in advance, addressed issues of efficiency, a price was paid in terms of participant perceptions about the overall fairness of the health goals development process.

Implications for Planning Theory

This section assesses the fit of the BC health goals planning exercise against various planning approaches. First, the BC health goals process is discussed in relation to various aspects of three grand planning approaches: (a) the rational model, also called the rational-comprehensive model, the rational actor model, or the classical model; (b) the incremental model, also referred to as the incrementalist model, the political model, or the governmental politics model; and (c) Allison's Model II (also known as the organizational process model). These broad planning approaches set the context for the discussion that follows which centres on two procedural planning models that have been widely applied in the health field: the management-by-objectives model and the PRECEDE-PROCEED model. These models speak

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43 Three of the 4 grand theories introduced in Chapter 2 will be considered here: the rational approach, the incremental approach, and Allison’s Model #2. The mixed scanning model will not be discussed since it represents a blending of the rational and incremental models.

44 Two of the 7 procedural health planning models introduced in Chapter 2, management-by-objectives and PRECEDE-PROCEED, are considered. Selection of the procedural models is based on the following reasoning: management-by-objectives is considered to be the most influential progenitor of health goals planning, and PRECEDE-PROCEED is the most highly evolved and time-tested health promotion model that includes the
more directly to the application of goals and objectives. Consideration is given to the ways in which the BC case reflects or differs from various processes, procedures, and assumptions that characterize these models. This section closes with suggestions on how the procedural models may be enriched, adjusted or extended to support the health goals development process.

Considering the BC Health Goals Process in Relation to the Grand Approaches to Planning

A discussion on the fit of the BC health goals initiative in relation to key aspects of the rational model, the incremental model, and Allison’s Model II is offered below.

Aims and Strategic Procedures of the Planning Process

The BC health goals development process endeavoured to establish a set of health goals with measurable objectives for the people of the province of BC “that reflects our understanding of how social, economic and environmental factors affect health, and provide a means of measuring our success over time” (BC Ministry of Health and Ministry Responsible for Seniors, 1993, p. 12). The initiative strived “to maintain and improve the health of British Columbians by enhancing quality of life and minimizing inequalities in health” (British Columbia, 1995). Once it was clear on its mission, the OPHO launched a planning initiative that would set forth an agenda for improved health for all the people of BC. This aligns closely with one of the central assumptions of the rational model of planning which, according to Dror (1993), strives to make

application of goals and objectives. Other models discussed in Chapter 2 are focused more narrowly (a) on the translation of national objectives (Model Standards), (b) on building organizational capacity to promote public health functions (APEXPH), (c) on the development and implementation of community health promotion programs in order to meet goals (PATCH); (d) on goals implementation (PERT), and (e) on the implementation of interventions at multiple sites for goal attainment (MATCH).
the "best" possible choices for future action toward some vision of the "good life" for all concerned.

Gilbert and Specht (1977) point out that within the rational perspective, planners go through a logical, systematic process to reach decisions based on the examination and analysis of relevant research, facts, values and theories. Also, issues are dealt with comprehensively; and typically, data are collected on what has been done in other jurisdictions that have attempted similar initiatives or faced similar problems. These procedures were variously represented in the BC goals process.

Reflecting the rational perspective, the OPHO undertook a logical, systematic process by first defining its expected outcome, which was a set of health goals that reflected the broader health determinants; and then setting forth strategic directions to successfully accomplish such. With its mission clearly in mind, the OPHO outlined a series of phases and steps to achieve the expected result, including clearly defining how, who, when, and by whom parties were consulted. The health goals development process followed a reasoned, methodical path once the OPHO made the deliberate decision to develop health goals based on the multiple influences on health. Further, data were collected and reviewed on health goals in other jurisdictions; and issues were addressed comprehensively in terms of the scope of the health goals which included all known proximal and distal health determinants. This differs from an incremental approach which considers a limited number of issues; and Allison’s Model II where planning scope is similarly limited by standard operating procedures, ongoing programs and interorganizational relations. Unlike the tenets of the rational model, the BC exercise did not undertake a comprehensive, critical review of the literature for the purposes of articulating health goals statements. Rather, review of the evidence focussed primarily on secondary sources related to the
broader determinants of health.

Finally, the BC health goals process aligns with the rational planning approach because of the centrality the rational model assigns to goals within the planning process. Goals typify the rational approach, as do clearly-stated values to guide the planning process. Goals may or may not be defined in the incremental model of planning; and values are not identified since, values, like plans, are fluid, and change with time and circumstance (Gilbert & Specht, 1977). Articulation of goals usually occurs in Allison’s Model II for the purpose of defining acceptable organizational performance (Allison, 1971). Delineation of goals and values that characterizes the rational approach is consistent with the BC health goals process; where the articulation of goals for the improved health of British Columbians rested on the shared principles of collaborative action, public participation, equitable access to health care and respect for diversity.

**Accommodation of Multiple Interests in the Planning Process**

The aspect of accommodating multiple interests in the BC health goals development process is most consistent with the incremental approach to planning. The incremental model of planning integrates the political dimensions of planning with the more technical aspects, which characterizes the rational approach. Incrementalism recognizes that planners act and make decisions within a political context characterized by conflict and negotiation, which introduce limitations and challenges to the planning process (Walt, 1994). Plans therefore, are political outcomes; negotiated by interest groups with varying perspectives, aims and powers (Lindblom, 1979; Walt, 1994).

Although there is interview evidence to suggest that all views were not adequately
represented in the BC health goals process, source documents, that commented on the intentions of the BC health goals development process, revealed that the OPHO attempted to accommodate as many interests and perspectives as possible. Efforts to accommodate multiple interests were accomplished through various consultation strategies coordinated by the OPHO including meetings and briefings with all government ministries, group meetings with over 100 provincial stakeholder organizations representing various sectors, and workshops with all regional health boards (which also included representation from the public at large).

Endorsement and commitment from multiple interests was judged critical to the development process because the health goals were to reflect the broader determinants of health; and would thereby touch on the mandate of all sectors, both within and outside government. Advancement of the health goals process and the likelihood of adoption and official endorsement of the health goals by Cabinet required broad-based backing.

Efforts by the OPHO to acquire support from the ministers and deputy ministers of all government ministries reflects the incrementalist perspective. The political context of the BC health goals process was evidenced further by the handling of health services as a priority area in the health goals. The inclusion of health services in the final rendition of the health goals came after expressed dissatisfaction from the Ministry of Health and increased pressure from some provincial associations to include traditional health sector interests.

The political aspects of planning might be especially relevant to the health goals process in BC, because BC adopted a health-determinants approach to health goals planning, and therefore, required the support of persons in power throughout the government. The political nature of planning might be less relevant to jurisdictions that choose a health-targeted approach

43 See the Chapter 4 section entitled, “Theme 9: Consultation and Participation.”
to health goals. Under this approach, health goals planning resides more heavily in the health sector and the need for support and commitment from multiple sectors is reduced in the initial planning phases, though they would still need to be increasingly involved in the more specific objectives that involve the programs, policies and regulations of their sectors. These examples point to the efforts by the OPHO to accommodate the multiple interests associated with the BC health goals process. More broadly, they help to illustrate the political nature of the health goals development process in BC.

To a lesser extent, the aspect of accommodating multiple interests aligns with Allison’s Model II. This model views planning as an organizational output and explains the role of organizations; most typically, governmental bureaucratic units, in the planning process (Allison, 1971). Under this model, parochial priorities drive planning; and organizational mandates establish and limit planning parameters. Efforts by the OPHO to “enter into the garden of other ministries” challenged the BC health goals process. Some ministries perceived this as “health imperialism;” and voiced concerns that “health” was taking on more than it ought to or had the right to. This may account for the resistance by some ministries to meet OPHO requests for ministry-specific information and for “concrete measurable objectives” relevant to their sector. Allison’s Model II points to the importance of issues related to organizational mandate, and the parochial nature of government ministries; and thereby offers a framework to better understand planning initiatives that involve, or rely on, multiple interests and sectors.

**The Role of the Public Interest in the Planning Process**

On issues related to the “public interest” or the “common good,” the BC health goals experience fits best with the rational model of planning. How the public interest is defined is a
function of whether one adopts an individualistic or unitary conception of public interest or common welfare (Wootton, 1945). The incremental school of thought subscribes to the individualistic view where there is no such thing as the public interest, “rather there are different publics with different interests” (Gilbert & Specht, 1977, p. 20). Public interest therefore is transitory, it changes as new groups and interests enter to influence the planning process. The rational planning perspective rests on the unitary conception of the public interest where planning is undertaken for the common good and more weight is attached to common ends than to unshared ends (Banfield, 1955). This is consistent with the aim of the BC health goals initiative to “maintain and improve the health of British Columbians,” and to “minimize inequalities in health status,” particularly in relation to aboriginal peoples, so that all British Columbians enjoy improved health and quality of life. The BC health goals process ventured to articulate a set of shared ends (projected health outcomes) for the people of BC.

Considering the BC Health Goals Process in Relation to Two Procedural Models in the Health Field

The BC health goals exercise is now discussed in relation to two procedural, practice-based models which have been time-tested and widely applied in the health field: the management-by-objectives model and the PRECEDE-PROCEED model. These models draw on the grand theories discussed above, and align most closely with the rational planning perspective. The discussion includes ways in which the BC case is reflected in or differs from various aspects of these models; followed by suggestions on how these models may be enriched, adjusted or extended to support or enhance goal setting in the health field.
Management-By-Objectives

Management-by-objectives underpins the goal-setting approach in population health promotion. As acknowledged in an earlier chapter, MBO is characterized as a philosophy of scientific management and planning that emanated from the business and defence/military sectors. Both private and public settings have widely applied MBO over the past twenty-five years. In relation to health goals, the US was the first jurisdiction to develop a comprehensive objectives-based health policy which firmly and explicitly applied the MBO methodology (Green, 1979; McGinnis, 1984, 1993; Mason, 1990b). Several other jurisdictions modelled the US approach to health goals, and in doing so, were similarly influenced by the MBO model. This section discusses how the BC health goals exercise reflects and differs from various aspects of the MBO planning perspective.

Assessing the Fit Between the BC Case and the MBO Model

The BC health goals exercise reflects several management-by-objectives assumptions and procedures. The MBO model rests on the belief that individuals (in the workplace) are most effective when they understand what they are working toward and what the expected final results will be (Garrison & Raynes, 1980). Attention is focused more heavily on outputs and results than on activities in the MBO model. An underlying motivation for health goals in BC was the need to encourage all sectors, both within and outside of government, "to work together toward demonstrable health gains." Health goals in BC were seen as a vehicle for galvanizing action toward a set of "results" that would eventually meet the mission for improved health and reduced health inequities. MBO assumes also that clearly outlined objectives must be consistent across the organization to achieve effective programs and desired outcomes (Odiome, 1965; McConkey,
1975; Lee, 1981). Proponents of health goals in BC believed that the provincial health goals would be used as a model for planning and priority setting by regional health boards and health-related groups and organizations. Consistency of goals, across government and non-government sectors, would “get everyone moving in the same direction” and thereby increase the likelihood of improved health outcomes for the people of BC.

Consistent with the MBO planning perspective, the BC health goals initiative proceeded through a set of systematic phases and steps and drew on various forms of technical expertise. This came in the form of expert advice from colleagues in government ministries and various stakeholder organizations, and ad-hoc consultation with individuals supportive of the health goals initiative; it also drew on a developing evidence base on the broader determinants of health, but reliance on this base of evidence fell short of providing more specific direction on the size of effects possible and particular interventions to meet targets.

The MBO approach strives also for measurability or specificity, but these were elusive elements of the BC experience. Although the final version of the BC health goals (and objectives) did not achieve measurability; the health goals planning initiative clearly set out to establish a set of goals with measurable objectives. The BC case resembled the MBO model in original intent, if not in result or outcome. Other jurisdictions reviewed in this study clearly met the standard of measurability; most evidently in the United States where “the element of quantification was placed as paramount,” and “broad non-numerical statements of good intentions only were not considered acceptable” (McGinnis, 1993, p. 1626). At the same time, the US included goals and targets on outcomes and processes that had not yet been measured on a population-wide scale. Measurability did not mean already measured on a national scale in the US initiatives.
Assessing the Lack of Fit Between the BC Case and the MBO Model

The lack of fit between the BC health goals exercise and the MBO model can be attributed largely to the business principles and procedures that underpin the model. This is not to lose sight however, of MBO’s history and development in the US defence department, then other sectors of government, as well as non-profit, voluntary health agencies. This section outlines a few aspects of the MBO model most inconsistent with goal setting in the health field.

One distinguishing inconsistency between the MBO model in business and goal setting in the health field is motive; that is, the overarching driving force of the planning exercise. The central objective of management-by-objectives in business is to identify and meet organizational goals and objectives that will be reflected ultimately in productivity, profit, and performance (Lee, 1981; Richards, 1986). Health goals planning strives to articulate goals and objectives that, if met, reflect or lead to improved health status indicators for the population at large. MBO in business is driven by profit; health goals planning is driven by motives that are more altruistic, and relate to, as noted above, the public interest or the common good.

MBO characteristically sets forth the hierarchy of objectives whereby organizational departments establish (second order) process and outcome objectives that underpin first-order objectives aimed at organizational efficiency and profit. This kind of layering of objectives was not reflected in the BC health goals initiative, but characterizes the approach taken in other jurisdictions. Australian and US objectives for example, involved sectors outside health in the establishment of second-order objectives in support of projected health outcomes or endpoints; their contributions were viewed more clearly as means rather than ends. The BC initiative grouped goals relating to health determinants with health goals relating to health outcomes as first order objectives or ultimate ends to be achieved. This approach required support from all
sectors, and meant that multiple mandates came into play. This was particularly relevant to the
specificity issue where efforts to establish measurable objectives in sectors outside the health
sector proved difficult. When the OPHO set out to quantify things by establishing targets, it was
perceived to be over-stepping into the purview of other ministries. While the MBO model
appears to fit well with those health goals initiatives that incorporated the hierarchy of objectives
principle (such as the US, England and Australia), its fit appears less snug when the health goals
planning process aims to establish broad-based health goals that include distal health
determinants and “encroach” on other-than-health sectors.

Another notable way in which the BC health goals exercise demonstrated a lack of fit
with the MBO model relates to the assignment of parties responsible for the attainment of health
goals. MBO asserts that the best way to meet organizational aims is to set measurable goals and
objectives and to hold parties accountable for their monitoring and attainment (Garrison &
Raynes, 1980). Although early versions of the BC health goals identified “lead sectors,” they
were not identified in the final published version. This scenario is inconsistent with the MBO
philosophy which links the accomplishment of organizational goals to performance
measurement. Although this was never really contemplated in BC, some jurisdictions have linked
goal attainment to program budgets. In the US, for example, the annual budget of the agencies of
the US Public Health Service are allocated based upon their anticipated contributions toward the
health objectives for the nation (Green, 1992).

What Does the BC Case Have to Say About the MBO Model?

The greatest contribution that MBO makes to health goals planning is as a framework to
guide the technical aspects of the exercise. MBO encourages, for example, a thorough review of
relevant facts, research and data related to health goals, and advocates for a comprehensive assessment of health goals development in other jurisdictions. It reinforces a commitment to measurability and the importance of stipulating the “who,” “how much,” “of what,” and “by when” conditions of specific objectives (Green & Kreuter, 1991). Finally, it focuses attention on outcomes in addition to activities; which could encourage a shift from resource-based planning to population-based planning in the health field.

The inconsistencies between the management-by-objectives model and the BC health goals exercise suggest that some potential exists for adjustment of the MBO model to better fit goal setting in the health field when the aim is the development of broadly-based health goals. First, an adjusted MBO model would incorporate a method that allows for the identification of priority issues in sectors outside of health, and the effective inclusion of those priorities into goal statements for improved population health. This implies accommodating the sensitive issues related to what could be referred to as “mandate clash” that characterized the BC experience. An enhanced MBO model would include procedural guidance to assist health goals planners with this task. As the evidence in this study suggests; unless this challenge is met, expectations for establishing measurable or specific health goals that address the multiple determinants of health are placed in jeopardy.

Additionally, a MBO model for goal setting in the health field would benefit by reframing the concept and strategies it espouses in language that is compatible with the health field and with health promotion. The traditional MBO approach describes the goal setting process in words friendly to the business and private sectors. Increasingly, language associated with the private sector -- such as accountability, efficiency, return on investment, and productivity -- have seeped into the health field. While an adjusted MBO model that is compatible with goals setting in the
health field would likely include such terms, one would hope that it would do so in a way that remains sensitive to and inclusive of concepts fundamental to health promotion and public health; such as equity, participation, empowerment, and shared responsibility.

**The PRECEDE-PROCEED Model and Health Goals Development**

Key aspects of the PRECEDE-PROCEED model in relation to the BC health goals exercise are discussed below. While the following discussion acknowledges the good fit of the BC health goals process with the PRECEDE-PROCEED model, it outlines also the ways in which they differ. This section closes with suggestions for consideration on how the PRECEDE-PROCEED model might be adapted to accommodate better the health-determinants approach to health goals planning typified in BC.

**Assessment of the Fit of the BC Case Against the PRECEDE-PROCEED Model**

Two conceptual-level issues and several procedural issues account for the good fit between the BC health goals development exercise and the PRECEDE-PROCEED model. The conceptual issues are (a) the theoretical richness of the PRECEDE-PROCEED model, and (b) the propositions that underpin the model. Developing health goals that address the multiple influences on health necessitates a broad understanding of diverse theories and bodies of literature relating to the multiple layers of causation between immediate and distal determinants of health. Glanz and Rimer (1995) recognize the contribution of three levels of theories that characterize population health promotion models such as PRECEDE-PROCEED. They include (a) *individual or intra-personal level* theories, such as stages of changes model, health belief model, consumer information processing model; (b) *interpersonal level* theories such as social
learning theory; and (c) community level theories including community organization, organizational change theory, and diffusion of innovations.

Theoretical diversity characterizes the PRECEDE-PROCEED model which has evolved over the past thirty years from many bodies of research including family planning, geographic and demographic studies, sociomedical studies in health services research, epidemiology, social psychological research in health education, and research in the areas of patient education, self-care, mutual aid, and public health (Green & Kreuter, 1991). The comprehensive theoretical foundation of PRECEDE-PROCEED makes it conceptually compatible with health goals planning that deliberately chooses to addresses both the proximal and distal determinants of health, and it has been made more so in the forthcoming third edition (Green & Kreuter, in press).

Two fundamental propositions that underpin the PRECEDE-PROCEED model account further for the good fit between the BC health goals exercise and this model. First, the PRECEDE-PROCEED model recognizes that health and health risks are caused by multiple factors. This philosophy underpins the BC case. Second, PRECEDE-PROCEED acknowledges that because multiple factors determine health, efforts to effect behavioural, environmental, and social change must be multidimensional and multisectoral (Green & Kreuter, 1991). This is consistent with the BC experience that sought to position the BC health goals as a government-wide initiative rather than a Ministry of Health initiative; and worked arduously for support and commitment from all ministries and sectors as a part of the development process.

Based on the two fundamental assumptions of the PRECEDE-PROCEED model, it aims to provide “systematic procedures, arrayed in a conceptual framework of causal relationships, to assess the determinants of health of the population” (Richard et al., 1996, p. 319). It begins with
the identification of the ultimate social benefits or quality of life, and then works backward in the causal chain to health; assessing the behavioural, environmental, educational, organizational, administrative, and policy determinants of health (Green & Kreuter, 1991).

__Fit on the Procedural Level__

Nine phases comprise the PRECEDE-PROCEED model. The PRECEDE framework, which constitutes the first five phases, is most relevant to the development of health goals for a population. PRECEDE includes a series of systematic steps to assist planners to work through the multiple factors that influence health and to arrive “at a highly focused subset of those factors as targets for intervention” (Green & Kreuter, 1991, p. 22). An overview discussion of each of the five phases is offered below with the aim to: (a) demonstrate how the BC health goals process reflects and differs from the PRECEDE framework on a procedural level, and (b) illustrate how the PRECEDE model better accommodates health goals planning that adopts a health-determinants approach than other models discussed in this paper.

- **Phase 1: Social Diagnosis**

  The social diagnosis phase of the PRECEDE framework entails a full assessment of the social, economic, demographic and environmental conditions of a population (Green & Kreuter, 1991). The social diagnosis reminds planners that health-related issues and problems must be viewed within the context of quality-of-life-concerns (Frankish et al., 1996b). The BC health goals process did not undertake a formal social diagnosis, as outlined in the PRECEDE framework. The BC initiative did, however, proceed with an understanding of the social, economic, demographic and environmental conditions and characteristics of the BC population; based on various provincial reports on health reform, environmental planning, sustainability,
working and living opportunities, and other reports produced by the OPHO.

Planning under the PRECEDE framework opens up the potential for multi-sectoral efforts (early on) by assessing conditions that extend beyond the health sector or system. In other words, the PRECEDE framework allows for the early detection of priority issues that originate outside of the health area and their reciprocal relationship with health. Accomplishing this in the first phase establishes a context for consideration of the broader determinants of health in the later stages of the model, where health goals and objectives are formulated.

• Phase 2: Epidemiological Diagnosis

The epidemiological diagnosis involves the identification and prioritization of specific health goals or problems that relate to the social goals of a population. The data examined in the epidemiological phase of PRECEDE provide the evidence on which to set goals and to design population health programs and policies. This phase has three purposes: (a) to provide empirical support for addressing a priority health problem; (b) to demonstrate the magnitude of particular health problems, and (c) to establish specific, measurable health objectives to address priority health issues. To meet these aims, the epidemiological diagnosis constitutes the following three steps: (a) assess and evaluate available prevalence and incidence data, (b) compare identified health issues or public health problems rated on (i) prevalence and incidence, (ii) importance (in term of their potential to influence quality of life issues), and (iii) capacity to influence population health positively in decreasing morbidity or mortality and increasing quality of life; and (c) the formulation of measurable health objectives (Green & Kreuter, 1991).

BC undertook an epidemiological diagnosis in relation to the goal that addressed health-specific issues. Although not as formalized as that suggested in the PRECEDE framework, the epidemiological diagnosis yielded a listing of several objectives that included quantified targets.
and measurement indicators. Generally, targets were set using the benchmarking or the normative method. Much of the epidemiological data that was drawn on in the formulation of health goals and objectives was readily available to the OPHO through the Provincial Health Officer's annual reports.

The chief benefit of Phase 2 of the PRECEDE framework is its provision of a "road map" to measurable health objectives. The epidemiological diagnosis walks planners through an orderly process to come up with objectives that specify who will change how much of what by when. Additionally, it guides planners to important sources and types of data to support the articulation of health goals and objectives. Finally, this phase assists planners with the difficult task of choosing among priorities by providing criteria to support their decision making. In these ways, the PRECEDE framework better accommodates the demands of health goals planning than other models discussed in this paper.

Although the actual articulation of overall health objectives occurs in this phase and is therefore most directly relevant to health goals development, the epidemiological diagnosis should be conducted "with an awareness of the subsequent stages in the PRECEDE framework which involve the identification and selection of specific channels and strategies for motivating, supporting and reinforcing" changes in the environment and the target population -- en route to improved health status and quality of life (Frankish et al., 1996b, p. 19). These remaining phases of the PRECEDE framework are touched on below.

- Phase 3: Behavioural and Environmental Diagnoses

Green and Kreuter (1991) define behavioural diagnosis as "a systematic analysis of the behaviour links to the goals or problems that were identified in the epidemiological or social diagnoses" (p. 126). The environmental diagnosis is a parallel analysis of factors in the social and
physical environment “that could be causally linked to the behaviour that was identified in the behavioural diagnosis, or directly to the outcomes of interest (health or quality of life)” (Green & Kreuter, 1991, p. 126). More specifically, Phase 3 of the PRECEDE framework uncovers health-related behavioural and environmental factors that are linked to priority health problems that were identified in Phase 2.

Phase 3 leads to the articulation of precise, measurable behavioural and environmental objectives that establish the basis for intervention design later in the planning cycle. Phase 3 allows for the advancement of what has been referred to in this paper as the “hierarchy of objectives.” It is here where objectives that address the broad influences on health can be articulated into “second-order objectives.” These second-order objectives represent those things that must be done to achieve the “first-order objectives”—those objectives established in Phase 2 that address health-specific issues or problems. In other words, Phase 3 provides the greatest opportunity for objective setting that addresses the underlying social, economic and environmental influences on health. As illustrated in this case study, several jurisdictions that have adopted a health-targeted approach to health goals, including the US, Texas, England, ACT and Australia, have effectively succeeded at incorporating the broader determinants of health into lower levels of the objective-setting hierarchy; with greater specificity but not with as much breadth as evidenced in BC’s goals. (See Chapter 2, pages 121-125.) The greater breadth of environmental determinants is addressed in the third edition of the book describing the PRECEDE-PROCEED model, where “environmental diagnosis” is renamed “environmental assessment” and its scope broadened accordingly to examine strengths as well as problems in the environment (Green & Kreuter, 1999, in press).
Phase 4: Educational and Organizational Diagnoses and 
Phase 5: Administrative and Policy Diagnoses

Phase 4 involves an analysis of factors predisposing, enabling and reinforcing specific 
health-related behaviours or lifespan development and lifestyles, and factors enabling 
environmental change. This phase of the PRECEDE framework consists of “sorting and 
categorizing the factors that seem to have direct impact on the target behaviour and environment” 
that were addressed in the previous phase (Green & Kreuter, 1991, p. 29). The careful assessment 
of predisposing, enabling and reinforcing factors assists planners in their decisions on which 
factors deserve highest priority as the focus for intervention. This phase is renamed “educational 
and ecological assessment” in the third edition, giving greater attention to the more distal 
determinants of behavioural and environmental changes (Green & Kreuter, 1999, in press). Phase 
5 further prepares the planning initiative for implementation. This phase centres on the 
assessment of the challenges and barriers to successful program implementation. This includes 
often the consideration of the legislative or policy variables that may act to promote or impede 
the development of specific programs and policies. It entails an assessment of the strengths, 
challenges and barriers to successful intervention and program implementation and the 
identification of “available” versus “needed” resources (Green & Kreuter, 1991).

The processes and procedures that comprise Phase 4 and 5 of the PRECEDE framework 
were not exhibited in the BC health goals process in any substantial way. This reflects in large 
part, early decisions by the OPHO not to delineate intervention strategies or programs to support 
achievement of the health goals as a part of the health goals development process (although pre-
published versions of the health goals identified lead sectors responsible for actions towards 
health goals). Regardless, Phases 4 and 5 of the PRECEDE framework support planners in their 
efforts to set forth linked strategies for meeting goals and targets articulated in earlier phases, and
to elaborate more on distal determinants of health in the hierarchy of objectives. The remaining phases of the PRECEDE-PROCEED model facilitate the progression of the planning process through program implementation (Phase 6), process evaluation (Phase 7), impact evaluation (Phase 8), and outcome evaluation (Phase 9).

Modification of the PRECEDE-PROCEED Model Based on the BC Health Goals Process

Health planners undertaking health goals face a challenging and complex process. The advantages of the PRECEDE-PROCEED model for health goals development are its ability to organize and focus health planners in the data collection and assessment stages of health goal formulation, to give full consideration of the multiple factors that influence health, and to develop effective strategies for meeting goals and targets. Further, the PRECEDE framework accommodates the development of a hierarchy of objectives that allows for the integration of objectives that address the broader determinants of health. By carefully working through the various stages of diagnosis and assessment, the PRECEDE-PROCEED model enhances the likelihood that health planners will formulate health goals that are relevant, realistic, and measurable. By providing planners with a well-tested mechanism for formulating objectives, PRECEDE-PROCEED is a health promotion model deserving of consideration by jurisdictions contemplating a health goals approach to population health promotion.

Although the PRECEDE framework is well-suited for the development of population health goals, findings from this study offer some suggestions for the modification of the model to accommodate more fully the kind of health goals process that was undertaken in BC. Suggestions for consideration are made to support the development of population health goals by planners who choose a “health-determinants pathway” to health goals. Figure 1 below illustrates the
PRECEDE-PROCEED model and Figure 2 portrays the suggested modifications to the model.

Suggestions for modification centre on Phase 3 of the PRECEDE framework and include the following:

- **An unravelling of the environmental, economic and social factors in Phase 3, the addition of “health service system;” and a relabelling of the “Environment” construct to the “Environment, Social, Economic, and Health service system” construct.**

Phase 3 of the PRECEDE framework is comprised of two main categories or constructs:

(a) Behaviour and lifestyle, and (b) Environment. Under this arrangement, social and economic factors are included as subset factors under the Environment construct. Findings of this study suggest a separating out or unravelling of those factors, and the inclusion of the health service system (although some health promotion scholars and practitioners might consider health services as a part of the environment determinant); in this way, each broader health determinant would be individually represented.

Modification of the model in this way would have several effects. It would suggest a balanced weighing of the several broader determinants of health (consistent with the BC experience) and facilitate the setting of distinct objectives for each of the broader determinants of health. It would help also to reinforce the hierarchy of objectives discussed earlier; where Phase 2 first-order objectives, which focus specifically on health issues; are supported by Phase 3 second-order objectives which address the broader determinants of health and represent those steps that must be taken to achieve the health-specific goals or aims.

Inclusion of the broad health determinants as second-order objectives in Phase 3 is especially important because issues that constitute this part of the model become the focus for intervention planning in later stages of the model. This adjustment would set into motion, in Phases 4 and 5, the identification, quantification and objectification of strategies and resources.
required to influence the predisposing, reinforcing, and enabling factors influencing or supporting behavioural, lifestyle changes, and changes relating to social, economic, environmental and health system conditions. Leaving the social and economic factors as a subset of the broader environment construct (as the model stands), may mean missed opportunities to establish objectives for priority issues related to all the broader health determinants; and thereby, to effect those factors in the name of improving the health and quality of life of a population.

- *A delineation of separate indicators for each of the environmental, social, economic and health service system health determinants.*

The PRECEDE-PROCEED model recognizes social and economic factors as a subset of the Environment construct. An unravelling of the environment construct into social, economic, and environmental factors and conditions allows for the clear delineation of separate measurement indicators for each of the health determinants. This would facilitate the development of precise, measurable objectives in each of the areas represented by the broader determinants of health. Delineation of indicators for each of the health determinants results in an augmentation of the many indicators already set forth in the PRECEDE framework. Figure 2 below includes suggestions for indicators for each of the broad health determinants.
Figure 1: PRECEDE-PROCEED Model

From: Green & Krueter, 1991, Health Promotion Planning: An Educational and Environmental Approach

Figure 2: Modification of the PRECEDE-PROCEED Model, Phase 3, Based on the BC Health Goals Initiative

Phase 3: Behavioral and Environmental Diagnosis

Examples of Indicator Categories for Broad Health Determinants:

Environmental:
- Natural environment
- Built environment

Social:
- Social participation
- Social supports
- Family functioning

Economic:
- Unemployment
- Working conditions
- Education
- Income

Health Care System:
- Canada Health Act
- Utilization rates
- Hospitalization rates
- Practice guidelines
Implications for the Health Goals Framework

As detailed in Chapter 3, the health goals framework that guided this study sought to capture and organize the apparent universe of factors that characterize and influence the health goals development process, as gleaned from planning theory and the published and source document literature. The health goals framework, which combines the theoretical understanding of health goals planning and the experience of other jurisdictions that have adopted a health goals approach, provided an *a priori* basis on which to examine the development of health goals in BC. More specifically, the health goals framework supported the following functions within this study: (a) data collection, by providing a basis for the interview instrument; (b) data management, by providing an orderly way to organize and code the data; (c) data analysis, by offering a systematic approach to the interpretation of the qualitative interview data and BC source documents; and (d) presentation of study findings.

The Health Goals Framework and the BC Case Study on Health Goals Development

One of the aims of this section is to compare the BC health goals exercise to the health goals framework. This section discusses the fit of the BC health goals process against the health goals framework for each of the three phases of the health goals development process. Comparisons take the form of summary tables along the following four dimensions: (a) dimensions that comprise the health goals framework, (b) dimensions included in the health goals framework and were exhibited in the BC case, (c) dimensions that constitute the health goals framework and were not exhibited in the BC case, and (d) dimensions that were not in the health goals framework but were exhibited in the BC case. This section suggests also modifications to the health goals framework based on the BC health goals experience. These
include suggestions for collapsed categories or dimensions, the incorporation of new dimensions, and adjustment to the order and content of framework themes. The section closes with a discussion on the significance of the fit or lack of fit between the BC case and the health goals framework.

Figure 3:
Fit Assessment of BC Case Against Health Goals Framework
Phase One: The Premonitory Phase

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<thead>
<tr>
<th>In health goals framework</th>
<th>In framework and in BC case</th>
<th>In framework not in BC case</th>
<th>Not in framework, in BC case</th>
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<tbody>
<tr>
<td><strong>Theme 1: Prevailing Circumstances</strong></td>
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<td>- Political</td>
<td>- Economic</td>
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| **Theme 2: Health System Environment** |
| - Health status | - Health status | - Peer pressure |
| - Health system efficiency | - Health system efficiency | - Research and academic precedence |
| - Health system capacity | - Health system capacity |
| - Health system satisfaction | - Health system satisfaction |
| - Health system orientation | - Health system orientation |
| - Health reform | - Health reform |
| - Health literacy | - Health literacy |

Modification of health goals framework components are highlighted in italicized font in the summary tables that follow and discussed in greater detail after presentation of summary tables for each phase. Readers may benefit by referring to Appendix E which outlines and describes the multiple themes and dimensions that comprise the original health goals framework.
In health goals framework | In framework and in BC case | In framework not in BC case | Not in framework, in BC case

**Theme 3: Proponents and Skeptics**

- Internal
- External
- Government-based
- Non-government
- Health sector
- Non-health sector
- Personal characteristics

**Theme 4: Perceived Benefits**

- Policy making
- Program planning & evaluation
- Health impact assessment
- Health inequity reduction
- Role and sector definition
- Health status monitoring
- Health priority setting
- Resource re-allocation
- Population-based planning
- Health system reorientation
- Intersectoral collaboration

**Theme 5: Triggers**

- Government endorsement
- Government legislation
- Consensus agreement
- Budgetary
- Commission recommendation
- Mass media

Suggested Modifications of the Health Goals Framework, Phase One

Based on the experience of the BC health goals exercise, the following modifications are suggested for the Premonitory Phase of the health goals framework:
• Incorporate four new dimensions that emerged out of the interview and source document data in relation to the premonitory phase.\textsuperscript{43}

The emergent dimensions and their associated operational definitions are:

(a) “Peer pressure” (Theme 2): Reflects the evidence that a realization that all other Canadian provinces as well as many jurisdictions around the world had adopted health goals as a population health promotion strategy influenced the context for health goals development in BC.

(b) “Research and academic precedence” (Theme 2): Reflects the evidence that the state of knowledge about the multiple influences on health and the mounting level of interest and writing in academic circles about the broader health determinants influenced the context for health goals in BC.

(c) “Public education” (Theme 4): Captures the evidence that educating and increasing awareness among the public and public bodies about what makes and keeps people healthy motivated interest in health goals in BC.

(d) “Health system accountability” (Theme 4): Reflects the evidence that health goals in BC were motivated by perceptions that health goals would increase accountability of the health system for health outcomes achieved.

• Collapse two dimensions, “Role and sector definition” and “Intersectoral collaboration” within Theme 4 of the health goals framework.

These dimensions refer to similar issues and captured corresponding data under Theme 4: Perceived Benefits. The level of overlap and redundancy suggests collapsing these dimensions into a single dimension under the label “Intersectoral collaboration.”

\textsuperscript{43} New dimensions that emerged out of the data are traced in the previous chapter where each is discussed in relation to the perceptions of study participants. Please refer to Chapter 4 for detailed descriptions and definitions of emergent dimensions.
would be operationally defined as follows: “The delineation of roles and responsibilities of health and other sectors to work effectively together to improve the health of a population.”

![Figure 4: Fit Assessment of BC Case Against Health Goals Framework Phase Two: Formulation Phase](image)

### Theme 6: Levels and Sectors
- Government sector
- Level of government
- Non-government sector
- Non-government level
- Quasi-government
- Diffusion

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<tr>
<th>In health goals framework</th>
<th>In framework, and in BC case</th>
<th>In framework not in BC case</th>
<th>Not in framework, in BC case</th>
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<tbody>
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<td>- Government sector</td>
<td>- Government sector</td>
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<td>- Non-government sector</td>
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<td>- Quasi-government</td>
<td>- Quasi-government</td>
<td>- Diffusion</td>
<td>- Diffusion</td>
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### Theme 7: Coordinating Mechanism
- Base
- Make up
- Capacity
- Political support
- Staff support
- Autonomy

### Theme 8: Strategic Approach
- Technical-Expert
- Bureaucratic-Political
- Incremental - Comprehensive
- Partisan - Non-partisan
- Derivative - Original
- Bottom-up / Top-down

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<thead>
<tr>
<th>- Technical-Expert</th>
<th>- Technical-Expert</th>
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<tr>
<td>- Bureaucratic-Political</td>
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<td>- Incremental - Comprehensive</td>
<td>- Incremental - Comprehensive</td>
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<td>- Partisan - Non-partisan</td>
<td>- Partisan - Non-partisan</td>
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<td>- Derivative - Original</td>
<td>- Derivative - Original</td>
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<tr>
<td>- Bottom-up / Top-down</td>
<td>- Bottom-up / Top-down</td>
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<tr>
<td>In health goals framework</td>
<td>In framework, and in BC case</td>
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<tr>
<td><strong>Theme 9: Consultation and Participation</strong></td>
<td><strong>Theme 10: Core Contributions</strong></td>
</tr>
<tr>
<td>- Selection Strategies</td>
<td>- Technical assistance</td>
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<tr>
<td>- Representation</td>
<td>- Funding</td>
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<tr>
<td>- Consultation mechanism</td>
<td>- Organization</td>
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<td>- Education and communications</td>
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<td>- Leadership</td>
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<td>- Promotion</td>
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- Previous consultation experience

- Time share

- Role of evidence

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**Suggested Modifications of the Health Goals Framework, Phase Two**

Based on the experience of the BC health goals exercise, the following modifications are suggested for the Formulation Phase of the health goals framework:

- **Incorporate three new dimensions that emerged out of the interview and source document data in relation to the formulation phase.**

  The emergent dimensions and their associated operational definitions are:

  (a) "Mandate fit" (Theme 6): Captures the evidence about the "fit" or lack of fit of mandates (roles, responsibilities and aims) between health and the various sectors that participated in the health goals development process.

  (b) "Previous consultation experience" (Theme 9): Reflects the evidence on how prior episodes of consultation of individuals or groups influences or sets the context for consultation on health goals.

  (c) "Role of evidence" (Theme 12): Reflects study findings on how evidence was applied in the formulation of health goals in a given jurisdiction.

- **Removal of the dimension entitled, "Time share," from Theme 11: Time and Budget, from the health goals framework.**

  "Time share" is defined in the health goals framework as "the contribution of time from participating parties in health goals development." This dimension is adequately covered by two other dimensions that comprise this theme: (a) "Paid time" which refers to the amount of remunerable time invested by key players in health goals planning, and (b) "Volunteer time" which refers to the amount of unremunerated time invested by key players in health goals development." Removal of "Time share" from Theme 11 decreases redundancy among theme dimensions.
The BC case study uncovered a cumbersome redundancy between Theme 6 and Theme 9, due in large part to a forced separation of data into two distinct categories: (a) one relating to who was involved in the health goals process (Theme 6: Levels and Sectors), and (b) one relating to how parties were involved (Theme 9: Consultation and Participation). Collapsing these themes involves a “moving over” of two (of a total of three) Theme 9 dimensions, “Selection strategies” and “Consultation mechanisms,” to Theme 6. The third dimension that comprised Theme 9, “Representation,” would be deleted because it is comprehensively addressed by the first five dimensions that comprise Theme 6. Based on these suggestions, Theme 9 would be extricated from the health goals framework and the “new” Theme 6 entitled, “Participants and Consultation Mechanisms,” would look like this:

<table>
<thead>
<tr>
<th>Theme 6: Participants and Consultation Mechanisms</th>
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<tbody>
<tr>
<td>- Government sector</td>
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<td>- Non-government sector</td>
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<td>- Non-government level</td>
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<td>- Quasi-government</td>
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<td>- Diffusion</td>
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<td>- Selection strategies</td>
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<td>- Consultation mechanisms</td>
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And, included as new dimensions:
- Mandate fit
- Previous consultation experience
### Figure 5: Fit Assessment of BC Case Against Health Goals Framework

**Phase Three: Articulation Phase**

<table>
<thead>
<tr>
<th>In original framework</th>
<th>In framework, &amp; in BC case</th>
<th>In framework, not in BC Case</th>
<th>Not in framework, in BC case</th>
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<tr>
<td><strong>Theme 13: Specificity and Methods</strong></td>
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<tr>
<td>- Shared vision</td>
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<td>- Specificity responsibility</td>
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<td>- Statement of principles</td>
<td>- Statement of principles</td>
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<td>- Goals</td>
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<td>- Objectives</td>
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<td>- Action Strategies</td>
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<td>- Language</td>
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<td><strong>Theme 14: Priorities Addressed</strong></td>
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<td>- Limited number/most</td>
<td>- Limited number/most</td>
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<td>- Priority-setting criteria</td>
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<td>- Health status</td>
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<td>- Health promotion</td>
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<td>- Health practices</td>
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<td>- Health equity and social equity</td>
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<td>- Determinants of health</td>
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<td>- Population subgroups</td>
<td>- Population subgroups</td>
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<td>- Health tools and supports</td>
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<td>- Quality of life</td>
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<td><strong>Theme 15: Health Determinants Scope</strong></td>
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<td>- Biology/individual genetics</td>
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<td>- Personal health practices</td>
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<td>- Education</td>
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<td>- Employment and work conditions</td>
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<td>- Health system</td>
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Suggested Modifications of the Health Goals Framework, Phase Three

Based on the experience of the BC health goals exercise, the following modifications are suggested for the Articulation Phase of the health goals framework:

- **Incorporate two new dimensions that emerged out of the interview and source document data in relation to the articulation phase.**

The emergent dimensions and their associated operational definitions are:

(a) “Specificity responsibility” (Theme 13): Captures the evidence on where the requirement for specificity or measurability of health goals resides within a given jurisdiction that adopts a health goals agenda.

(b) “Health determinants awareness” (Theme 16): Reflects the evidence on a broadening of understanding or increased awareness of the public and public bodies on the multiple influences on health as an early spin-off of the health goals process.

- **Removal of the dimension entitled, “Limited number/most” from Theme 14: Priorities Addressed, from the health goals framework.**

The “Limited number/most” dimension of Theme 14 refers to the number of priority
health-related issues that are addressed in the health goals for a given jurisdiction. This issue is adequately covered by the dimension entitled “Incremental-Comprehensive” in Theme 8, which defines “incremental” as a “small-step approach to health goals planning where a limited number of key health-related issues are identified and translated into health goals;” and “comprehensive” as an “exhaustive approach to health goals planning where most key health-related issues are identified and translated into health goals.” The similarity of these dimensions resulted in unnecessary redundancy in the data collection and data analysis phases of the study.

- **Collapse Theme 15: Health Determinants Scope into Theme 14: Priorities Addressed.**

  Theme 15: Health Determinants Scope, which addresses the scope or range of health determinants addressed in health goals for a given jurisdiction; can be effectively collapsed into the “Health determinants” dimension of Theme 14: Priorities Addressed. A separate and independent Theme 15: Health Determinants Scope sets up an artificial separation from the concept of concern -- health determinants; and a description of that concept -- the range of health determinants addressed. Because Theme 15: Health Determinants Scope can be comfortably accommodated within the “Health determinants” dimension of Theme 14, it is recommended that Theme 15 be collapsed into the “Health determinants” dimension of the health goals framework.

  Modification of the health goals framework as suggested above accounts for the “first round” refinement of the health goals framework. It yielded the addition of nine emergent dimensions, the collapse of four redundant dimensions, and the integration or combination of two framework themes. The modifications help to decrease redundancy of framework dimensions and themes and enhance the overall clarity of the framework. Ways to further refine the health goals framework are discussed later in this chapter.
Significance of the Fit or Lack of Fit Between the BC Case and the Health Goals Framework

The discussion above illustrates two phenomena: (a) some dimensions that comprised the health goals framework were not exhibited in the BC case, and (b) some dimensions arose out of the BC case that were not included in the health goals framework. The degree to which a given health goals exercise touches on the various dimensions in the health goals framework may reflect its pathway to health goals; taking one road may result in greater attention to some dimensions than others. A (distal) health-determinants approach to health goals for example, may touch on a different number and mix of dimensions than a (proximal) health-targeted approach - in relation to issues such as “perceived benefits” of health goals (Theme 4), “levels and sectors” (Theme 6), “consultation mechanisms” (Theme 9), and “priorities addressed” (Theme 14).

Failing to “reach” a particular dimension in one instance of health goals development, therefore, does not jeopardize that dimension’s “place” in the health goals framework; because that dimension might fit closely with health goals planning elsewhere. Interesting issues arise also from the emergent dimensions in the BC health goals exercise. Dimensions that evolved from the BC case but did not appear in the health goals framework are not necessarily unique or distinguishing to the BC case. They may be relevant to other jurisdictions that undergo a health goals exercise.

The degree to which the BC experience fits or does not fit with the health goals framework tests the framework’s face, consensual, predictive and content validity; rather than generalizability of the health goals framework in a more global sense. Where the health goals framework can be taken from here, in order to improve its generalizability to other settings, is an issue for discussion later in this chapter.
Implications for Research

The findings from this study enhance and extend our understanding of the health goals development process in British Columbia. Variations in situations, people, contexts and jurisdictions remind us that findings generated from a single case study must be generalized with caution. It is worthwhile, however, to raise questions and propose hypotheses on health goals planning that flow from this study for testing in other settings or jurisdictions. This section raises questions and suggests areas for further inquiry based on the major findings that were discussed earlier in this chapter.

Further Inquiry Linked to the Premonitory Phase of Health Goals Planning

One avenue for further research relating to the context and motivation for health goals in the premonitory phase is the relationship between government political ideology and the approach to health goals planning. Results from this study suggest that the “liberal” ideology of the NDP government of BC encouraged the establishment of health goals that “reflect our understanding of how social, economic and environmental factors affect health;” and that governments more conservatively inclined would be more likely to establish health goals that are more health-specific in nature. Does the political ideology of the government of the day influence the pathway to health goals adopted by a given jurisdiction? Which political ideologies are more consistent with a distal or broad health-determinants pathway to health goals and which are more consistent with a health-targeted pathway, and why? Would the health goals for BC look different today, (that is, would they address different issues and priorities), if the health goals development process transpired under the leadership of the Liberal Party of BC or the Reform Party of BC?
Additional research is needed also on the role and influence of proponents and skeptics in the health goals development process; specifically, the role of the “health goals champion.” This study provided evidence that the leadership and commitment of the Provincial Health Officer propelled the health goals agenda forward in BC. This was attributed in large part to his vision, resolution and personal qualities; and in part to the perceived non-partisan stance of his office. The ideological orientation of the OPHO and the health goals exercise was compatible with that of most participants in the nonmedical arms of the health sector involved. Additional research would further our understanding of the influence of supporters and opponents in the health goals planning process; and help to ascertain how leaders rally support, maximize opportunities and overcome challenges that typify health goals planning aimed at the development of health goals that address broader-than-health issues.

Further Inquiry Linked to the Formulation Phase of Health Goals Planning

Three areas relating to the formulation phase of health goals warrant further exploration. First is the need for additional examination of methods, strategies and practices that encourage and sustain support for health goals planning that is based on the broad health determinants from both representatives of traditional health interests within the health sector, and representatives of sectors outside of health. Results from this study revealed several challenges to the development of broad-based health goals related to intersectoral relations and “mandate fit.” These included (a) perceptions among sectors outside of health that health was overstepping its mandate, (b) reluctance from traditional health interests and the Health Ministry to embrace the health goals because of feelings of alienation, that their interests and mandates were not reflected in the health goals; and (c) hesitancy at the level of some ministry bureaucracies to support and participate in
activities related to health goals planning.

Dr. Ilona Kickbusch, then Director of the Division of Health Promotion, Education and Communications with the World Health Organization, proposed in her keynote address to the US Healthy People 2000 Consortium Meeting in November 1996 that “strategies need to be found that motivate a multitude of actors with quite different main objectives [mandates] around a commitment to health.” Kickbusch acknowledged the challenges of multi-sectoral planning initiatives and suggested that health goals that “aim for classification based on key determinants of health” require effective involvement from diverse sectors and settings (such as cities, schools, hospitals, workplaces, prisons, and homes). This case study raises some provocative issues related to intersectoral partnerships and health goals, and uncovers several challenges to health planning, when it purposefully extends beyond the parameters of the health field. Further research is needed to determine what kinds of mechanisms and processes effectively engage and sustain support from colleagues outside the health professions and organizations, when health goals planning is driven by an agenda that includes the social, economic and environmental influences on health.

Additional analysis should be conducted also to further our understanding of the relationship between health goals consultation processes and the articulation of health goals. Results of this study point to a “conditioning” of the health goals development process through the use of pre-determined health goal statements and orchestrated consultation sessions. What priority issues would have been included in the BC health goals if consultation sessions and ministry briefings were not organized around the health determinants theme? Whose interests would have been represented? What trade-offs would have occurred? Can consultation processes be better designed to accommodate dissenting opinions on what should or should not be included
as priority issues in health goals? Further research would help to determine those consultation processes and mechanisms most effective in soliciting, accommodating and translating the various views and interests that come to bear on the health goals development process.

Further examination is required also of the role and influence of the health goals coordinating mechanism in health goals planning. Findings from this study suggest that the health goals process in BC was influenced by (a) a unified commitment by the members of the health goals coordinating mechanism (the OPHO) to the health determinants philosophy, and (b) the level of autonomy of the health goals coordinating mechanism relative to the Ministry of Health. While some believed that bureaucratic and operational autonomy of the OPHO estranged some units of the Ministry of Health; others believed that the arms-length relationship between the OPHO and the Ministry of Health freed the OPHO from the “bureaucratic machinations” of the Health Ministry, allowing it to chart its own course to health goals.

One wonders if the BC health goals would have been articulated differently under the coordination of an entity other than the OPHO. How would the health goals statements have differed, for example, if the BC Ministry of Health coordinated the health goals process? One could surmise that health goals developed by the Ministry of Health would focus more on health services issues (reflecting their mandate); and less on the broader determinants of health. This scenario would likely yield reluctance by proponents of the broad health determinants to endorse such narrower health goals; because these individuals view health goals as a way to shift public understanding and resources away from health services toward those influences on health that originate outside the health sector. Additional research would contribute to our understanding of how the physical and philosophical positioning of the coordinating mechanism influences the development process and the final articulation of health goals.
Further Inquiry Linked to the Articulation Phase of Health Goals Planning

An apparent avenue for further research relating to the articulation phase of health goals development is the relationship between health-goal specificity and the range of priority issues addressed; that is, the degree to which health goals can be both measurable and inclusive of the broad health determinants. The evidence from this study suggests that health goals can either be broad in scope, addressing the global social, economic and environmental influences on health, and not be measurable; or they can be limited in scope, focusing on traditional health-specific issues, and be very specific and measurable.

This raises some issues for speculation about the BC health goals exercise. One could hypothesize that BC would have ended up with Cabinet endorsed, measurable health goals if it had taken a health-targeted pathway to health goals, that focused on health specific-issues; rather than a health-determinants pathway, that focused on the broad factors associated with health. Whether this was a real option for BC is another question. The Provincial Health Officer faced several forces that compelled a health-determinants approach, including (a) mounting evidence in academic and research circles on the broad determinants of health; (b) strong criticism by some that health goals developed by other jurisdictions were over-fixated on health-specific issues; (c) direction from the government of the day (in their New Direction policy response to the 1991 Royal Commission) that the health goals address all health influences; and (d) ideological commitments from within the health goals coordinating mechanism (the OPHO) to move beyond traditional health issues to include the social, economic, and environmental influences on health. These forces may lead some to conclude that the Provincial Health Officer could not have “got away with” anything but a health-determinants approach to health goals. In the end, broad-based health goals that addressed all the known influences on health were established for BC -- without
the capacity for measurement.

Examining the relationship between the specificity of health goals and health determinants in other settings may provide some further insight into this issue. The results of this study show that jurisdictions such as the US, Australia and England achieved measurable health goals while addressing some broader health determinants; albeit less than in BC. Further research could focus on how other jurisdictions addressed and possibly overcame the kinds of challenges to measurability faced by BC. Specific items for comparative examination might include, (a) ways in which sectors outside health were brought into the health goals process, (b) methods to access information and expertise from non-health sectors, and (c) methods and strategies to overcome resistance to health-goal measurability from political leaders. Closer analyses of health goals development in other jurisdictions may shed some light on what this study has demonstrated -- the difficult and strained relationship between health-goal specificity and health-goal breadth.

The Health Goals Framework and Further Research

In an earlier section, modifications to the health goals framework were suggested and account for what might be considered an early refinement of the framework. Assessing the fit of the BC case against the health goals framework as a part of this study amounted to a “first test” of the framework’s face, consensual and content validity. The next logical step would be more formal testing of the health goals framework in multiple settings, possibly in the form of cross-country multiple case study analyses. Cross-country validation would be sought for what was discovered (that is, those framework dimensions that were touched on) in the BC case, while looking for evidence on those things in the health goals framework that were not touched on in
BC, but that might play out in other instances across the country. Multi-site testing of the framework would facilitate the development of practice guidelines and recommendations to assist jurisdictions that endeavour to develop and apply health goals as a strategy for population health promotion.

Additional Implications for Health Promotion Practice

Besides the theoretical and research implications discussed above, this case study suggests various applications in health promotion practice. Several have already been implied in earlier sections of this chapter. Study findings demonstrate a need for health promotion practitioners to incorporate collaborative planning methods that criss-cross and merge the vertical stovepipes of government ministries and sectors. Health promotion practitioners must continue to strive for effective ways of fostering intersectoral partnerships for population health planning and health goals development. These challenges may be supported by broad-based interdisciplinary education and training for health promotion practitioners that includes knowledge of planning, public health, health reform, and the politics of health.

This study points also to a need for health promotion practitioners to adopt and advance effective methods of applying evidence in order to facilitate decision making related to health goals planning for population health promotion. Finally, this study suggests implications for the policy-making side of health promotion practice. Health goals and objectives, by pointing out that health requires more than investment in health care; may help to cultivate an attitude of appreciation for health promotion, disease prevention and population health among government policy makers, who increasingly require a convincing rationale to support of these kinds of programs and initiatives.
While a single case study cannot generate sweeping recommendations on health goals planning; it can offer various items for consideration by health goals planners. This study provides a decision framework for health goals planning. It offers a range of issues to consider - or a set of categories to contemplate - by planners of health goals. It is worthwhile to remember that this study was based on jurisdictions with common features. Other jurisdictions may view the process and factors revealed in this case study as irrelevant or very relevant. It is incumbent upon planners elsewhere to decide which of the issues judged salient in the BC case, may or may not apply to their own health goals planning initiative; and what other issues or factors might need to be included, based upon the unique characteristics and realities of their own jurisdiction.

Scenarios for Health Goals Planning

Based on the results of this study, two scenarios for health goals planning can be proposed for consideration by regional planners in BC and by other jurisdictions whose aim is to develop measurable health goals that address the broad influences on health. These scenarios are based on three propositions that can be drawn from this study. First, health goal planners are challenged by multiple factors in efforts to develop health goals that are broad-based and highly-specific. Second, health goals planning that rests on a health-determinants philosophy relies on the support and commitment of the health sector and sectors outside of health, both within and outside of government. Third, health goals that incorporate the broad health determinants need not exclude traditional or established health interests. Balance can be struck between issues relating to health risk, health gain and health services; and issues relating to the social, economic, and environmental influences on health. These propositions underpin the two scenarios presented below.
Planning scenario #1 for measurable, broad-based health goals involves the development of two sets of health goals. The first set of goals addresses health-specific issues such as preventable illness and injury, disability, morbidity and mortality, risk factors, health protection, and health promotion and disease prevention. These health goals aim for a high degree of specificity. They start with broad goals, supported by measurable, time-limited objectives, augmented by a set of targets. Targets are based on agreed indicators and quantify the desired change. This set of health goals is developed by the health sector, including government ministries or departments and non-government agencies, which have jurisdiction over health-specific issues as a part of their operational mandate.

The first set of health-specific health goals is then handed-off to sectors outside of health to serve as a model for the establishment of a second set of health goals that address the social, economic, and environmental influences on health. Those sectors whose mandates are typically touched on when health goals aim to address the known influences on health define the second set of goals. Using the health-specific goals as a developmental framework, colleagues in sectors outside health establish measurable, concrete objectives in those areas for which they have direct jurisdiction; and the data, expertise and interest to get the job done. The outcome is a set of health goals that includes equal representation of all health determinants; and goal specificity is achieved for both health-specific and health-determinants issues.

Planning scenario #2 reflects what has been referred to in this paper as the hierarchy of objectives. Under this scenario, first-order objectives address health-specific issues and represent the endpoints or health outcomes that are being sought. The broader health determinants comprise second-order objectives and represent those things that have to happen in the shorter term in order to achieve the health outcomes captured in first-order objectives. Unlike the
approach above, this scenario does not articulate separate health goals for each of the broad health determinants; rather, the social, economic and environmental influences on health are woven into the health goals hierarchy as action steps toward the stated health outcomes. The Australian Capital Territory health goals initiative which set out to incorporate the broader environmental and social perspectives on health reflects this scenario. According to Lyons (1995), while the ACT’s priority areas are generally risk factor and disease focussed; the underlying goals, targets, strategies and supporting discussion focus predominantly on the health of individuals within their social and environmental contexts.

Under planning scenario #2, overall responsibility for health goals development rests with the health sector. However, sector-specific advisory panels would be struck to oversee the technical exercise of devising distinct, measurable, time-limited, second-order objectives related to the broad health determinants. In this way, objectives addressing the social, economic and environmental influences on health would be formulated within representative sectors; by individuals who have the interest, data, and expertise to effectively take on the task. This approach resembles the US health goals initiative where various lead agencies were assigned responsibility for the technical activities associated with the objectives for the nation. Health goal planners who adopt this approach, may choose to consider the PRECEDE-PROCEED health planning model; especially the modified version of the model discussed earlier in this chapter, to guide their health goals planning.

Either of the planning scenarios discussed above increase the likelihood of establishing measurable health goals that address the multiple influences on health. The rather simple description of each scenario presented here should not minimize the very real challenges faced by
any health goals initiative that attempts to meet the twin aims of specificity and representation of the broad health determinants. The challenges and opportunities posed by this approach have been, of course, the dominant focus of this paper.
REFERENCES


# APPENDIX A

## Allison’s Models of Planning

<table>
<thead>
<tr>
<th>Allison’s Paradigm</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Unit of Analysis</strong></td>
<td>Government action as choice</td>
<td>Government action as organizational output</td>
<td>Government action as political resultant</td>
</tr>
<tr>
<td><strong>Organizing Concepts</strong></td>
<td>National/provincial government is main actor</td>
<td>Various organizational / departmental actors, Parochial priorities and perceptions, Fractionated power, Sequential attention to goals - goals viewed as constraints to define acceptable performance, Attention to standard operating procedures, programs, repertoires, Organizational learning &amp; change, Uncertainty avoidance, Central coordination &amp; control</td>
<td>Players in positions, Parochial priorities and perceptions, Personal goals and interests, Stakes and stands, Power, motivations, perceptions &amp; maneuvers of players, Game rules</td>
</tr>
<tr>
<td><strong>Patterns of Inference</strong></td>
<td>Government action = choice with regard to objectives</td>
<td>Government action = output largely determined by present Standard operating procedures, ongoing programs, organizational /departmental goals</td>
<td>Government action = as a result of bargaining and negotiation</td>
</tr>
<tr>
<td><strong>General Propositions</strong></td>
<td>Action as rational choice, Aims and choices are valued, Logic of action, Actions reflect strategic directions, Predictions of how decisions are made or how governments act are generated by calculating the rational thing to do in a situation, given specified objectives</td>
<td>Action as organizational output, Appreciates importance of interagency goals / conflict, Organizational accommodation, Predictions reflect established organizations and fixed procedures and programs</td>
<td>Action as political resultant, Bargaining games among players, Predictions are generated by identifying the game in which an issue will develop, the relevant players, and their relevant power and skill</td>
</tr>
</tbody>
</table>
APPENDIX B

Listing and Description of Health Determinants

1. *Income and Social Status*: It is not the amount of wealth but its relative distribution which is the key factor that determines health status. Similarly, social status affects health by determining the degree of control people have over life circumstances and, hence, their capacity to take action.

2. *Social Support Networks*: Support from families, friends and communities is important in helping people deal with life situations and to maintain a sense of mastery over life circumstances.

3. *Education*: Education that is meaningful and relevant, prepares people with knowledge and skills for daily living, enables them to participate fully in their community, and increases opportunity for employment.

4. *Employment and Working Conditions*: Meaningful employment, economic stability and a healthy work environment are associated with good health.

5. *Physical Environment*: Factors such as air and water quality, housing and community safety have a major impact on health.

6. *Biology and Genetic Endowment*: Refers to “physiological make-up” as an important health determinant.

7. *Personal Health Practices and Coping Skills*: Personal health practices are key in preventing disease and in promoting self-care. Effective coping skills enable people to be self-reliant, solve problems and make healthful choices.

8. *Healthy Child Development*: Positive prenatal and early childhood experiences have a significant effect on subsequent health.

9. *Health Services*: There is a relationship between the availability of preventive and primary care services and improved health (e.g., health education on healthful choices, and well baby and immunization clinics).

(Source: *Strategies for Population Health: Investing in the Health of Canadians* (Federal/Provincial Territorial Advisory Committee on Population Health, 1994).
Multiple Theories That Characterize Population Health Promotion Models

1. Individual or Intra-personal Level Theories:

   Stages of Change Model: Focus is on the individual’s readiness to change or attempt to change toward healthy behaviors
   
   Health Belief Model: Focus in on an individual’s perception of the threat of a health problem and the appraisal of recommended behaviors for preventing or managing the problem.
   
   Consumer Information Processing Model: Focus is on processes by which consumers acquire and use information in their decision making

2. Interpersonal Level:

   Social Learning Theory: Behavior is explained by a 3-way, dynamic reciprocal theory in which personal factors, environmental influences, and behavior continually interact

3. Community Level:

   Community Organization: Emphasizes active participation and development of communities that can better evaluate and solve health and social problems
   
   Organizational Change Theory: Focus is on processes and strategies for increasing the chances that healthy policies and programs will be adopted and maintained in formal organizations
   
   Diffusion of Innovations: Addresses how new ideas, products and social products spread within a society and from one society to another

(Source: Theory at a glance: A guide to health promotion practice, Glanz & Rimer, 1995.)
APPENDIX D

Six Sample Jurisdictions and Associated Health Goals Initiatives Encompassed by the Literature Review

1. *Promoting Health/Preventing Disease: Objectives for the Nation* (US Department of Health and Human Services, 1980) chronicles the first comprehensive national policy to improve the health of Americans by setting forth 225 specific objectives to improve the health of Americans in the decade 1980 to 1990. The second round of goal setting set forth 300 targets organized into 22 priority areas in the report *Healthy People 2000*. The US health goals initiatives were facilitated by the federal government, involved extensive public review, and, since 1980, has sustained several changes in federal administration. To date, forty-seven states, the District of Columbia and Guam have adopted or adapted the national objectives, and 70% of local health departments are using *Healthy People 2000* as a framework for health promotion.

2. *Goals and Targets for Australia's Health in the Year 2000 and Beyond* (Nutbeam et al., 1993) develops national goals and targets for the improved health of Australians in four key areas. This initiative was proceeded by an earlier round of health goals chronicled in *Health for all Australians* (Health Targets and Implementation Committee, 1988) which represents Australia's "first national attempt to compile goals and targets for improving health and reducing inequalities in health status among population groups." The development process was broad based and involved sectors outside of health. The health goals address the underlying determinants of health and focus attention on social, economic and environmental influences on health. The health goals have been translated from the national to the state level.

3. The *Health of the Nation* initiative in England has been acknowledged by the WHO as a model of Health For All for countries to follow to set targets for improved health. *Health of the Nation* (1992) selects five key areas for action and sets national objectives and targets in each area. The national government coordinated the goals process and consulted government agencies, voluntary, consumer and business sectors.

4. *Healthy Texans 2000* is modeled after the national *Healthy People 2000* initiative. *Healthy Texans* was developed with input from more than 1,000 Texans from public, private and voluntary sectors. Targets are set for health topics with four major objective categories. Health goals are viewed as a way to shift attention to health promotion and disease prevention and away from health services.

5. As stipulated in the Medicare Agreement Act of 1992, the national and state/territorial governments in Australia were required to agree to national goals and targets for health by 1994. The Australian Capital Territory in *ACT Health Goals & Targets for the Year 2000* (1994) expand upon national health priorities to reflect local health priorities. Special workshops and meetings were convened over a twelve-month period to solicit input on health goals from interested organizations and individuals.
6. In *Population Health Goals For Saskatchewan* (1994), the province of Saskatchewan identified six major goals that focus on the health of the population as a whole rather than individual health and give recognition to the broad factors that determine or influence health. The goals development process was coordinated by the Provincial Health Council and informed by public input. Representative citizen working groups were established to set measurable objectives and propose public policy strategies.
## APPENDIX E

### Study Conceptual Framework: Health Goals Framework

<table>
<thead>
<tr>
<th>Component</th>
<th>Factors or Themes</th>
<th>Dimensions</th>
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<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Prevailing circumstances</td>
<td>Demographic, social, political and economic factors</td>
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<td></td>
<td>Health system environment</td>
<td>Health status, health system efficiency, capacity, satisfaction, orientation, health reform, health literacy</td>
</tr>
<tr>
<td><strong>Motivation</strong></td>
<td>Proponents &amp; skeptics</td>
<td>Internal, external, government/non-government based, health/non-health sector, personal characteristics</td>
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<td></td>
<td>Perceived benefits</td>
<td>Policy making, program planning and evaluation, health impact assessment, health inequity reduction, role and sector definition, health status monitoring, health priority setting, resource re-allocation, population-based planning, system reorientation, inter-sectoral collaboration</td>
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<td></td>
<td>Triggers</td>
<td>Government endorsement, government legislation, consensus agreement, budgetary requirement, mass media</td>
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## FORMULATION PHASE

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<tr>
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<td>Structure</td>
<td>Levels and sectors</td>
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<td></td>
<td>Coordinating mechanisms</td>
<td>base, make up, capacity, political support, staff support, autonomy</td>
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<td>Process</td>
<td>Strategic approach</td>
<td>Technical/expert, bureaucratic/political, incremental/comprehensive, partisan/non-partisan, derivative/original, bottom-up / top-down</td>
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<td></td>
<td>Consultation and participation</td>
<td>Selection strategies, representation, consultation mechanisms</td>
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<td>Resources</td>
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<td>Technical assistance, funding, organization, education and communications, leadership, promotions</td>
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<td>Time and budget</td>
<td>Set-aside time, time frame, paid time, volunteer time, time share, set-aside budget, subsumed budget, direct &amp; indirect costs, source, budget share</td>
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<td>Data requirement, types, sources, quality, access, availability, management</td>
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## ARTICULATION PHASE

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<td>Goals</td>
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<td>Shared vision, statement of principles, goals, objectives, indicators, targets, strategies, language</td>
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<td></td>
<td>Priorities addressed</td>
<td>Number and priority-setting criteria, health status, health promotion, health practices, health equity and social equity, determinants of health, population subgroups, health care system, health tools and supports, quality of life</td>
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<td></td>
<td>Health determinants scope</td>
<td>Biology/individual genetics, personal health practice, coping skills, healthy child development, physical environment, income and social status, social support networks, education, employment and conditions, health system</td>
</tr>
<tr>
<td>Other</td>
<td>Late-stage developments</td>
<td>Post-consensus edits, partnership and coalition building, intersectoral initiatives, community development, diffusion, policy extension, institutionalization</td>
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</tbody>
</table>

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APPENDIX F

Case Study Variation By Type and Design

Case studies vary by type and design. Yin (1994) identifies three types of case studies: exploratory, descriptive, and explanatory case studies.

Exploratory case studies strive to define study questions and to illuminate a likely hypothesis or generate theory for testing at a later time, either by applying a similar (case study), or a different research strategy. They are also used to determine the feasibility of the desired research procedures (Yin, 1993; Yin, 1994). Often, exploratory studies rely on fieldwork and data collection which are undertaken to discover theory by directly observing social phenomenon or events in natural settings (Glaser & Strauss, 1967). Only broad features of the study design are determined ahead of time in an exploratory study.

Descriptive case studies are aimed at presenting a complete description of a phenomenon within its context. Often, descriptive studies trace the sequence of events over time, describe an event or phenomenon that has rarely been the topic of previous investigation, and discover key phenomena related to the issues under examination. Theory helps to guide descriptive case studies by establishing parameters for the description and by directing the researcher to relevant data.

Explanatory case studies aim to explain what causes produced what effects. Explanatory case studies gather and analyse data related to cause-effect relationships, based on hypotheses drawn from explanatory theories pertinent to the issues under examination. Refer to Appendix I for examples of descriptive (Box 1) and explanatory (Box 3) case studies.

Case studies may be further differentiated by single-case and multiple-case designs (Yin, 1994).

Single case studies are appropriate (a) when a single critical case represents the test of significant theory and aims to confirm, challenge, or extend theory, (b) when a researcher has an opportunity to observe and analyse a phenomenon previously inaccessible to scientific observation, whereby the single case yields descriptive information that will be revelatory; (c) when the case represents an extreme or unique case that may be so rare that it is worth documenting and analysing (Yin, 1994).

Multiple case designs involve two or more cases where each case is considered to be a ‘whole’ study “in which convergent evidence is sought regarding the facts and conclusions for the case. Multiple case design rests on a ‘replication logic’ whereby “each case’s conclusions are considered to be the information needing replication by other individual cases” (Yin, 1994, p. 49).
Finally, within the single or multiple case study, there may be:

**Holistic** design, which comprises a single unit of analysis, considers the context of the case, and examines the global nature of an issue under examination (such as an entire program or process).

**Embedded** design, which constitutes multiple units of analysis and looks specifically at various subunits that can logically be identified within the case and examines, for example, individual projects that comprise an overall program or process.
Yin (1994) contends that a common misconception of science is that, traditionally, the five established research strategies - experiment, survey, archival analysis, history, and case study - have been arrayed hierarchically; where case studies are typically aligned with the exploratory phase of an investigation; where histories and surveys are considered most appropriate for the descriptive phase; and where experiments are relied on for explanatory or causal inquiries. Yin (1994) denounces the traditional, hierarchical approach to social science research and suggests instead a pluralistic view which both recognizes the unique contributions of each research strategy and ensures effective matching of methodology to study aims.

This hierarchical view (however) is incorrect... Case studies are far from being only an exploratory strategy. Some of the best and most famous case studies have been both descriptive (for example, Whyte's Street Corner Society, 1943/1955) and explanatory (Allison's Essence of Decision: Explaining the Cuban Missile Crises, 1971)... The more appropriate view of these different strategies is a pluralistic one. Each strategy can be used for all three purposes - exploratory, descriptive, or explanatory... Nevertheless, this does not imply that the boundaries between the strategies - or the occasions when each is to be used - are always clear and sharp. Even though each strategy has its distinctive characteristics, there are large areas of overlap among them. The goal is to avoid gross misfits—that is, when you are planning to use one type of strategy but another is really more advantageous (p. 3)

From this perspective, research strategies are not mutually exclusive. Each strategy offers a distinct advantage within some situations or under certain prevailing circumstances. According to Yin (1994), choosing among research strategies is based on three conditions: (a) the type of research question that is posed, (b) the extent of control an investigator has over actual behavioural events, and, (c) the degree of focus on contemporary as opposed to historical events. Generally, case studies are the preferred research strategy when: (a) a "how" or "why" question is being asked, (b) about a contemporary set of events with some real-life context, (c) over which the investigator has little or no control" (Yin, 1994, p. 9). Other research strategies - survey research, archival analysis, histories, and experiments - are suited to other research contexts or situations.

The kinds of conditions that are linked to each of the five major research strategies in the social sciences are noted below.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Type of research question</th>
<th>Requires control over events</th>
<th>Focuses on contemporary issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiment</td>
<td>How, why</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Survey</td>
<td>Who, what, where, how many, how much</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Archival analysis</td>
<td>Who, what, where, how many, how much</td>
<td>No</td>
<td>Yes / no</td>
</tr>
<tr>
<td>History</td>
<td>How, why</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Case Study</td>
<td>How, why</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Source: R. K. Yin, 1994, *Case Study Research: Design and Methods*

Through decades of applying and refining the case study method, Yin and others (Stake, 1986; Merriam, 1988, Stoecker, 1991) have sought to include case study among the established methodologies in social science research. To be considered a complete method of empirical research, research strategies must define the conditions for each of the following:

(a) designing the investigation
(b) collecting the relevant data
(c) analysing and interpreting the data
(d) reporting the findings

Similar to other science research strategies, sound case study method fully describes these component parts, and in so doing, can be characterized as a “full fledged method for conducting research” (Yin, 1993, p. 33), or as a “comprehensive research strategy” (Yin, 1994, p. 13), comparable to other established research methodologies.
APPENDIX H

Philosophical Underpinnings of This Study

Guba and Lincoln (1994) profile four alternative inquiry paradigms:
(a) positivism
(b) postpositivism
(c) critical theory and related ideological positions
(d) constructivism

Defining inquiry paradigms comes about as a result of answering the questions related to ontology, epistemology, and methodology. Responding to these questions places this study within the postpositivism inquiry paradigm.

The postpositivism approach that underpins this study:

• Assumes an ontology which can be characterized as critical realism. Critical realism assumes that “real” reality exists but only imperfectly and probabilistically, largely due to the “fundamentally intractable nature of phenomena” and to “basically flawed human intellectual mechanisms” (Guba & Lincoln, 1994, p. 110). Any claims about reality therefore, must be subject to the widest possible critical examination in order to “facilitate apprehending reality as closely as possible (but never perfectly)” (Guba & Lincoln, 1994, p. 110). Translating this reasoning to this study, means that there is some “real” way of going about the task of establishing health goals in BC; that the real nature of the development process, through rigorous critical examination, can be comprehended, although imperfectly. This differs from, for example, a constructivism paradigm, that would assume that there are multiple socially-constructed versions of “truth” regarding the health goals development process.

• Assumes an epistemological stance characterized as modified dualist/objectivist, rather than a dualist or monist approach to inquiry (Guba & Lincoln, 1994). (A monist perspective views the inquirer and the inquired-into as a single, interactive entity where data are created as a result of the interaction between the inquirer and inquired-into, rather than the inquirer being objective and independent of the knowledge creation process, which typifies the dualist view). Modified dualism is a compromised position from dualism (characteristic of positivism) where the investigator and investigated are assumed to be independent entities, where little influence between them occurs, and where values and biases are prevented from influencing outcomes. Modified dualism claims that dualism is not possible to maintain, although objectivity still remains a “regulatory ideal.” Objectivity is maintained through “external guardians” of objectivity such as critical traditions that include asking questions to assess the “fit” of the findings with preexisting knowledge; and by establishing objectivity through the critical community such as consultation with professional peers, editors, and referees. In this study, objectivity is enhanced by judging the “fit” of the findings against the health goals framework. The framework is based on preexisting knowledge from both real-life experiences of several jurisdictions and planning theory. Objectivity was further established by inviting a panel
of international experts on health goals to establish face and consensual validity of the study’s conceptual (health goals) framework.

Postpositivism assumes a methodology that can be characterized as *modified manipulative* where the aim of inquiry is to explain and knowledge consists of “nonfalsified hypotheses that can be regarded as probable facts” (Guba & Lincoln, 1994, p. 112). Postpositivism aims to address some of the criticisms associated with positivism traditions by “doing inquiry in more natural settings, collecting more situational information, introducing discovery as an element in inquiry, and ... soliciting emic viewpoints ... as well as [contributing] to grounded theory” (Guba & Lincoln, 1994, p. 110). These aims of postpositivism are sought largely through the increased utilization of qualitative procedures and techniques. (Both qualitative and quantitative methods can be used with any of the four research paradigms, Guba & Lincoln, 1994). Although explicit hypotheses are not articulated in this study, the conceptual framework (which is theoretically and empirically grounded in the literature on health goals) constitutes a set of implicit hypotheses.
APPENDIX I

Examples of Case Studies, Adapted From Yin, 1994

BOX 1: A Famous Descriptive Case Study

Street Corner Society (1943/1955), by William F. Whyte, has for decades been recommended reading in community sociology. This book is a classic example of a descriptive case study. Thus, it traces the sequence of interpersonal events over time, describes a subculture that had rarely been the topic of previous study, and discovers key phenomena - such as the career advancement of lower income youths and their ability (or inability) to break neighborhood ties.

The study has been highly regarded despite its being a single-case study, covering one neighborhood ("Cornerville") and a time period now more than 50 years old. The value of the book is, paradoxically, its generalizability to issues on individual performance, group structure, and the social structure of neighborhoods. Later investigators have repeatedly found remnants of Cornerville in their work, even though they have studied different neighborhoods and different time periods.

BOX 2: “Exploration” as an Analogy for an Exploratory Case Study

When Christopher Columbus went to Queen Isabella to ask for support for his “exploration” of the New World, he had to have some reasons for asking for three ships (Why not one? Why not five?), and he had some rationale for going westward (Why not south? Why not south and then east?). He also had some (mistaken) criteria for recognizing the Indies when he actually encountered them. In short, his exploration began with some rationale and direction, even if his initial assumptions might later have been proven wrong (Wilford, 1992). This same degree of rationale and direction should underlie even an exploratory case study.

Box 3: An Explanatory Case Study

Even a single-case study can often be used to pursue an explanatory, and not merely exploratory (or descriptive), purpose. The analyst’s objective should be to pose competing explanations for the same set of events and to indicate how such explanations may apply to other situations.

This strategy was followed by Graham Allison in Essence of Decision: Explaining the Cuban Missile Crises (1971). The single case is the confrontation between the United States and the Soviet Union over the placement of offensive missiles in Cuba. Allison posits three competing theories or models to explain the course of events, including answers to three key questions: why the Soviet Union placed offensive (and not merely defensive) missiles in Cuba in the first place, why the United States responded to the missile deployment with a blockade (and not an air strike or invasion), and why the Soviet Union eventually withdrew the missiles. By comparing each theory with the actual course of events, Allison develops the best explanation for this type of crises.

Allison suggests that this explanation is applicable to other situations, thereby extending the usefulness of his single-case study. Thus Allison cites the U.S. involvement in Vietnam, nuclear confrontation more generally, and the termination of wars by nations as other situations for which the theory can offer useful explanation.
APPENDIX J

Operational Definition of Framework Themes

I. PREMONITORY PHASE

A. Context

Theme 1: Prevailing Circumstances

The social, political and economic realities of a given jurisdiction comprise the prevailing environment that shapes the context for health goals in the premonitory phase. The "prevailing circumstances" theme of the health goals framework refers to those factors or conditions outside of the health system that establish or influence the context for health goals development within a given jurisdiction. While the "health system environment" theme (described later) refers to contextual characteristics of the health system itself, the prevailing circumstances refers to the broader social, political and economic characteristics of a given jurisdiction that comprise or influence the context or environment for health goals development. Examples of social, political and economic factors that comprise or influence the context for health goals development in the premonitory phase include the following:

- **Demographic factors** of a given jurisdiction including the statistical characteristics of a population such as size, distribution, diversity and age.
- **Social factors** of a given jurisdiction such as social status, social stability, social support networks, social policy, family, work and living conditions, and cultural trends.
- **Political factors** of a given jurisdiction such as political ideology, political will, existing public policies, policy-making processes, political agendas and priorities, interest group lobbying, participatory traditions such as civic-mindedness, and overlap and division of federal/provincial responsibility for special populations such as aboriginal and prison populations.
- **Economic factors** of a given jurisdiction such as the rate of economic growth, rate of inflation, rate of employment, and existing monetary policies.

Theme 2: Health System Environment

Just as various characteristics of the larger social-political-economic environment establish a context for health goals, so do various prevailing features within the health system. Health system refers to health care organizations, public health organizations and other organizations and institutions having a health mandate. The "health system environment" theme of the health goals framework refers to those distinguishing and prevailing characteristics within the health system which establish, comprise or influence the context for health goals in the premonitory phase. The health system environment theme can be further distinguished from the "triggers" theme presented later: whereas "triggers" refer to the precipitating or decisive factor(s) that launch health goals for a given jurisdiction and confer legitimization, the health system environment theme refers more broadly to the systemic, contextual characteristics of the health...
system that create a supportive environment for health goals. Key characteristics of the health system environment that create a context for health goals for a given jurisdiction in the premonitory phase include the following dimensions:

- **Health status** of the population refers to the health and well-being of a population in terms of health status indicators.
- **Health system efficiency** includes the GNP expenditure on health, resource allocation, return on health dollars invested, and accountability for health impact and outcomes.
- **Health system capacity** refers to the supply and coverage of health services and the ability of the health system to meet the needs and expectations of the population of a given jurisdiction and to sustain that ability over time.
- **Health system satisfaction** refers to the level of acceptance, gratification and confidence expressed by users, beneficiaries, providers and policy makers of the health system in a given jurisdiction.
- **Health system orientation** refers to the primary focus of the health system in terms of the relative priority placed upon medical or illness issues versus health promotion, disease prevention and wellness issues.
- **Health reform** refers to initiatives to reorganize and transform the health system that may be expressed as jurisdictional health policies or extra-jurisdictional policies such as the international policy of *Health for All by the Year 2000*.
- **Health literacy** refers to the experiences, exposures, values, attitudes, beliefs, assumptions and knowledge of health-related issues by the people of a given jurisdiction.

### B. Motivation

**Theme 3: Proponents and Skeptics**

The “proponents and skeptics” theme of the health goals framework is described along two dimensions. Proponents are those individuals who initiate the call for health goals in a given jurisdiction and then take the necessary action to drive or propel the initiative forward in the premonitory phase. Proponents provide the leadership necessary to move the health goals from the conceptual to actual realm; proponents are often considered to be champions of the health goals cause. While proponents are most active in the premonitory phase, they may remain engaged throughout the health goals process, often as the coordinating mechanism in the development phase. Skeptics are those individuals who question or interfere with the initial call for health goals, are antagonistic to the health goals initiative or take actions intended to stall or defuse the health goals process. Proponents and skeptics may be internal, driving (in the case of proponents) or interfering with (in the case of skeptics) the health goals process from within a given jurisdiction; or external, providing motivation or disincentive for health goals from outside the boundaries of a given jurisdiction. Additionally, proponents and skeptics may be based within or beyond the government sector or within or beyond the health sector. More specifically, proponents and skeptics of health goals may include the following:

- **Internal** proponents and skeptics are those individuals within a given jurisdiction that drive (proponents) or interfere (skeptics) with the initial calls for health goals in the premonitory phase.
• **External** proponents and skeptics are those individuals beyond the jurisdiction that drive or interfere with the initial calls for health goals in the premonitory phase.

• **Government-based** proponents and skeptics are those individuals who drive or interfere with the initial calls for health goals and are located in bureaucratic or political bodies at the national, provincial/state, regional or local level.

• **Non-government-based** proponents and skeptics are those individuals who drive or interfere with the initial calls for health goals and are located outside of the government sector, within voluntary, non-profit, business or academic agencies.

• **Health sector** proponents and skeptics are those individuals who drive or interfere with the initial calls for health goals and are located within the health sector, ministry or bureaucracy.

• **Non-health sector** proponents and skeptics are those individuals who drive or interfere with the initial calls for health goals and are located beyond the health sector, ministry or bureaucracy.

• **Personal characteristics** of key individuals who support or interfere with the health goals development including their training, education, leadership style, values, experiences, beliefs, assumptions and knowledge.

**Theme 4: Perceived Benefits**

The “perceived benefits” theme of the health goals framework refers to the anticipated contributions of health goals as a strategy for addressing health-related issues within a given jurisdiction. Perceived benefits provide a rationale to support or endorse the health goals approach. Perceived benefits may differ by the various parties and stakeholders contemplating health goals in the premonitory stage. Perceived benefits of health goals include the following:

• **Policy making** where health goals serve as a foundation for the formulation of health policy and health-enhancing public policies.

• **Program planning and evaluation** where health goals set the parameters for program planning and development and provide a standard to measure and evaluate programs.

• **Health impact assessment** where health goals allow for the appraisal of the impact of health-related programs and policies on health.

• **Role and sector definition** where health goals provide a means by which the health and related sectors can define their roles relative to the health of the people of a given jurisdiction.

• **Health inequity reduction** where health goals contribute to positive health and health-related outcomes for all members and groups of a given jurisdiction.

• **Health status monitoring** where health goals allow for the tracking of the health of the population in terms of health status indicators.

• **Health priority setting** where health goals support the identification of priority health and health-related issues in a given jurisdiction.

• **Resource re-allocation** where health goals facilitate the redirection of resources to priority health areas and activities.

• **Population-based planning** where health goals promote planning based on the needs of the population of a given jurisdiction rather than resource-based planning which tends to rationalize existing resources and activities.
• **Reorientation of the health system** where health goals support a shift in focus from health-care to health promotion, disease prevention or the broad determinants of health.

• **Intersectoral collaboration** and other processes engendered by the goal-setting experience that are perceived as secondary benefits of health goals development.

**Theme 5: Triggers**

The “triggers” theme in the health goals framework refers to the precipitating event, occurrence or phenomenon that is ultimately linked to the launching of health goals within a given jurisdiction. Whereas the health system environment theme (discussed earlier), refers to the broad influences within the health system that set the context for health goals, “triggers” refer to the irresistible force or milestone event that confers official legitimacy for health goals and propels the health goals process forward within a given jurisdiction. Triggers advance health goals from the premonitory phase, where health goals are contemplated, to the formulation phase, where health goals are developed. Triggers often constitute some form of formal recognition or affirmation by political or decision-making bodies. More specifically, triggers for health goals in a given jurisdiction may include the following:

• **Government endorsement** refers to a political proclamation of support for health goals that falls short of official legislation.

• **Government legislation** where health goals are mandated and formally adopted as government policy.

• **Consensus agreement** among key stakeholder groups to adopt health goals for a given jurisdiction.

• **Budgetary** where health goals appear for the first time as a budget line item in an agency or program budget.

• **Commission recommendation** where health goals are sanctioned by an expert committee convened by governments to make recommendations for a given jurisdiction. Examples would be royal commissions or blue ribbon commissions.

• **Mass media** where discussion on health goals is generated and health goals information is disseminated.

**II. FORMULATION PHASE**

**C. Structure**

**Theme 6: Levels and Sectors**

The “levels and sectors” theme of the health goals framework refers to the range and mix of players, interests and orientations that are involved in the health goals development process within a given jurisdiction. While other themes in the health goals framework make reference to the varying interests and parties involved in health goals (such as the consultation and participation theme and the coordinating mechanism theme discussed later), the levels and sectors theme addresses more directly the types and levels of interests involved and the likelihood of diffusion of health goals across jurisdictions. Various combinations of levels and sectors that may be involved in health goals development include the following:
• **Government sector** includes participation in health goals development from the various ministries or departments that comprise government. These may include: health, social services, economic development, housing, community planning, culture and arts, justice, education, transportation, and recreation and sport.

• **Level of Government** includes participation in health goals development by governmental bodies from the national, state or provincial level, regional, or municipal or community level.

• **Non-government sector** includes participation in health goals development from bodies or groups that are not associated with government. These include the voluntary or non-profit sector, the business sector, the academic sector, professional associations, and public and grassroots involvement.

• **Non-government level** includes participation in health goals development by non-governmental bodies from the national, state or provincial, regional, or municipal or community level.

• **Quasi-government bodies** includes participation in health goals development from bodies or groups that are linked to government but operate autonomously. These may include regional health boards, district health authorities, community health councils and crown corporations.

• **Diffusion** refers to the expectation that health goals developed by one jurisdiction will be adopted by other jurisdictions. Diffusion may be from one government level to another, from one government sector to another, or from the government sector to the non-government sector.

**Theme 7: Coordinating Mechanism**

The “coordinating mechanism” theme of the health goals framework refers to the central body or mechanism that is established to coordinate, lead, monitor and manage the formulation of health goals throughout the health goals formulation phase. Often, the coordinating mechanism that is established during the health goals formulation phase is sustained throughout the health goals implementation and monitoring phases. Key dimensions of the coordinating mechanism in health goals development include the following:

• **Base** constitutes two elements of health goals coordination. *Headquarters* is the entity or location where the overall authority for the coordination of health goals resides. There is normally only one headquarters for any given jurisdiction. *Operations center* is the entity or location where the work of health goals is taken on. There may be multiple operations centers, each responsible for coordinating its own piece of work. Within any given jurisdiction, the headquarters and the operations center may constitute a single entity or base; or each may be distinct entities, located at different sites and involving different groups or participants. The headquarters or operations center(s) may be government-based (either within one ministry department or within an inter-ministerial body; non-government-based (situated within the academic, non-profit or volunteer sectors); or comprise a coalition, constituted of both government and non-government representatives (who oversee and manage the initiative).

• **Make-up** refers to the mix of various interests and the degree of intersectoral representation on the health goals coordinating mechanism for a given jurisdiction.
• **Capacity** implies the level of knowledge and expertise on health goals that is represented on the coordinating mechanism for health goals, or that may be serve as advisory or side committees to the coordinating mechanism.

• **Political support** refers to the degree of commitment or assistance from government or political leaders for the health goals coordinating mechanism in a given jurisdiction.

• **Staff support** refers to the degree or level of assistance provided by support staff to the coordinating mechanism in a given jurisdiction.

• **Autonomy** refers to the degree to which the coordinating mechanism is able to function independently throughout the health goals formulation phase.

D. Process

Theme 8: Strategic Approach

The “strategic approach” theme of the health goals framework refers to the broad or overall strategy employed in the development of health goals. More specifically, strategic approach refers to how planning groups organize for, attend to or engage in the development of health goals for a given jurisdiction. Significant variation exists in the strategic approach to health goals and can occur along the following continua:

• **Technical - Expert** strategic approach where a technical approach is perfunctory in nature, is characterized by routinized tasks and duties, and does not incorporate or necessitate professional judgement; an expert approach rests upon the use and advice of individuals who are considered to have expertise in various aspects of health goals such as specific diseases or conditions, health promotion and disease prevention, health status indicators, epidemiology and health services.

• **Bureaucratic - Political** strategic approach where a bureaucratic approach to health goals relies on the direction and advice of civil servants and the bureaucratic leadership; a political approach relies more heavily upon the direction and advice of elected political officials and/or interest or pressure groups.

• **Incremental - Comprehensive** strategic approach where an incremental approach implies a small step approach to health goals where a limited number of key health issues are identified and translated into health goals (additional priority health issues may be formulated into health goals at a later time); a comprehensive approach implies an exhaustive approach to health goals where most key health issues of a given jurisdiction are identified and translated into health goals.

• **Partisan - Non-partisan** strategic approach where a partisan approach bases health goals development on political ideology, agenda, or party; and a non-partisan approach removes the health goals development process from the political agenda and does not link it to any particular political party or ideology.

• **Derivative - Original** strategic approach where a derivative approach bases health goals on existing jurisdictional health or health-related initiatives, programs or policies; and an original approach develops health goals as a new initiative that does not build on existing jurisdictional initiatives, programs or policies.

• **Bottom-up - Top-down** strategic approach where a bottom-up approach implies health goals development from a lower constituency (such as a community or region) to a higher
constituency (such as state/province or nation); and a top-down approach implies health goals development from a higher constituency to a lower constituency.

Theme 9: Consultation and Participation

The “consultation and participation” theme of the health goals framework refers to the ways in which the interests, priorities and opinions of various parties and constituencies are solicited and incorporated into the health goals development process. The consultation and participation theme not only addresses the strategies employed to canvass various groups, but considers also the means by which participants are selected to participate as well as the mix of interests or orientations that contribute to the health goals development process. More specifically, the consultation and participation theme of the health goals framework encompasses the following dimensions:

- **Selection strategies** refers to how and by whom participants are chosen for consultation in the health goals development process.
- **Representation** refers to the mix of interests, orientations, disciplines or persuasions that are consulted during the health goals development process. Representation includes both the breadth of representation, that is, how broad the net is cast in terms of the numbers of different interests or parties consulted, as well as the depth of representation, which refers to the relative amount of consultation provided by each party or interest consulted. Representation also considers the degree or level of participation and consultation in health goals development and recognizes that the level of involvement by participating groups may vary throughout the development process.
- **Consultation mechanisms** refers to the methods employed by a given jurisdiction to consult with various groups and interests about health goals in the health goals formulation phase. Examples vary by jurisdiction from the very formal to the very informal and may include methods such as white papers, consultation documents, focus groups, community surveys, town meetings and workshops.

E. Resources

Theme 10: Core Contributions

The “core contributions” theme of the health goals framework refers to the duties, responsibilities and assignments assumed by the various parties and interests involved in the health goals development process to support the formulation of health goals for a given jurisdiction. Core contributions help to move health goals development forward. Typically, core contributions are clearly delineated and linked to the expertise of the various interests represented on the health goals coordinating mechanism. The core contributions theme includes the following dimensions:

- **Technical assistance** includes contributions of knowledge, skills and information related to the development to health goals.
- **Funding** includes financial support for the direct and indirect costs associated with health goals development.

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- **Organization** includes the definition and assignment of roles relative to health goals development and implementing and managing activities.
- **Education and communication** refers to activities and efforts that inform or enlighten a given jurisdiction about the role, aim and utility of health goals.
- **Leadership** refers to activities and efforts put forth by champions of health goals to advocate for and sustain the health goals development process.
- **Promotion** refers to activities related to the “selling” of health goals as an action strategy to address health and health-related issues within a given jurisdiction.

**Theme 11: Time and Budget**

Key dimensions that define the “time and budget” theme of the health goals framework are as follows:

**Time:**
- **Set-aside time** refers to specific allocation and scheduling of time for health goals development.
- **Time frame** refers to the total time designated for health goals development.
- **Paid time** includes amount of remunerable time invested by key players in health goals development.
- **Volunteer time** includes the amount of unremunerative time invested by key players in health goals development.
- **Time share** refers to the contribution of time from participating parties in health goals development.

**Budget:**
- **Set-aside budget** refers to the specific allocation of funds for health goals development.
- **Subsumed budget** implies that no money is set aside for health goals development; rather, health goals costs are absorbed by the lead agency/party or by some combination of participating parties.
- **Direct costs** refers to those costs directly related to the health goals initiative such as staffing and travel.
- **Indirect costs** refers to those cost which are not directly associated with health goals development such as time away from regular work and facility operational costs.
- **Source** refers to the origin of funding for health goals development.
- **Budget-share** refers to the contribution of budget from participation parties in health goals development.

**Theme 12: Data**

The “data” theme in the health goals framework refers to how data are applied in goal-setting, the types of data used, the sources of data, access to data, factors related to the quality and availability of data, and the use or establishment of data management systems. These issues are detailed below.
• **Data requirement** refers to how data are applied in the development of health goals in terms of whether health goals are formulated in only those areas where data are available or whether goal setting proceeds in areas where data do not exist or are unavailable.

• **Data types** includes the range of data that may be drawn upon to formulate health goals such as epidemiological data, environmental data, lifestyle data, social and economic data, health systems data and demographics.

• **Data sources** include both the repositories of data such as vital events registries, census records, epidemiological surveillance systems, disease registries, and routine health services data; and data generated from primary data collection such as sample or community surveys and needs assessments.

• **Data quality** relates to the usefulness of data in terms of data comparability, validity, reportability, currency and periodicity.

• **Data access** refers to the ability of health goals planners to acquire or secure data for the purposes of formulating goals. Access may be limited by various factors such as confidentiality, data ownership issues and cost.

• **Data availability** relates to whether data relevant to health goals are available for procurement by health goals planners.

• **Data management system** refers to the use and/or concurrent development of an information management system to support health goals development in a given jurisdiction.

### III. ARTICULATION PHASE

**F. Goals**

**Theme 13: Specificity and Methods**

While the “priorities addressed” and the “health determinants scope” themes of the health goals framework (discussed later) refer precisely to the content of health goals or, more directly, to what the goals say; the “specificity and methods” theme of the health goals framework considers the foundation from which health goals emerge and the extent to which health goals are specified or operationalized and the methods applied to accomplish this. Specificity of health goals varies across jurisdictions, with some jurisdictions presenting stated goals as stand-alone entities, and others elaborating in great detail about the founding principles of health goals, the level of targeting, and the methods or strategies for goals accomplishment. More particularly, health goals in the articulation phase of the health goals development process may be operationalized along the following dimensions:

• **Shared vision** refers to the collective image or conceptualization of optimal health and health-related conditions for a given jurisdiction.

• **Statement of principles** are the overarching core beliefs and values of a given jurisdiction that establish the foundation for health goals.

• **Goals** are broad statements of desired future states or conditions that are potentially attainable in the long term within a given jurisdiction.
• **Objectives** are clear, concise, potentially measurable statements of intent/expectation for health within a given jurisdiction. Objectives strive to answer the questions of “who,” “how much,” “of what,” and “by when.”

• **Indicators** are measures or statistics that signify where the jurisdiction stands on an objective. Indicators allow us to measure change or progress. Indicators require reliable data that can be tracked over time. Sometimes more than one indicator is used to measure different aspects of complex objectives.

• **Targets** are quantified statements of the amount and timing of desired change expected on an indicator; targets are usually stated in rate form and stipulate the date by which the change is to be achieved. [Targets may be established by normative standards where the level of performance on an indicator reflects levels achieved in a comparable jurisdiction or setting (normative standards are often referred to as “benchmarks);” theoretical standards where targets are set based on knowledge gained from research about what is reasonably attainable; historical standards where targets are based on the extrapolation of levels on an indicator from past or present levels to future estimates; absolute standards where targets aim for complete eradication of the problem; or compromise standards where targets are negotiated through some reasonable adjudication of the other four methods]

• **Action strategies** are the methods and interventions employed to accomplish the stated goals and objectives, including steps to be taken and parties responsible.

• **Language** refers the use and application of words and text in the articulation of health goals to portray meaning, tone, or orientation; for example, “national” versus “federal” health goals.

**Theme 14: Priorities Addressed**

The “priorities addressed” theme of the health goals framework refers to the number and types of priority health and health-related issues that are identified and translated into health goals for a given jurisdiction. Health goals in the articulation phase of health goals development may vary by priority along the following dimensions:

**Coverage and Criteria:**

- **Limited number** of priority health issues are addressed in health goals.
- **Most** priority health issues are addressed in health goals.
- **Criteria** refers to the considerations used to choose among health issues for goals development.

**Types:**

- **Health status** where health goals articulate the level of health of a population as indicated by measures such as rates of death, disease, disability, dissatisfaction and discomfort.
- **Health promotion** where health goals focus on wellness, health promotion and disease prevention.
- **Health practices** where health goals focus on individual lifestyle choices.
- **Health equity and social equity** where health goals seek to establish comparable levels of health and social benefits to all people of a given jurisdiction.
- **Determinants of health** where health goals consider those factors that influence health that lay beyond the health system such as social, environmental and economic influences on health.
- **Population subgroups** where health goals are articulated for special population groups.
such as aboriginal people, people with disabilities or people of minority groups.

- **Health care system** where health goals are articulated in terms of the performance of the health care system and the management and delivery of health services such as system efficiency, access, availability, and accountability.

- **Health tools and supports** where health goals consider the infrastructure support for health such as public policy, research and information.

- **Quality of life** where goals seek to measure outcomes other than health that are secondary benefits of health.

**Theme 15: Health Determinants Scope**

The “health determinants scope” theme of the health goals framework *refers to the scope or range of health determinants addressed in health goals for a given jurisdiction*. Health goals may include *proximal* health determinants, which include those factors that influence health that have historically been viewed as under the individual’s control and relate to or his or her immediate environment; or *distal* health determinants, those influences on health that are further removed from an individual and his or her immediate environment and include the global social, economic and environmental influences on health. Any one health determinant may be proximal or distal, depending on the individual’s life stage or circumstance. More particularly, health goals for a given jurisdiction may articulate determinants of health in the following ways:

- **Biology and individual genetics** refers to the physiological and genetic constitution of individuals.

- **Personal health practices** refers to an individual’s choices, lifestyle and behaviors related to health, disease prevention and self-care.

- **Coping skills** include an individual’s ability to deal with stress, solve problems and be self-reliant.

- **Healthy child development** includes prenatal and early childhood experiences and conditions.

- **Physical environment** includes air, soil and water quality as well as housing and safety of communities.

- **Income and social status** refers to amount of wealth, the relative distribution of wealth within a given jurisdiction, and social standing of individuals in terms of their capacity to control life circumstances and take effective action.

- **Social support networks** includes support from family, friends and communities.

- **Education** refers to formal education that promotes employment opportunities as well as informal education that provides knowledge and skills for daily living.

- **Employment and working conditions** refers to meaningful employment that promotes economic stability as well as work environments that are safe and supportive.

- **Health system** includes the availability of preventive, treatment and rehabilitative health services as well as the planning, management, organization and evaluation of health services.
G. Other

Theme 16: Late Stage Developments

The “late stage developments” theme of the health goals framework refers to those processes, initiatives or spin-offs that may come about as a result of the health goals process that are not necessarily expected or anticipated, and may confer secondary benefits or conditions. Some late stage developments are as follows:

- **Post-consensus edits** refers to the adjustment of health goals, generated by bureaucratic or political interests late in the health goals process, that become incorporated into officially published health goals for a given jurisdiction.

- **Partnerships and coalition building** where partnerships merged in health goals are sustained beyond health goals planning or modified to characterize new initiatives or planning exercises.

- **Intersectoral or interdisciplinary initiatives** where new initiatives emerge that mirror the process and structure of health goals in terms of cooperative liaison between multiple and distinct sectors, interests or disciplines.

- **Community development** where the health goals development process contributed to community capacity building and community empowerment.

- **Diffusion** in terms of the movement or adoption of health goals by jurisdictions beyond the originating jurisdiction; either from lower to higher governments (state/provincial to national), or from higher to lower governments (from state/provincial to regional or community), or from government to non-government sectors.

- **Policy extension** of health goals where health goals extend beyond their original intent as a stand-alone policy and are incorporated into broader health or public policy initiatives within a given jurisdiction.

- **Institutionalization** where health goals are linked to funding arrangements and departmental or ministry budgets are set according to the contribution of programs and policies toward the achievement of health goals within a given jurisdiction.
APPENDIX L

Letter of Introduction

Date
Interviewee Name & Address

Dear [Interviewee]:

The Institute of Health Promotion Research at the University of British Columbia is conducting a research study entitled, “Case Study of the Health Goals Development Process in the Province of British Columbia.” The UBC Institute of Health Promotion Research is involved in the study of health promotion and population health research initiatives. This research project is planned and directed by the Institute and is supported by a grant from the BC Health Research Foundation. We appreciate your willingness to be interviewed in support of the project, and are able to confirm your interview appointment with Treena Chomik on (date, time, place).

The interview will take the form of a conversation or dialogue and take about 90 minutes to complete. We will be asking you to reflect upon your experience in the development of health goals for the province of British Columbia. The Health Goals For British Columbia initiative was undertaken by the Office of the Provincial Health Officer in 1995 and 1996 to identify health priorities for a healthy population and to establish population health goals for the people of BC. The purpose of our research project is to identify and examine key themes related to health goals development and articulation. More particularly, interview questions will address the following key issues related to the health goals development process:

• Conditions and factors, both within and outside the health system, that set the context for health goals development in BC
• Structures, processes and resources necessary for health goals development such as participating parties; coordinating mechanism; consultation processes; and time, budget and data requirements.
• Factors related to the articulation of the BC health goals in terms of the number and types of priorities addressed and the degree to which health goals have been operationalized into measurable objectives, targets and action strategies.

Your participation in this research project will enhance the ability of the study to provide useful information to government and community leaders regarding planning and policy making in health. Participation is voluntary and you have the right to refuse to participate or to terminate the interview at any time. Respondents will not be identified to anyone other than the Principal Investigator of the study, Dr. Lawrence W. Green, and the project staff. Interviews will be taped to facilitate analysis of the data and interview results will be reported in summary format only.

Once again, thank you for your assistance on this study. I look forward to meeting with you on (date). If you have any questions or concerns regarding this research project, please contact Dr. Lawrence W. Green at 604-822-5776. If you have any concerns about your treatment
as a research participant, you may contact the Director of Research Services at the University of British Columbia, Dr. Richard Sprately, at 822-8598.

Yours sincerely,

Treena Chomik  
Ph.D. Candidate  
Institute of Health Promotion Research  
University of British Columbia
I, the undersigned, agree to participate in this interview for the purpose of the research project entitled, "Case Study of the Health Goals Development Process in the Province of British Columbia." I am assured that only Dr. Lawrence W. Green, Principal Investigator, and the project staff will have access to the interview data, that no participant will be named individually in the analysis and reports, and that all individual responses will remain anonymous, unless the participant requests that their comments be attributed to them. Any such attributed comments will be cleared with the participant.

I am aware that participation is voluntary and I have the right to refuse to participate or to terminate the interview at any time.

I acknowledge that I have received a copy of the consent which I may retain for my records.

Name: ___________________________ Signature: ___________________________

Date: ___________________________
APPENDIX N

Master Interview Guide: Main Questions

A. Generally speaking, what was your role in the BC health goals process? (Introductory question)

1. Based on your experience with the health goals initiative, what general conditions or factors existed in the province of BC (that were outside of the health system) that influenced or set the context for health goals?

2. What conditions or factors existed within the BC health system that set the context and provided a supportive environment for the development of health goals in BC?

3. Who were the proponents for the health goals initiative in BC? Can you identify a “champion” for health goals? // Were there any skeptics of the health goals initiative? // What individuals or groups did not support an early call for health goals?

4. What were considered to be the primary benefits of provincial health goals? What kinds of contributions were health goals expected to make in the province of BC?

5. What would you consider to be the main precipitating event or “trigger” that propelled the health goals initiative forward in BC? Was there a particular event or occurrence that legitimized the health goals and set the health goals development process in motion?

6. What groups or parties were involved in the development of health goals in BC? // Did you believe or intend that the provincial health goals would be adopted by other levels of the health system (such as RHBs or CHCs) or other groups or organizations?

7. Who or what would you identify as the central coordinating mechanism for the health goals development process in BC? // What were the key defining features or characteristics of the coordinating mechanism?

8. How would you characterize the overall strategy or approach to the development of the provincial health goals? To the best of your knowledge how did the development or planning group organize itself or engage in the goals development process?

9. Who was consulted in the health goal development process? // By whom were participants chosen for consultation in the health goals development process? // Were there any particular criteria that were used to make decisions about who would be consulted? // Did the level of consultation with selected groups vary during the health goals development process? // What kinds of methods were used to solicit input?
10. What kinds of contributions did you or your group/agency make toward the development of the provincial health goals? What kinds of duties, tasks or responsibilities did you or your group/agency take on?

11. Do you believe that sufficient time and budget was dedicated to the development of the provincial health goals? // Did you have set aside time, budget and personnel? // Was there a set time frame to complete the process? // Was there a shared contribution of time and budget by participating parties?

12. What role did data play in the development of health goals? // How were data applied; that is, were health goals and targets developed in areas where data did not exist or were not available? // How were data accessed and managed? // What types and sources of data were used?

13. To what degree have the BC health goals been operationalized in terms of goals, objectives, targets and strategies? // What methods were used to set targets? // Was attention was paid to language as a means to portray meaning, tone or orientation of health goals?

14. I understand that you are familiar with the kinds of priority health and health-related issues that are identified in the health goals. Are you aware of any criteria were used to choose among health issues for goals development? Are you satisfied with the priorities areas that have been addressed?

15. I understand that you are familiar with the kinds of health determinants are addressed in the provincial health goals? Are you satisfied with the range of health determinants addressed in the health goals?

16. Reflecting upon the health goals process, are you aware of any late stage occurrences or initiatives that came about as a result of or evolved from the BC health goals initiative? // Were there any unanticipated or unexpected developments or spin-offs that transpired in the late stages of the health goals initiative?

17. Our attempt in today’s interview was to capture the salient themes of health goals development and articulation in BC. Do you believe we have missed any central themes, processes or mechanisms? Is there anything else you would like to add?
Appendix O

Coding Scheme

(1) /Premphase
(1 1) /Premphase/Context
(1 1 1) /Premphase/Context/Prevailing Circumstances
(1 1 1 1) /Premphase/Context/Prevailing Circumstances/Demographic Factors
(1 1 1 2) /Premphase/Context/Prevailing Circumstances/Social Factors
(1 1 1 3) /Premphase/Context/Prevailing Circumstances/Political Factors
(1 1 1 4) /Premphase/Context/Prevailing Circumstances/Economic Factors
(1 1 2) /Premphase/Context/Health System Environment
(1 1 2 1) /Premphase/Context/Health System Environment/Status
(1 1 2 2) /Premphase/Context/Health System Environment/Efficiency
(1 1 2 3) /Premphase/Context/Health System Environment/Capacity
(1 1 2 4) /Premphase/Context/Health System Environment/Satisfaction
(1 1 2 5) /Premphase/Context/Health System Environment/Orientation
(1 1 2 6) /Premphase/Context/Health System Environment/Reform
(1 1 2 7) /Premphase/Context/Health System Environment/Literacy
(1 2) /Premphase/Motivation
(1 2 3) /Premphase/Motivation/Proponents & Skeptics
(1 2 3 1) /Premphase/Motivation/Proponents & Skeptics/Internal
(1 2 3 2) /Premphase/Motivation/Proponents & Skeptics/External
(1 2 3 3) /Premphase/Motivation/Proponents & Skeptics/Government-based
(1 2 3 4) /Premphase/Motivation/Proponents & Skeptics/Non-government
(1 2 3 5) /Premphase/Motivation/Proponents & Skeptics/Health Sector
(1 2 3 6) /Premphase/Motivation/Proponents & Skeptics/Non-health Sector
(1 2 3 7) /Premphase/Motivation/Proponents & Skeptics/Personal Characteristics
(1 2 4) /Premphase/Motivation/Perceived Benefits
(1 2 4 1) /Premphase/Motivation/Perceived Benefits/Policymaking
(1 2 4 2) /Premphase/Motivation/Perceived Benefits/Program planning & evaluation
(1 2 4 3) /Premphase/Motivation/Perceived Benefits/H-impact assessment
(1 2 4 4) /Premphase/Motivation/Perceived Benefits/H-inequity reduction
(1 2 4 5) /Premphase/Motivation/Perceived Benefits/Role & Sector Definition
(1 2 4 6) /Premphase/Motivation/Perceived Benefits/H-status monitoring
(1 2 4 7) /Premphase/Motivation/Perceived Benefits/H-priority setting
(1 2 4 8) /Premphase/Motivation/Perceived Benefits/Resource re-allocation
(1 2 4 9) /Premphase/Motivation/Perceived Benefits/Population planning
(1 2 4 10) /Premphase/Motivation/Perceived Benefits/Reorientation
(1 2 4 11) /Premphase/Motivation/Perceived Benefits/Intersectoral collaboration
(1 2 5) /Premphase/Motivation/Triggers
(1 2 5 1) /Premphase/Motivation/Triggers/Govtendorsement
(1 2 5 2) /Premphase/Motivation/Triggers/Govtlegislation
(1 2 5 3) /Premphase/Motivation/Triggers/Consensus agreement
(1 2 5 4) /Premphase/Motivation/Triggers/Budgetary
(1 2 5 5) /Premphase/Motivation/Triggers/Commision recommendation
(1 2 5 6) /Premphase/Motivation/Triggers/Mass media
(2) /Formphase
(2 3) /Formphase/Structure
(2 3 6) /Formphase/Structure/Levels & Sectors
(2 3 6 1) /Formphase/Structure/Levels & Sectors/Govtsector
(2 3 6 2) /Formphase/Structure/Levels & Sectors/Govtlevel
(2 3 6 3) /Formphase/Structure/Levels & Sectors/Nongovtsector
(2 3 6 4) /Formphase/Structure/Levels & Sectors/Nongovtlevel
(2 3 6 5) /Formphase/Structure/Levels & Sectors/Quasigovt
(2 3 6 6) /Formphase/Structure/Levels & Sectors/Diffusion
(2 3 7) /Formphase/Structure/Coordinating mechanism
(2 3 7 1) /Formphase/Structure/Coordinating mechanism/Base
(2 3 7 2) /Formphase/Structure/Coordinating mechanism/Makeup
(2 3 7 3) /Formphase/Structure/Coordinating mechanism/Capacity
(2 3 7 4) /Formphase/Structure/Coordinating mechanism/Political Support
(2 3 7 5) /Formphase/Structure/Coordinating mechanism/Staff Support
(2 3 7 6) /Formphase/Structure/Coordinating mechanism/Autonomy
(2 4) /Formphase/Process
(2 4 8) /Formphase/Process/Strategic Approach
(2 4 8 1) /Formphase/Process/Strategic Approach/Techexpert
(2 4 8 2) /Formphase/Process/Strategic Approach/Bureapolitical
(2 4 8 3) /Formphase/Process/Strategic Approach/Incremcomprehensive
(2 4 8 4) /Formphase/Process/Strategic Approach/Partisan&nonpartisan
(2 4 8 5) /Formphase/Process/Strategic Approach/Derivoriginal
(2 4 8 6) /Formphase/Process/Strategic Approach/BottomTop
(2 4 9) /Formphase/Process/Consultation & Participation
(2 4 9 1) /Formphase/Process/Consultation & Participation/Selectionstrategies
(2 4 9 2) /Formphase/Process/Consultation & Participation/Representation
(2 4 9 3) /Formphase/Process/Consultation & Participation/Consultation mechanisms
(2 5) /Formphase/Resources
(2 5 10) /Formphase/Resources/Core Contributions
(2 5 10 1) /Formphase/Resources/Core Contributions/Technical Assistance
(2 5 10 2) /Formphase/Resources/Core Contributions/Funding
(2 5 10 3) /Formphase/Resources/Core Contributions/Organization
(2 5 10 4) /Formphase/Resources/Core Contributions/Edcommunication
(2 5 10 5) /Formphase/Resources/Core Contributions/Leadership
(2 5 10 6) /Formphase/Resources/Core Contributions/Promotion
(2 5 11) /Formphase/Resources/Time & budget
(2 5 11 1) /Formphase/Resources/Time & budget/Set-aside time
(2 5 11 2) /Formphase/Resources/Time & budget/Timeframe
(2 5 11 3) /Formphase/Resources/Time & budget/Paid time
(2 5 11 4) /Formphase/Resources/Time & budget/Volunteer time
(2 5 11 5) /Formphase/Resources/Time & budget/Timeshare
(2 5 11 6) /Formphase/Resources/Time & budget/Set-aside budget
(2 5 11 7) /Formphase/Resources/Time & budget/Subsumed budget
APPENDIX P

Case Study Protocol

"A case study protocol is more than an instrument. The protocol contains the instrument but also contains the procedures and general rules that should be followed in using the instrument ... It is intended to guide the researcher in carrying out the case study" (Yin, 1994, p. 63).

I. Case Study Research Questions

Implications of the Case for Theory:

1. What factors, as perceived by participants in BC, obstructed or facilitated the formulation and articulation of health goals that were considered for submission, or adopted by, the Cabinet of the government of British Columbia?

Implications for Modification of Planning Models:

2. Which aspects of the BC health goals setting exercise fit best with the established planning models and what does the BC experience suggest for the application of existing models for goal setting in health?

Implications for Research:

3. What recommendations can be drawn from the goal-setting experience in British Columbia to guide and inform further study on the formulation and articulation of provincial health goals?

Implications for Practice:

4. What implications for planning practice can be drawn from this study for the formulation and articulation of health goals in other jurisdictions and at the regional or local level in BC?

This study is an exploratory and descriptive investigation of the health goals development process in the province of British Columbia that proposes to answer the following questions: Several issues support a comprehensive examination of the health goals development process. These include (a) the broad acceptance (adoption) of health goals as an planning and policy tool for population health promotion, (b) the complexity of health goals development, (c) the variation in approaches to health goals development, and (d) the need to clarify the fit between the practice of health goal setting and established planning theory.
II. Procedures: Data Collection

A. Gaining Access to Interviews and Source Documents

- Letter of support from the Office of the Provincial Health Officer
- Meeting with seconded professor hired to support health goals project to provide overview and history of project
- Meeting with consultant to the health goals project to provide overview of project and to obtain a list of possible interviewees
- Obtain UBC ethical consent

B. Establishing Sample and Scheduling Interviews

- Identify purposive sampling of twenty-three based on “those most involved and interested.” Consisting of four subgroups who participated in the BC health goals process: (a) regional health boards (5), (b) provincial ministries (5), (c) provincial stakeholder organizations (8), (d) Office of the Provincial Health Officer (5)
- Schedule (23) interviews at a location convenient to participant
- Prepare letter of introduction explaining purpose of study and confirming time and place of interview

C. Preparing for Interviews

- Confirm interview appointments
- Review master interview guide and operational definitions
- Prepare interview consent form
- Ready tape recorder
- Review background material (if available) on participant (for example, previous written submissions to health goals office on content of health goals)
- Dress professionally as representative of UBC and IHPR

D. Conducting Interviews

- Develop a clear schedule of interview activities expected to be completed within a three month period (July-September, 1997)
- Confirm “disaster plan” procedure with colleagues for calling for assistance or guidance, if needed, while in the field interviewing (for example if the interviewee does not show up or substitutes a junior person to take their place)
- Ensure sufficient resources including laptop computer, tapes, paper, paper clips, computer disks, reading materials

E. Post Interview Activities

- Secure data - computer disks, tapes and transcripts in locked cabinet
- Write-up interview-specific notations after each interview that comments on the overall quality of the interview (mood & rapport), (b) methodological or procedural issues
(coverage of interview items, level of probing/follow-up question), (c) interviewees overall contribution to the topic under examination and any unique insights or perspectives offered

- Reflect on interview and consider adjustments to improve or augment subsequent interviews

F. Gathering BC Source Documents

- Schedule visit to Office of the Provincial Health Officer in Victoria to gather source documents
- Arrange with consultant to acquire any additional materials
- Get consent and make copies of materials

III. Case Study Interview Questions, Master Interview Guide

This section includes the list of interview questions and links each question to the source(s) drawn on: “I” = interviewee; “SD” = source documents

<table>
<thead>
<tr>
<th>Questions</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Generally speaking, what was your role in the BC health goals process? (Introductory question)</td>
<td>(I)</td>
</tr>
<tr>
<td>1. Based on your experience with the health goals initiative, what general conditions or factors existed in the province of BC (that were outside of the health system) that influenced or set the context for health goals?</td>
<td>(I &amp; SD)</td>
</tr>
<tr>
<td>2. What conditions or factors existed within the BC health system that set the context and provided a supportive environment for the development of health goals in BC?</td>
<td>(I &amp; SD)</td>
</tr>
<tr>
<td>3. Who were the proponents for the health goals initiative in BC? Can you identify a “champion” for health goals? // Were there any skeptics of the health goals initiative? // What individuals or groups did not support an early call for health goals?</td>
<td>(I)</td>
</tr>
<tr>
<td>4. What were considered to be the primary benefits of provincial health goals? What kinds of contributions were health goals expected to make in the province of BC?</td>
<td>(I &amp; SD)</td>
</tr>
<tr>
<td>5. What would you consider to be the main precipitating event or “trigger” that propelled the health goals initiative forward in BC? Was there a particular event or occurrence that legitimized the health goals and set the health goals development process in motion?</td>
<td>(I)</td>
</tr>
<tr>
<td>6. What groups or parties were involved in the development of health goals in BC? // Did you believe or intend that the provincial health goals would be adopted by other levels of the health system (such as RHBs or CHCs) or other groups or organizations?</td>
<td>(I &amp; SD)</td>
</tr>
<tr>
<td>7. Who or what would you identify as the central coordinating mechanism for the health goals development process in BC? // What were the key defining features or characteristics of the coordinating mechanism?</td>
<td>(I &amp; SD)</td>
</tr>
<tr>
<td>8. How would you characterize the overall strategy or approach to the development of the provincial health goals? To the best of your knowledge how did the development or planning</td>
<td>(I &amp; SD)</td>
</tr>
</tbody>
</table>
9. Who was consulted in the health goal development process? // By whom were (I & SD) participants chosen for consultation in the health goals development process? // Were there any particular criteria that were used to make decisions about who would be consulted? // Did the level of consultation with selected groups vary during the health goals development process? // What kinds of methods were used to solicit input?

10. What kinds of contributions did you or your group/agency make toward the development (I) of the provincial health goals? What kinds of duties, tasks or responsibilities did you or your group/agency take on?

11. Do you believe that sufficient time and budget was dedicated to the development of the (I) provincial health goals? // Did you have set aside time, budget and personnel? // Was there a set time frame to complete the process? // Was there a shared contribution of time and budget by participating parties?

12. What role did data play in the development of health goals? // How were data applied; (I & SD) that is, were health goals and targets developed in areas where data did not exist or were not available? // How were data accessed and managed? // What types and sources of data were used?

13. To what degree have the BC health goals been operationalized in terms of goals, (I & SD) objectives, targets and strategies? // What methods were used to set targets? // Was attention was paid to language as a means to portray meaning, tone or orientation of health goals?

14. I understand that you are familiar with the kinds of priority health and health-related (I & SD) issues that are identified in the health goals. Are you aware of any criteria were used to choose among health issues for goals development? Are you satisfied with the priorities areas that have been addressed?

15. I understand that you are familiar with the kinds of health determinants are addressed (I & SD) in the provincial health goals? Are you satisfied with the range of health determinants addressed in the health goals?

16. Reflecting upon the health goals process, are you aware of any late stage occurrences (I) or initiatives that came about as a result of or evolved from the BC health goals initiative? // Were there any unanticipated or unexpected developments or spin-offs that transpired in the late stages of the health goals initiative?

17. Our attempt in today's interview was to capture the salient themes of health goals (I) development and articulation in BC. Do you believe we have missed any central themes, processes or mechanisms? Is there anything else you would like to add?

IV. Data Analysis Plan

A. Transcription of Taped Interviews

- Coordinate with transcriber and set schedule for transcription of (23) taped interviews
- Institute procedures to ensue quality of transcription such as (a) draft set of guidelines for transcriber to follow, (b) established procedure for "spot" transcription checks, and (c) establish necessary procedures with software consultant early to ensue transcripts are produced in the proper format (readable by NUD*IST software)
B. Code Interview Transcripts and Source Documents

- Integrate health goals framework into NUD*IST software program and generate coding scheme (116 codes linked to framework themes and dimensions)
- Review operational definitions in advance of coding sessions; operational definitions guide the assignment of codes of text units
- Manual coding of interview transcripts and source documents
- Establish protocol for dealing with important or revelatory chunks of data that does not fit into coding scheme (e.g., new codes for “new and emerging themes”)

C. Detailed Data Analysis

- Define “reading” of data -- first for familiarity, then to establish consistences, similarities and contradiction of participant responses; summarize key findings related to each theme; and identify potential quotations that exemplify key perceptions, phenomena, or points of view
- Make clear the tactics and procedures drawn on to make sense of the data such as noting patterns, clustering, making metaphors, counting, making comparisons, and noting relationships
- Establish how the data will be presented such as thematic writing and data displays
- Clarify and follow criteria to establish quality of findings (credibility, transferability, dependability, confirmability)

V. Study Write-Up

- Customize to reader(s) or audience (dissertation committee and examiners)
- Develop chapter outlines
- Review chapter outlines with colleagues and committee members for content and format
- Develop chapter circulation and feedback plan;
- Guard against committee member burnout and prepare drafts in “nearly final draft” quality
- Continuously refine chapters
APPENDIX Q

Case Study Database

The central aim of the case study database is to ensure that documentation consists of two separate collections: (a) the data or evidentiary base, and (b) the report of the investigator, whether in article, report, thesis, or book format (Yin, 1994). The principal reason for separating these two collections is for the purpose of secondary data analysis. Only if the case study data is held separate from the case study report, can the database be “the subject of a separate, secondary analysis, independent of any reports by the original investigator” (Yin, 1994, p. 95).

A. Data Constituting The Case Study Database

This study’s case study database was comprised of the following:

- Interviewee contact list consisting of interviewee names, affiliation, address, phone number, and, E-mail address.
- Written submissions from some study participants regarding their feedback on the content of preliminary health goals.
- Interview transcripts from (23) interviews
- Computer diskettes of interviews
- Audio tapes from (23) interviews
- Interview-specific notations with researcher notes related to overall quality of interview, methodological and procedural issues, interviewee contributions and insights.
- BC source documents including various public relations and working documents on health goals development

B. Storage and Management of Case Study Database

- Evidentiary materials are stored in a locked cabinet
- Evidentiary materials will be made available to colleagues for secondary analysis when the study is complete and the case study report (dissertation) written
- Data has remained separate from the case study report throughout the course of the study
APPENDIX R
Considerations for the Case Study Researcher

A. Develop skills. Commonly desired skills that may be learned and practised by case study researchers to facilitate effective case study research:

- Ask good questions
- Be a good listener and do not become trapped by personal ideologies and preconceptions
- Be adaptive and flexible so that new study situations and conditions can be seen as opportunities rather than threats
- Be well-informed and have a firm grasp of the issues being studied
- Remain unbiased by preconceived notions, including those derived from theory
- Be sensitive and responsive to contradictory evidence.
- Take time to prepare for the case study by reviewing relevant literature, seeking advice from colleagues and professors, and becoming aware of the full range of theories that may relate to your study

B. Be prepared for the complexities of case study research.

Yin (1994) cautions students that case study research, although often perceived to be easier to conduct than other research strategies, is characteristically difficult to oversee and “actually puts greater demand on a researcher’s intellect, ego, and emotions far more than other research strategy” (p. 55). Case study research challenges the researcher because data collection procedures are not often routinized, data analysis frequently involves the application of multiple techniques, and the researcher confronts “continuous interaction between the theoretical issues being studied and the data being collected” (Yin, 1994, p. 55).

Too many people are drawn to the case study strategy because they believe it is ‘easy.’... Many social scientists - especially budding ones - think the case study strategy can be mastered without much difficulty. Their perception is that they will have to learn only a minimal set of technical procedures, that any deficiencies in formal, analytic skills will be irrelevant, and that a case study will allow them simply to “tell it like it is.” No perception could be farther from the truth. In actuality, the demands of a case study ... are far greater than those of any other research strategy. Case study research is remarkably hard, even though, case studies have traditionally been considered to be 'soft' research. Paradoxically, the 'softer' a research strategy, the harder it is to do (Yin, 1994, p. 55).
### Establishing Representativeness of Views

<table>
<thead>
<tr>
<th>TERM</th>
<th>REFERS TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;One&quot;</td>
<td>One respondent</td>
</tr>
<tr>
<td>&quot;A few&quot;</td>
<td>More than 1 &amp; less than 10% of respondents</td>
</tr>
<tr>
<td>&quot;Some&quot;</td>
<td>Between 10% &amp; 30% of respondents</td>
</tr>
<tr>
<td>&quot;Several&quot;</td>
<td>Between 30% &amp; 50% of respondents</td>
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<tr>
<td>&quot;Many&quot;</td>
<td>Between 50% to 75% of respondents</td>
</tr>
<tr>
<td>&quot;Most&quot;</td>
<td>Between 75% &amp; 99% of respondents</td>
</tr>
<tr>
<td>&quot;All&quot;</td>
<td>100% of respondents</td>
</tr>
</tbody>
</table>
APPENDIX T

Provincial Stakeholder Organizations Participating in BC Health Goals

Aboriginal Health Council of BC
Acupuncture Association of BC
Advanced Education Council
Agriculture in the Classroom Foundation
Association of Naturopathic Physicians of British Columbia
BC Association of Chiefs of Police
BC Association for Community Living
BC Association of Community Care
BC Association of Police Based Victim Assistance Services
BC Coalition of People with Disabilities
BC Council for the Family
BC Council of Licensed Practical Nurses
BC Federation of Agriculture
BC Federation of Labour
BC Health Association
BC Healthy Communities Network
BC Lung Association
BC Mental Health Society
BC Non-Profit Housing Association and M'akola Housing Society
BC Pricare
BC Principals' and Vice-Principals' Association
BC Public Health Association
BC Safety Council
BC School Superintendents' Association
BC School Trustees Association
BC Teachers' Federation
BC Women's Hospital and Health Centre
Beef Information Centre
British Columbia Association of Optometrists
British Columbia Association of Podiatrists
British Columbia Association of Respiratory Therapists
British Columbia Dental Hygienists' Association
British Columbia Dietitians' and Nutritionists' Association
British Columbia Health Coalition
British Columbia Manufacturers' Association
British Columbia Pharmacy Association
British Columbia Psychological Association
British Columbia Recreation and Parks Association
British Columbia Society of Occupational Therapists
British Columbia's Children's Hospital
Business Council of British Columbia

Canadian Acupuncturists Headquarters Association
Canadian Association for School Health
Canadian Association of Rehabilitation Personnel
Canadian Cancer Society
Canadian Chinese TCM & Acupuncture Society
Canadian Co-operative Association
Canadian Diabetes Association
Canadian Institute of Public Health Inspectors
Canadian Mental Health Association
Caregivers Association of British Columbia
Centre for Curriculum & Professional Development
Certified Dental Assistants Provincial Board of British Columbia
Chief Coroner's Office
College of Pharmacists of British Columbia
College of Physicians and Surgeons of British Columbia
College of Physiotherapists of British Columbia
Construction Labour Relations Association of BC
Consumer Association of Canada
Council of Forest Industries

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## APPENDIX U

### Regional Health Boards Participating in the BC Health Goals Development Process

<table>
<thead>
<tr>
<th>Region</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coast Garibaldi</td>
<td>Peace River / Liard</td>
</tr>
<tr>
<td>Fraser Valley</td>
<td>Vancouver</td>
</tr>
<tr>
<td>Burnaby</td>
<td>Cariboo</td>
</tr>
<tr>
<td>West Kootnay / Boundary</td>
<td>North West</td>
</tr>
<tr>
<td>Northern Interior</td>
<td>North Okanagan</td>
</tr>
<tr>
<td>North Shore</td>
<td>Upper Island / Central Coast</td>
</tr>
<tr>
<td>South Okanagan / Similkameen</td>
<td>Central Vancouver Island</td>
</tr>
<tr>
<td>Thompson</td>
<td>Capital</td>
</tr>
<tr>
<td>Richmond</td>
<td>Simon Fraser</td>
</tr>
<tr>
<td>South Fraser Valley</td>
<td>East Kootnay</td>
</tr>
</tbody>
</table>
Goal 1: Increase the number of years British Columbians live in good health by enhancing quality of life; reducing preventable illness, injuries and premature deaths; and minimizing inequalities in health status.

Goal 2: Ensure that all British Columbians have adequate income, employment opportunities and education; with a valued role to play in supportive families, workplaces and communities.

Goal 3: Ensure a safe, secure, healthy physical environment, including the natural ecosystem and the human-built environment in homes, schools, workplaces and communities.

Goal 4: Foster strong, empowered individuals in supportive and participatory communities.

Goal 5: Increase public understanding of the determinants of health, and facilitate public participation in informed decision making on all factors that affect population health.

Goal 6: Ensure effective use of societal resources to improve population health, including an appropriate balance between investment in cost-effective health care services and investment in the other determinants of health.

Goal 7: Foster cooperation between all levels of governments to resolve issues impacting the health of First Nations.

Genesis:

- Result of (a) the first health goals drafting workshop in October 1994 hosted by the OPHO and included representatives of various provincial ministries and stakeholder organizations, (b) review by OPHO of health goals of other jurisdictions, and (c) reworking and refining of health goal statements by OPHO
- Used as the basis for consultation with government ministries (April to June 1994) and provincial stakeholder organizations (August to October 1994) for input on health goals
APPENDIX W

Health Goals, Version II
November 1995

Goal 1: Foster positive and supportive living and working conditions in all our communities.

Goal 2: Support all individuals to develop the capacities, skills and attitudes we need to thrive and meet life’s challenges.

Goal 3: Ensure an environment that is naturally diverse and has clean, healthy and safe ecosystems of air, water and land for humans and all living things, now and for future generations.

Goal 4: Ensure that our public policies and investments recognize all of the important influences on our health, and result in the best possible health outcomes.

Goal 5: Reduce preventable illness, injuries and premature deaths.

Goal 6: Foster joint action to improve the health of Aboriginal peoples.

Genesis:

- Result of feedback from Ministries and provincial stakeholder organizations
- Incorporated into publication titled, Health Goals for British Columbia: Identifying Priorities for a Healthy Population, A Draft for Discussion, OPHO, November 1995
- Used as the basis for consultation on health goals with Regional Health Boards at regional workshops which included public consultation

Changes in goal statements from Version I:

- No mention of “health care services”
- Goal 5 of Version I is dropped
- Some reworking and reorganization of other goals
Goal 1: Positive and supportive living and working conditions in all our communities.

Goal 2: Opportunities for all individuals to develop and maintain the capacities, skills and attitudes we need to thrive and meet life’s challenges.

Goal 3: A diverse and sustainable natural environment with clean, healthy and safe ecosystems of air, water and land.

Goal 4: An effective and efficient health care system that provides equitable access to appropriate services.

Goal 5: Balanced investment of resources between health care and other important influences on our health, based on the evidence about what makes and keeps us healthy.

Goal 6: Improved health for Aboriginal peoples, to achieve comparable health status between Aboriginal peoples and the general population.

Goal 7: Reduction of preventable illness, injuries, disabilities and premature deaths.

Genesis:

- Result of consultation with RHBs (and previous input from ministries and provincial stakeholder organizations)
- Used as the basis for second round of consultations/briefings with government ministers and deputy ministers

Changes in goal statements from Version II:

- Goal 3, “and all living things, now and for future generations” is omitted
- New goal (4) for health care system
- Goal 5, change from “ensure that our public policies and investments recognize all the important influences on our health,” to “balanced investments of resources between health care and other important influences on health.”
- Goal 6 reference to “foster joint action “ is omitted
Goal 1: Positive and supportive living and working conditions in all our communities.

Goal 2: Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health.

Goal 3: A diverse and sustainable natural environment with clean, healthy and safe air, water and land.

Goal 4: An effective and efficient health service system that provides equitable access to appropriate services.

Goal 5: Improved health for Aboriginal peoples.

Goal 6: Reduction of preventable illness, injuries, disabilities and premature deaths.

Genesis:

• Result of reworking and reorganization of health goals by OPHO representatives, and second round consultation on health goals with key government ministers and deputy ministers.

• This version of health goals comprised the Cabinet Submission where government leaders were asked to consider the goals and objectives only; and not targets, indicators or lead sectors.

Changes in goals statements from previous Version III:

• Goal 2, "attitudes" is omitted and "and to make choices that enhance health" is added
• Goal 3, "ecosystems" is omitted
• Goal 4, "health care system" changed to "health service system"
• Goal 5, "to achieve comparable health status between Aboriginal peoples and the general population" is omitted
• What was Goal #5 in Version 3 is dropped
Goal 1: Positive and supportive living and working conditions in all our communities.

Goal 2: Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life’s challenges and to make choices that enhance health.

Goal 3: A diverse and sustainable physical environment with clean, healthy and safe air, water and land.

Goal 4: An effective and efficient health service system that provides equitable access to appropriate services.

Goal 5: Improved health for Aboriginal peoples.

Goal 6: Reduction of preventable illness, injuries, disabilities and premature deaths.

**Genesis:**

- This represents the version of health goals that were published in December, 1997 for public dissemination.

**Changes in goal statements from previous Version IV:**

- Goal 4, “natural” environment was changed to “physical” environment.

**NOTE:** A reprint of the final version of the BC health goals, associated objectives, and indicator examples follows. (Source: *Health Goals for British Columbia*, Ministry of Health and Ministry Responsible for Seniors, June 1997.)
Goal 1: Positive and supportive living and working conditions in all our communities.

The most important influences on our health are the conditions we experience in our day-to-day lives. Meaningful work, healthy and supportive workplaces, sufficient income, safe and well designed communities, supportive families and participation in social networks significantly enhance our health.

<table>
<thead>
<tr>
<th>Employment Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| 1 Improve and maintain equitable opportunities for employment for British Columbians by expanding the diversity of the economy and ensuring the sustainability of economic activity. | • Gross Domestic Product per capita  
• Index of sustainable economic welfare  
• Unemployment rates                                                                                                                                                                           |                                                                        |                                                                           |
| 2 Reduce the concentration of marginalized and disadvantaged groups in lower paying and lower status jobs, and increase social recognition and valuing of jobs at all levels. | • Unemployment rate and average income by selected population groups (youth, women, visible minorities, Aboriginal peoples, persons with disabilities)  
• Women’s representation in positions of influence (e.g., percent of elected officials, school principals, university faculty who are women) |                                                                        |                                                                           |
| 3 Reduce the impact on individuals and communities of job loss, for example, through effective industrial adjustment strategies and re-training initiatives. | • Duration of unemployment  
• Unemployment rates for individuals and families (one or more family breadwinners unemployed)                                                                                                               |                                                                        |                                                                           |
| 4 Increase participation in decision-making and reasonable control over work tasks for all types of workers. | • Job satisfaction measures  
• Work stress index                                                                                                                                                                                                   |                                                                        |                                                                           |
Goal 1 (continued)

<table>
<thead>
<tr>
<th>Employment Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
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</thead>
<tbody>
<tr>
<td>5 Improve and maintain quality of life in the workplace, including:</td>
<td>• Workplace injury rate</td>
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<td>• protection from physical hazards and freedom from harassment;</td>
<td>• Number of licensed day care spaces per 100 children, age 0-5</td>
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<tr>
<td>• family friendly policies: policies and supports to help balance work and family</td>
<td>• Percent of workers covered by family friendly policies</td>
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<tr>
<td>responsibilities; and,</td>
<td>(e.g., paid maternity leave)</td>
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<tr>
<td>• policies and supports for workers with disabilities, chronic illnesses or other</td>
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<tr>
<td>special needs.</td>
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<tr>
<td>6 Improve and maintain appropriate supports and protection for workers in non-standard</td>
<td>• Indicator(s) to be developed</td>
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<td>employment situations such as part-time work, job sharing, home employment and self-</td>
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<td>employment.</td>
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<tr>
<th>Income Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
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</thead>
<tbody>
<tr>
<td>7 Reduce poverty in British Columbia.</td>
<td>• Low income (poverty) rate by age group and family structure</td>
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<tr>
<td>• Child poverty rate by family structure</td>
<td>• Percent of population on Income Assistance</td>
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<tr>
<td>• Ability to purchase nutritious food (cost to purchase nutritious food basket</td>
<td>• Income Assistance support allowance or monthly income at</td>
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<td>compared to income at minimum wage).</td>
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<td>8 Reduce the gap between British Columbians at the lowest and highest income levels</td>
<td>• Equality in income distribution measured by Gini coefficient</td>
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<td>to achieve a more equitable income distribution.</td>
<td>• Percent distribution of families by income group</td>
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<tr>
<td>• Gender wage gap</td>
<td></td>
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<tr>
<td>Participation and Social Integration Objectives</td>
<td>Examples of Indicators</td>
<td>Targets</td>
<td>Strategies</td>
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<tr>
<td>9 Increase the safety and security of communities throughout BC, including: • increased sense of personal safety and mutual responsibility for safe communities; and, • reduced crime and interpersonal violence.</td>
<td>• Crime rates by type (property, person, other) • Percent of women who report ever experiencing physical or sexual violence • Victimization rates by type (theft of personal property, violent crime, household victimizations)</td>
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</tr>
<tr>
<td>10 Increase opportunities to develop positive and supportive interpersonal relationships and social networks, including: • access to organized and informal community-based sports, recreation, social, arts and cultural activities; • opportunities and supports for voluntary activities; and, • access to self-help and mutual support activities.</td>
<td>• Volunteer rate of working-age population • Percent of population who are members in voluntary/community organizations • Social support measures • Percent of voters who voted</td>
<td></td>
<td></td>
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<tr>
<td>11 Increase opportunities and supports for healthy family functioning, including: • education and supports for effective parenting; • affordable quality child care and other supports for working parents; • recognition and supports for unpaid family caregivers; and, • access to self-help and mutual support resources for families.</td>
<td>• Percent of families headed by lone-parent • Number of licensed daycare spaces per 100 children, age 0-5</td>
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### Goal 1 (continued)

<table>
<thead>
<tr>
<th>Housing and Community Design Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| **12** Increase access to affordable housing that meets household needs, with reasonable choice in tenure, building type and location, including:  
  - affordability of home ownership for first-time buyers;  
  - sufficient amount and variety of moderately priced rental housing; and,  
  - affordable and accessible housing options for individuals with low incomes or other special needs. | - Percent of renters who can afford a starter home  
  - Percent of renter households in housing need (households without access to suitable, adequate and affordable housing)  
  - BC Housing wait list for subsidized housing | | |
| **13** Increase the range of secure housing options and housing stock for people who are homeless or at risk of homelessness. | - *Indicator(s) to be developed* | | |
| **14** Improve and maintain the design of communities to ensure quality of life for residents, including:  
  - accessible public places for all persons;  
  - appropriate transportation infrastructure, including public transportation; and,  
  - neighbourhoods with appropriate access to services and amenities required for health, security and stability, and protection from hazards that harm quality of life. | - Percent of streets/neighbourhoods that are pedestrian friendly  
  - Percent of land in open spaces  
  - Usage rate of library and community centres  
  - Percent of residential areas within given distance of parks, schools and public transit  
  - Acres of parks per 1000 residents  
  - Percent of streets with bicycle paths  
  - Rate of public transit ridership | | |
Goal 2: Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life’s challenges and to make choices that enhance health.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve and maintain supports to ensure all young children receive the best possible start in life, including: • appropriate pre- and post-natal care; • effective early childhood nurturing and parenting; and, • appropriate early childhood stimulation, socialization and education.</td>
<td>• Exposure to tobacco smoke during pregnancy • Breast-feeding, low birth weight, pre-term birth and stillbirth rates • Infant (0-364 days) mortality rate • Child mortality rate, all causes and specific preventable causes • Respiratory disease hospitalization rate for children • Number of sexual and non-sexual assaults against children under age 17 • Rate of child abuse and neglect • Percent of children (age 0-3) with normal growth and development • Percent of children who enter school &quot;ready to learn&quot; • Incidence of family violence and incidence of family violence witnessed by children</td>
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</table>
### Goal 2 (continued)

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
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</thead>
<tbody>
<tr>
<td>2 Improve and maintain the skills and personal characteristics British Columbians need to participate fully in the social, cultural and economic life of the province, through learning opportunities and supports to develop: • a sense of personal effectiveness, self-reliance and self-esteem; • skills for acquiring knowledge, thinking critically, solving problems, making informed decisions, communicating effectively, managing life events and coping with stress; • awareness of individual rights and a capacity to exercise personal responsibilities as members of society; and, • a commitment to life-long learning.</td>
<td>• School completion rate • Level of educational attainment • Adult literacy rate • Psychological well being scale • Rate of high chronic stress • Emotional distress measure • Self-esteem index</td>
<td></td>
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</tbody>
</table>
| 3 Improve and maintain the skills and capacities of British Columbians to find productive employment in a competitive labour market, including: • appropriate employment competencies for youth and young adults, developed within a flexible, accessible formal education system; and, • capacity of those in the workforce to adapt and respond to changes in skill requirements and labour market demands, through access to education and training opportunities throughout adult life. | • Unemployment rates for youth and older workers • Unemployment rate by level of educational attainment

*Indicators that could be developed:*
  - number of spaces/opportunities for older workers to retrain
  - number of employers providing opportunities for older workers to retrain and improve skills | | |
Goal 2 (continued)

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Examples of Indicators</th>
<th>Targets</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>4</td>
<td>Improve and maintain individual capacity and supports for making healthy lifestyle choices to enhance personal well-being and reduce health risks by: • increasing the percentage of British Columbians who do not smoke; • reducing the percentage of British Columbians who use alcohol or drugs inappropriately or excessively; • increasing the percentage of British Columbians who regularly participate in healthy physical activity; • increasing the percentage of British Columbians who have a healthy diet; • increasing the percentage of sexually active British Columbians who use appropriate contraception and safer sex practices; and, • increasing the percentage of British Columbians who use appropriate safety practices, such as safe driving habits, safe participation in sports, protection from over exposure to the sun.</td>
<td>• Smoking rate • Regular heavy drinking rate • Percent of population engaged in regular physical activity • Percent of students enrolled in physical education • Percent of population with healthy weight • Percent of calories consumed as fat • Driving after drinking rate • Bicycle helmet use rate • Percent of population with two or more sexual partners in past year • Teen pregnancy rate • Abortion rate</td>
<td></td>
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<tr>
<td>5</td>
<td>Increase or maintain the capacity for independent living of persons who require assistance with activities of daily living due to disabilities or limitations in their physical, mental, social or emotional functioning, including: • access to necessary supports and services, including recognition of and supports for family and other informal caregivers; and, • capacity to take responsibility for, or participate in, planning and managing personal supports and services.</td>
<td>• Percent of population with a disability, handicap or activity limitation due to an ongoing health problem • Percent of population with a disability (mobility, agility, seeing, hearing, speaking, other) • Percent of population living in long term care facilities, age 65+</td>
<td></td>
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</table>
Goal 3: A diverse and sustainable physical environment with clean, healthy and safe air, water and land.

Sustaining a healthy environment is essential to our long term physical survival and to our sustained social and economic well-being. As well, contamination of the physical environment can pose immediate threats to human health. Our challenge is to balance protection of the physical environment with the need for sustained economic activity, while protecting human health and respecting the interests of individuals and communities.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Examples of Indicators</th>
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</thead>
</table>
| 1 Improve and maintain air quality throughout British Columbia. | • PM10 (fine particulate) levels  
• PM10 emissions by source (e.g., industry, transportation, prescribed burning, wildfires)  
• Percent of municipalities with bylaws restricting smoking  
• Percent of schools, day care centres and health institutions with smoke-free policies  
• Percent of workers employed in smoke-free workplaces | | |
| 2 Improve and maintain the quality and safety of water throughout British Columbia. | • Number of boil-water advisories  
• Water Quality Index  
• Residential water use per person | | |
| 3 Improve and maintain a sustainable, safe and nutritious food supply for all British Columbians. | • Percent of food supply produced in BC  
• Total area of agricultural land reserve | | |
| 4 Improve and maintain the quality of land and soil across British Columbia. | • Percent of land base in protected areas  
• Per capita solid waste disposal rate | | |
| 5 Decrease damage to the global atmosphere. | • Greenhouse gas emissions  
• Thickness of ozone layer | | |
Goal 3 (continued)

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Examples of Indicators</th>
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</table>
| 6 Minimize the negative impact of human settlement and activity on the long term sustainability of natural ecosystems. | • Percent of native BC plant and animal species "red listed" (threatened, endangered, or candidates for such)  
• Percent of land base in protected areas  
• Resource consumption levels (e.g., fish stocks, forest land harvested and/or regenerated, fossil fuel consumption rates)  
• Ecological Footprint - total amount of land required to provide all material and energy used per capita for daily living (food, shelter, transport, consumer goods and services, disposal of wastes) |               |            |
Goal 4: An effective and efficient health service system that provides equitable access to appropriate services.

<table>
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<tr>
<th>Objectives</th>
<th>Examples of Indicators</th>
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</thead>
</table>
| 1          | **Universality** - Percent of population registered for health care insurance (overall, by region, and among special needs populations)  
**Accessibility** - Systematic variation in utilization rates by region/area and by type of service (e.g., hospitalization, home care, residential care)  
**Accessibility** - Percent of hospital cases treated within client's community/region of residence  
**Comprehensiveness** - Discrepancy between recommended availability of core services and actual service provision (overall level and trends, and by region/area) | Indicator(s) to be developed. Indicators could be developed on the following concepts:  
- deviation between actual annual funding to regions and allocations recommended by funding formula  
- changes resulting from ongoing review and revision of funding formula  
- expansion of the funding formula to include additional health services |
Goal 4 (continued)

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<thead>
<tr>
<th>Objectives</th>
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<th>Strategies</th>
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</table>
| 3 Improve access to services that have been proven cost-effective but not uniformly or consistently used, and decrease utilization of services, technologies and medications which the evidence indicates are inappropriate, ineffective or over-utilized. | - Utilization rates for cost effective services (child immunizations, mammography screening for women, age 50+)  
- Utilization rates for services that evidence indicates are ineffective, inappropriate or over-utilized  
- Number of deaths due to medically treatable diseases and adverse effects of drugs in therapeutic use  
- Hospitalization rates due to complications of care, misadventure during surgical/medical care or adverse effects of therapeutic drugs  
*Indicators that could be developed:*  
- use and results of quality assurance, practice guidelines, utilization management and performance monitoring methods  
- client satisfaction measures | | | |
Goal 5:  Improved health for Aboriginal peoples.

Aboriginal peoples experience very significant health status inequities that have occurred as part of the historical legacy of our province and country. This goal highlights the need for action to reduce these inequities, including changes to ensure greater self-determination for Aboriginal communities.

| Overall indicators for the goal:                       | • Life expectancy  
|                                                     | • Infant mortality  
|                                                     | • Age standardized mortality rates of Aboriginal (or Status Indian) peoples compared to total population of British Columbia |
| Socio-economic indicators                              | • Education levels  
| (Aboriginal peoples compared to general population):   | • Unemployment rate  
|                                                     | • Low Income  
|                                                     | • Lone parent families |

NOTE: Although considerable work toward developing objectives and indicators for this goal has occurred, more discussions are still needed. A process to finalize specific objectives and indicators must include the extensive involvement of Aboriginal peoples, and must complement the other processes and negotiations that are underway concerning Aboriginal health, First Nations self-government and other key issues. Therefore, no objectives or indicators are being presented at this time.
Goal 6: Reduction of preventable illness, injuries, disabilities and premature deaths.

A considerable number of our major health problems can be prevented through specific targeted interventions. This goal identifies achievable and measurable reductions in health problems that take a significant toll on the health of British Columbians, and for which effective prevention or early intervention strategies are available.

<table>
<thead>
<tr>
<th>Objectives</th>
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<tbody>
<tr>
<td>Reduce cardiovascular disease.</td>
</tr>
<tr>
<td>Reduce breast cancer, cervical cancer, lung cancer and melanoma skin cancer.</td>
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<tr>
<td>Reduce respiratory disease.</td>
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<tr>
<td>Reduce or maintain current very low levels of vaccine preventable disease.</td>
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<tr>
<td>Reduce cases of active tuberculosis.</td>
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<thead>
<tr>
<th>Examples of Indicators</th>
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<tbody>
<tr>
<td>• Mortality rate for cardiovascular disease</td>
</tr>
<tr>
<td>• Percent of population with risk factors for cardiovascular disease: high blood pressure, high blood cholesterol, current smokers, overweight, physical activity and amount of fat in diet</td>
</tr>
<tr>
<td>• Breast cancer, lung cancer and melanoma incidence and mortality rates</td>
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<tr>
<td>• Screening mammogram rates, women age 50+</td>
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<tr>
<td>• Cervical cancer screening, incidence and mortality rates</td>
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<tr>
<td>• Mortality and hospitalization rates for respiratory diseases</td>
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<tr>
<td>• Immunization rates for 2 year olds; school entry children; grade 6 children (hepatitis B); and adults, age 65+ (influenza and pneumonia)</td>
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<tr>
<td>• Number and rates of reported cases of vaccine-preventable diseases (e.g., measles, mumps)</td>
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<tr>
<td>• Number of haemophilus meningitis deaths, age 0-4</td>
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<tr>
<td>• Rates for active tuberculosis and drug resistant cases</td>
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Goal 6 (continued)

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<th>Examples of Indicators</th>
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<th>Strategies</th>
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<tr>
<td>6 Reduce HIV infection.</td>
<td>• Rate of AIDS cases, AIDS deaths and yearly rate of increase</td>
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<td></td>
<td>• Number of new positive HIV cases by risk category (injection drug users, men who have sex with men, other)</td>
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<td></td>
<td>• Percent of pregnant women screened for HIV</td>
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<td></td>
<td>• Number of HIV-infected children born</td>
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<td>7 Reduce sexually transmitted diseases.</td>
<td>• Reported rates of sexually transmitted diseases (chlamydia, gonorrhea and infectious syphilis)</td>
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<td></td>
<td>• Hospitalization rates for pelvic inflammatory disease</td>
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<td></td>
<td>• Ectopic pregnancy rate</td>
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<td>8 Reduce the incidence and impact of chronic disabling conditions</td>
<td>• Prevalence of chronic disabling conditions</td>
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<tr>
<td>9 Reduce unintentional injuries and premature deaths.</td>
<td>• Mortality and hospitalization rates due to unintentional injuries (transportation, fire, drowning and water-related, workplace, home and residential, and sports and recreation)</td>
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<td></td>
<td>• Potential years of life lost rate for unintentional injuries, age 0-75</td>
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<td>10 Reduce injuries and premature deaths from interpersonal violence and abuse.</td>
<td>• Mortality rate for homicide</td>
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<td></td>
<td>• Number of gun deaths</td>
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<td></td>
<td>• Percent of adolescents who carry weapons</td>
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<td></td>
<td>• Percent of adolescents who participate in physical fights</td>
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<td></td>
<td>• Percent of women ever experienced physical or sexual violence</td>
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<tr>
<td>Objectives</td>
<td>Examples of Indicators</td>
<td>Targets</td>
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<tr>
<td>11 Reduce deaths from use of illegal drugs.</td>
<td>• Number and rate of deaths due to illicit drug use&lt;br&gt;• Number of physicians prescribing methadone</td>
<td></td>
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<tr>
<td>12 Reduce water-borne and food-borne diseases.</td>
<td>• Reported number of cases of enteric (intestinal) diseases (e.g., E-coli, Campylobacteriosis, Hepatitis A)&lt;br&gt;• Number of water borne disease outbreaks</td>
<td></td>
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<tr>
<td>13 Reduce neural tube defects.</td>
<td>• Rate of congenital anomalies and neural tube defects</td>
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<tr>
<td>14 Reduce the negative impact of mental illness.</td>
<td>• Hospital admission/re-admission rates for mental illness&lt;br&gt;• Total units of housing available for persons with mental illness&lt;br&gt;• Prevalence of depression</td>
<td></td>
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</tr>
<tr>
<td>15 Reduce suicides.</td>
<td>• Mortality rates from suicide&lt;br&gt;• Percent of adolescents who ever considered suicide</td>
<td></td>
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<tr>
<td>16 Reduce the incidence and spread of infectious diseases, particularly emerging infectious diseases, through improved surveillance.</td>
<td>• Number of cases and rate of emerging infectious diseases such as Lyme disease, hepatitis C, malaria and hantavirus</td>
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</table>