Barely a day passes when the health minister doesn't announce progress on a particular "target" in some DHB somewhere in the country.

With six targets and 20 DHBs, there are multiple opportunities to report on progress, both the good and the bad, and the public impression gained is that of a health sector moving forward, under precise ministerial direction and control.

The Government claims "health targets provide a clear and specific focus for action to ensure that this health care is of the highest quality and within the best possible time, to improve quality and efficiency, in a tight fiscal environment." The Ministry of Health and the National Health Board are promoting these targets through the media as a matter of significant public interest, and providing information to assist the public see "how their DHB is performing". But do the current targets provide such assurance?

Consider an analogy from the Rugby World Cup - a "target" approach to winning the global championship would have the New Zealand coach Graham Henry focusing on a small number of discrete aspects of the game. For example, he may make the assumption that, if the line-out ball was thrown correctly, the half back's pass was faultless, and the high ball was cleanly caught, then the rest of the game would look after itself.

He would then report to the media on target performance - "Henry applauds 95 per cent of line-out balls correctly thrown" - and not on the result of the game.

Obviously, such targets would apply to only a handful of team members, missing the actions and contributions of those not reported on.

The assertion here, to use that old adage, is that the whole is greater than the sum of its parts. Winning the Rugby World Cup requires performance across the team, both in discrete skills and in the way all the skills work together to produce something greater. The same is true for the health sector.

The incumbent Government came into office with a "steady as she goes" policy message for the health sector. They picked up the focus on targets from the previous Government, redesigned those targets to be simpler and more publicly palatable, and positioned them much more strongly as "the" indicator of health system performance, rather than as "an" indicator of health system performance.

Significant changes were made to health sector targets in their scope, and also their importance, in guiding the overall health system. The minister of health dramatically
narrowed their scope and made a priority of the activities of hospitals. In doing so, he removed a focus on population health outcomes and completely removed from view any indicator of the major, but less publicly visible, parts of health sector activity - mental health and primary healthcare.

The change in scope of the target from "ambulatory sensitive hospitalisations" to "emergency department waiting times" illustrates this well. According to the minister of health, the old target, of "ambulatory sensitive admissions" which was introduced to monitor the performance of the primary care sector, was "a very difficult concept", while the new target focused on emergency departments was easier to understand being "more focused on the areas the public are more concerned about".3

THE OLD Reducing ambulatory sensitive (avoidable) hospital admissions: There will be a decline in admissions to hospital that are avoidable or preventable by primary healthcare for those aged zero to 74 years across all population groups.4

THE NEW Emergency department waiting times: Ninety five per cent of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours.1

Ambulatory sensitive hospitalisations are indeed complex but the outcome they refer to is not. It relates to a measure of the primary healthcare sector activity, and informs the question: is the primary healthcare sector doing all it can to prevent people ending up unnecessarily in hospital? In other words, it is a measure of the performance of the most cost-effective frontline of the health sector.

Emergency department waiting times are indeed simpler; they measure how long you will spend waiting in ED for treatment. This is useful information - important if you are running an ED department or a person waiting with a broken leg - but of marginal relevance to the work of the entire primary healthcare sector.

It also provides only a small window into the effectiveness and efficiency of the hospital-based A&E services, and little emphasis on what matters most - patient outcomes. Most would prefer a longer wait and less chance of a lifelong limp.

Achieving good outcomes for emergency care is a lot more complex than having a short waiting time. Elevating just one aspect of the care pathway to national importance has a role in addressing specific problem areas. However, over time, this solitary focus will run the risk of losing sight of what a service is trying to achieve. This tendency towards oversimplification has been taken to even greater extremes when we consider some of our major health challenges.

The Government's complete removal of the target on "improving nutrition, increasing physical activity, reducing obesity", illustrates further this dilemma between complexity and simplicity.
It was a difficult target to report on, in part because of the time frames it takes to achieving these goals, but also because they have not been wildly popular with the public who perceived it as the pointy end of the "nanny state".

It was also not popular with powerful private sector interests, such as the food and beverage marketing industry. And it was heavily branded by the previous Government, being seen as a "Labour Government" policy rather than a New Zealand government policy.

So, the removal of this target by the incoming government, with its greater emphasis on economic growth and a need to establish its own brand identity, was almost inevitable.

However, the underlying health problems remain. New Zealand's adult obesity rate is third only to the US and Mexico with 26.5 per cent of adults obese in 2007. Many commentators on New Zealand's health system, from Gareth Morgan to the OECD, argue obesity control should be a major plank of public health policy, both for the good of our health and the good of the economy. Removing the health system's explicit focus away from our biggest national emerging health and economic problem is a sad example of the triumph of short-term expediency over common sense.

The Government's removal of the mental health target is also instructive. Mental health is a leading and increasing cause of morbidity for New Zealanders. Mental illness, and the services to support them, have been the Cinderella of the New Zealand health system, holding none of the glamour of helicopter rescues and surgical procedures.

Mental health isn't inherently popular with the public, despite very constructive efforts by successive governments to change popular perception of people with mental illness, but it is a set of conditions that most people in the health sector are dealing with most of the time.

The vast combination of causes, treatments and interventions that make up a modern mental health service do not lend themselves to being described by a single indicator. However, its undervalued status, alongside its high burden, mean that governments do have a responsibility to ensure this aspect of health service provision is given the necessary support and prominence. Targets are an inadequate tool for doing this.

The core issue at stake here is our ability to accept the complex nature of health and health services. The recent past tells us disastrous health outcomes are in store for New Zealand's most vulnerable populations as a result of current rises in unemployment and decreasing investment in the social sector.

A health system that had the capacity to learn from this recent negative experience would be better equipped to avoid the health carnage that is being created in the current economic downturn. Focusing only on a discrete subset of skills won't win a rugby world cup for New Zealand - focusing only on discrete targets won't improve the health outcomes for all New Zealanders.
Creating targets has been popular across the political spectrum. They were first introduced by the Labour Government in the 1980s,\textsuperscript{11} and the current batch was introduced in 2007 on the advice of Treasury officials\textsuperscript{12,13} as a way of improving health system performance, modelled on the "success" of such an approach in the National Health Service in the UK.

However, at the same time as targets were being enthusiastically grasped on this side of the world, there was a growing body of international evidence they were not very effective in improving whole health system performance.

Things have since moved on as seen in a recent statement by the UK minister of state for health: "We will get rid of all politically motivated process targets, not backed by clinical evidence. We will focus on the outcomes that matter - those that support clinical results, not distort them. And, in place of endless, prescriptive top-down targets, we will support high quality care and services. A range of quality standards, prepared through NICE, will act both as a best practice guide for clinicians and as a means of holding them to account.\textsuperscript{14}

Targets do have their uses - this discussion is about their misuse as the major public face of health system performance, and not their use per se. It is totally appropriate for a health manager in a DHB to have a target for immunisation coverage for instance, or for the head of an ED to keep track on waiting times as part of the overall functioning of their department.

They also have symbolic value in demonstrating to the health sector that we now live in an age where it is possible to get real-time information about parts of system performance. And they have the advantage of apparent clarity, as easily understood targets are able to be followed by the public and the media.

The disadvantage is they have limited relevance to what the actual health system is doing as most health system activity is not covered by targets. This risks losing the focus on problems and approaches, which the system is required to address.

The Government, in its stewardship of health, needs to acknowledge human health is a complex business. Important health outcomes, such as health equity, can best be achieved by supporting the idea of a health system as a "complex adaptive system" rather than a linear integrated one.

The health system has highly trained professionals, able to respond to local contexts and solve problems. The system should support their autonomy, and their ability to solve problems effectively. It should be viewed more as a living organism, with a strong learning culture, and an ability to evolve and adapt.\textsuperscript{15}

An overemphasis on narrowly defined targets and micro-management at the national level does not foster such an environment.
The solutions to many of the health challenges we face in New Zealand are found outside of the health sector.

Changes to liquor laws, trade agreements impacting on drug costs, and health impacts from climate change all impact on health and health equity.

The New Zealand Health sector has the skills, knowledge and experience to forge a path forward in these uncertain times - but it needs leadership at all levels that can embrace the complexity of the challenge before it. As noted in a recent review of health equity in the UK: "The time is now ripe for a further step change which would reflect the need for a better way of handling complexity, jurisdictional boundaries and the mobilisation of the creative energies of staff right across the public policy system." A similar step change is required here in the New Zealand health sector if we are to meet the real challenges of our times.

References available under 'GP Resources' at www.nzdoctor.co.nz

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