6. Choosing performance indicators

Australia will need to know the results of the approaches implemented now and into the future. It will be essential to monitor progress at three levels:

- Health status and outcomes
- Determinants of health
- Health (and other) systems performance

Identification of progress needs a performance framework that shows:

- How well in the longer term we are achieving health status and outcomes (for example, deaths attributable to obesity and overweight, to tobacco and to alcohol)
- How well in the longer term we are addressing obesity, tobacco and alcohol in relation to the determinants of health (for example, measure the proportion of adults who are overweight or obese, daily smokers and at risk of long-term harm from alcohol)
- Whether there are improvements in Indigenous health status

These kinds of measures are affected by many factors, and changes cannot easily be attributed to specific programs. It can also take many years before an impact on personal behaviours and health outcomes is achieved.

To balance this longer term measurement with some short-term measures, indicators will also need to be set to measure *health and related systems performance*. These measures are more closely related to the specific priority interventions and in some cases will be most sensitive in the short term to their effective introduction (for example, public education campaigns).

Some interventions may be difficult to measure using current information systems (for example, alcohol outlet density) and will require the development of new systems.

The proposed performance indicators in each category are tabled below.

Table 6.1

Proposed performance indicators for priority interventions in the areas of tobacco, alcohol and obesity prevention

TIER 1. HEALTH OUTCOMES (ALL TO BE REPORTED BY INDIGENOUS STATUS)		
OBESITY	TOBACCO	ALCOHOL
Deaths attributable to overweight and obesity	Deaths attributable to tobacco	Deaths attributable to alcohol
Hospital separations attributable to overweight and obesity	Hospital separations attributable to tobacco	Hospital separations attributable to alcohol

TIER 2. DETERMINANTS OF HEALTH (ALL TO BE REPORTED BY INDIGENOUS STATUS)		
OBESITY	TOBACCO	ALCOHOL
Proportion of adults (18+ years) overweight or obese	Proportion of adults (18+ years) who are daily smokers	Proportion of adults (18+ yrs) at risk of long-term harm from alcohol
Proportion of children (12–17 years) overweight or obese	Proportion of children (12–17 years) who are daily smokers	Proportion of adults (18+ years) at risk of short-term harm from alcohol at least once per month
Proportion of adults (18+ years) eating sufficient daily serves of fruit and vegetables		Proportion of children (14–17 years) at risk of long-term harm from alcohol
Proportion of adults (18+ years) insufficiently physically active to obtain a health benefit		Proportion of children (14–17 years) at risk of short-term harm from alcohol at least once per month
Proportion of people walking, cycling or using public transport to travel to work or school		
Proportion of babies breastfed for six months or more		

TIER 3. HEALTH AND HEALTH-RELATED SYSTEM PERFORMANCE		
OBESITY	TOBACCO	ALCOHOL
Recall of public education and social marketing campaigns promoting healthy eating and physical activity	Recall of public education and social marketing campaigns promoting quitting and discouraging smoking uptake	Recall of public education and social marketing campaigns promoting safe alcohol use
Number of advertisements for energy-dense, nutrient-poor food during children's television viewing times	Price of cigarettes	Taxation incentives for the production and consumption of low-alcohol products
Food price disparity in rural and remote areas	Proportion of tobacco outlets selling to children	Alcohol outlet density by city/town/region
Number and proportion of state and municipal plans that include steps to tackle obesity (improve public transport, build cycle paths and footpaths, protect open spaces)	Number and proportion of retailers breaching tobacco-related legislation	Legislation to restrict the promotion of alcohol

TIER 3. HEALTH AND HEALTH-RELATED SYSTEM PERFORMANCE		
OBESITY	**TOBACCO**	**ALCOHOL**
Number and proportion of schools with comprehensive programs in place that support healthy eating and physical activity	Legislation to prohibit all remaining forms of promotion of tobacco	Systems and practices to proactively police licensed venues, events and harms
Number and proportion of workplaces (with over 50 staff) that have comprehensive programs in place that support healthy eating and physical activity	Best-practice legislation relating to tobacco marketing, licensing and sales to children	Proportion of people at risk of short- or long-term harm from alcohol receiving brief interventions in primary healthcare settings
Number of overweight or obese people receiving brief interventions in primary healthcare settings	Proportion of current teenage smokers who reported that they had personally purchased their most recent cigarette	Expenditure on research and evaluation relating to alcohol control for Indigenous communities and other disadvantaged populations
Per capita coverage of a relevant allied health workforce (for example, public health nutritionists and health promotion practitioners) by state and region	Proportion of current smokers receiving brief interventions in primary healthcare settings	
Expenditure on research and evaluation relating to controlling overweight and obesity in Indigenous communities and other disadvantaged populations	Expenditure on research and evaluation relating to tobacco control for Indigenous communities and other disadvantaged populations	

ENABLING INFRASTRUCTURE

- Use of data generated from surveillance system focused on the behavioural, environmental and biomedical risk factors for chronic disease
- Number of staff working in appropriate public health activities
- Places for community-based training for primary healthcare (and other) workforce
- Expenditure on research and development of targeted social marketing and public education efforts and to coordinate national media advertising with local program delivery
- Uptake of Medicare Benefits Schedule prevention benefit item
- Expenditure on prevention research, including understanding of social determinants of health behaviour, modelling of health impact of policy options and evaluation of programs
- Satisfaction of health and other groups (including community organisations, private sector, and other interests) with engagement with government health agencies

6.2 Monitoring the indicators

Health outcomes indicators can be monitored using existing data collections. In most cases these indicators are already routinely reported by the Australian Institute of Health and Welfare in *Australia's Health* and related reports. Mortality and hospital separations attributable to overweight and obesity are exceptions; however, the data needed to estimate these are readily available.

Determinants of health can be monitored using existing data collections. Measured data on height and weight for adults and children were collected in the 2007–08 *National Health Survey* and the 2007 national *Kids Eat, Kids Play* survey. Data relating to active transport are less readily available. *The National Health Survey* collects data only on whether people walked for transport; however, state-based telephone surveys have collected more detailed information on mode of transport to work and school.

The addition of five-yearly national health studies would enhance our monitoring of prevention polices, activities and outcomes.

6.3 Setting targets

Detailed work will be required in order to set targets for our proposed indicators. Targets should be set for the indicators in all three tiers. However, if, under the Council of Australian Governments (COAG) system, payments are to be tied to performance against targets, we suggest that indicators for this purpose be selected from the health and related systems performance tier. More work would be needed to refine many of the indicators in this tier for this purpose.

In many cases, targets would need to be state or territory specific, recognising differences in the current population prevalence of health risk factors, population profiles (for example, socio-economic status, Indigenous population) and the challenges in introducing interventions in different settings (urban/rural/remote).

6.4 Governance and performance monitoring

COAG is currently developing a system of National Partnership Payments (NPPs) aimed at providing incentive payments to states and territories for reforms, or for specific and agreed joint projects, within a new performance and assessment framework. To receive funding, states and territories must deliver 'nationally significant economic and social reforms'. Payments are structured, with a fixed duration, and offer up-front facilitative/reward payments for achievement against performance benchmarks.

There are many different ways in which funding incentives can be provided. Examples of pay-for-performance incentives exist in the personal healthcare area in Australia, as well as internationally.

Incentives can be tied to global performance or to specific service items. Both rewards and penalties have been incorporated into previous Medicare agreements for hospital funding, and experience suggests that a punitive system has high transactional costs and does not encourage a transparent and collaborative approach.

A simple approach is to have a quantum of funds that is 'at risk' for each state and tied to the achievement of targets in that state. For example, incentive payments could be provided for against reaching a target of reduction in smoking prevalence in the state.

A more competitive approach is to have a pool of funds with states receiving funds proportional to their performance towards joint health outcomes. For example, the additional funding available to a jurisdiction would be dependent on the reduction in smoking in that state relative to the national reduction in smoking prevalence.

Incentive payment systems, particularly those based on health outcomes, have several inherent risks:

- Difficulties in attributing change to specific state reform efforts, given the need for joint action leading to joint outcomes.
- Inconsistencies that arise where there are inadequate or incomparable data collection systems, which either under-report or over-report.
- Overemphasis placed on particular actions to the exclusion of other important health concerns distorts the focus of work.
- Higher rewards for those who start with more resources or relatively easier tasks compared to those with more complex tasks and fewer funds.
- Slow rates of change in health indicators, along with the many socio-economic determinants that can influence health outcomes.

The payment system will need to be underpinned by:

- A sound monitoring system – including both the adequacy of data and indicators, and an appropriate process of review
- Agreement about the appropriate points in time for assessment
- Mechanisms for stimulating improvements should performance be disappointing

Given that the data systems related to prevention activities need further development, a phased approach may be necessary, with indicators modified or incorporated as the NPP system evolves.

6.5 The monitoring system

A good monitoring system is essential for preventative health reform to work and to ensure that Commonwealth, state and territory activity is regularly reviewed. It can also play a critical role to assist learning, as well as assessing performance. In addition, beyond the compilation of data, there are several important principles:

RELEVANCE

- Link with governance processes including other reporting and monitoring systems
- Link with and contribute to health program improvement
- Analyse and interpret to address key policy concerns and potential for action

DATA COLLECTION

- Build on existing systems for data collection (including surveys and administrative data)
- Work on improving specificity of national reporting and harmonisation of jurisdictional data systems (through common data definitions and standards)
- Build on indicators proposed through key international consensus and reporting frameworks, using proxy indicators when collecting additional data is not feasible
- Have a designated national focal point, located within an appropriate setting, with accountability for data collection and dissemination

REPORTING

- Have a regular reporting time frame
- Offer sufficient specificity (including location, sex, ethnicity, age and socio economic status)
- Provide quantitative and qualitative indicators and analyses, which ensure that local contexts are explicitly taken into account in the reporting system
- Enable analysis and reporting of trend data on core sets of indicators
- Enable analysis and reporting by appropriate groupings involving a similar population mix for comparative assessment (75)
- Have a manageable set of core indicators nationally but also develop optional modules that allow for harmonisation and comparison across similar communities or regions

- Have an accessible, appealing and user-friendly reporting style that engages and is useful to stakeholders
- Provide annual reporting against the proposed National Preventative Health Strategy
- Provide regular public reports on progress

CAPACITY BUILDING

- Capacity building mechanisms and processes in place to train and support an enhanced understanding of meaning and action potential of the key performance indicators
- Capacity building at regional and local levels
- Create a continuing social process for accountability by developing mechanisms to bring together key stakeholders at both national and global levels to review and discuss action requirements arising from leading health indicators

QUESTION

- Are these measurements appropriate? If not, what would you propose?