A brighter future—measuring how we are tracking with the National Strategic Framework

Linda Proietti-Wilson, Kim Atkins

Service Planning and Design Unit, Department of Health and Human Services, Tasmania

In 2011–12 the Rural Health Standing Committee of AHMAC published the National Strategic Framework for Rural and Remote Health. This is a national policy with a vision that ‘people in rural and remote Australia will be as healthy as other Australians’. This vision expresses our collective aspirations towards humanity and focuses attention on the need to address health inequities experienced by people living in rural and remote areas. This is important because health inequities are seen to contribute to generally poorer health outcomes in rural and remote areas as evidenced by a range of objective measures including lower life expectancy, higher mortality rates, higher prevalence of mental health problems and higher deaths from chronic disease, to name a few.

The Framework has five strategic goals focused on:

1. Access: Improved access to appropriate and comprehensive health care for people living in rural and remote areas
2. Service models and models of care: Improved effectiveness, appropriateness and sustainability of health care in rural and remote areas
3. Health Workforce: Improve the level of appropriately skilled and supported health workforce in rural and remote areas
4. Collaboration, Partnerships and Planning: Promote collaborative health service planning and policy development in rural and remote areas
5. Governance: Promote strong leadership, governance, transparency and accountability for rural and remote health services.

The Framework is not intended to be prescriptive, rather it is intended to guide the effort and investment that goes into service planning and delivery in rural and remote areas and it can be used by governments, health service providers, communities, advocacy groups and members of the public.

In addition to the Framework, the Rural Health Standing Committee felt that a reporting tool was needed to monitor progress against the implementation of the framework. This paper outlines the process used to develop a draft reporting tool for the committee to consider, and highlights lessons learned along the way.

Our task was to work with jurisdictional representatives to develop an agreed road map towards achievement of the framework’s objectives, an appropriate set of quantitative and qualitative measures underpinned by reporting criteria and an agreed set of principles to underpin the indicators.

Two constraints on the development of the reporting set were that we were not to introduce new reporting indicators or duplicate existing reporting, and we were not to significantly increase the burden of reporting.

Finally, we had to ensure a core set of indicators that would be used by all jurisdictions.
Our first step was to understand the conceptual and quality issues in relation to performance indicators per se in order to ensure that our process was robust from the outset. To that end we

- did a lot of consulting with data analysts within our own Department, National Rural Health Alliance, COAG Reform Council, and Australian Bureau of Statistics staff
- reviewed the published literature
- undertook training.

What we found was that there was no single approach that could be applied to our task because rural and remote health services and service systems across Australia is a complex and fragmented group of entities with different characters, resources, and priorities. Not having a unified system, as such, we couldn’t isolate separate functions of that system and measure their performance (as for standard key performance indicators). Rather, we needed to focus on progress indicators.

To this end we studied:

- the relevant health plans from each of the jurisdictions and the Commonwealth
- the relevant Agreements between the Commonwealth and the jurisdictions and the reporting requirements they entailed
- the existing data publications

which included:

- National Health Care Agreement 2012
- National Indigenous Reform Agreement 2011
- National Health Information Agreement 2011
- Intergovernmental Agreement on Federal Financial Relations 2009
- Aboriginal and Torres Strait Islander Health Performance Framework
- National Health Performance Framework
- various National Partnership Agreements
- COAG Reform Council reports
- reports of government services.

All of this helped us ensure that whatever we produced was consistent with what jurisdictions were planning to implement or were, in fact, implementing, and dovetailed with their existing reporting requirements.

In the end we managed to stick close to a standard ‘input-output-outcomes’ model typically used to measure performance (refer Diagram 1)
The approach that we began with assumed that we could measure the activities that the jurisdictions were undertaking toward each goal of the Framework. However, in focusing simply on what jurisdictions were doing (which were essentially inputs), we were losing sight of the aspirational outcomes of the Framework, which were about better health for people in rural and remote Australia. So, we did a rethink and decided to look at the world from the perspective of the gap between urban and rural/remote health outcomes, since these gaps are the central driving force behind the Framework as a national policy document. That was a decisive move.

Because health outcomes have social determinants, we knew that we couldn’t directly demonstrate the effect of jurisdiction’s activities on health outcomes, but we could try to show their effects the gap.

We went to the Framework and pulled out the key health issues occupying the gap, and we looked for current nationally mandated reporting associated with those conditions. From this analysis we proposed a set of quantitative indicators (which forms one part of the reporting system):

- higher infant/child mortality
- lower life expectancy
- high rates of obesity
- high rates of diabetes
- high rates of mental health problems
- high rates of smoking
- high rates of alcohol consumption
- high rates of low birth weight babies
- high reported rates of high blood pressure
- high injury rates.

In addition, a consistent theme had emerged throughout our discussions and from the literature review and that is the proposition that “You get what you measure”. Therefore, in order to bring about real change, we recognised the need to be measuring—and reporting—what we wanted to get, namely, how...
jurisdictional activity can affect the disparity between the health of people living in urban areas and those in rural and remote areas.

So we set about aligning the jurisdictions’ activities with the ‘health gap’ indicators, and we came up with a two part reporting system, that is a simple tool, and we think will work for everyone (refer Diagram 2).

**Diagram 2** Reporting kit

**PART 1—SELF-ASSESSMENT**

<table>
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<th></th>
<th>Complete</th>
<th>On track</th>
<th>Progressing with issues</th>
<th>Not started</th>
<th>Comments</th>
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<tbody>
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<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; activity 2 addressing outcome area&gt;</td>
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**PART 2—HEALTH STATUS DATA**

<table>
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<th>RA 2-3</th>
<th>RA 4-5</th>
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The first part contains a narrative self-assessment about activities, accompanied by very simple evaluative criteria for progress (complete/on track/progressing with issues/not started).

The second part contains a core set of high level indicators for health status and health service performance disaggregated by remoteness.

Although we can’t demonstrate direct causality between jurisdictional initiatives and health status—not least because health status has multiple social determinants—we can show an indirect relation by having a structure in which each part contextualises the other. This also made the process robust at two levels:

1. by using tested and appropriate core quantitative indicators, and
2. by making self-assessment ‘answerable’ to those indicators.

In this structure, self-assessment plays an explanatory role in relation to the (changing) health status data of the relevant populations; and the objective data testifies to the claims of the self-assessments. Each contextualises and makes meaningful the interpretation of the other (this is a sophisticated kind of gestalt model).1

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1 It is important to note that the objectivity of quantitative data is never absolute. Quantifying data may appear to be a value-free technical exercise, but it necessarily conceals a whole range of subjective decisions that present situations in certain limited ways (e.g., via subjective choices about inclusion and exclusion criteria and decisions about where and how to collect data). So while quantitative data strives for objectivity, objectivity itself is only an ideal, a certain construction of reality, which ultimately, needs to be understood through an act of interpretation. By framing the quantitative data with the self-assessments we actually get better information, not worse.
Each form a distinct part of the whole picture of a populations’ health status, but the whole picture relies on thinking these two parts together (refer Diagram 3).

Diagram 3  Gestalt Model

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In our efforts to find the appropriate indicators, we undertook a very careful examination of Australia’s existing data collection and reporting activities, and set about mapping the complex maze of data pathways. Overall, we have found that there is a still-evolving system of data collections and reporting functions within jurisdictions and between jurisdictions and the Commonwealth. And there is clear commitment across governments to address a range of data quality issues, notably the need to improve the quality of data by disaggregation by remoteness/SES/Indigeneity.¹

This will require cooperation between the jurisdictions and the Commonwealth and between the different agencies and service providers within the jurisdictions—everyone has a role to play.

We recognise that there are quality issues with data. For example, some population groups are small. A difficulty with some of our core indicators is that they are not reported every year. Some, such as smoking rates, high blood pressure and rates of alcohol consumption are collected every three years. However, three years is probably a realistic time-frame in which to expect to see the effects of jurisdictional initiatives (this approach is validated by SMART criteria²).

Three lessons we have learned along the way in relation to health performance reporting are:

- you get what you report
- don’t be immobilised by perceived barriers
- we all have a role to play.

So we can look forward to better data, and that is good news because, following the principle that “you get what you measure”, reported data plays a fundamental role in determining what rural and remote Australia does and does not “get”. Therefore, the availability and quality of the data used for reporting health of rural and remote Australia is fundamental to achieving improved health services and health status in those areas.

And that is what we are all aiming at.

¹ For example, National Healthcare Agreement 2012 Social Inclusion and Indigenous Health outcome. This outcome states that: “All performance indicators, where it is possible, and appropriate to do so, to be disaggregated by Indigenous status, disability status, remoteness area and socio-economic status to assess whether these social inclusion groups achieve comparable health outcomes and service delivery outcomes to the broader population.” (A-5)

² SMART criteria - Specific, Measureable, Accountable, Results-Orientated, Time-bound

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**Recommendation**
That the state, Northern Territory and Commonwealth governments adopt an agreed set of indicators to monitor progress towards reducing the gap between urban and rural/remote health outcomes.

**References**


**Bibliography**


