

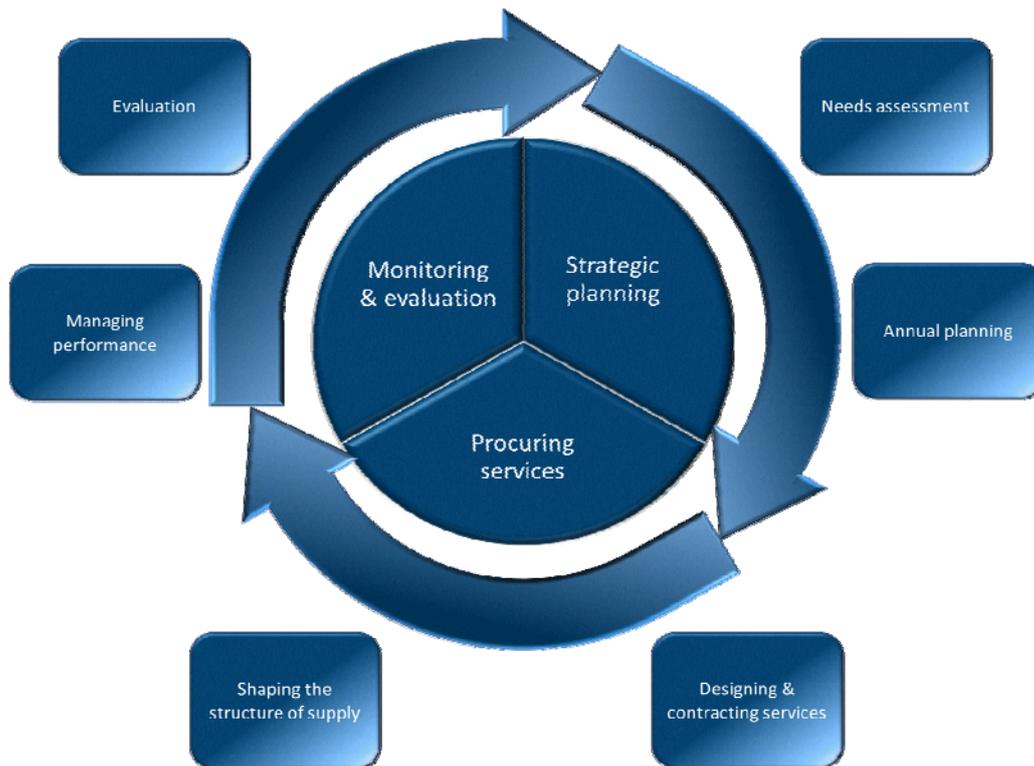


Australian Government
Department of Health

phn
COMMISSIONING

An Australian Government Initiative

Needs assessment guide



December 2015

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Note

This guide does not override the requirements set out in the PHN Funding Agreement.

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1. THE PHN COMMISSIONING FRAMEWORK

Primary Health Networks (PHNs) were established in July 2015, with the objectives of:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

The PHN Guidelines state that:

PHNs will work towards achieving these objectives on the basis of an understanding of the health care needs of their communities through analysis and planning. They will do this through knowing what services are available and help to identify and address service gaps where needed, including in rural and remote areas, while getting value for money.¹

Figure 1. The PHN Commissioning Framework



Figure 1 depicts the PHN Commissioning Framework. There are three phases in the cycle – strategic planning, procuring services, and monitoring and evaluation.²

This commissioning framework has been developed so that PHNs can ensure that their commissioning approach is consistent with the approach adopted for the programme as a whole and that the process results in consistent, comparable and measurable outputs and outcomes.

It is important to keep in mind that commissioning is a holistic approach to enable PHNs to work as strategic organisations at the system level. It is not merely a process. It is expected that PHNs may well be engaged in different parts of the cycle throughout the year (such as monitoring contracts). While PHNs are required to undertake a review and update of the needs assessment annually, in practice the needs assessment should be under continual review as new information, data and experience become available.

Commissioning

‘Commissioning’ is a continual and iterative cycle involving the development and implementation of services based on planning, procurement, monitoring, and evaluation. While a commissioning approach is used in a number of sectors other than health care it has been a key feature of the health system in the United Kingdom since the 1990s and is also a feature of health systems in New Zealand and the United States of America. Commissioning describes a broad set of linked activities, including needs assessment, priority setting, procurement through contracts, monitoring of service delivery, and review and evaluation.

A key characteristic of commissioning is that procuring or purchasing decisions occur within a broader conceptual framework. The difference between purchasing and commissioning in the health care context has been described as follows:

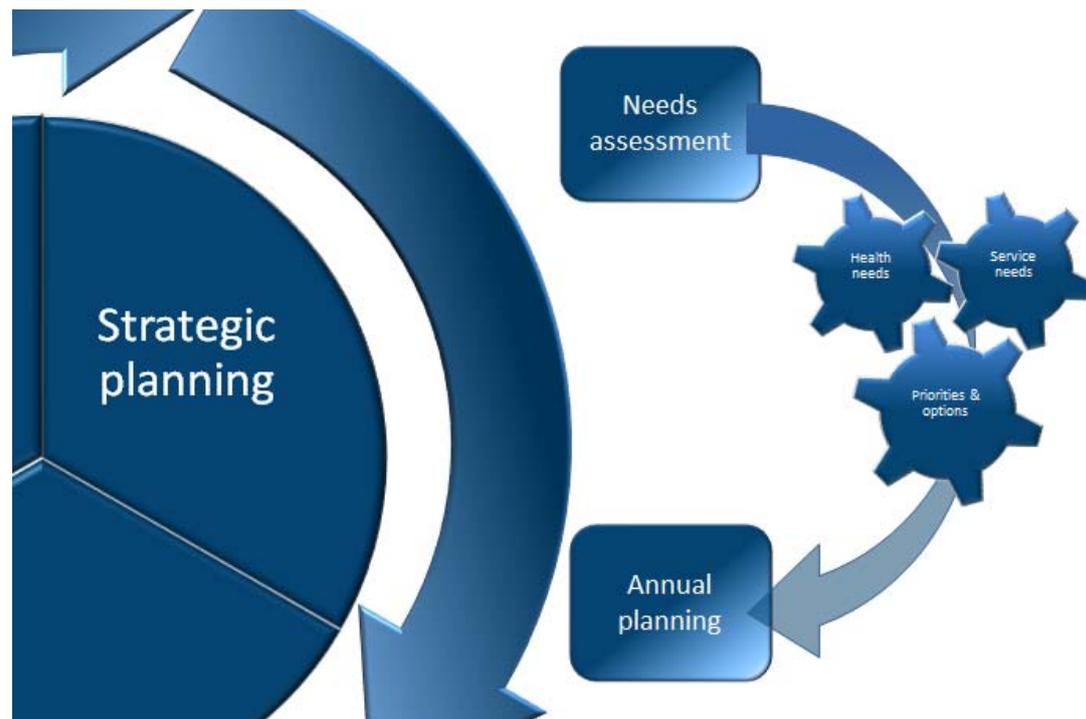
Commissioning is a term used most in the UK context and tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A *commissioner* decides which services or healthcare interventions should be provided, who should provide them and how they should be paid for, and may work closely with the provider in implementing changes. A *purchaser* buys what is on offer or reimburses the provider on the basis of usage.³

As the health systems are different, PHN commissioning will of course differ from the experiences of other countries. However, the fundamental elements remain valid in the Australian context.

The Strategic Planning phase

Strategic planning is the first phase in the PHN Commissioning Framework. It consists of two stages – undertaking a needs assessment in order to identify and prioritise opportunities for activity, followed by the development of annual plans. The two components are closely linked, but distinct. Annual plans will be informed by factors other than the needs assessment such as cost, capacity and timing.

Figure 2. The Strategic Planning phase



Undertaking an analysis and assessment of the health and service needs of people in the PHN region enables the PHN to identify opportunities and set priorities for planning. These plans in turn shape the activities which enable it to achieve the PHN objectives.⁴

2. NEEDS ASSESSMENT

A Needs assessment is:

a systematic method of identifying unmet health and healthcare needs of a population and making changes to meet these unmet needs. It involves an epidemiological and qualitative approach to determining priorities which incorporates clinical and cost effectiveness and patients' perspectives. This approach must balance clinical, ethical, and economic considerations of need—that is, what should be done, what can be done, and what can be afforded.⁵

Undertaking a needs assessment provides the PHN with the opportunity to engage with Local Hospital Networks (or equivalents) and other key planning and funding agencies in order to ensure alignment of effort and investment. This involves the identification and analysis of key data and other forms of information.

Opportunities for community empowerment will also begin in the needs assessment stage. Consulting communities is a key method for understanding factors which affect their health and quality of life, and is a means of recognising the needs of disadvantaged groups which may not be represented in routine statistical collections.⁶ While a range of engagement approaches will need to be considered, Community Advisory Committees and Clinical Councils must play key roles in the development of the needs analysis.

As commissioning is ongoing and iterative, the needs assessments of future years will themselves be informed by the experience of previous years and by the learnings gained from the experience of monitoring and evaluating previous activities and investment.

Needs assessments should use existing data and evidence where possible and not duplicate the efforts of others, particularly Local Hospital Networks (or equivalents). Needs assessments should also:

- analyse relevant and current local and national health data including, but not limited to, data collected by Local Hospital Networks (or equivalent);
- review health service needs and available service provision in the region;
- identify health services priorities based on an in-depth understanding of the health care needs of the communities within the PHN region; and
- be informed by clinical and community consultation and market analysis.

The needs assessment will contribute to the development and implementation of an evidence-based Annual Plan to address national and PHN specific priorities relating to patient needs and service availability and gaps in the PHN region.

While it is important for the needs assessment to be systematic this does not mean it attempts to cover the entire scope of primary health care. The PHN needs assessment should focus on:

- the PHN objective of efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes;
- the PHN objective of opportunities to improve coordination; and
- the six key priorities for targeted work: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

PHNs should ensure that attention is given to the health needs of Indigenous Australians, recognising the commitment of all parties to Closing the Gap.

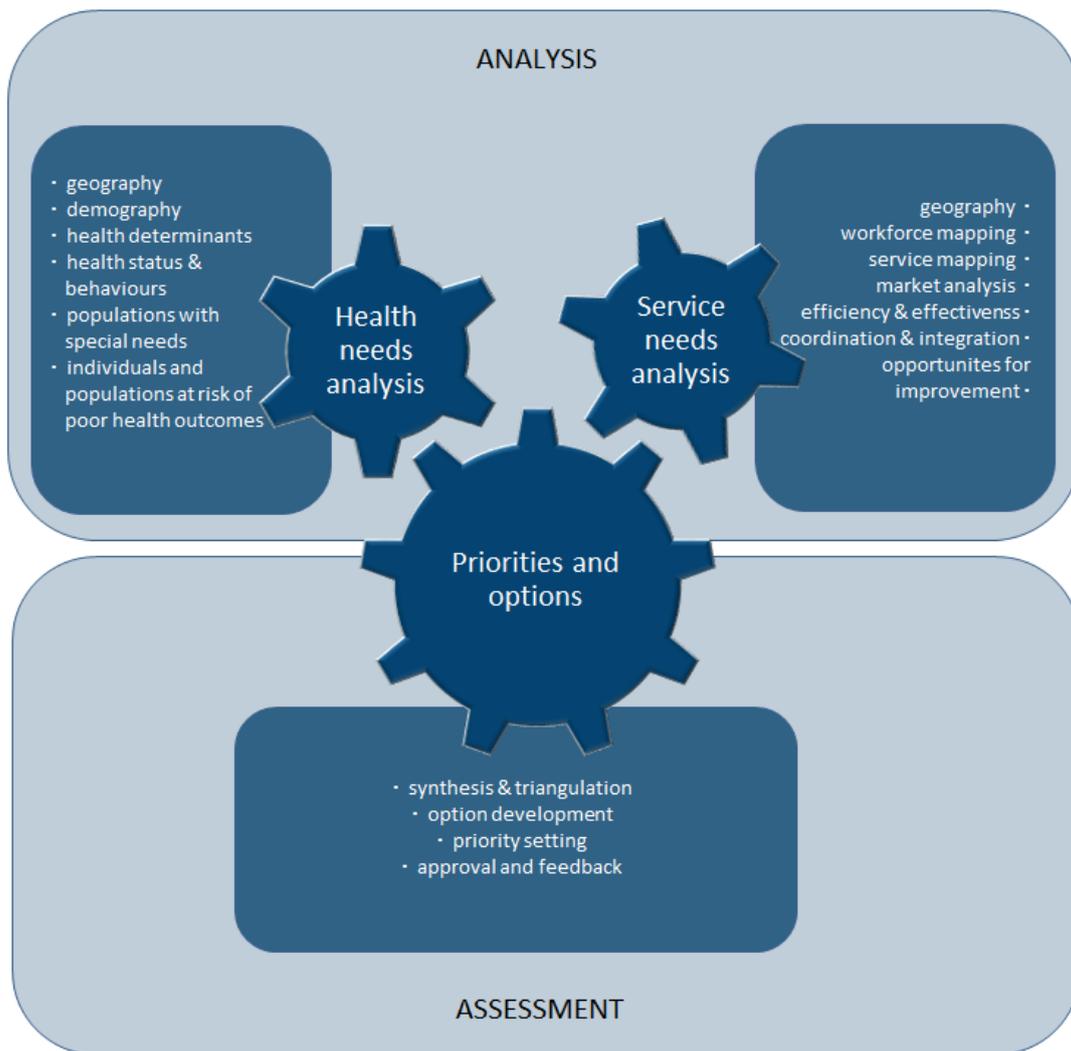
Structure

The PHN needs assessment consists of two parts: analysis and assessment (Figure 3).

The main paradigm for the first part is *analysis* – the examination and documentation of health needs and service needs within the region. The analysis of health needs and the service analysis are shown as separate. While health needs and service needs are interlinked, it is important to consider each independently in the first instance. This does not mean to suggest ignoring the very real relationships between health needs and the nature and capacity of health services, as of course the nature of service provision (or lack of) can impact on health status. Equally, the region's demography also shapes, over time, the distribution of services. It is expected that these two work streams will be undertaken concurrently and for each to inform the other. Putting these two perspectives together is largely undertaken in the *assessment* part.

The main paradigm for the second part is *assessment* – where the PHN exercises a level of judgement about relative priorities, considers a number of alternative options and makes sometimes quite difficult decisions. It is important to remember that the needs assessment is not a plan. The needs assessment concludes with the identification of opportunities, priorities and options. Proposals for how these are acted upon – which may be through direct investment in purchasing services or by other means – are part of the subsequent planning stage.

Figure 3. Structure of the needs assessment



In both *analysis* and *assessment* the focus moves progressively from the general to the specific. In the health and services needs analysis it is expected that the PHN will move from a general analysis of – for example – population or workforce distribution across the entire region and towards a focus on particular groups, locations or service types that appear to be emerging as potential priorities. A similar narrowing of focus will characterise the assessment, as the PHN moves to a position where it can identify opportunities, priorities and options.

Approach

Two broad kinds of information will be sourced throughout the needs assessment. The first is information and data (both qualitative and quantitative) from a wide range of sources. The second is from consultations with communities, health professionals and other stakeholders.

Data and other sources of information

The Department of Health (the department) will consult with PHNs and other stakeholders about data needs in general, and what might be provided through a national website. It is also expected that through undertaking a baseline needs assessment PHNs will identify and further clarify data needs, with a particular focus on the six key priority areas for targeted work.

It is recognised that each PHN will have differing and sometimes unique sources of information available to them, which may be in a variety of forms and in some cases subject to restrictions on its use. As a result, there is no requirement for PHNs to develop a standardised population health profile or description of the nature of the health system or health service provision in the PHN.

PHNs can use information from the previous Medicare Locals, including the Comprehensive Needs Analyses, data and other information available through corporate knowledge and stakeholder networks. Potential data sources should be evaluated against standard measures of quality, such as the ABS Data Quality Framework.⁷

A number of data sources may be useful for both health needs analysis and service needs analysis. For the baseline needs assessment it is expected that the PHN will make use of a wide range of sources, including but not limited to the following:

- Australian Bureau of Statistics (ABS) Census and Census-derived data on demographics, including the Socio Economic Indices for Areas (SEIFA) and profiles of health including the National Health Survey, the National Nutrition and Physical Activity Survey and the National Health Measures Survey, the National Aboriginal and Torres Strait Islander Health Survey, the National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey, and the National Aboriginal and Torres Strait Islander Health Measures Survey
- a range of Australian Institute of Health and Welfare (AIHW) and National Health Performance Authority (NHPA) datasets and publications, including the METeOR metadata registry
- Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and Practice Incentives Programme (PIP) data
- aged care data (both residential and community based) such as Commonwealth Home Support Programme, or Department of Veterans Affairs (DVA) data
- mental health data such as the Access to Allied Psychological Services (ATAPS) data collection

- information on Indigenous data from a range of sources
- the Australian Childhood Immunisation Register
- the National Notifiable Diseases Surveillance System
- resources from the Royal Australian College of General Practitioners (RACGP)
- data from practices through clinical audit tools, and the Bettering the Evaluation and Care of Health (BEACH) data
- health workforce data
- State and Territory Health Department data
- data from Local Hospital Networks or equivalents (including individual acute and community care services)
- Local Government data
- information on the PHCRIS website
- information on the PHIDU website, such as the Social Health Atlas of Australia
- National Health Services Directory (NHSD) and Healthdirect
- there are also some mapping tools that may be useful to PHNs.⁸

Other sources of information that may inform needs assessment are being considered in the development of the PHN Performance Framework, during which the department will consult with PHNs and other stakeholders. The Performance Framework will encompass three tiers of performance. The *national tier* will centre on a small set of headline indicators to assess performance against health outcomes. The *local tier* will assess performance using local performance indicators selected by PHNs through formal planning processes. The *organisational tier* will focus on compliance with contractual arrangements in key areas of establishment, operations and activity.⁹

There are a number of other sources of information that PHNs can use in structuring their thinking about the needs assessment. Many of these are frameworks that have been developed to classify and organise data and indicators about health status, service delivery and opportunities for quality improvement.¹⁰ Information on overall health performance frameworks and reporting is provided in the publication by the Australian Institute of Health Innovation, *Performance indicators used internationally to report publicly on healthcare organisations and local health systems*.¹¹

Consultation

Different approaches may be necessary for PHNs to tailor their consultation to specific regional characteristics and community needs. Whatever the approach, PHNs should ensure:

- a systematic approach is in place for identifying target groups and stakeholders, particularly those in the six key priority areas for targeted work, and determining consultation methodologies;

- consultation and engagement is undertaken in a structured and informed manner;
- targeted processes are used as necessary to gather the views of vulnerable or hard to reach population groups and to engage with specific groups, including Indigenous Australians;
- robust processes exist to capture, analyse and synthesise information gained from consultations; and
- mechanisms are in place to provide feedback on the consultations to both participants and communities more generally.

Consultation occurs throughout the needs assessment. While it is expected that the bulk of consultation will occur as PHNs undertake the health and service needs analyses, it is also an important element in the final stage of assessing and prioritising need.¹²

Consultations with communities

Consultation with the community can provide qualitative insights into the health needs of the population that cannot be elicited from data alone. Community consultation is essential in order to obtain information about the perceived needs of local communities and individuals, insight into the experiences of patients, consumers and carers, and their perspectives on how primary health care should be improved and where it is already working well.

Consultations can help identify barriers to positive health and wellbeing, ascertain how satisfied the local community is with existing health service provision and identify which health service provision could be improved to better meet their needs.

Consultation needs to gather both general views and the views of vulnerable or hard to reach population groups and those with specific health issues and support needs, which may be limited by health literacy, perceptions or knowledge of what options are available. PHNs should also recognise cultural diversity within their region and design appropriate consultative approaches. Community Advisory Committees are central to any community consultation.

Consultations with health professionals, providers, funders and other stakeholders

The perspectives of health professionals, providers, funders and other stakeholders can differ from community and consumer views, and are equally important in informing the needs assessment. Consultation with these stakeholders is necessary to obtain their perspectives and advice on health and service issues and needs.

Clinical Councils are central to the consultation process, including in the identification of key stakeholders and possible consultation mechanisms. Consulting with these stakeholders will provide an important perspective in areas such as:

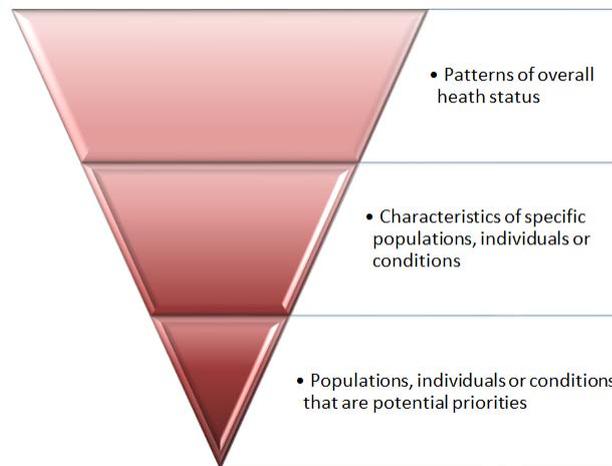
- the incidence and prevalence of health conditions and disease trends, including issues that influence health outcomes at the local level;

- workforce needs including capacity building and quality improvement, size, distribution and discipline mix, including issues and barriers at the local level;
- the efficiency and effectiveness of current service delivery models and opportunities for improvement;
- coordination and linkages between services and opportunities for improvement;
- the spread of services across the spectrum of prevention, diagnosis, early intervention, treatment, rehabilitation and continuing care; and
- vulnerable groups and barriers to access.

3. ANALYSIS

Health needs analysis

Figure 4. Health needs analysis



The intention of the health needs analysis is to ensure the PHN has an understanding of the health status and needs of individuals, populations and communities relevant to its role within both the health system and the broader environment.

The health needs analysis will need to make use of a range of demographic and epidemiological data, alongside structured consultations. It will also require some consideration of the wider social and economic determinants of health.

Figure 4 illustrates how the PHN moves through the various steps that make up this stage. The focus will progressively narrow towards an identification of people, populations or conditions that are likely to be priorities for the PHN.

The elements required to undertake a health needs analysis are discussed below. This is so that PHNs can ensure they cover all expected elements and in doing so progressively move towards identifying key priorities. In practice, many of these elements are inter-related or overlapping and the overall process will be iterative.

Geography

The Australian Statistical Geography Standard (ASGS) should form the basis of sub-regions the PHN develops for the purposes of demographic analysis, using the SA 3 level as the building block. Demographic data should be analysed at the SA 2 level where possible. The ASGS also includes the Indigenous Urban Centres and Localities and the Remoteness Area classifications. Depending on the data, there may be reasons for also using LHN subdivisions or Local Government Areas. Use of classifications such as postcodes and electorates is generally discouraged.

Demography

Key demographic data will also be derived from the ABS Census or Estimates of Resident Population. Information on population trends can be significant, and the SEIFA is an important tool.

Health determinants

The nature and importance of various health determinants will vary from PHN to PHN. It is difficult to generalise about how each PHN will treat this area, but a guiding principle should be that the various areas under consideration are analysed in terms of their impact on health rather than issues in their own right. There are a number of frameworks and reference points, particularly the work of Wilkinson, Marmot, and the WHO.¹³ Information on levels of health literacy in the PHN is also an important consideration.¹⁴

Health status and behaviours

At this point in the process the focus is on the PHN region as a whole. A range of morbidity and mortality data will need to be examined, alongside a process of consultation. This would include data from the Australian Health Survey and other ABS and AIHW surveys. Techniques for disaggregation or synthetic estimates at small area level need to be robust. As an example, the National Health Performance Framework sub-components are:

Health status

- deaths (mortality rates and life expectancy measures)
- health conditions (prevalence of disease, disorder, injury or trauma or other health-related states)
- human functions (alterations to body structure or function [impairment], activity limitations and restrictions on participation)
- wellbeing (measures of physical, mental and social wellbeing of individuals).

Health behaviours

- attitudes, beliefs, knowledge and behaviours such as patterns of eating, physical activity, smoking and alcohol consumption, and participation in cancer screening programmes.¹⁵

Where possible the analysis of health status should consider the make-up of the PHN region's total fatal and non-fatal burden in comparison with national and jurisdictional data, and whether or not this can be understood using measures such as disability-adjusted life years or other appropriate measures. While PHNs are expected to have a focus on chronic disease, the burden of communicable disease and injury needs to be considered.

Populations with special needs

This step may well cover much of the same ground as the work on health status, behaviours and determinants, but from a different starting point. In an influential article, the epidemiologist George Rose argued that:

I find it increasingly helpful to distinguish between two kinds of aetiological question. The first seeks the cause of cases, and the second seeks the cause of incidence. ‘Why do some individuals have hypertension?’ is a quite different question from ‘Why do some populations have much hypertension, whilst in others it is rare?’ The questions required different kinds of study, and they have different answers.¹⁶

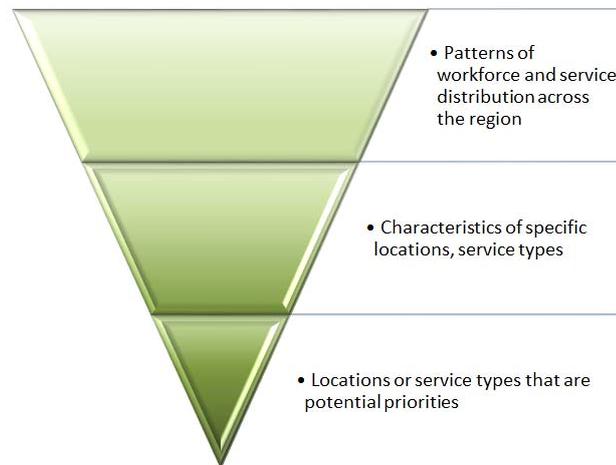
Many of the previous steps may have focused on the health conditions of individuals, albeit aggregated into groupings of one kind or another based on a number of premises. The needs assessment should involve an explicit consideration of populations with special needs that does not necessarily start from a health-related premise. This would involve identification of populations based on characteristics such as ethnicity, location, gender, age, socioeconomic status etc. and may identify issues or inequities specific to these (suicide in youth, injury in farming communities, etc.) which were less evident in the preceding analyses.

Individuals and groups at risk of poor health outcomes

This final step combines evidence from all of the above. Where possible, analysis may involve looking at relative measures of need such as disease rates in comparison to benchmarks or targets, national or jurisdictional averages, or to rates in other comparable regions.¹⁷

Service needs analysis

Figure 5. Service needs analysis



The intention of the service needs analysis is to ensure that the PHN has an understanding of the region's services and health infrastructure relevant to its role within both the health system and the broader environment.

An analysis of geography, workforce and services should provide each PHN with an overall picture of the nature of the health workforce and services in their region. In the latter parts of the analysis PHNs are asked to focus on service need issues from the perspective of the PHN objectives of efficiency, effectiveness and coordination.¹⁸

Figure 5 illustrates how the PHN moves through the various steps that make up this stage. The focus will progressively narrow towards an identification of specific locations, service types or relationships between services that are likely to be priorities for the PHN.

As with the health needs analysis, many of these elements are inter-related or overlapping and the overall process will be iterative.

Geography

There are a number of geographies that are essentially administrative or related to service delivery rather than demographic factors, including the boundaries of both PHNs and LHNs and jurisdictional borders. In analysing service need PHNs should consider how these are important in relation to the health system's capacity or performance at the regional level. This can include issues such as cross-border flows, distribution of services in adjacent PHN regions (particularly in urban areas), referrals both out of and into centralised services such as large teaching hospitals, specialist and allied health services, and the location of specialist imaging or diagnostic services. Variations in services provided by different local government authorities within a PHN region may also be relevant.

Workforce mapping

PHNs should look at information on the health workforce in the PHN region. If available, this could include:

- number and distribution by type, such as GPs, allied health, pharmacy, specialist services such as psychiatry, community health services etc.;
- characteristics such as full or part time, public versus private, qualified but not working in health care etc.; and
- relationships between professional groups.

Service mapping

Service mapping involves identifying and documenting the range of services available within the PHN region, and the kinds of relationships that exist between services. The needs assessment should consider aspects such as:

- **location** – including but not limited to physical location, hours of opening, with consideration of identifiable gaps. For rural areas this would also include outreach services, for urban areas it may involve some consideration of services outside the PHN borders but accessed by people from within the PHN;
- **utilisation** – including MBS and PBS data, a range of hospital data, such as use of Emergency Departments and Potentially Preventable Hospitalisations, other measures of occasion of service, and with a consideration of under-utilisation, duplication and waste;
- **accessibility** – including financial and cultural barriers and access to specialists and secondary referred services, access to services after hours;
- **responsiveness** – such as wait times;
- **capability** – such as skills and competence;
- **acceptability** – such as cultural sensitivity, patient experience of and satisfaction with the quality of care; and
- **quality** – such as practice accreditation and PIP enrolment.

Service mapping can also include consideration of the system's ability to deal with public health emergencies (such as an influenza pandemic) and issues around regional coordination that may impact on emergency preparedness.

Market analysis

As part of its focus on the supply side, the PHN should be alert to evidence on how the health market works in its area. This includes thinking about parts of the market not currently active in health care, but where there are potential opportunities for engagement. This is not necessarily limited to specific suppliers, but could involve services such as informatics or business models from other sectors.

Efficiency and effectiveness of health services

In this step, the PHN should consider service provision in terms of different concepts of efficiency:

- technical efficiency – the cost at which services are produced;
- allocative efficiency – how services reflect consumer preference, from a given set of resources; and
- dynamic efficiency and sustainability – the capacity of the system to sustain workforce and infrastructure, to innovate and respond to emerging needs.¹⁹

In terms of effectiveness, PHNs should consider accepted dimensions of effectiveness. The AIHW defines effectiveness as how well the outputs of a service achieve the stated objectives of that service. Indicators to measure this will cover characteristics such as access, quality and appropriateness, including issues such as cultural competency of services for Indigenous and CALD communities.^{20 21}

An analysis in terms of equity is also important. A focus on programmes and the way they are funded, rather than on what the patient needs, allocates resources inequitably as well as inefficiently.²² Horizontal equity is exhibited when services are equally accessible to everyone in the community with a similar level of need, and vertical equity is exhibited when it accounts for the special needs of certain groups in the community and adjusts aspects of service delivery to suit these needs.^{23 24 25}

Coordination between and integration of, services

PHNs should analyse the level of coordination and integration of health care services in the region, where opportunities may exist for improvement and the presence or absence of services that seek to directly address coordination. Consideration could include evidence in areas such as:

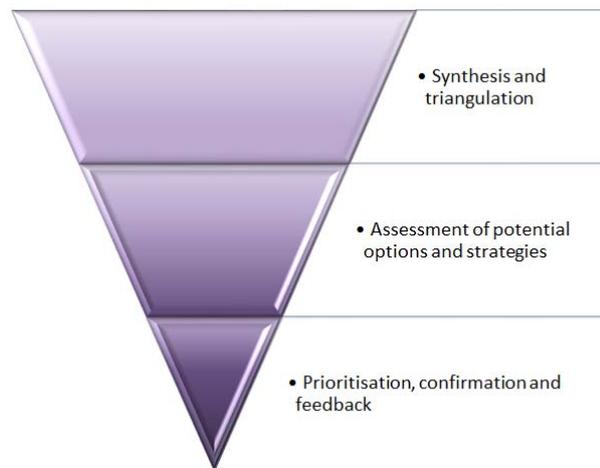
- shared health records and other e-health initiatives;
- examples of integrated service delivery;
- models such as the Patient Centred Medical Home;
- transitions between acute care and primary care;
- coordination between general practice and allied health;
- linkages between health and social services (aged care, disability services, youth, child and family services, housing); and
- referral patterns and health pathways.

Strengths and weaknesses

This final step combines evidence from all of the above. It is acknowledged that in some areas the baseline 2015-16 needs analysis will be preliminary. In the first iteration PHNs may not have developed a comprehensive understanding of the overall health market, or fully developed ways to assess service need from a perspective of efficiency, effectiveness and coordination.

4. ASSESSMENT

Figure 6. Assessment, priorities and options



Assessment has the following purposes:

- to *synthesise* and *triangulate* evidence from consultations and the analysis of the health and service need components; and
- on the basis of this, identify opportunities for further consideration; and
- determine *priorities* and assess *options* for further development in the PHN Annual Plan.

When considering options, it is expected that at this point the PHN would be seeking information from a variety of sources (including literature and systematic reviews) on the nature of interventions and approaches that have been implemented elsewhere, evidence of their success and appropriateness for use in the PHN. Some of this evidence may have emerged during the first two stages.

Figure 6 illustrates how the PHN moves through the various steps that make up this stage. The focus will progressively narrow towards an identification of people, populations or conditions that are likely to be priorities for the PHN and identify options to address these.

Synthesis and triangulation

Issues and needs arising from the data or identified through the community, professional and stakeholder consultations will have been summarised into consistent themes progressively. This information and evidence now needs to be compared and cross checked.

Triangulation is the use of more than one method of enquiry to assess and verify findings. It is used to bring the results of the qualitative and quantitative analyses together and to confirm major themes and key issues identified through the needs assessment process. Here triangulation can be used to cross check, confirm and/or verify the issues identified through community and stakeholder consultations with the findings of the analyses of data or service utilisation patterns.

The matrix below illustrates a simple method to compare how issues raised in community or stakeholder consultations can be cross checked with health needs data or service usage information. A simple star scoring method can be used to assess and compare a list of health and service needs generated from the consultations and data analyses.²⁶

Figure 7. Triangulation matrix

Issue	Community/ consumer feedback	Service provider feedback	Health needs analysis	Service needs analysis	Triangulation result
Health Issue					
Service issue					

Priority setting and options

Prioritisation, or priority setting, applies to the full range of opportunities for PHN activities, not just new or marginal ones. This involves an assessment of whether current service arrangements are best suited to meeting identified need. Whatever processes are adopted for prioritisation, PHNs need to ensure that:

- they are evidence-based;
- are balanced and take account of the views of different groups and parties; and
- decision-making processes are transparent, fair and reasonable.^{27 28}

It is expected that as the needs assessment progresses the PHN will be identifying the kinds of interventions, programmes or policies that have been developed in the past to address a number of the identified health and service needs. These should now be assessed as possible options on the basis of their likely appropriateness (including funding available, effectiveness, efficiency and value for money).

The existence or otherwise of evidence based models will inevitably impact on priority setting. An issue may be identified as a priority, but with no obvious way forward the PHN may need instead to invest in further development, which is consistent with its longer term role in shaping the market.

5. SUMMARISING THE FINDINGS

Developing a summary of the findings of the health needs analysis, service needs analysis and the priority setting process will help to inform PHN Annual Plans and facilitate reporting and information sharing. In addition, the department may use this information to inform programme and policy development.

The following tables illustrate how key information from the needs assessment can be provided in a simple and common format. This does not prevent PHNs using the needs assessment process to develop more detailed or different outputs (such as population health profiles) as circumstances require.

PHNs will report to the Department of Health on their needs assessment activity.

Table 1. Outcomes of the health needs analysis

This table illustrates how findings of the health needs analysis can be summarised.

Identified Need	Key Issue	Description of Evidence
<i>e.g. Health status</i>	<i>Poor self- assessed health status in (specific locations)</i>	<i>NHPA analysis of ABS Patient Experience Survey 2013–14. Variation within PHN obtained through consultations. Utilisation of hospitals and general practices.</i>
<i>e.g. Chronic disease</i>	<i>Lifestyle and risk factors impact on the development of (identified) chronic diseases</i>	<i>Variations between population groups and locations. Evidence from community consultations on diet, smoking, drug and alcohol use, physical activity and health determinants. Hospitalisations for chronic diseases.</i>

Table 2. Outcomes of the service needs analysis

This table illustrates how findings of the service needs analysis can be summarised.

Identified Need	Key Issue	Description of Evidence
<i>e.g. Service coordination</i>	<i>Lack of easily understood and accessible referral pathways across settings and providers</i>	<i>Proportion of GPs, community based medical specialists and allied health providers with secure messaging systems. Discharge information, analysis of directory and eligibility criteria for services, awareness of services from consultations with consumers and health professionals.</i>
<i>e.g. Mental health</i>	<i>Lack of child and adolescent psychiatry services in specific locations.</i>	<i>Identified through consultation with mental health workers and school counsellors. Data on available psychiatric sessions per capita, waiting list for assessment and caseload information.</i>

Table 3. Opportunities, priorities and options

This table illustrates how PHNs can summarise the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- may be considered in the development of the PHN Annual Plan, and supported by PHN flexible funding;
- may be undertaken using programme-specific funding; and
- may be led or undertaken by another agency.

Priority	Possible options	Expected outcome	Possible performance measurement	Potential lead

6. ANNUAL PLANNING

The Needs Assessment component has a definite endpoint with the identification of opportunities, priorities and options. Decisions about which activities will be undertaken to take these forward are the concern of the annual planning – the second component of the strategic planning phase.

In their Annual Plans, PHNs may pursue a number of priorities through flexible funding. In addition, some priorities may more appropriately be addressed through the use of separate programme-specific funding. While an annual plan has a particular focus on the upcoming financial year it will also include medium and longer term perspective.

A number of areas may be identified where further investigation is required. There may also be identified priorities where it will take longer to develop responses, or where it is more appropriate that another agency such as Local Hospital Networks or equivalents would take the lead role.

ENDNOTES

¹ Australian Government Department of Health. *Primary Health Networks Grant Programme Guidelines* 2014. p.7.

² The commissioning cycle is most commonly presented in a diagram. This diagram is based largely on that developed by the NHS Information Centre and used to support World Class Commissioning between 2000 and 2010. See the [NHS Information Centre archive](#) and [Commissioning Handbook for Librarians](#). Another model that is used extensively, with variations, was developed by the Institute for Public Care. First developed in 2003 and since adapted by a number of different agencies, the IPC cycle shows the relationship between strategic commissioning (the outer circle) and procurement, contracting and purchasing (the inner circle). This model follows the 4 step Plan-Do-Study-Act cycle first developed by Deming and used as the basis for many quality control and continuous improvement programmes. See: Institute of Public Care. *Commissioning for Health and Social Care*. Oxford Brookes University 2014, pp.11-13. Bovaird T et al. *Commissioning across government: review of evidence*. Third Sector Research Centre Research Report 86: for the UK National Audit Office. August 2012, pp.48-49.

³ Smith J, Curry N, Mays N, Dixon J. *Where next for commissioning in the England NHS?* The Nuffield Trust and the King's Fund 2010, p.12. Also see Øvretveit J. *Purchasing for health: a multidisciplinary introduction to the theory and practice of health purchasing*. Open University Press 1995.

⁴ Australian Department of Health. *Primary Health Networks Grant Programme Guidelines* 2014.p.10.

Commissioning is characterised by a strategic approach to procurement that is informed by the baseline needs assessment and associated market analysis undertaken in 2015-16. Commissioning will enable a more holistic approach in which PHNs can plan and contract medical and health care services that are appropriate and relevant to the needs of their communities. Commissioning is further characterised by ongoing assessment to monitor the quality of services and ensure that relevant contractual standards are fulfilled. It is expected that PHN commissioning capabilities will continue to develop over time.

⁵ Wright J, Williams R, Wilkinson JR. *Development and importance of health needs assessment*. BMJ 1998; 316: 1310-1313. Also see Katterl R et al. *Regionally-based needs assessment in Australian primary health care*. PHCRIS 2011.

⁶ Smith B, Kwok Cho Tang, Nutbeam D. *WHO Health Promotion Glossary: new terms*. Oxford University Press 2006.

⁷ [ABS Data Quality Framework](#) Cat No. 1520.0. 2009 and [National Statistics Service: Data Quality Online](#). The ABS DQF is comprised of seven dimensions of quality, reflecting a broad and inclusive approach to quality definition and assessment. The seven dimensions of quality are *Institutional Environment, Relevance, Timeliness, Accuracy, Coherence, Interpretability and Accessibility*. All seven dimensions should be included for the purpose of quality assessment and reporting. However, the seven dimensions are not necessarily equally weighted, as the importance of each dimension may vary depending on the data source and context.

⁸ See the following.

ABS	ABS website - Census homepage ABS website - census - SEIFA ABS website - Australian Health Survey ABS website - Profiles of Health, Australia 2011-13 ABS website - Australian Aboriginal and Torres Strait Islander Health Survey: Physical activity, 2012-13
AIHW	AIHW website - Homepage AIHW website - Metadata Online Registry homepage
NHPA	NHPA website - Homepage
Medicare	Department of Health website - MBS online Department of Human Services website - Medicare item statistics/reports
ACIR	Department of Human Service website - Australian Childhood Immunisation Register for health professionals
Notifiable Diseases	Department of Health website - National Notifiable Diseases Surveillance System Department of Health website - National Notifiable Diseases Surveillance System Annual report
RACGP	RACGP website - Homepage
Indigenous health	Department of Health website - Aboriginal and Torres Strait Islander Health Performance Framework Australian Indigenous Health InfoNet website - Homepage
DVA	Department of Veterans Affairs website - Data and Statistics - Statistics about the veteran population
Mental health	Access to Allied Psychological Services website - Minimum dataset ABS website - Mental Health Statistics AIHW website - Mental Health
Health workforce	Health Workforce Australia website - History Health Workforce Australia website - National Statistical Resource AIHW website - Workforce AIHW website - Workforce publications
BEACH	University of Sydney website - Medicine Research Centre - Bettering the Evaluation and Care of Health
PCHRIS	Primary Health Care Research and Information Service website - homepage
PHIDU	University of Adelaide website - Public Health Information Development Unit University of Adelaide website - Public Health Information Development Unit- Data
APHCRI	Australian National University website - National Centre for Geographic and Resource Analysis in Primary Health Care
NHSD	National Health Services Directory website - Homepage
Healthfirst	Health First Network website - Homepage

⁹ [PHN Performance Framework](#)

¹⁰ See the following:

- National Health Information Standards and Statistics Committee (NHISSC). *The National Health Performance Framework 2nd Edition 2009*. the Australian Health Performance Framework consists of three domains; health status, determinants of health and health system performance. [Click](#)

[here to go to AIHW website - Metadata Online Registry - National Health Performance Framework](#). This performance framework is used (in a slightly modified form) to monitor progress in Indigenous Australian health outcomes, health system performance and broader determinants of health. Australian Health Ministers' Advisory Council. *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*. AHMAC 2015. This is the 5th in this series which have been released every two years since 2006. [Click here to go to the Department of Health website - Aboriginal and Torres Strait Islander Health Performance Framework](#)

- Productivity Commission. *Report on Government Services* 2014. Chapter 1: Approaches to performance measurement. This framework groups indicators under three broad headings of equity, effectiveness and efficiency, with access as a subset of both equity and effectiveness. Note that this framework is specifically designed to report on government services. [Click here to go to the Australian Government Productivity Commission website - Report on Government Services](#)
- National Health Performance Authority. *Performance and Accountability Framework* 2011. The Medicare Local component was based on the ROGS and proposed 31 initial indicators for Medicare Locals. [Click here to go to the National Health Performance Network website - Performance Indicator Reporting](#)
- CIHI. *A performance measurement framework for the Canadian health system*. Canadian Institute for Health Information 2012; IBM. *Evaluation of the Health Information Roadmap Initiative: Roadmap II and Roadmap II Plus*. 2007. The Canadian Health Roadmap has four dimensions: health status, non-medical determinants of health, health system performance, and community and health system characteristics.
- *The Triple Aim* considers health care in terms of improving the health of populations, improving the individual experience of care, and reducing the per capita costs of care for populations. This model is a key element in performance measurement in many US health care organisations – particularly since the Affordable Care Act – and is being adopted in a number of countries including New Zealand, the UK and Canada. [Click here to go to the Institute for Healthcare Improvement website - Homepage](#)

¹¹ Hibbert, P., Hannaford, N., Long, J., Plumb, J. and Braithwaite, J. *Final Report: Performance indicators used internationally to report publicly on healthcare organisations and local health systems*. Australian Institute of Health Innovation, University of New South Wales 2013.

¹² The International Association for Public Participation's core values, code of ethics, and public participation spectrum are a useful foundation for informing stakeholder engagement. See: [Click here to go to the International Association for Public Participation Australasia website - Homepage](#)

¹³ See the following:

- Wilkinson RG, Marmot M. *The Solid Facts: the social determinants of health* 2nd edition. International Centre for Health and Society, WHO 2003. Wilkinson RG. *Socioeconomic determinants of health: Health inequalities: relative or absolute material standards?* BMJ 1997: 314:591. Wilkinson RG, Pickett KE. *Income inequality and population health: a review and explanation of the evidence*. Social Science and Medicine 2006: 62: 1768-1784.
- Marmot M. *Social determinants of health*. Oxford University Press 2005. Marmot M et al. *Closing the gap in a generation: health equity through action on the social determinants of health*. The Lancet 2008: 372: 1662-1669. See the [Institute of Health Equity](#) for more information and links.
- WHO. *Closing the gap in a generation: Health equity through action on the social determinants of health*. WHO. Final Report of the Commission on Social Determinants of Health 2008. [2011 World Conference on Social Determinants of Health](#).

¹⁴ ACSQHC. *Health literacy: taking action to improve safety and quality*. Australian Commission on Safety and Quality in Healthcare 2015. p.2.

¹⁵ See endnote 11 above. The National Health Performance Framework locates 'health behaviours' within the Health Determinants rather than the Health Status domain. The Aboriginal and Torres Strait Islander Health Performance Framework uses the sub components of 'health conditions', 'human function', 'life expectancy and wellbeing' and 'deaths'.

¹⁶ Rose G. *Sick individuals and sick populations*. International Journal of Epidemiology 2001; 30: 427-432. First published International Epidemiological Association 1985. p.428. See also Merchant A et al. *Insights from cross-population studies: Rose revisited*. International Journal of Epidemiology 2005; 34: 344-246 [commentary].

¹⁷ [The National Health Performance Healthy Communities reports](#) are an example of comparisons between 'peer groupings' of Medicare Locals. A range of methodologies are found in Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD. *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: AIHW 2007. The AIHW is currently undertaking the third Australian burden of Disease Study using 2011 data with results expected in the first half of 2016. [Click here to go to the AIHW website - Burden of Disease](#)

¹⁸ The PHN may wish to consider the effectiveness, efficiency and coordination of services within the scope of a broader description of quality. There are many examples of these and include the work of Donabedian, the Australian Commission on Safety and Quality in Health Care, the WHO or the US Institute of Medicine. See the following:

- Donabedian A. *The seven pillars of quality*. Archives of Pathology and Laboratory Medicine 1990: 114: 11:1115-1118, and Donabedian A. *Evaluating the quality of medical care*. Milbank Quarterly 1966: 44: 3 Pt 2. Reprinted 2005: 83: 4: 691-729.
- Australian Commission on Safety and Quality in Health Care. *Australian Safety and Quality Framework for Health Care*. 2012
- WHO. *Quality of care: A process for making strategic choices in health systems*. World Health Organisation 2006. pp.9-10.
- Institute of Medicine. [Crossing the Quality chasm: a new health system for the 21st century](#) US IOM 2001. See also ARHQ. [National Quality Measures Clearinghouse - Domain Framework](#). The US Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) has a 'domain framework' which takes the definition of quality to another level.

¹⁹ [AIHW website - Metadata Online Registry - Report on Government Services - Effectiveness](#) and [AIHW website - Metadata Online Registry - Report on Government Services - Efficiency and Sustainability](#)

²⁰ [AIHW website - Metadata Online Registry - Report on Government Services - Effectiveness](#) [summarised]

- *Access indicators* measure how easily the community can obtain a service. Access has two main dimensions, undue delay (timeliness) and undue cost (affordability). Timeliness indicators can include waiting times (for example, in public hospitals and for aged care services). Affordability indicators relate to the proportion of income spent on particular services (for example, out-of-pocket expenses in children's services).
- *Appropriateness indicators* measure how well services meet client needs. Appropriateness indicators also seek to identify the extent of any underservicing or overservicing. Data on differences in service levels can indicate where further work could identify possible underservicing or overservicing.

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- *Quality indicators* reflect the extent to which a service is suited to its purpose and conforms to specifications. There is usually more than one way in which to deliver a service, and each alternative has different implications for both cost and quality. Information about quality is needed to ensure all relevant aspects of performance are considered.

²¹ Australian Government. *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*. p.142.

Improving the cultural competency of health care services can increase Aboriginal and Torres Strait Islander peoples' access to health care, increase the effectiveness of care that is received, and improve the disparities in health outcome. Cultural competency requires that organisations have a defined set of values and principles, and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally.

²² Australian Government. *Reform of the Federation White Paper: roles and responsibilities in health*. Issues paper 3. Dec 2014. [Click here to go to the Australian Government Reform of the Federation White Paper website - Roles and Responsibilities in Health Issues Paper Three - Equity](#)

²³ [AIHW website - Metadata Online Registry - Report on Government Services - Effectiveness](#)

²⁴ Duckett S, Willcox S. *The Australian Health Care System* 4th edition. Oxford University Press 2011. pp.304-306. The areas used as overall headings for evaluating health care systems are equity, quality, efficiency and acceptability. Duckett and Willcox see effectiveness as a component of allocative efficiency, along with technical efficiency and priority setting. In this dynamic efficiency is conceptualised a bit differently and concerns the extent to which the health care system as a whole, and its constituent elements, adapt to change and innovation.

²⁵ World Health Organisation. [Health Systems Financing: the path to universal coverage 2010](#) p.61.

Efficiency... is a measure of the quality and/or quantity of output (i.e. health outcomes or services) for a given level of input (i.e. cost). So efficiency gains could help to contain costs – an important objective in many countries – by reducing the costs of service delivery. However, no one wants to contain costs by reducing health outcomes, so seeking efficiency gains should also be seen as a means of extending coverage for the same cost.

²⁶ This is a shorter version adapted from the Medicare Local Comprehensive Needs Assessment Tools and Resources, Appendix K. The star scoring system proposed was:

- * rarely raised as an issue/not evident in data
- ** raised as an issue/somewhat evident in data
- *** raised frequently as an important issue/concern evident in data
- **** raised frequently as a high priority issue or concern needing action/significant concern evident from data

²⁷ Robinson S, Dickenson H, Williams I, Freeman T, Rumbold B, Spence K. *Setting priorities in health: a study of English primary care trusts*. The Nuffield Trust 2011, p.13.

²⁸ NHS Institute for Innovation and Improvement 2012. [Prioritise Commissioning Opportunities](#)
Also see the [Qualitas Consortium](#) and the [Commissioning Handbook for Librarians](#)