

Development of Australian chronic disease targets and indicators

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About the Australian Health Policy Collaboration

The Australian Health Policy Collaboration was established at Victoria University in 2015 to build from the work of the health program at the Mitchell Institute over the previous two years. The Collaboration is an independent think tank that aims to attract much required attention to the critical need for substantial and urgent health policy reform focused on addressing chronic disease on a national scale.

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1. Introduction

The Australian Health Policy Collaboration (AHPC or Collaboration) is facilitating development of a set of targets and indicators to measure and track the prevention and management of chronic diseases in Australia. Working with organisations that also have a commitment to prevention, accountability for both public health targets and action will be pursued.

The WHO *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020* aims to reduce the burden of non-communicable diseases (NCDs) by 2025, through action on nine targets measured by 25 indicators of performance (WHO, 2013A). The WHO Global Action Plan provides a broad framework against which Australian progress can be measured. The WHO focus on NCDs is restricted to four types of NCDs—cardio-vascular diseases, cancer, chronic respiratory diseases and diabetes—which make the largest contribution to morbidity and mortality due to NCDs, and on four risky behaviours—tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

The AHPC work on chronic disease policies for Australia takes a broader approach to chronic diseases, including for example, mental illness (Willcox 2014). The WHO 25 x 25 targets are a key set of measures for Australia to assess and draw from, however, national measures must be tailored to the Australian context.

This paper should be read in conjunction with the baseline technical paper (Leung & Tolhurst 2015), for which it provides context and background. It reviews work relevant to chronic disease prevention indicators and targets in Australia, and explores related issues.

2. Why measuring progress is important: accountability

A performance framework that aligns to the broader strategic goals and priorities of the health care system, and is structured across multiple domains, is recognised internationally as an important element of healthcare improvement (Hibbert et al 2013; Bureau of Health Information 2014). Health status and outcome targets and indicators should inform system improvement and lead to action.

Historically in Australia, governments have not been required to give a reckoning of, or answer for, their performance in relation to prevention of chronic diseases. Often the focus is on hospitals and acute care, rather than prevention. Accountability involves one actor answering to another, and an assessment of how well obligations to achieve specific goals have been met (Swinburn et al, 2015). Australian governments over time, have made varying commitments and set varying goals with regard to the prevention of chronic disease. Currently there is no regular public reporting against national chronic disease prevention targets, and indeed, there are no agreed targets.

The AHPC seeks to explicitly promote accountability, in order to both encourage action on prevention, and civil engagement in these issues.

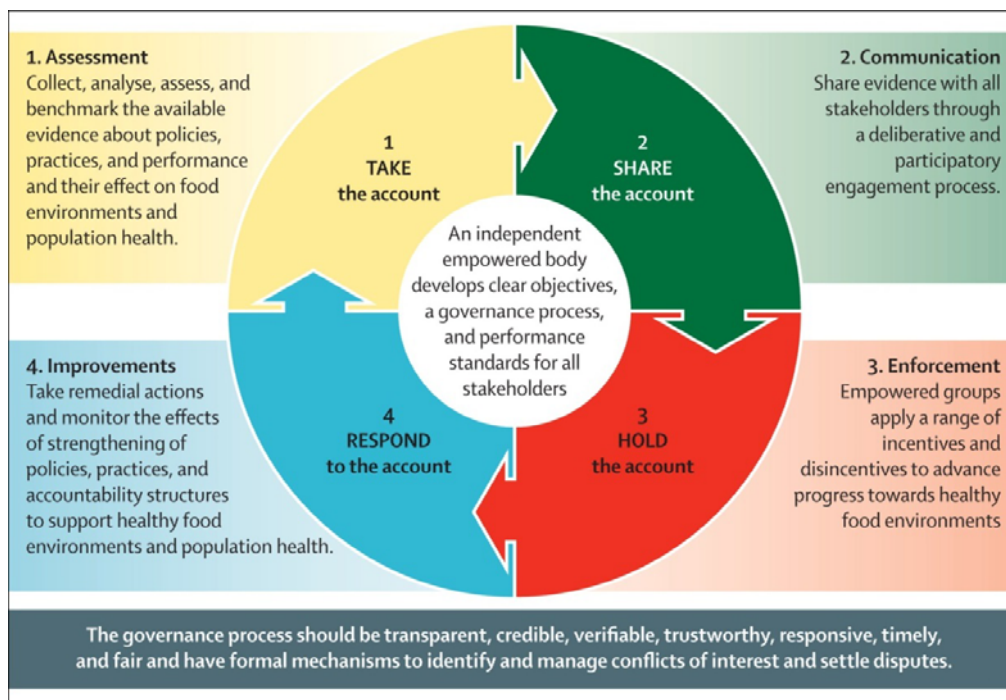


Figure 1: Accountability framework adapted from Kraak and colleagues, applied to healthy food environments. It can also be applied to chronic diseases more broadly.

Source: Swinburn et al (2015).

The first step of the accountability cycle described by Swinburn et al (2015) is assessment. This requires measurement of progress towards agreed goals. Working with others, the AHPC seeks to establish a set of targets and indicators, linked but not restricted to the WHO 25 x 25.

The second step of the accountability framework is communication, and involves wide dissemination of progress made by governments in the implementation and meeting of targets set in national and international plans for action against chronic diseases. It also involves sharing evidence on the implementation of recommended actions to meet the targets.

The third step of the accountability cycle is enforcement. This step involves affected stakeholders acknowledging achievements and sanctioning poor performance of other stakeholders. Swinburn argues that this step is often the weakest component of the accountability framework (2015). The strongest accountability lever for the government to hold the private sector to account is via legal mechanisms.

The fourth step of the accountability framework is making improvements. It involves changes in policies and practices by governments, industry and consumers.

3. Criteria for selecting targets and indicators

Different criteria can be used to select indicators (COAG 2011, AIHW 2011), and there may be indicators that are valid, reliable, relevant and appropriate to Australian chronic disease prevention policy that are not part of the 25 x 25 set. The choice of indicators for chronic disease prevention

involves values and the exercise of judgement. As Hibbert et al note, ‘indicators deemed important will be in the foreground and privileged; and those not will receive less attention, even though the issues they represent may require attention or be considered important by some stakeholders’ (2013 p.83).

Some of the criteria for indicator selection used previously in Australia are outlined below. Although this paper focuses on population health, consideration of other health system indicators is included. The literature on national healthcare system performance emphasizes the importance of a logical, acceptable, and viable conceptual framework to underpin development of a national performance indicator set (Hibbert 2013), and this approach can also be applied to population health.

AIHW, in selecting key indicators of progress (KIP) for chronic disease and associated determinants, used the following criteria to select indicators (2011):

- Be relevant
- Be applicable across population groups
- Be technically sound (valid, reliable, sensitive (to change over time) and robust)
- Be feasible to collect and report*
- Lead to action (at various population levels, for example, individual, community, organization/agency)
- Be timely
- Be marketable

*the selection of indicators was not driven by data availability

Note: the order of the criteria does not indicate priority

In developing the KIP set, AIHW structured indicators into four categories, from category 1 (high-impact indicators in nature that can be used for ‘one-headline statistic’ reporting) to category 4 (indicators that require further research and development).

The National Health Performance Authority (NHPA) monitors and reports on healthcare system performance in Australia. The NHPA Performance Assessment Framework (PAF) lists selection criteria for performance indicators that are not dissimilar to the AIHW KIP criteria (COAG 2011):

Table 2: PAF Selection criteria (COAG 2011)

Policy	Scientific soundness	Efficiency
Relevance and appropriateness for policy makers	Valid	Administratively simple and cost effective
Avoidance of perverse incentives	Reliable	
Relevance to the NHHN agreement and the National Health Reform Agreement	Attributable	
	Comparable	
	Ability to measure progress over time	

An earlier publication by AIHW was *A set of performance indicators across the health and aged care system* (2008). The overall objective of this work was to develop a performance indicator set by which the community could judge the performance of the system as a whole. Rather than criteria, the paper lists objectives for the indicator set to be:

- Suitable for public reporting
- Reflect the range of activity across the health and aged care system, and the responsibilities of both the Commonwealth and state and territory governments, and
- Focus on outcomes for patients and clients, and on other major issues for stakeholders, including equity.
- In addition, AIHW noted that a priority had been to ensure that the performance indicators:
 - Reflect reform directions announced by Health Ministers
 - Encourage positive changes within a 'balanced scorecard' assessment of performance
 - Are amenable, as appropriate, to performance benchmarks and targets
 - Are robust measures, and
 - Largely draw on current health and aged care information infrastructure.

AIHW, in this work on health and aged care indicators, identified six indicators relating to prevention and four to better health (AIHW 2008). Some of these relate to the WHO indicators—for example, cancer screening rates and risk factor prevalence. Others take a broader view—for example, the proportion of the health dollar that is spent on prevention programs. Inclusion of some broader items, such as the investment in prevention, in a set of chronic disease prevention indicators may enhance accountability, particularly if there is benchmarking against other like countries.

The National Preventative Health Strategy (2009) set targets in areas such as tobacco, obesity and alcohol, and included some of the *Closing the gap* targets. Equity is an important consideration in health. The development of Australian population targets and indicators for chronic diseases will be informed by evidence on the health status and needs of population groups that experience socioeconomic and other disadvantage.

A significant omission from the WHO targets and indicators is mental health. The decision to omit mental health was based on the existence of the *WHO Global Mental Health Action Plan 2013-2020*, which has six global targets to be attained by 2020 (2013B). There are potential synergies with these sets of targets (Galea 2014), and it would be beneficial to include one or more mental health target or indicators in a national approach to chronic disease prevention, such as the WHO goal to reduce the rate of suicide by 10 per cent by 2020 (WHO 2013B). Australia over time has included mental health as part of the burden of chronic disease. Dementia was added as a national health priority area in 2012, and AIHW includes depression in its list of 12 chronic conditions.

Overall, as noted above, a logical, acceptable and viable conceptual framework encompassing multiple domains, is important in establishing a set of chronic disease indicators and targets. Hibbert et al (2013) recommended in relation to the PAF, that the framework would be enhanced by:

- Publishing key information on criteria underpinning indicators;
- Being explicit about the target population of published performance data; and
- Learning from robust indicator development processes internationally.

4. WHO 25 x 25 targets and indicators

In May 2013, UN Member States formally adopted the WHO global monitoring framework for the prevention and control of NCDs, including nine global targets and 25 indicators, as part of a comprehensive "Omnibus" Resolution at the 66th World Health Assembly. This requires all countries to set national NCD targets; develop and implement policies to attain them; and establish a monitoring framework to track progress. A recent progress report notes that while some countries are making progress, the majority are off course to meet the global NCD targets (WHO, 2014). WHO will submit reports on progress made in implementing the action plan to the World Health Assembly in 2016, 2018 and 2021 and reports on progress achieved in attaining the 9 voluntary global targets in 2016, 2021 and 2026 (WHO 2014).

The Australian data available from the *Global status report on NCDs 2014* suggests there is little or no progress being made in preventing and controlling chronic diseases in Australia (with tobacco control being the exception) (Leung & Tolhurst 2015).

5. National work on targets and indicators, and health surveillance

To assess progress in relation to prevention, Australia needs an agreed chronic disease prevention monitoring framework, and the data to support it. The WHO framework provides a significant international set of targets, and there is prior national work upon which to draw.

Recent Australian publications relevant to chronic disease prevention targets and indicators include:

- work by the National Preventative Health Taskforce (2009);
- the National Partnership Agreement on Preventive Health (2009);
- the National Health Reform PAF (2011); and
- AIHW publications including A set of performance indicators across the health and aged care system (2008) and Key indicators of progress for chronic disease and associated determinants (2011).

Indicators are central to driving positive change, and to measuring progress towards or away from goals. Many potential indicators can be used to demonstrate health variations between different social groups, including Indigenous and other Australians, and people living in cities, rural and remote areas, to inform and influence policy and health service responses. For example, equity indicators may reflect both equity of access, whereby all Australians would be expected to have adequate access to services; and; equity of outcome, whereby all Australians would be expected to achieve similar health outcomes arising from access to services (COAG 2011).

Chronic disease indicators need to encompass both trends in chronic diseases and trends for their determinants and risk factors. Changes in risk factors and behaviours such as smoking, lack of physical activity and inadequate nutrition are considered important in the prevention of chronic disease. However, establishing trends for risk factors is difficult, and relies on the availability of ongoing, consistently collected national data.

Data is still becoming available from the 2011-13 Australian Health Survey (AHS). The AHS expanded the traditional National Health Survey and National Aboriginal and Torres Strait Islander Health Survey to collect information on physical activity and nutrition behaviours, anthropometric and biomedical measures of nutrition status and chronic disease risk in the general and Aboriginal and

Torres Strait Islander populations. The 2011-13 AHS was the first survey since 1995 to gather information about the nutritional status of Australians.

From 2014/15 the ABS Australian Health Survey will revert to its traditional form (<http://www.health.gov.au/nutritionmonitoring>). Accurate monitoring of chronic diseases and related risk factors requires a long term commitment to regular collection of risk factor data for chronic diseases (including anthropometric and biomedical measures).

6. AHPC approach

The development of chronic disease targets and indicators is linked to a vision of reducing the impact and incidence of chronic diseases through preventive interventions (Willcox 2015). The intended audience for the targets and indicators is government, policy-makers, and civil society.

In considering targets and indicators, the AHPC proposes using the AIHW criteria (2011):

Chronic disease indicators must:

- Be relevant
- Be applicable across population groups
- Be technically sound (valid, reliable, sensitive (to change over time) and robust)
- Be feasible to collect and report
- Lead to action (at various population levels, for example, individual, community, organization/agency)
- Be timely
- Be marketable.

7. Conclusion

The AHPC has gathered and analysed available baseline information for chronic diseases in Australia, as a starting point for chronic disease target and indicator consideration (Leung & Tolhurst 2015). Using criteria described in this paper, the Collaboration will work with health stakeholders from the public and non-government sectors to review the WHO targets and indicators as applied to Australia, and consider complementary indicators.

The AHPC will support a process that will initially discuss the baseline and possible additional indicators; and the potential shape of a framework and report card. Technical working groups will focus on particular areas. The Collaboration will support a consultation process to validate the targets and indicators with key groups from the non-government sector and academia.

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