Performance Measurement in the Community Health Sector: benefits and pitfalls

G. Jolley, South Australian Community Health Research Unit, Flinders Medical Centre, Bedford Park, SA 5042

Introduction

This paper reports on several aspects of research into the use of performance indicators in the community health sector, conducted at the South Australian Community Health Research Unit over the last 3 years. The work to date has included a review of literature on performance measurement in a community health context, (Baum and Duckett 1999), release of a South Australian discussion paper to encourage ideas and debate about the issues, (Jolley 1999) and participation by the author in a project, funded by the SA Department of Human Services, to identify and trial performance indicators in community health services. In a separate but related study, interviews with key stakeholders are planned for later this year.

The community health sector

One of the difficulties in describing and evaluating the community health sector is that there is little general agreement on what it is and what it does. There are different definitions at international and national levels, with no Australian national policy or peak body. Even within South Australia, metropolitan and country community health services have different organisational structures, different service focus and different data reporting systems.

Community health practice, as a component of primary health care, is underpinned and informed by the values and principles espoused in the Alma Ata Declaration on Primary Health Care (WHO, 1978), and the Ottawa Charter for Health Promotion (WHO, 1986). In summary these are:

- Recognition of the broad social, economic and environmental determinants of health and illness
- The importance of health promotion and disease prevention
- The importance of community participation in decision making
- The importance of working with a variety of sectors outside of health
- Seeing equity as an important outcome of health service intervention.

In South Australia, community health services are provided by a variety of public sector agencies. Some agencies are stand alone community health centres and others are co-located with other organisations. The services provided by community health are diverse: one-to-one (medical/clinical care and counselling), group programs (health education and support groups) and community development. Many of these activities involve multi-disciplinary teams and use a variety of strategies to protect and promote the health of their defined communities.

Performance measurement in the community health sector

From the 1980s, new public management techniques, modelled largely on private sector management practices, have been introduced by democratic governments worldwide. The intention of these changes is to increase customer responsiveness and efficiency while focussing on outcomes rather than activity. Associated with these new management practices has been an interest in performance monitoring, from Western governments and funders of human services, as a result of the shift to market based economic reforms. The community health sector is under increasing pressure to be accountable to funders and communities for the quality of its services, and to measure the health outcomes that result from its work.

For the acute health care sector, the interest in performance indicators is to provide information to compare individual health units, organisations or systems against a benchmark or standard (National Health Ministers' Benchmarking Working Group 1998). One of the future directions arising from the Second National Report (NHMBWG 1998) is to extend performance measurement from the acute care setting to the community health setting. A broad definition of community health is used by this group to include most non-institutionalised health care. The report states that with an increasing emphasis on service substitution and integration, and the growing interest in preventive approaches to health care, the role of community health has become more important and the need for accountability and quality improvement in the provision of community health services has increased. The NHMBWG report outlines some of the obstacles to be overcome in developing performance indicators for this sector. Community health services, it suggests:

- are more diverse and diffuse in nature than acute care
- are not restricted to institutional boundaries
- often involve an overlap of service programs and providers (NHMBWG 1998).

Community health services are themselves interested in developing performance measurement as a way to demonstrate the value of community health and primary health care to funders and purchasers. There is some concern that, if performance in the community health sector is not reported on or made visible in the way that it is in the acute hospital sector, then community health will 'lose out' in political and budget arenas.

Summary findings from review

The case for performance measurement in the community health sector:
Indicators can be used to compare performance against inter-industry and international standards or benchmarks, or in their absence, against targets. They can provide information to assist planning, policy development, program design, refinement of objectives, setting targets and standards and allocating resources.

Performance measurement may assist management control by monitoring standards and providing a vehicle for accountability to various stakeholders. For services and workers, measurement of performance may assist in demonstrating the value of the work that they do to funders and the community. Performance indicators can also be useful as part of a broader evaluation.

The case against performance measurement in community health sector
The nature of much community health work is such that demonstrating causal links between interventions and outcomes is very difficult. Much of the potential benefit is long term, is influenced by external, environmental factors and is about prevention rather than incidence of illness or disease. The developmental nature of much primary health care means that specific objectives may change over time. Other challenges are the diversity of communities, variation in expectations and needs across stakeholder groups and the difficulty of reducing qualitative experiences to a quantitative measure.

The quality and validity of data collected is of common concern in performance measurement. Compliance in data collection is significantly reliant on the collectors seeing some value in the reporting. There is little value added by data collection in community health services currently and providers may feel they are asked to collect and provide data that is not used by anybody. In the community health sector, a mix of data collection systems has been developed by different states. In South Australia, the main format for data describing community health activity in the metropolitan area is the Community Health Statistical System (CHSS). Although well-supported in the field, many limitations have been identified and there seem to be few people making use of the information collected.

Input, output and outcome, and notions of efficiency, customer service and quality assurance have been borrowed from the private (for-profit) sector without careful consideration of their meaning in a publicly-funded human services setting. Many would argue that primary health care, and community health, needs to demonstrate efficiency and effectiveness if it is to maintain or increase the proportion of health sector spending. For services targeted to individuals this will be easier than for those activities which are aimed at a population level. There is concern that this later activity may lose out in funding opportunities and priorities if it cannot develop performance indicators to demonstrate the value of what it does. In the community health sector a third 'E', equity, is an underpinning principle and it has been suggested by the field that equity should be included in a performance framework for community health.

'SA developing performance indicators' project

Description of project
Towards the end of 1999, a South Australian working group consisting of researchers, practitioners and the SA Department of Human Services (DHS) funding and policy people with an interest in performance indicators for community health, was established. In March 2000, this group convened a workshop meeting of community health managers and staff and representatives from the DHS. The workshop was well-attended and provided an opportunity to develop common understanding and a way to proceed. A small grant was obtained from the DHS and the working group produced and piloted a performance indicator development process. The intention was to develop and trial a process for performance indicator development that was participatory and inclusive of all stakeholders. An invitation was issued for Development Groups to further trial the process. Seven groups were set up and were

guided through the process of developing performance indicators in a series of facilitated workshops.

Three different frameworks were offered for performance indicator development (Ottawa Charter for Health Promotion, Primary Health Care principles and Capacity Building model) with each Development Group nominating the framework and performance area they wished to work with. One group comprised of women's health services chose to use a women's centred approach.

Framework	**Performance area**
Ottawa Charter	▪ Strengthening community action ▪ Creating supportive environments
Primary Health Care principles	▪ Equity of health outcomes ▪ Access and equity
Capacity Building model	▪ Workforce development
National Women's Health Policy and other policy documents	▪ Women's Centred Approach

In the facilitated workshops, each Development Group clarified their understanding of the performance area and brainstormed the essential components that would demonstrate work in this area. A ranking process identified the top three components and performance indicators for these were developed, specifying the data required, the data source and methods for collection.

The data collection phase ran from October to November and a workshop in December brought all the players together to reflect on the learning that had taken place. In early 2001, the performance indicators that had been developed by each group were piloted by another group in a different service setting in order to test transferability and robustness. The final reflection workshop was held in May to bring the results together. Participants were positive about many of the aspects of the project, however a number of concerns were also highlighted.

Summary of findings

Resource requirements

The development of performance indicators using a participatory process such as the one trialed in this project is resource intensive. The working group members were supported by their various agencies to commit considerable time to planning, managing, facilitating workshops and writing. The community health services that took part also donated time and resources to the process. Only some of these costs were able to be reimbursed from the project funds.

Skill development

One of the reasons for the resource intensity was the need to develop knowledge and skills about performance measurement in the sector. This is important to ensure 'ownership' and commitment to the performance indicators developed, the subsequent data collection processes and a willingness to use the information generated.

Shared understanding
One of the challenges for the development groups was in coming to a clear, shared understanding of the performance areas under review. For example, 'strengthening community action' is a oft recited strategy in the Ottawa Charter, but it was clear from group discussions that this term had many different meanings for people working in the community health sector. The performance area needs to be defined carefully before critical aspects of performance can be identified.

Data systems
An ongoing concern is the lack of data systems that can adequately record the full range of community health activity. For the performance indicators trialed in this project, services were, for the most part, able to retrieve data from CHSS, planning and evaluation documents, program reviews and worker journals or logs. However, it is unlikely that data from these sources are consistent across sites, across time, or even workers. Data systems currently in use record activity in terms of numbers and characteristics of clients and type of service supplied. Most practitioners believe that their population level work in health promotion and community development is poorly captured.

Lack of benchmarks
Participants in the project expressed frustration at the lack of benchmarks with which to compare their performance data. The lack of base-line measures was identified as a problem for services and makes it unclear how to set realistic and achievable performance indicators. For example, a performance indicator trialed for 'strengthening community action' was 'number and proportion of community people involved in community action over a one year period'. The question from the group was, how do we know whether a performance indicator of, say, involvement by 5% of the adult population reflects good or poor performance?

Conclusions

At present there is a lack of agreement about the role and scope of the community health sector. There is no national or state level policy for community health in Australia and so no agreed objectives from which to develop meaningful indicators. Work needs to occur at national and state level so that policy-driven goals and objectives are established. These can then be used as a foundation for identifying domains of performance and what constitutes 'good performance' by all the stakeholders. Only then will it be appropriate to start development of performance indicators.

Performance indicators in the acute care sector have proved difficult to develop and there are many gaps in data availability and quality, despite this work being ongoing since 1994. The complexity of community health, and its philosophical underpinning, have a large impact on the potential for developing appropriate indicators for monitoring and measuring performance. While indicators of mortality and morbidity are fairly well established for use in the medical context, measurement of positive health and well-being still presents a challenge. Attributing changes in health and well-being in individual and communities to community health performance is even more difficult.

There is also still much to be done in developing evaluation methodologies that are rigorous while at the same time appropriate for measuring participatory, developmental, long term and complex outcomes.

References

Baum F. and Duckett S. (1999) *An overview of the nature and scope of the community health sector with a view to developing national performance indicators*. Commonwealth Department of Health and Aged Care. Awaiting publication

Jolley G. (1999) *Performance Indicators for Community Health: a South Australian discussion paper*, South Australian Community Health Research Unit, Adelaide

National Health Ministers' Benchmarking Working Group (1998). *Second National Report on Health Sector Performance Indicators*. Canberra, Commonwealth Department of Health and Family Services

World Health Organisation (1978) *Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR.* Geneva, WHO and UNICEF

World Health Organisation (1986) Ottawa Charter for Health Promotion. *Health Promotion* 1 (4) i-v