

Victorian Healthcare Association

Population Health Planning Framework

STEP 3 IDENTIFY AND PRIORITISE THE ISSUES

This section addresses the process of identifying, prioritising, and agreeing on the area-based issues requiring action, and involves:

- forming a planning group
- selecting and collecting data
- analysing population health data to identify a range of health issues impacting upon the community
- prioritising and selecting health issues for action and investment

This section outlines these processes in more detail, along with listing possible data and indicators (and their sources) that can be used for population health planning.

The planning group

The planning group is the group that gathers and analyses population health data to identify priority issues. The planning group comprises key partners from the leadership team, and additional representatives from other sectors, government, and the community may also join this group.

The group will need to possess or obtain the required expertise for data gathering and analyses, such as skills in “social epidemiology, public health and health social science, urban or rural planning, community development, local government planning, and economic development” (Keleher 2011a:332). These skills may be broader than those required for other health planning approaches due, in part, to the level of data interrogation required to link the social and health conditions of the population (Keleher 2011a:331).

Collecting the data

Population health data and indicators

Population health planning data is used both to identify priority issues and evaluate the efficiency, efficacy, and equity of programs implemented (see section 4). In this section, the use of data for identifying priority issues will be addressed.

The term ‘indicators’ is often used synonymously with ‘data’. In the population health planning context, *indicators* refers to measures for the identification of trends in social, environmental, and cultural factors and outcomes at local, regional, and national levels (Wiseman et al 2006). Indicators can therefore be used for comparing between areas or examining change within an area over time.

In selecting which data and indicators to use, planning groups are often faced with conflicting values and assumptions. These different perspectives must be considered, along with the community’s needs, interests, and concerns (Ontario Ministry of Health and Long Term Care 2006). The decision-making processes used to select data and indicators must be transparent and documented.

For population health planning, the data and indicators will be:

1. obtained through existing or new data collections
2. critically examined and compared
3. used to determine priority issues
4. used to evaluate population health actions

The breadth of population health planning data

Data used for population health planning is much broader than simply measures of death, disease and disability, demographic, and health utilisation characteristics, which provide only part of the population health picture (Public Health Agency of Canada 2001a). Consideration must also be given to the various determinants of health and quality of life, (eg, environmental, mental and social wellbeing, quality of life, income, employment, education), and to community knowledge of these issues. This ensures that a population health approach to planning is grounded in a social model of health.

Data and indicators can be broadly grouped into the following categories:

- *Area characteristics* – the physical characteristics of the area of interest (eg, availability of transport, location of schools)
- *Population characteristics* – the composition and attributes of the population(s) of interest (eg, age, gender, cultural and linguistic background, social norms, community attitudes)
- *Socio-economic characteristics* – the economic and social position of the population(s) of interest relative to that of other populations (eg, income, home ownership, education levels)
- *Health characteristics* – the prevalence and incidence of wellbeing, illness, disease, quality of life, and the self-reported health status and key health concerns of the population(s) of interest
- *Utilisation characteristics* – the acceptance of, barriers to, and frequency of service use, access to services, including waiting lists for specific services

A comprehensive list of possible data and indicator sources is included at the end of this section.

The importance of locally-generated data

Data sources should be sought that provide insights into local health and wellbeing which are not available from mainstream sources. This may include data reporting on the uptake and use of services, and is often collected by individual agencies during their routine operations. Other ongoing or ad hoc data collections derived from local needs assessments, satisfaction surveys, service mapping, case studies, and community consultations are also meaningful when undertaking population health planning.

Social determinants data

Data on the social determinants of health must be considered for population health actions to be effective and appropriate (Public Health Agency of Canada, 2001a). There is substantial evidence linking general health outcomes with these determinants. Understanding the type and nature of causal links between a health issue and its determinants is complex, as there are varying degrees of evidence. The combination of qualitative and quantitative data, obtained from a range of sectors, peak bodies, and university research, often gives the most accurate picture for understanding the causal relationships of social determinants (Keleher 2011a).

The following sources for accessing social determinant data can provide starting points for comparing population groups' inequality and inequity (refer to 'valuing equity' section):

- [Australian Bureau of Statistics](#) (ABS)*
- [Public Health Information Development Unit](#) (PHIDU)
- [Health Intelligence Unit](#) (Victorian Department of Health)

*The ABS Socio-Economic Indexes for Areas (SEIFA) index is a useful summary measure of socio-economic disadvantage. Further information is discussed in the 'Health Determinants data sources' section below.

A more comprehensive list of sources for social determinants of health data for Victoria is available from [Monash University- Population Health Data Sources \(2010\)](#)

Death, disease, and disability data

Data on death, disease, and disability includes:

- causes and rates of mortality and potentially [avoidable mortality](#)
- burden of disease and disability data
- quality of life data
- self-assessed/ reported health
- hospital emergency presentations and admissions
- potentially preventable hospitalisations (eg, [ambulatory care sensitive conditions](#)).

Combined indicators of mortality and morbidity provide meaningful information for population health planning, as they allow comparison of the impact of different health conditions using a common metric. The most common examples of these indicators include the [Disability Adjusted Life Year](#) (DALY), [Health Adjusted Life Expectancy](#) (HALE), and [Quality Adjusted Life Year](#) (QALY). [The burden of disease in Australia](#) has been reported by the Australian Institute of Health and Welfare, for 1996 and 2003, while that for [Victoria](#) has been reported by the Victorian Department of Human Services for 1996 and 2001.

Population health planning also requires inclusion of data that measures the positive dimensions of health, (eg, the ability to function in daily life, self-esteem, social participation, physical activity, nutrition, and health literacy). Evaluating absence of symptoms of disease is an insufficient measure of health. The annual [Victorian Population Health Survey](#) (DH 2011) has collected and reported information at the state and regional levels about the health, lifestyle, and wellbeing of Victorians aged 18 years and over, since 2001. VPHS information at a local government level has been available since 2008.

Analysing the data

Population health status

The analysis of data and indicators provides a comprehensive picture of the status of the population by answering the following questions:

- How healthy is the population?

- Is their health improving? (This involves measuring and monitoring health indicators over time)
- Who is healthy and who is not? Where do health inequities exist?
- What can we learn from current trends in health status to help prepare for the future? Are there any emerging issues?
- What are the key health issues and inequities? Which population groups are most affected?

(Public Health Agency of Canada 2001a:9)

From the answers to these questions, a range of key population health issues will be identified and prioritised for action.

Entry points for data analysis

There can be various starting points for data examination. The Public Health Agency of Canada calls these 'entry points', (eg, examination may begin with burden of disease data, smoking rates or socio-economic data). These are all valid entry points which are not unique to population health planning. Since population health planning considers social determinants, any given 'entry point' will, in theory, lead to an exploration of other possible entry points and the identification of one or more population groups of particular concern (see Table 1 below).

As this toolbox focuses on area-level population health planning, an obvious entry point is a geographical group, (eg, residents of Melbourne's North West metropolitan region). However, investigation of diabetes in an area may use a disease-based entry point to understand the determinants and population groups involved.

Table 1: Examples of entry points and population groups

Further Information

For further information, please contact:

Tom Symondson
Acting Chief Executive
Victorian Healthcare Association
Level 6, 136 Exhibition Street,
Melbourne, VIC 3000
Email: tom.symondson@vha.org.au
T: 03 9094 7777 M: 0429937997