

Regionally-based needs assessment in Australian primary health care

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Expert Review

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Executive summary

Needs assessments in primary health care provide information to plan and change services, with the ultimate goal of improving the health of a population.³ It is the first step in health care services planning, and involves identifying and analysing a region's health problems and potential target group.⁴ For the purposes of this report, need was defined as "the population's ability to benefit"³ as this lends itself most usefully to health services planning. This report also reflects on International and Australian models that may inform approaches to needs assessments in Australia.

A number of models were identified in the literature reviewed. The best method for regionally-based needs assessments in Australia depends on a number of factors, including the scope and purpose of the needs assessment and the time and financial resources available to the organisation. A summary of the different approaches to needs assessments is shown in Table 1.

Table 1 Summary of approaches to regional needs assessments in primary health care

Approach type	Premise	Pros	Cons
Global	Focuses on available health services and identifying 'gaps' using epidemiological data. Priorities & cost-utility trade-off determines commissioning decisions.	Comprehensive, well-rounded. Considers financial implications.	Likely to be time and resource intensive. Does not include community perspectives.
Epidemiology	Focuses on disease incidence & mapping service availability.	Effectively identifies areas of need in great detail.	Time consuming. No focus on community/national priorities.
Community	Based on community perspectives of need, using a community development type approach.	Garners local support and perspectives effectively.	Ignores national priorities, quantitative data. Time consuming.
Comparative	Reviews services in one area compared to services in another area.	Useful in the absence of relevant data.	Unreliable method of determining need.
Corporate	Based on 'expert' perspectives.	Good for understanding local circumstances.	Ignores consumers and data-informed priorities.
Life course	Looks at the stages and risks of the development of chronic disease.	Only method with a developed approach to tackling chronic disease.	Views disease development as a linear process, which is not always accurate.

The degree of comparability across regions depends on the types of data that are used for the needs assessments rather than the approach used to assess need. Data that are collected systematically under consistent conditions (such as data collected by the Australian Bureau of Statistics) will be more comparable than data that are less well defined and collected from other sources at irregular time points.

Numerous examples of regional needs assessments were examined for this report. While the overarching reason for undertaking needs assessments was to improve the health status of their populations, in all countries reviewed, the main purpose of needs assessments in primary health care was to reallocate limited health care funds in a more equitable and efficient manner. The countries with comparable health systems are shown in Table 2, where the key aspects of their needs assessments are compared.

Table 2 Comparison of approaches to regional needs assessments internationally

	England	Scotland	Ontario, Canada	New Zealand
Organisation	Primary Care Trusts	National Health Service Boards	Local Health Integration Networks	District Health Boards
Purpose of NA	Identify local needs and priorities.	Engage in collaborative decision-making on service provision and integration.	Community and provider consultation.	Assessment of population's capacity to benefit from health services prioritised within cost constraints.
Utilisation of NA	Informs the regional strategic planning (including non-health areas) and commissioning decisions.	Community consultation informs a Local Delivery Plan, which is a performance agreement that is consistent with the government focus.	Informs an Integrated Health Service Plan and an Annual Service Plan.	Feeds into a prioritisation process and into strategic and annual plans.
Local vs. national priorities	Both nationally and locally informed. Locally informed need is translated into performance targets.	Mostly nationally focused. Is linked to performance targets.	Mostly nationally focused. Resultant service plan must be aligned with the Ministry's vision.	Mostly nationally focused, derived from the NZ Health Strategy Health Targets.
Procedure	Conducted jointly with local government and health services into a Local Area Agreement.	Conducted by a sub-committee of the National Health Service Board comprised of health service organisations, professionals and consumers.	Led by Local Health Integration Networks though there is collaboration with health providers and community members.	Led by District Health Board, though public and providers are included.
Frequency	At least three yearly to inform Local Area Agreement planning cycles.	Ongoing committee work feeds into annual planning processes.	Evolving three year plan with annual updates.	Three years to inform a 5-10 year planning cycle
Data source	Centralised data repository managed by the national government. Access facilitated and analytical tools are provided.	Datapak from Scottish government provides data.	Centralised data repository managed by the Canadian government. Online analytical tools which produce customised reports are provided.	Centralised data repository managed by the government. Access is facilitated and advice on additional data and analysis is provided.
Community consultation method	Public/local organisations can join the Local Involvement Networks, which provides information on needs and perceptions.	Facilitated by an intermediary body (Public Partnership Forum).	Multiple strategies are used as appropriate to their communities but must involve French speakers and First Nations.	Within minimum standards District Health Boards use methods appropriate to the community.
Consultation standards	National Health Service Constitution mandates consultation.	National Health Service Boards must follow a Participation Standard.	Local Health Integration Networks consult using a common assessment tool.	Minimum guidelines are provided by the government.
IT infrastructure	National IT infrastructure for National Health Service, managed by Department of Health.	National Health Service administrative infrastructure.	Ministry collates many sources of administrative data but this is poorly integrated. Work on a single IT infrastructure has stalled.	District Health Boards collate information on services in their region. This is not aggregated upwards.

While evaluating the effectiveness of needs assessments in terms of health and/or health care outcomes is not feasible, several elements of needs assessments have been identified that may contribute to better planning and more successful implementation of strategies.

These include:⁵

- ⇒ Educational strategies to improve health professionals' understanding and skills in assessing health needs
- ⇒ Involving local public health teams for support and guidance
- ⇒ Starting with a simple, well-defined health topic to develop experience and confidence
- ⇒ Ensuring sufficient time, resources and commitment are available. Sharing time and resources among health professionals reduces each individual's commitment and strengthens the team
- ⇒ Encouraging inter-agency collaboration (eg. social services, local authorities, volunteer groups)
- ⇒ Integrating results of needs assessments with planning and purchasing to ensure changes are implemented.

Overall, the literature suggests that the optimal approach to conducting needs assessments in primary health care is to gather the best available information; involve clinicians in the process; and ensure needs assessment is closely connected to the planning process.

The models reviewed in this report identified a number of discussion and consideration points relevant to possible approaches to regional needs assessment in Australia. These include:

- ⇒ *The policy and strategic environment in which needs assessments take place.* Some countries had well-defined strategic and policy environments (including performance frameworks), which complement and support the development of needs assessments. However, due to broader system factors and political considerations, some overseas models failed to provide efficient service delivery reorganisation in line with the findings of needs assessments.
- ⇒ *Source and comparability of data across regions.* Data collection was generally undertaken by national governments. Some service availability data were collected at the local level. Community perspectives were gathered by the regional organisations.
- ⇒ *Usefulness and availability of data.* Relevant research and health economic data and/or geographically segregated data were often difficult to obtain.
- ⇒ *National vs. regional.* Where there are variations between nationally and regionally identified need, significant tensions can arise; and the degree to which local voices will be considered through needs assessments should be made as explicit as possible.
- ⇒ *Community engagement.* Challenges were encountered in community consultation for needs assessments. Community engagement was undertaken in a number of different ways by regional organisations. Although some established consultation groups or forums, most also sought public feedback on need. Managing community expectations is challenging and this can be exacerbated by an inappropriate approach to consultation.
- ⇒ *Prioritisation of needs.* While the collection of data for needs assessments is not controversial, the prioritisation of needs is often debated and can result in community-driven conflict.
- ⇒ *Costs.* Needs assessments are resource intensive and the frequency with which they are conducted should be limited. Organisations must also be given sufficient time to act on the findings of the needs assessments.
- ⇒ *Resources and skills.* Skills and capacity deficits may affect organisations' ability to undertake needs assessments. These deficits may affect their ability to undertake the relevant analyses as well as their ability to communicate effectively between the needs assessment and planning sections of organisations.



- ⇒ *Mechanism to inform policy.* No clear or systematic method for feeding information upwards to inform policy was identified in the countries reviewed. Although it is the intention of the new English reforms to amend this, the mechanism by which this will occur could not be identified.

1 Introduction

Needs assessments in primary health care provide information to plan and change services, with the ultimate goal of improving the health of a population.³ This report reviews the key trends in regionally-based needs assessments in Australia and internationally. It describes the approaches to undertaking needs assessments, and the critical elements for consideration in needs assessments. We reviewed experiences of countries with health systems that were comparable to Australia: New Zealand, England, Scotland and Canada, with a particular focus on their experiences and potential relevance to needs assessments in the Australian health care context. The conclusions of this report reflect on the learnings from overseas experiences that may be relevant to approaches to needs assessments in Australia.

1.1 Aim and scope

The aim of this *Policy Issue Review* was to provide information relevant to possible approaches to regionally-based needs assessments in the Australian context. The question was:

What regionally-based needs assessment models have been reviewed in relevant local and international literature? The report considered:

- ⇒ How are regionally-based needs assessments undertaken?
- ⇒ What information is typically collected?
- ⇒ How is this information analysed and reported?
- ⇒ How are the results utilised?
- ⇒ What successes and challenges were encountered in these environments? (**see comment below)

**While the available literature was replete with the 'challenges' associated with undertaking needs assessments, there was no discussion about 'successful' needs assessments. This is not surprising as needs assessments are used primarily for planning purposes and it is the effectiveness of interventions and efficiency of services implemented *after* a needs assessment that are often evaluated. Needs assessments may generate a list of unmet needs and inefficient or inappropriate care in the target community; and potential strategies to address them. However, if the recommendations informed by a needs assessment are not implemented effectively in a timely manner, it is unlikely that services to patients or their overall health status will change. Thus, while the needs assessment process itself may be optimal, it is the results of needs assessments (ie. the follow-up activities) that need to be used effectively to improve outcomes for patients. Consequently, this question was revised and the report focuses on the lessons learned from needs assessments undertaken in different environments.

In addition, the review addressed the following:

- ⇒ how needs assessment fits into systems
- ⇒ the frequency of needs assessment
- ⇒ how needs assessment is incorporated into accountability frameworks
- ⇒ how needs assessment is fed upwards to enable policy making
- ⇒ systems and IT infrastructure for sharing needs assessment horizontally and vertically across organisations, or barriers to this
- ⇒ problems experienced and how these have been addressed.

NB: The review of international literature was limited to those countries where findings have real potential to inform work being done in Australia, eg. New Zealand, UK, Canada. Full details of the methods used in developing this report can be found in the appendix (Section 7.1).

1.2 Definitions of ‘need’ and ‘needs assessment’

A simple and widely accepted definition of **need** in the health care context is “the population’s ability to benefit from health care”.⁶ This definition distinguishes need from demand, which is potentially infinite, and supply, which is what is being provided. It is linked to health services in that it depends on the potential of health services (across the continuum of care) to manage health problems⁶ and acknowledges that the ability to fund health care services is limited.

Bradshaw⁷ developed a description of four types of need that should be considered when conducting needs assessments:

- 1 *Normative need*: based on expert opinion derived from research
- 2 *Expressed need*: what can be inferred by a population group’s use of services
- 3 *Comparative need*: derived from comparing the services in one area to those in another area with a comparable population
- 4 *Felt need*: that which is expressed by community members.

A well-developed needs assessment will examine all of these ways of understanding need.

A simple, commonly cited definition of **needs assessment** is “the assessment of a population or community’s ability to benefit from health care”.³ This is directly linked to the definition of need (above). A more recent, detailed definition describes needs assessment as “a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities”.⁶ It is a systematic way to identify unmet health care needs in a community and develop strategies to meet those unmet needs. In simple terms, it entails examining what should be done, what can be done, and what is affordable.⁵

1.3 Purpose and objectives of needs assessments

The overarching **purpose** of a needs assessment in health care is “to gather the information required to bring about change beneficial to the health of the population”.⁸ It is a tool for proactive planning to improve health services, pre-empt potential barriers and identify opportunities to improve health.⁹

The principal **objectives** of needs assessments (in primary health care) are to:^{6,10}

- 1 plan and deliver the most effective care to those in greatest need (ie. determine whether those who receive a service need it; and those who need a service receive it)
- 2 apply the principles of equity and social justice in practice
- 3 ensure that scarce resources are allocated where they provide maximum health benefit
- 4 work collaboratively with the community, other professionals and agencies to determine the types of health care teams required to address the issues of greatest concern (ie. identify and define interdisciplinary collaborations; stimulate the engagement of members of the primary care team; and define funding required for resources to support establishment of teams)
- 5 specify services and other activities that impact on health care. Activities include:
 - o Gathering information on population health and health needs
 - o Assessing incidence and prevalence (ie. how many people need a specific service or intervention?)
 - o Determining effectiveness/cost-effectiveness of services

- Assessing baseline services (knowing what currently exists is necessary to identify what needs to be changed or introduced).

Given that needs assessments are an integral part of priority setting,⁶ reallocation of funding resources is one of the primary objectives of needs assessments (this was true for all examples of national needs assessments in the UK, Canada, and New Zealand – see chapter 4 for more detail). Reallocation of resources may occur following the identification of four main factors:⁸

- 1 People who are not receiving beneficial healthcare interventions (unmet needs)
- 2 People who are receiving ineffective health care (releases resources for unmet needs)
- 3 People who are receiving inefficient health care (releases resources for unmet needs)
- 4 People who are receiving inappropriate health care (health outcomes could be improved).

While it could be argued that “all needs should be met”, needs assessments are conducted typically “within the context of finite resources”^{6,8} However, an exploratory phase of needs assessments free from the constraints of resource shortages may be valuable in the early stages.⁶

*Successful health needs assessments require a practical understanding of what is involved, the time and resources necessary to undertake assessments, and sufficient integration of the results into planning and commissioning of local services.*⁵

Determining the goals at the outset of a needs assessment is critical to choosing the approach taken.⁷ A lack of clear objectives and goals was problematic in the early stages of regional needs assessments in England and New Zealand.^{11,12} In these contexts, the absence of clear objectives led to a failure of the assessments to fit in with other planned activities¹³ and, inevitably, a lack of impact on service provision related to funding allocation (see Section 4 for more details on assessments in these jurisdictions).¹¹

In determining the purpose and objectives of the needs assessments, the following questions are important to ask at the outset:¹⁴

- ⇒ What is the purpose of the assessment? (eg. to clarify what should be done, or just to highlight problems?)
- ⇒ How will need be determined?
- ⇒ What is the extent and focus of the needs assessment?
- ⇒ How will commissioning work/purchasing of services be undertaken? (to allow analysis to match how the information will be used)
- ⇒ Who are the relevant stakeholders to be consulted and at what stage will they be consulted?
- ⇒ How much change is realistic?
- ⇒ What are the parameters of the health need to be assessed, acknowledging that there will be a trade-off between the breadth and depth of the assessment?
- ⇒ How will the outcomes be evaluated to assess if success has been achieved?

Answering these questions have proved critical to needs assessment activities that have been undertaken overseas.^{14,15}

2 Approaches to needs assessment

In this section, six key approaches^a to undertaking needs assessments are described: the global, epidemiological, community-based, comparative, corporate, and the life course approach. These approaches vary in their scope, use of data and degree of community consultation. The key stages in each approach are described, with a brief overview of the pros and cons. Regional needs assessments in Australia are likely to use a combination of these strategies to identify the health needs of their populations.

2.1 Global approach

The global approach to needs assessments is also known as locality based health needs assessments.¹⁴ This approach uses epidemiological data, though it focuses on health care services (as opposed to disease or illness focused). This results in the identification of service gaps and inefficiencies.

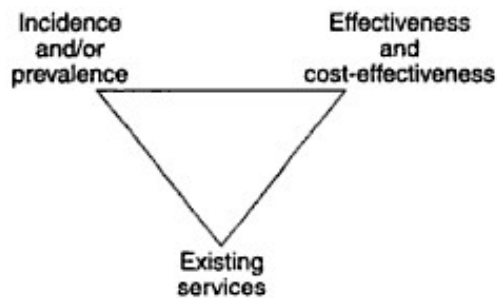
According to Coster,¹⁴ the global approach follows an eight step process:

- 1 *Setting of objectives:* Determined by performance frameworks, health care acts.
- 2 *Gathering information about the population characteristics:* Who are the people in need of health services within the catchment area?
- 3 *Gathering information about disease, disability and risk factors:* What conditions do people present with? This need can be segregated on the basis of geographical area, age, cultural background, gender to give a more detailed picture of needs.
- 4 *Gathering information about health care service availability:* This includes information on providers and provider numbers, service utilisation, and community and provider views on service provision.
- 5 *Needs analysis (ie. 'gap analysis'):* In New Zealand, this took the form of the gap between the performance indicator targets and the true reality in the catchment area. This could also use a priorities framework instead of a performance framework.
- 6 *Review of effectiveness of current and alternative health care interventions.*
- 7 *Review of the cost-effectiveness of current and alternative health care interventions.*
- 8 *Prioritisation of the interventions:* This can be informed by the gap analysis, community and expert consultation and effectiveness/cost-effectiveness information.

2.2 Epidemiologically-based approaches

Epidemiologically-based needs assessments are based on the principle of determining “what is effective and for whom”.⁸ These are multi-agency approaches which collect in-depth information about specific populations.¹⁶ The depth of epidemiological analysis means it is more time-consuming than community, comparative or corporate approaches. In contrast to the global approach, epidemiologically-based approaches are very medical and ‘disease focused’.^{14,17} The foundational elements of the epidemiological approach are shown below in Figure 1.

^a Each approach defined need as “the population’s ability to benefit from health care”.¹⁴



Source: ¹⁷

Figure 1 The foundational elements of epidemiological needs assessments

Epidemiologically-based approaches have six basic components:

- 1 *A statement of the problem and context:* This includes the problem and its context and the major inputs or issues relevant to the problem. This normally focuses on a particular disease.
- 2 *Sub-categorisation:* Normally of the disease. This focuses on severity, prognosis, age, location. What is a relevant sub-categorisation depends on the nature of the problem.
- 3 *Prevalence and incidence:* Uses a descriptive epidemiological approach. A focus on health service commissioning also involves a calculation of the people who would benefit from treatment.
- 4 *Mapping of service availability and cost:* This may come from budgeting information or research.
- 5 *Review of effectiveness and cost-effectiveness of services:* Effectiveness can be derived from research, patients' acceptability of a treatment and cost per patient at the margin^b (rather than average cost per patient).
- 6 *Establishing a model of care and suggested recommendations.*

In some situations, a seventh step that focuses on identifying research and information gaps encountered during the needs assessment processes may be appropriate for subsequent needs assessments.¹⁷

2.3 Community-based approaches

Community-based needs assessments differ significantly from the global approach described above. They rely heavily on public consultation and user involvement in determining priorities and needs. Other characteristics of the community-based approach include the tendency to:

- ⇒ examine smaller geographical areas
- ⇒ engage in large amounts of fieldwork
- ⇒ maintain a flexible, community development approach
- ⇒ be derived largely from qualitative data.¹⁸

These approaches are very 'bottom up' compared to epidemiological and health economics informed approaches, which are very 'top down'. The steps involved in a community-based approach generally consist of the following:

- 1 Definition and characterisation of the catchment area.
- 2 Mobilisation of the community to establish a collaborative professional-public relationship.

^b Cost at the margin refers to the cost that arises when one additional unit of a product or service is produced. This is important in health services as it takes into account costs that are fixed (such as infrastructure, salaries and other inputs) which can sometimes be over or underestimated if one uses average costs.

- 3 Development of diagnostic and resource inventories in consultation with the public.
- 4 Development and implementation of community-based interventions.
- 5 Establishment of a cyclical monitoring and evaluations process.¹⁹

Formerly, this was a popular approach. However, it is less used now, perhaps due to its time intensiveness, as well as perceptions by health authorities of a loss of control of priorities and processes.¹⁴

2.4 Comparative approaches

Comparative approaches focus on the services received in one area compared to another.⁸ This approach may be appropriate in the absence of data or information on disease prevalence or population numbers. In an Australian context, this may be useful when working with populations that are not adequately enumerated within national censuses, such as Aboriginal or Torres Strait Islander people, those who are homeless or people who have disabilities; and their respective health care needs. Caution is advised in the use of comparative approaches. However, they have been shown to be useful techniques in the absence of relevant data.^c

2.5 Corporate approaches

Unlike the approaches described above, the corporate approach does not rely on epidemiological data.^{8,14,17} Alternatively, it involves the collection of perspectives from key stakeholders and informants (see Figure 2 below).



Source:¹⁷

Figure 2 Contributors to the corporate approach to needs assessment

This approach has been criticised as it allows providers and vested interests to control the priority setting process, leading to a blurring of need vs. demand for health care services. However, this approach may be useful to understand how need is shaped by local circumstances.¹⁷ The corporate approach may also be useful for determining purchasing priorities in situations where there is a number of services of equal effectiveness and efficiency, by reflecting on the acceptability of an approach to the local constituents.¹⁴ Therefore, this process can integrate a 'local voices' element into needs assessment.

^c An example of how the comparative approach can be used can be found at the National Health Service Comparators website ²⁰ <http://www.ic.nhs.uk/services/nhs-comparators>.



2.6 Combined life course and logic model approach

A life course approach is not typically considered to be one of the 'approaches' to needs assessment. However, the Australian Government's focus on chronic disease makes it a relevant addition to the needs assessment process.

A life course approach to health and epidemiology focuses on the importance of particular events at different times in a person's life and how those events contribute to chronic disease outcomes:

[It is] the study of long-term effects on chronic disease risk of physical and social exposures during gestation, childhood, adolescence, young adulthood and later adult life. It includes studies of the biological, behavioural and psychosocial pathways that operate across an individual's life course, as well as across generations, to influence the development of chronic diseases.²¹

This is particularly important when considering ways to intervene in the development of chronic disease that has a long development period during which preventative health interventions may be implemented.²²

This approach is informed by the development of a 'logic model' that outlines the stages and influences that are informed by the available research. The stages of logic models are developed by starting with the outcome (eg. the development of Type II diabetes) with the factors contributing to the outcome entered in an iterative process. What emerges is a model of projected future chronic disease rates based on known risk factors. These risk factors and stages of disease development are then used to target the health interventions.

3 Elements of needs assessment

3.1 Health care legislation, policy and strategic direction

The development of a needs assessment are informed by strategic guidance from policy.²³ To some extent, the policy and strategic environment clarified the framework for the needs assessment and prioritisation process in the countries reviewed for this report.^{14,23} This is particularly important because 'need' is a complex concept that is perceived differently by different stakeholders.²⁴

A framework assists regional planning organisations to guide their data collection and manage and prioritise perspectives of people, information and data. High level policy and strategic documents can assist in this process. Such documents may include:

- ⇒ Strategic or policy documents focusing on national or state health care priorities or goals
- ⇒ Performance frameworks specifying the outcomes on which the organisation will be assessed
- ⇒ Acts or legislation which specify the type or manner of the work that is to be commissioned or carried out
- ⇒ Similarly, legislation or treaties that specify public or minority group consultation processes and the rights of certain groups to be considered
- ⇒ Contracts specifying the scope of an organisation's responsibilities (eg. they may focus only on primary health care or include social determinants of health).^{14,23}

Funding will also be a factor that determines the scope and comprehensiveness of needs assessments.¹²

3.1.1 Tensions between Government priorities and local needs

All governments in countries reviewed for this report have developed comprehensive, detailed policy frameworks for health priorities. The main advantage of having a fully developed policy framework is nationwide consistency between initiatives and programs to guide local action.

However, it is also important for health systems to respond to local need. When a national government devolves needs assessment to a regional health authority, tensions can arise between the strategic priorities of the national government and the needs identified at the regional level.^{12,25,26} Internationally, local level priorities that are incongruent with the national priorities have resulted in confusion and difficulties in developing a regional plan.^{12,25,26}

3.2 Data types and sources

The types of data used in needs assessments are highly variable and depend on the scope of work to be undertaken by the organisation. The focus may be on data that are directly disease related (such as incidence of certain disease) through to more distant precursors to the development of disease (such as health risk factors or even more distantly, socioeconomic variables). Data should also reflect longitudinal trends to allow for the prediction of future demands rather than a single 'snapshot' in time (see the Life Stage Model of Chronic Disease in Section 2.6).¹⁵ A list of the types of data used in needs assessments can be found in the appendix (Section 7.2).

3.2.1 Data sources

Overall, data were collected by a central government administration in the countries reviewed (see the country profiles in Section 4), thereby ensuring consistency and comparability of data between

regions.^{25,27,28} For centrally collected data, care must be taken to obtain a large enough sample to be representative of the area.^{d29}

In contrast, regionally collected data are prone to problems of reliability and comparability across regions.³⁰ In addition to comparability issues, there may be a lack of skill necessary to collect data at the local level. Despite these difficulties, the collection of local data may be necessary in instances where there is no national data source or where there are unique local circumstances. However, for national performance indicator relevant data, data obtained from a central administration are preferable.³⁰

PHC RIS' experience of issues with locally collected data falls into three main categories:

- ⇒ Inconsistent use of a definition for what it is to be collected, and what is an appropriate statistical indicator
- ⇒ Time related factors, such as when the data were collected
- ⇒ A lack of data reliability, especially when the numerators and denominators for percentages are obtained from different sources.

3.2.2 Software

The jurisdictions reviewed for this report are at different stages in establishing centralised IT infrastructures for health care data. The English National Health Service is well advanced in this respect, whereas Ontario is working towards centralised systems. In the latter case, data sets are poorly coordinated, with nearly 2 000 health indicators in use and 100 administrative databases, many containing duplicate data.³¹

The capacity for integrated data collection in Australia is limited by the diversity of organisations and funding jurisdictions providing health care. The AIHW collects, analyses and reports on many health services, community services and housing data sets.³² To do so, they collaborate with all levels of government, universities and health services across Australia. This is enabled by negotiation and Memoranda of Understanding. Currently, the AIHW are building capacity in data linkage and metadata standards to achieve greater consistency and comparability between administrative data sets.³²

3.3 Geographically based data use

3.3.1 Geographic Information Systems (GIS)

"GIS is a system to place information (data) on a map (spatial referencing), so that it can be usefully interpreted."³³ Geographic Information Systems (GIS) are used increasingly in health care planning to link and integrate multiple data sources and provide visual maps of the relationships between health, service provision and geography.³⁴ A recent Australian study reviewed the use of GIS to explore problems of workforce, access to services, equity and disease prevalence; and to inform workforce and health service planning and disease prevention activities.¹

GIS has been used successfully to analyse GP distribution patterns in Adelaide,³⁵ Perth³⁶ and rural and remote South Australia.³⁷ This technology is more accurate than previous studies of administrative regions and enables a finer grain of detail to identify areas of poor access at the neighbourhood level.³⁵

^d This was a problem in the UK where patient experience data was not collected in sufficient detail for a reliable estimate.²⁹ This led to people contesting the data that was obtained.

3.3.2 Geo-demographics

Geo-demographics uses socio-economic data to profile people in geographical areas according to their socio-demographic characteristics and features of their neighbourhood,² thus identifying areas with high need.² Geo-demographics is a widely used technique in England.

Overseas examples using GIS and geo-demographic technologies

Healthscape¹, USA: Developed by the Robert Graham Centre (not for profit), this is an interactive web based mapping tool <www.healthlandscape.org>

Mosaic², UK: Mosaic was developed as a commercial enterprise in the UK with licences sold to government agencies when required
<<http://www.experian.co.uk/assets/business-strategies/brochures/mosaic-uk-2009-brochure-jun10.pdf>>

3.4 Research and economic evaluations

Research and economic evaluations can inform the efficiency and effectiveness of a particular service and provide suggestions for alternative approaches.³⁸ In conducting needs assessments and mapping current activities, regional health organisations must decide whether current commissioning and purchasing arrangements reflect best practice to ensure the maximum effectiveness. The drive for best practice in health care and its service delivery must be balanced with the need for cost efficiency so the greatest good can be obtained with a finite budget. Research and economic evaluations can inform both of these processes and have formed a critical component in previous health needs assessments.³⁸

Despite the fact that research is an important component in needs assessments, it has not always been widely used.³⁸ This has been attributed to the unsuitability of some research evidence for use in a practical commissioning context.³⁸ In addition, the assumptions on which economic evaluations are based have been unrealistic for some environments, meaning costs need to be recalibrated to suit local circumstances.¹⁴

3.5 Community consultation

All of the countries reviewed have introduced legislation to guarantee public consultation by health service planners. In England, the National Health Service Constitution³⁹ and Health and Social Care Bill,⁴⁰ which is currently being considered by parliament, propose a shift in power that transforms the relationship between citizen and service through the principle of "no decision about me without me". Similar legislative requirements exist in Ontario, Canada⁴¹ and New Zealand.⁴² Special priority is given to Maori people in NZ, as the Treaty of Waitangi requires the government to consult with Maori people.¹⁴

Some countries have established formal community consultation groups when undertaking needs assessment and health service planning. These organisations facilitate public consultation and provide advocacy for local voices and perspectives.⁴³ While the composition of organisational boards varies between countries, they often comprise health care professionals, organisational managers, consumer representatives and the public.⁴⁴

Some governments have also established minimum standards for consumer consultation for regional health care planning organisations. These are formalised through governance agreements and their reporting processes. For example, the Scottish Health Council provides a Participation Standard,⁴⁵ which allows this to be done in a systematic and comparable way. Similar standards, which ensure comparability, exist in Ontario through the use of a Common Assessment Tool.^{e46,47}

3.5.1 Challenges in community consultation

The following issues were identified in community consultation:

- ⇒ Balancing the amount of consultation so that useful information is obtained, but not so much that it is overwhelming and cannot be used effectively.⁴⁸
- ⇒ Insufficient skills and financial resources for the consultation.⁴⁹
- ⇒ Difficulty reaching minority or isolated groups.⁴⁹
- ⇒ Challenges in consolidating the variety of consumer views.⁴⁹
- ⇒ Limited consumers' abilities to provide meaningful contributions, due to the lack of knowledge or experience.⁴⁹
- ⇒ Balancing the findings of the consultation with the government health priority areas.²⁵
- ⇒ Managing community expectations.^{49,50}
- ⇒ Fear of criticism for decisions taken.⁴⁹

3.6 Skill sets

A wide range of skills are required to undertake a needs assessment. Effective needs assessments require the skills of, and input from, epidemiologists, public health specialists, economists or health economists, clinicians and the public.⁵¹ The wide variety of skills needed has presented difficulties in other countries where certain skills (particularly epidemiology and health economics) were in short supply.⁵⁰

Those undertaking needs assessments must also be able to appreciate the capacities of other professionals involved in the process. When these different professional perspectives do not link effectively, this may result in an inability for others to effectively use the information.¹⁵ In the UK, some organisations concluded that capacity building is needed between those conducting and those using the needs assessments,¹⁵ as the teams who were involved in purchasing and commissioning were unable to articulate what data they needed to capture and analyse. Similarly, those conducting the needs assessment were unable to understand the perspectives of commissioners and to produce needs assessments that involved more than just a population's demand for health care.

An introductory guide for undertaking needs assessments (community health) has been developed. The guide contains information for practitioners and a training module for educating those involved in conducting needs assessments.¹⁰

3.7 Prioritisation and decision making

Prioritisation is the last stage of the health needs assessments process.¹⁴ This involves weighting the data, perspectives and other information collected according to a pre-defined framework of importance. This is a challenging and politically charged process, which has caused controversy

^e The Common Assessment Tool can be found here:

http://www.centrollhin.on.ca/uploadedFiles/Home_Page/Get_Involved/LHIN%20Community%20Engagement%20Guidelines%20and%20Toolkit%20-%20February%202011%20-%20FINAL.pdf

overseas.⁵² Boards involved in prioritising regional health care needs in the UK have shied away from the task as they feel ill-equipped to make the moral judgement calls regarding resource allocation.⁵³

Debate centres not only on the prioritisation framework itself, but also on 'who decides' or has input into developing the framework.⁵² Australian research has shown that around 75% of the public feels they should have input into priority setting for distributing funding across health care programs, medical procedures, and different population groups.⁵⁴ Therefore, it appears that public consultation in the priority setting phase may be critical in the Australian context, though this will not be a panacea to avoid the differences of opinions.

In Australia, prioritisation for health care funding has typically been based on previous funding allocation.⁵⁵ Other approaches include:

- ⇒ *Core services approach*: Attempts to define minimum standards for services⁵⁶
- ⇒ *Economic evaluations*: A comparative analysis of different courses of action in terms of their costs and consequences⁵⁶
- ⇒ *Delphi approaches*: A methodology for developing consensus from a panel of experts¹⁴
- ⇒ *Development of Quality of Life Adjusted Life Years (QALYs)*: Ranking procedures in terms of the costs per QALYs gained.⁵⁶

However, the academic literature indicates that the most widely accepted process to priority setting is Programme Budgeting and Marginal Analysis (PMBA). PMBA is based on the economic concepts of opportunity cost and cost at the margin (see footnote (a) on page 4). Typically, there are five key questions that are asked when prioritising needs using the PBMA approach:

- 1 What resources are available in total?
- 2 In what ways are these resources currently spent?
- 3 What are the main candidates for more resources and what would be their level of effectiveness?
- 4 Are there any areas of care which could be provided to the same level of effectiveness but with fewer resources, thereby releasing those resources to fund candidates from question 3?
- 5 Are there areas of care which, despite being effective, should receive fewer resources because a proposal from question 3 is more effective (per dollars spent)?⁵⁶

Whilst the PMBA appears to be the most academically accepted process for developing the prioritisation framework, it is also very resource intensive.³⁸ Research using a PMBA approach showed that developing a prioritisation framework for a period of 10 years took approximately six months.³⁸

4 Examples of needs assessment

This section of the report reviews examples of needs assessments and the health care systems that support them. New Zealand, England, Scotland, and Canada (Ontario) were reviewed, as were the experiences of the Divisions of General Practice in Australia. In addition to these jurisdictions, the proposed changes for England, a number of additional Canadian provinces and Australian state-health organisations are provided in the appendix (Section 7.4 onwards). For each example, some policy and systemic context is provided, and the following questions were addressed:

- ⇒ How are needs assessments undertaken?
- ⇒ What and how is the information for needs assessments collected?
- ⇒ How is the information from the needs assessment analysed and reported?
- ⇒ How are needs assessments utilised?
- ⇒ What were the lessons learned in these environments?

Where possible, information on how needs assessments were used to inform national (or provincial) policy development has been provided.

4.1 New Zealand

4.1.1 Context

In 2001, New Zealand began a process of health reform. This involved significant structural changes, including the introduction of 21 District Health Boards. District Health Boards have the responsibility for commissioning and organising the provision of health and disability services within specific geographic boundaries. District Health Boards' statutory objectives are designed to:

- ⇒ improve, promote and protect the health of communities
- ⇒ promote the integration of health services, especially primary and secondary care services
- ⇒ promote effective care or support for those in need of personal health services or disability support.⁵⁷

District Health Boards are governed by the New Zealand Public Health and Disability Act 2000, which prescribes their operations, including needs assessments and a framework for how they are to be conducted. The New Zealand Health Strategy, which focuses on 13 health targets, has been translated into a set of indicators for District Health Boards to guide their activities.¹⁴ This also guides their needs assessments. For more information on how the needs assessment fits in with the wider accountability framework, see the appendix (Section 7.3).

4.1.2 How are needs assessments undertaken?

Needs assessments are undertaken every three years⁵⁰ to cover a strategic planning cycle of 5-10 years.¹² The government does not prescribe the exact frequency for needs assessments and so each District Health Board conducts them at a slightly different time. Needs assessments in New Zealand are an assessment of the population's potential to benefit from health care services prioritised according to effectiveness, including cost-effectiveness, and funded within available resources.⁵⁰ Therefore, it is an assessment of service needs, insofar as District Health Boards are able to respond to them within their resources and capacity.

4.1.3 What and how is the information collected?

Large amounts of data are contained within District Health Boards' needs assessments. These include:

- ⇒ Population demography (including socio-demographic data, such as unemployment rates, education and housing)

- ⇒ Rates of health promotion and risk factors for disease
- ⇒ Disease incidence, including chronic, infectious and notifiable disease
- ⇒ Population-specific service needs (eg. elderly people, children and adolescents)
- ⇒ Culture-specific data, such as Maori and refugee health data
- ⇒ Primary and acute care service utilisation
- ⇒ Rates of avoidable hospitalisations.⁵⁸

District Health Boards focus on current and projected health care needs with analysis using geographical techniques.¹⁴

Some District Health Boards outsource the data collection phase to contractors who specialise in public health and epidemiology.⁵⁸ Many other District Health Boards use their own skills and resources to produce the needs assessments. The Ministry of Health assists District Health Boards by facilitating access to the data they need, including advice on:

- ⇒ sources of data
- ⇒ data quality
- ⇒ analytical techniques
- ⇒ the provision of centrally-held health and disability support data
- ⇒ data available from other central agencies.⁵⁷

The demographic data obtained by District Health Boards are compared to the services available to meet the needs of the population. This 'stocktaking of health care services' includes primary care practitioners, allied and public health professionals, Indigenous-specific services, and secondary and acute care resources and personnel. Data collection, which is the responsibility of the District Health Board, focuses on the number, availability and distribution of the health care providers.

4.1.4 How is the information analysed and reported?

Generally, the following steps are undertaken:

- 1 Collation of the datasets
- 2 Forecasting of demographic and service utilisation data
- 3 Identification of other local service gaps
- 4 Analysis of local community perceptions of service provision
- 5 Projection of current and predicted service gaps, as well as possible areas of unnecessary service provision.¹⁴

A framework was developed, with accompanying toolkits to assist District Health Boards with the prioritisation of identified needs.⁵⁷ Prioritisation of the identified needs is based on five "decision principles" specified by the New Zealand Government:

- 1 efficiency
- 2 cost
- 3 equity
- 4 Maori health
- 5 acceptability to the public.^{57f}

^f To see how this prioritization might be implemented at the local level see the example of the Taranaki District Health Board: <http://www.tdhb.org.nz/funding_planning/policies.shtml>

District Health Boards experienced significant difficulties in the prioritisation phase of the needs assessments.¹² They failed to divert money away from existing services based on prioritisation principles. This may be due to the complexity of the process and difficulties in managing the political repercussions of service disinvestment.¹²

4.1.5 How are needs assessments utilised?

In New Zealand, needs assessments form part of a strategic planning and accountability framework, as shown in Figure 3.



Source:¹⁴

Figure 3 Strategic and policy context for District Health Boards' needs assessments

4.1.6 Learnings from the New Zealand experience

A number of challenges were encountered by District Health Boards during the needs assessment process:^{12,50}

- 1 The New Zealand Government defined the concept of need as "the capacity to benefit". However, this economic interpretation did not necessarily correspond with the interpretations of other primary health care stakeholders.
- 2 Challenges in managing the stakeholder perceptions that were at odds with a rationalised health care budget.
- 3 District Health Boards were charged with meeting health needs which is an intersectoral government responsibility. However, District Health Boards are only able fund 'health services need'. Thus, their ability to bring about change in health outcomes was limited.
- 4 District Health Boards lacked knowledge and skills in linking needs assessments, need prioritisation, and its integration to planning and purchasing of local health services.
- 5 Difficulty in removing funding from existing services to allocate towards the new priorities.
- 6 A lack of competency in conducting health needs assessments existed, including public health, epidemiological, statistical and health economic skills.
- 7 Very short timeframes were set for the District Health Boards' needs assessments, which resulted in many publishing their needs assessments late.
- 8 Challenges in balancing the multiple inputs and perspectives into the prioritisation process.

4.2 England 2007-2011

4.2.1 Context

Following a major review in 1989, the National Health Service has been driven by an ethos of patient choice and responding to local needs and preferences, with responsibility for health care devolved to the regional organisations.⁵⁹ In 2006, a White Paper by the UK Department of Health⁶⁰

identified the need for regular needs assessments of the health and wellbeing status of the population to inform local planning and commissioning of services. This exercise became known as Joint Strategic Needs Assessment (though will be described in this report simply as needs assessments).

Needs assessments are currently the responsibility of a coalition of local government organisations and Primary Care Trusts. Primary Care Trusts are statutory organisations, monitored by a strategic health authority and accountable to the Secretary of State for Health. There are 152 Primary Care Trusts in England and each has their own board and budget that is responsible for determining needs, consulting with the people and ensuring that services are adequate for, and accessible to, their population. They provide some care directly, controlling funding for hospitals; and commission other services, including general practice and other primary health care services.⁵⁹

In 2007, the Darzi Review⁶¹ of the National Health System (National Health Service) envisioned a system that was fair, personalised, effective, safe and locally accountable. After extensive consultation during 2010, further reform was proposed which included the gradual abolition of Primary Care Trusts and shifting responsibility for needs assessment to local government authorities.⁶² If passed, these changes will be phased in over four calendar years, with early testing of the new arrangements commencing in 2010-11 and Primary Care Trusts being abolished in 2013.

This review presents separately the current and proposed models of needs assessment. For more information on the proposed reform, see Section 7.4 in the Appendix.

4.2.2 How are needs assessments undertaken?

In England, needs assessments are undertaken for the spectrum of health, education and social needs, rather than health as a stand-alone issue.⁶³ Needs assessments are undertaken by a group of local and government organisations (including Primary Care Trusts) called the Local Strategic Partnerships.⁹

The needs assessment in England is defined as:

*a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve the health and wellbeing outcomes and reduce inequalities.*²³

Data that are used in the needs assessments reflect need as identified by the local government – Primary Care Trust coalition. As well as national level indicators, each coalition chooses additional indicators to reflect local needs.

4.2.3 What and how is information collected?

Data for the needs assessment are derived from a centralised dataset, which is maintained by the National Health Service.⁶⁴ These data include demography, social and environmental context, lifestyle and risk factors, burden of ill health and health services.^{28,65}

⁹ A useful site for resources, including needs assessment templates can be found here: http://www.lancashire.gov.uk/office_of_the_chief_executive/lancashireprofile/jsna/needsassessments.asp

The National Health Service provides an online analytical tool, data downloads and links to original data sources. The existing health data sets have been modified to allow users to access data at the level of the local authority, Primary Care Trust or smaller geographical areas.^{28,64}

The range of areas in which need may be assessed are specified through the available data, whereas the identification of a need is chosen at the regional level. In 2008, most of the identified needs focused on youth unemployment, housing affordability, obesity, crime rates, smoking rates and community cohesion.⁶⁶

4.2.3.1 Public consultation

The Local Involvement Networks (LINKs) were convened by the Primary Care Trusts to facilitate public consultation.^h LINKs provide a forum through which people can provide feedback on needs assessments.³⁹ The Local Strategic Partnerships also hold public consultations to survey the public about needs in their local areas.

4.2.4 How is information analysed and reported?

Needs assessments in England are used to create a set of shared priorities and to harmonise the work of the health, education and social services sectors in England.⁶³ This allows governments to tackle the social determinants of health in ways that were not possible in the other countries reviewed in this report.

In England, the government instructs that needs assessments should take into account both current and future need.²³ This means they should include a long term assessment of five to ten years into the future,²³ though at a minimum will inform the three yearly local government planning cycles.²³



Figure 4 Key questions that should be answered by English needs assessments

^h See⁶⁷ for an evaluation of the early implementation of LINKs



Figure 5 Future questions that should be answered by needs assessments

Needs assessments are published on the PRIMARY CARE TRUST websites. They are written in plain English and are accessible to the general population. Figure 4 and Figure 5 provide examples of key questions in English needs assessments.

4.2.5 How are needs assessments utilised?

The needs assessments are utilised to inform local area strategic planning for a host of different government and non-government organisations.^{23,48} The results are used for the commissioning activities of the Primary Care Trusts, as well as other local government organisations (ideally including non-government organisations).²³

The priorities identified in regional needs assessments are used to develop a set of locally relevant performance indicators for the local government - Primary Care Trust coalition.⁶⁸ These priorities are negotiated with the national government. The coalition has a further 35 priority targets that are identified by the national government.ⁱ

4.2.6 Learnings from the English experience

A 2010 review of the English needs assessment process¹⁵ found that, while all needs assessments reflected broad concerns about the health and wellbeing of their communities, they varied widely in length, focus and content with gaps evident in the analysis of trends, prediction of demand and supply. These data gaps:

...continue[d] to reinforce 'convenient truths' and allow[ed] persistent health inequalities and status quo to continue unchallenged, with missed opportunities for more effective service delivery.¹⁵

The review identified several important limitations of the process, including:

- ⇒ A lack of involvement in the planning and design of the needs assessment by those commissioning services.¹⁵
- ⇒ In some cases, specific data needed to inform decision-making about commissioning services were missing
- ⇒ Services were rarely involved in providing information on demand and some commissioning strategies contained detailed information about demand that was not derived from the needs assessment
- ⇒ While public health analysts have similar competencies to those commissioning services, the two groups differ in background and training and both groups need skill development to communicate more effectively

ⁱ There are a third set of performance indicators that are for Primary Care Trusts only. These are separate, though each of these performance frameworks target the same goals.

- ⇒ The use of the information obtained through public consultation was a challenge for those undertaking needs assessments. A number of studies found that public feedback was not represented in the final needs assessments.^{48,49}
- ⇒ Emphasis was placed on the collection of quantitative data⁴⁸
- ⇒ When the public information was used, it was based on the commissioners' belief in the information.⁴⁹ This failure to represent the public perspective was attributed to over-consultation⁴⁸ and the wide and discrepant perspectives that emerged during consultations.⁴⁹

Primary Care Trusts experienced difficulties in other areas of public consultation, including:

- ⇒ lack of resources
- ⇒ inability to reach and represent minority or more isolated groups
- ⇒ the limited ability of the public to make sound judgements because of lack of scientific knowledge
- ⇒ the dangers of giving false hope
- ⇒ the fear of condemnation for decisions taken.⁴⁹

More systematic, rigorous methods of public consultation were recommended to overcome these challenges in public consultation,^{48,49} including avoiding over-consultation and an emphasis that 'less is sometimes more'.

4.3 Scotland

4.3.1 Context

The responsibility for running the National Health Service in Scotland is devolved to 14 regional Boards. The Boards are responsible for strategy development and implementation, resource allocation and performance management.⁶⁹ Scottish National Health Service Boards, which do not operate independently from government and are accountable to Government Ministers,⁶⁹ are required to produce and submit a Local Delivery Plan, which forms a performance and delivery agreement with the Scottish Government Health Department.

In addition to the National Health Service Boards, the National Health Service has eight Special Health Boards that provide services for the whole of Scotland. These include National Health Service Health Scotland, which has responsibility for population health, research and evaluation; and Healthcare Improvement Scotland, which provides advice on effective clinical practice, setting standards of care and monitoring performance.⁶⁹

4.3.2 How are needs assessments undertaken?

Health policy and priority setting is made at a national level based on consultation, national data and evidence sources.⁴⁴ Needs assessments, which are undertaken by the regional National Health Service Boards, are in the form of community consultations and collaborative decision-making on service provision and integration.

Planning for primary health care is undertaken by Community Health Partnerships. These are sub-committees of the National Health Service Boards with responsibility for primary health care and social support services. Their membership includes at least one GP, nurse, health care manager, local councillor, staff representative, community representative, representative from a voluntary organisation and diverse allied health professionals.⁴⁴

In most cases, each Board has one Community Health Partnership, but in some cases there are two or more. Their roles include addressing health inequalities and linking agencies. Their linking

function has been likened to functioning like an electrical adaptor by "*acting horizontally across different areas of vertical service provision to help broker joint working and, where appropriate, integration.*"⁴⁴

4.3.3 What and how is information collected?

The Scottish Public Health Observatory⁷⁰ is a collaborative agency that provides access to a national data collection. These data are provided at National Health Service Board level and the Observatory also provides a Health and Wellbeing Profile for each Community Health Partnership. Some data are derived from the Quality and Outcomes Framework. Other data come from Better Together,⁷¹ the patient experience program in Scotland, which conducts a patient experience survey of GP practices and inpatients.

In 2007, the Scottish Government's Better Health, Better Care Action Plan⁷² stressed the importance of patient participation. National Health Service Boards are required to consult with their communities⁷² and the Scottish Health Council supports this by providing a Participation Standard,⁴⁵ which allows consultation to be undertaken in a systematic and comparable way. Boards report on using the categories of the Participation Standard, and the extent to which they involve the public in service planning and improvement and have governance arrangements in place to support this. Each Community Health Partnership has a Public Partnership Forum, made up of patient groups, voluntary organisations and members of the public, which provides a forum for public consultation.⁶⁹ Representatives from the Public Partnership Forum participate in Community Health Partnerships meetings.

4.3.4 How is information analysed and reported?

Community Health Partnership committees meet at least six times per year and have an average of 20 members. Their role includes planning, monitoring performance, providing advice, noting actions taken and making decisions on service development. Decision-making is collaborative and diverse perspectives are brought into the decision-making process.

*National Health Service Boards should continue with planning arrangements at local and regional level, engaging with local and regional partners across the full range of health policy, planning, service redesign and delivery issues... Boards are free to use the formats and timings that suit them and their partners, within existing agreements and guidance on local, community and regional planning. Boards should ensure that they continue to fulfil their statutory obligations on co operation and public involvement.*⁴⁴

The 14 National Health Service Boards are bound by strong accountability agreements with the Scottish Government, including the national outcomes framework, the national health targets and Single Outcome Agreements relating to national health priority areas. Regional planning is collaborative and results in a Local Delivery Plan for service delivery.

*Boards should ensure that all of these activities and their [Local Delivery Plans] are consistent with the quality ambitions outlined in The Healthcare Quality Strategy for National Health Service Scotland and the direction set in Better Health, Better Care.*⁷³

4.3.5 How are needs assessments utilised to inform policy?

Strictly speaking, the needs assessment, in the form of community consultation and collaborative decision-making, is not fed upwards to the Scottish Government. The National Health Service

Boards are accountable to the Scottish Government for the *outcomes* they achieve rather than the *content* of the consultation processes. Accountability for outcomes is assessed through national guidelines and standards, annual accountability reviews and through meeting their health outcomes targets.⁷²

4.3.6 Learnings from the Scottish experience

A 2011 review of the Community Health Partnerships^{44,69} found some lack of clarity about their roles, an inability to overcome cultural barriers and lacked authority needed to implement the changes needed to meet their responsibilities.

4.4 Canada: Ontario

4.4.1 Context

In Canada, responsibility for health is divided between federal and provincial governments. The federal government sets standards, and is responsible for public health, drug and food safety, data collection and research and provides services to First Nations and Inuit populations.⁷⁴ Health care planning and service provision is the responsibility of the provinces and systems vary considerably in the way they manage their responsibilities.⁷⁴

In Ontario^j, the Ministry of Health and Long Term Care devolves responsibility to regional health authorities called Local Health Integration Networks. The 14 Local Health Integration Networks were established in 2006 under the Local Health System Integration Act⁴¹ in order to improve the fragmentation and complexity of the health system, reduce duplication, better coordinate service delivery, improve access, and to move to an organisational model that devolved authority to local organisations which combine system planning with management of health care delivery.²⁵

The Local Health Integration Networks collaborate with local health providers and community members to perform needs assessments; and to plan, integrate and fund health services, including hospitals, community care, community health centres, mental health, addictions services and long term care in a region. The Ministry retains responsibility for public health, primary care, ambulance services, and health programs provided at a provincial level.⁴⁷

The relationship between Local Health Integration Networks and the Ministry is governed by an Accountability Agreement, which includes performance goals and objectives, performance standards, targets and measures, and a budget plan.⁷⁵

4.4.2 How are needs assessments undertaken?

The Local Health System Integration Act requires Local Health Integration Networks to develop and make public an Integrated Health Service Plan. This plan is developed in consultation with the community, which is defined in the Act as patients and other individuals in the geographic area, health service providers and employees of the local health system.⁴¹

A variety of consultation strategies are used, including committees of service users and health professionals. Each Local Health Integration Network is free to determine the process, format and frequency of community engagement activities, based on the characteristics of the community.⁷⁵ However, Local Health Integration Networks are required to involve First Nations and French language groups, health service providers and health professionals.⁴⁷

^j Case studies of additional Canadian provinces can be found in the Appendix, Section 6.5

Local Health Integration Networks are also required to assess their consultation strategy using a common assessment tool and to report to the Ministry on their consultation process as part of their accountability agreement.⁴⁶

4.4.3 What and how is information collected?

The federal government provides a country wide system of health indicators through the Canadian Institute for Health Information⁷⁶ and Statistics Canada.⁷⁷ As well as producing yearly reports on health indicators, Statistics Canada⁷⁸ provides an interactive online tool that generates customised reports using more than 80 health indicators. Data sources include national health surveys, census data and service use statistics. Data are available at regional level, allowing comparison of regional results to provincial data.

Some provinces (Newfoundland and Labrador, Nova Scotia and Prince Edward Island) have developed online tools (Community Accounts)^{77,79} to produce statistical reports at community level.

4.4.4 How is information analysed and reported?

The Integrated Health Service Plan takes the form of a strategic plan. It is operationalised in an Annual Service Plan, an evolving three year plan, which outlines how the Local Health Integration Network will implement the strategies and objectives for their communities.⁸⁰ This is updated every year.

The Annual Service Plans are aligned with the Ministry's vision, items identified in Accountability Agreements as well as priorities identified in the Integrated Health Service Plan and emerging priorities identified by the community. It also includes 'environmental scanning' (demographic data), service use data and risk assessment, which includes financial cost pressures. The Annual Service Plan then provides detailed plans for addressing priorities.⁸⁰

4.4.5 How are needs assessments utilised to inform policy?

The extent to which community consultation conducted by the Local Health Integration Networks informs policy making at a provincial level is difficult to determine, as no references to Local Health Integration Network data were found in the available national reports and there was no explicit discussion about how information was used to inform policy. In 2009-10, the Ontario Ministry of Health and Long Term Care conducted a large scale consultation to develop a health framework for the rural and northern region.⁸¹

Community consultation is only one input into the Integrated Health Service Plan. However, the Local Health Integration Networks report to the Ministry and it is likely that issues identified in reports are acted upon to some degree.

Data collections are provided at national level and accessed at regional level for planning purposes. The national data collection contains service use data but there was no information about how this is collated.

4.4.6 Learnings from the Ontario experience

An effectiveness review of the Local Health Integration Networks conducted in 2008²⁵ found a number of emerging issues related to change management as the new system replaced the old. The authors identified issues relating to:

- ⇒ decision-making processes
- ⇒ reviewing and aligning resources

- ⇒ enhancing collaboration processes and partnerships
- ⇒ refining accountabilities and processes
- ⇒ governance.

In particular, a problem arose over where Ministerial authority ends and Local Health Integration Network authority begins, which resulted in duplicated needs assessment and planning processes and disputes over decision-making authority.

From a change-management perspective it appeared the Local Health Integration Networks were taking on their new authority while the Ministry of Health and Long Term Care, in some instances, was holding onto its traditional role.²⁵

The authors recommend developing “a framework that clearly identifies who has decision-making authority over processes, functions, and the decision-making process for which there is currently a lack of clarity.”²⁵

They identified early on that in order to be effective there needed to be significant cross-Local Health Integration Network collaboration. However, this generated many committees and workgroups required that a structure be established to support this. The process of setting up the Local Health Integration Networks was a “significant effort”, which was demanding on the Chairs and CEOs, and generated heavy workloads.^k

4.5 Australia

4.5.1 The policy context

In Australia, responsibility for health is divided between federal and state/territory governments. Under National Health Reform, the Commonwealth Government aims to readjust the balance from a hospital-centric ill-health emphasis to a focus on primary health care.⁸²

On 2 August 2011, the Commonwealth Government signed the final details of national health reforms with all States and Territories which aims to improve health outcomes for all Australians and ensure a sustainable health system.⁸³ Under the Agreement, the Australian Government will pay for 45 per cent of growth in hospital services in 2014-15, increasing to 50 per cent in 2017-18, thereby creating incentives to shift the health care focus to primary health care (which is more cost effective).⁸²

4.6 Australia: national programs

Regional needs assessments have been an element of a number of programs delivered in Australia, in some cases including work undertaken by the Divisions of General Practice (referred to henceforth as *Divisions*). Two current programs involving Divisions require needs assessments as part of their contractual obligations. These are reviewed in the following section. Some examples of activities undertaken at the state level can be found in the appendix (Sections 7.6 and 7.7).

^k The MOHLTC-LHIN Effectiveness Review²⁵ documents the change management process and is important reading for those planning similar changes to the Australian health system: http://www.lhins.on.ca/page.aspx?id=1062&ekmense1=e2f22c9a_72_396_btnlink

4.6.1 The Rural Primary Health Services

4.6.1.1 How are needs assessments undertaken?

The Rural Primary Health Services (RPHS) program aims to improve access to a range of primary and allied health care services and activities in rural and remote communities.⁸⁴ It is delivered by States and Territories, non-government organisations, Local Governments and through some Divisions of General Practice.⁸⁵ Each of the funded organisations is expected to undertake regular community needs assessments and ensure their service delivery models are both responsive to community needs and practical, acknowledging the geography, demography and remoteness of their community. These needs assessments span a program planning period of three years and inform the development of the service providers' Service Delivery Plans.

4.6.1.2 What and how is information collected?

According to the Department of Health and Ageing⁸⁶, RPHS needs assessment must include a summary of identified health priorities for the community, including a range of stakeholders' support for proposed activities; prioritisation of identified need; and management of practical considerations. A Needs Assessment Template prepared by the Department of Health and Ageing is a program requirement. Areas of focus should include:

- ⇒ national, regional and local health priorities (especially priorities for key groups such as the Indigenous population)
- ⇒ health promotion and preventive health priorities
- ⇒ demographic features, eg. age, Indigenous, Culturally and Linguistically Diverse (CALD)
- ⇒ epidemiological information
- ⇒ small town clusters
- ⇒ strengths and gaps in allied health service provision
- ⇒ adverse environmental factors.⁸⁶

Consultation with stakeholders is a crucial part of the RPHS needs assessment. Funded organisations need to demonstrate that they have consulted with a wide variety of stakeholders.⁸⁶ The Department may request documentary evidence of community consultation for a needs assessment.

4.6.1.3 How are needs assessments analysed and reported?

The Department of Health and Ageing provides Divisions with a suggested template for their RPHS needs assessments, though this is not prescriptive.⁸⁶ A comprehensive needs assessment is undertaken every three years.⁸⁶ A review of a small sample of needs assessments indicates that they have used the suggested template, which focuses on:

- ⇒ National, regional and local health priorities
- ⇒ Local demographic information
- ⇒ Epidemiological information
- ⇒ Communities who need priority service provision
- ⇒ Description of the current levels of service provision
- ⇒ Strengths and gaps in the local areas service provision
- ⇒ Potential barriers to service delivery.^{87,88}

A description of how the RPHS needs assessment has been translated into strategic priority areas is included in the needs assessment template.^{87,88} Divisions also specified who they engaged with from the local area when conducting the needs assessment, and how they were engaged.^{87,88} A range of data sources are used, and data are sourced from the Australian Bureau of Statistics, the Public Health Information and Development Unit, PHC RIS and their own personal surveys.^{87,88}

The Divisions RPHS needs assessments are used to inform their service delivery plans; and are sent directly to the Department of Health and Ageing.

4.6.1.4 How are needs assessments utilised to inform policy?

While needs assessments do inform policy at the level of the Divisions' operational service plans,^{86,87,88} there is no evidence of a specific mechanism for information to be fed upwards to inform policy.

4.6.2 Closing the Gap – Improving Indigenous access to mainstream primary care

This Closing the Gap program, delivered through the Divisions Network, also requires Divisions to undertake needs assessment.⁸⁹ The process for undertaking the needs assessment and its presentation are at the discretion of each Division and State Based Organisation. Divisions have the flexibility to target particular practices or specific communities. However, at a minimum, the needs assessment is expected to inform the Divisions' program-specific strategic planning and address the objectives of the Indigenous Health Project Officer and Outreach Worker. It is also expected to focus on:

- ⇒ the service delivery model
- ⇒ the process to identify and respond to local needs
- ⇒ barriers to accessing mainstream primary care
- ⇒ prioritisation of needs
- ⇒ risk management strategies.⁸⁹

Development of a needs assessment must involve consultation with stakeholders, including local Indigenous health services as well as Indigenous community members.⁸⁹

4.6.2.1 What and how is information collected?

A needs assessment report is expected to be a descriptive summary of the issues and include headings such as: local Indigenous population characteristics; existing mainstream and Indigenous health services; and stakeholder views and expectations.⁸⁹ Suggested sources of information include existing Division or SBO records; ABS; AIHW; public health websites; University research groups; state government research; stakeholder consultations; surveys and so forth.

4.6.2.2 How is information analysed and reported?

Divisions are required to upload a copy of their needs assessment report through PHC RIS' Divisions Online Reporting System. The National Performance Indicator number four asks "[what is the] Impact of collaboration with local Indigenous services to address shared planning and priority setting."⁹⁰

Analysis is expected to cover the priorities and access needs of the local Indigenous population as well as strengths, weaknesses, gaps and barriers of the current service provision.⁸⁹ It should also identify options for program implementation including existing models that could be adapted locally. Options are prioritised in consultation with local Indigenous stakeholders. A risk assessment and management plan for program implementation is required.

4.6.3 Learnings from the Divisions' experiences in conducting needs assessments

Aside from the programs reviewed above, Divisions have also undertaken needs assessments for various state programs (such as the Primary Care Partnerships).⁹¹ This suggests that there are some existing skills that may be utilised for regional needs assessments.

However, the needs assessments undertaken to date by Divisions are very limited in scope (eg. mental health) and they have been conducted for relatively small catchment areas (eg. compared to Medicare Locals). They also follow the consultative, corporate method of needs assessments with little or no evidence of the use of research, data, epidemiology or explicit prioritisation of the needs identified. Methods of collecting information have tended to focus on outreach visits and online surveys.⁹²

Nevertheless, for the Closing the Gap and Rural Health programs, some Divisions have successfully translated identified need into strategic plans. This is particularly evident for barriers and enablers to service delivery and, to a lesser degree, service gaps.

Divisions that are represented in the first tranche of Medicare Locals are likely to demonstrate a particular strength in community engagement due to their established track record in this area. In 2009, 97% of Divisions undertook community engagement for program development or evaluation.⁹³ However, community engagement was only used approximately two thirds of the time for the purposes of needs assessments (60%).

In recent times, AGPN has focused significantly on upskilling Divisions in community engagement. In 2006-2007, a major initiative for the AGPN was the Engaging Effectively with Communities Project.⁹⁴ This national project provided the Network with education and training about the benefits and also the requirements of community participation. The Project provided practical tools to assist successful engagement. In 2010, AGPN organised a Skills Development Workshop on Community Engagement.⁹⁵ This year, AGPN released a Community Engagement Toolkit for Medicare Locals, which is designed to facilitate appropriate and effective community engagement.⁹⁶

More recently, there has been an increased focus on health service planning, including needs assessments. In August 2011, AGPN conducted a Health Service Development/Models of Care Masterclass of which needs assessment formed a significant component.⁹⁷

¹ This toolkit can be found here:

http://www.centraalhln.on.ca/uploadedFiles/Home_Page/Get_Involved/LHIN%20Community%20Engagement%20Guidelines%20and%20Toolkit%20-%20February%202011%20-%20FINAL.pdf

5 Discussion

There is considerable variation in the manner in which regional needs assessments were undertaken in the context of different health care systems in countries reviewed in this report. Despite this, there is a degree of commonality regarding some of the challenges encountered in different countries. This section reflects on the key themes between the countries and their implications for future regional needs assessments in Australia.

5.1 The impact of needs assessments

Needs assessments are only as good as the planning and implementation that accompanies them. Since most of the objectives of needs assessments are aspirational and not measured for impact (eg. delivering effective care to those in most need; equity and social justice, working collaboratively), the countries reviewed focused on reallocation of funding to improve efficiency. Evidence from those countries suggests that the planning, implementation and subsequent service commissioning has failed to result in the reallocation of funding to more efficient or effective health care projects.¹²

The reasons for this failure to impact on commissioning were based primarily on political considerations. In Scotland, GPs were indifferent and/or failed to cooperate with regional planning organisations.⁴⁰ English regional planning organisations had concerns about the political repercussions of removing funding from already funded services:

*Population needs assessment typically attracts little attention and faces scepticism from operational managers. If needs assessment threatens the status quo, its findings risk rejection, particularly by those who have an interest in preserving existing arrangements.*¹⁵

Two large-scale studies of the influence of needs assessments in the National Health Service^{98,99} reported similar findings, suggesting that political factors and bargaining carry more weight in the final determination of needs.

As negative political repercussions of service disinvestment have occurred in most countries reviewed, this may also be a concern in Australia.

5.2 Regional vs. national priorities

A common theme across different countries was the tension between nationally and locally identified needs and priorities.⁶² As health systems representatives, regional planning organisations are expected to perform as a conduit to national governments' priorities in the regional context. Similarly, they are intended to provide a forum to identify and act upon local level needs. These two (sometimes opposing) forces are mediated by the regional planning organisations.⁶²

5.3 The need for a clear strategic priority framework

Need is not a fixed construct, and what constitutes need may be identified differently by different organisations and community stakeholders.¹⁰⁰ People's health care needs are infinite, and therefore guidance may be required to determine the breadth, depth and focus of needs assessments in primary health care.

As reported above, the degree to which the framework identifies and defines what constitutes need should be balanced with the local community's ability to define their own needs. That is, the

government's delineation of need may change over time, with more specification in the early phase when support is required, and greater scope for local need as capacity is developed within the regional planning organisation. A review of needs assessments in New Zealand reported the following conclusions:¹⁴

- ⇒ Provision of documents outlining the parameters of needs assessments and what is considered 'best practice' in undertaking needs assessments will guide regional planning activities.
- ⇒ Links between the need assessments and performance assessment relative to these needs should be developed and articulated to regional planning organisations prior to them undertaking needs assessments.
- ⇒ Expectations of the method to be used in needs assessments (eg. data, evidence on cost effectiveness, community input) should be articulated.
- ⇒ Guidelines regarding the depth, breadth, and degree to which needs assessments should predict future needs should be provided by the Government to guide regional planning bodies activities.

5.4 Resources needed to undertake needs assessments

Well-developed needs assessments, which consider inputs from data, research and public and providers' priorities, take considerable time to complete.³⁸ This may be exacerbated in the Australian environment where there are deficits in the skills required to undertake needs assessments.¹⁰¹

This raises the question of depth vs. breadth of needs assessments. Some evidence indicates that needs assessments have a greater impact on planning and prioritisation when they are focused on specific issues or groups rather than an entire region.¹²

The presence of a framework may assist in defining the scope of an assessment. In England, the need for breadth to understand the health of the population was identified but there was also a need for depth, so as to inform specific commissioning decisions. However, there were insufficient resources for both.¹⁵

The high level of resource intensity also raises questions about the frequency at which needs assessments should be undertaken. In other countries reviewed, the frequency of undertaking needs assessments was not specified (though a rough guide of three yearly intervals was suggested in a number of cases). Time should be allowed for organisations to respond to the needs identified within their assessments.

5.5 The challenges of prioritisation

While the *collection* of data and information on need is not in itself controversial, it is the *prioritisation* of this information that is in dispute.^{50,53,102} The challenge for prioritisation is to balance the priorities of all people and organisations involved in health, including those of the government, the local population, and health care practitioners.

No clear mechanism for overcoming these difficulties was described in the available literature. While New Zealand had a prioritisation framework¹⁴, this did not translate into different purchasing decisions, which may be related to the politics of disinvestment in services.¹² Prioritisation frameworks assisted in allocating *new* funding, but they failed to have an impact on existing services.

5.6 Needs assessments informing policy

Little evidence of systematic processes to inform policy was identified in this review. Needs assessments were derived mainly from centrally managed national data sets. Data were generally collected by the central government so there was no need for local data collection to be fed upwards to inform larger government strategies.

Generally, information obtained at the local level pertained to needs that were identified by the community and practitioners. The qualitative nature of this information does not lend itself to being systematically fed upwards to inform policy. However, under the proposed new UK system devised by the Conservative-Liberal Democratic government, local consultation will be fed upwards systematically through the *HealthWatch* organisations, which have a role in informing the Minister and the Commissioning Board. However, the mechanisms by which this will occur are unclear. In New Zealand¹⁴ and the Canadian provinces⁸⁰, needs assessments (which include local data and consultation) and their subsequent planning documents, form the basis of an accountability agreement with the government, but they are not centrally collated or standardised.

5.7 Managing community expectation

Managing stakeholder expectations was a significant problem overseas.^{14,50} In New Zealand, stakeholders' opinions were occasionally at odds with a rationalised health care budget.^{14,50} Stakeholders perceptions may also be at odds with each other and, in these instances, regional planning organisations needed to act as moderators between different stakeholders' perceptions.

There are multiple points at which the local community can be engaged in the needs assessment process. A framework, which explicitly lays out the community's role and what they expect will happen with the information they provide, may assist in managing expectations. A framework specifying the way community input is used has been implemented with variable success in New Zealand.¹² Well informed, trained consumers may also assist in obtaining the most meaningful engagement from community members.¹⁴ Governments also need to allocate sufficient resources for regional planning organisations to undertake community engagement.

5.8 Data collection and comparability

In most cases, the data used in needs assessments were obtained from a centralised source managed by the national government.^{25,27,99} In some cases, assistance with data access and analytic tools were offered.^{57,77,79} The analysis and interpretation was generally the responsibility of the regional planning organisation. In most situations, the data to be used for assessing need were at the discretion of the planning organisation, with the exception of Scotland, where a datapack was provided, thereby limiting the scope of the data to be used.^m

In each of the countries reviewed, data were comparable because they were collected by the central government under consistent conditions.^{14,64,76,77,78} Within a specific country, or a system or region within a country, the degree to which comparability is an issue depends on *why* data needs to be comparable. If it is for reasons related to funding, the most reliable data would usually be sourced from existing central and reputable sources (eg. central statistical services).

^m AGPN has commissioned PHIDU to produce Medicare Local population health profiles similar to the work in Scotland.¹⁰³



5.9 Skills and capacity deficits

Needs assessments, which were previously undertaken for specific programs by Divisions of General Practice, tended to follow a more corporate approach. They focused on consultation with the local public and providers rather than focusing on data, epidemiology, cost-effectiveness and efficiency. This suggests that skill and knowledge deficits may become apparent in undertaking new approaches to needs assessments, at least in the early stages.¹⁰¹ This is consistent with problems of skills deficits reported in other countries.^{14,15,50}



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7 Appendices

7.1 Methods used in this report

This project entailed conducting a jurisdictional review of countries that were most relevant to the Australian context (ie. Australia, New Zealand, England, Scotland and Canada). A data extraction template was developed. Websites of the health systems of the nominated countries were inspected and information was gleaned from reports, legislation, administrative documents and websites to complete the template. Where possible, multiple sources were examined to triangulate the accuracy and currency of information. This process was complemented by a PubMed search using the following search strategy:

("needs assessment" OR "local evidence" OR "priority setting" OR "magnitude of the problem" OR "needs analysis" OR "regional assessment" OR "resource allocation" OR planning OR consultation OR "community needs analysis" OR "community profiling" OR "unmet need" OR "service gaps" OR "environmental scan" OR "priority setting" OR "asset mapping" OR GIS OR "health indicators" OR "strategic planning")

AND

(community OR region OR province OR district OR state OR "Primary Care Trust" OR "Local Health Integration Network*" OR LHIN OR "Joint Strategic Needs Assessment*" OR JSNA OR "District Health Board*" OR "General Practice Network" OR "Department of Health" OR "primary health care" OR "primary care" OR "health promotion")

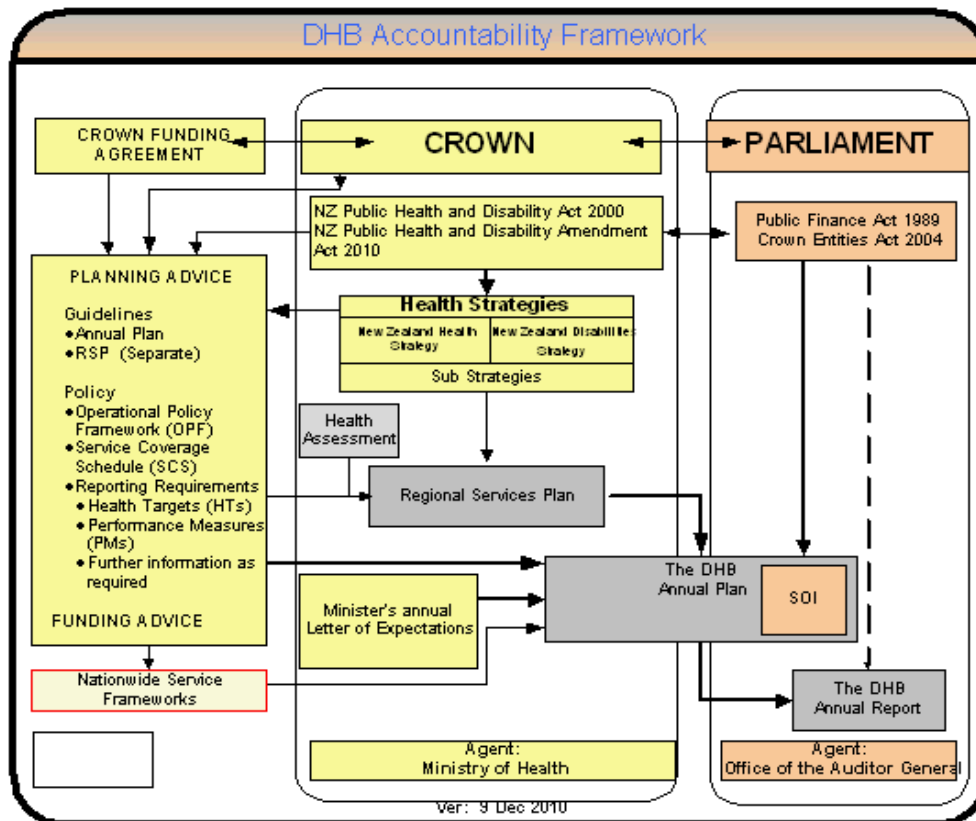
Articles were selected for their applicability to the data extraction template. A snowballing strategy was used to locate additional sources.

7.2 Types of data used in overseas needs assessments

Data that have been used in needs assessments internationally include:

- ⇒ Demographic data: age, gender, birth rates, population projections
- ⇒ Health care risk and protective factors
- ⇒ Immediate: smoking, overweight or obesity
- ⇒ Distant: education level, housing related factors
- ⇒ Rates of illness, chronic and infectious
- ⇒ Health promotion and disease prevention activities
- ⇒ Contacts with health care practitioners: rates and reasons
- ⇒ Contacts with the acute care sector: rates and reasons including avoidable admissions
- ⇒ Mortality rates
- ⇒ Group specific data: refugees, Aboriginal or Torres Strait Islander groups, youth or the aged population
- ⇒ Referral rates to specialist and other primary health care practitioners
- ⇒ Disability rates
- ⇒ Numbers of health care practitioners in the area and their work equivalence
- ⇒ Waiting times for services.

7.3 NZ District Health Board Accountability Framework



Source:⁹⁵

Figure 6 District Health Board Accountability Framework

7.4 Proposals for the UK from 2011 onwards

7.4.1 The policy context

The National Health Service reforms set out in the Health and Social Care Bill are still subject to Parliamentary approval. However, the proposed reforms are set out in the 2011 document *Liberating the National Health Service: Legislative framework and next steps*.⁶² Reform continues the agenda of local needs assessment and public accountability. It includes the establishment of a new public health service, *Public Health England* to lead action on the determinants of health and evolving the *Local Involvement Networks (LiNs)* into *HealthWatch* organisations, led by *HealthWatch England* located within the *Care Quality Commission*.

Primary Care Trusts will be abolished and *GP Consortia* will commission regional services, guided by, and responsible to, the *National Health Service Commissioning Board*. *GP Consortia* will be statutory bodies with an identity and responsibilities separate from member practices. The first GP consortia will be operational in 2011.

Health and Wellbeing Boards, located in local authorities, will be created to coordinate commissioning at the local level across the National Health Service, social care, children's and public health services. These *Health and Wellbeing Boards* will include *GP Consortia* as well as local sector representatives.

7.4.2 How are needs assessments undertaken?

Under the new system, local authorities and GP consortia will have an equal and explicit obligation to prepare the needs assessment, and to do so through the Health and Wellbeing Board.⁴⁰

7.4.3 What and how is information collected?

Needs assessments will include:

- ⇒ Population level demographic data
- ⇒ Social and place data-including housing, employment, education crime, social benefits
- ⇒ Lifestyle determinants of health
- ⇒ Epidemiology
- ⇒ Service access and utilisation
- ⇒ Evidence of effectiveness
- ⇒ Community perspectives
- ⇒ Other local data.⁹⁸

7.4.3.1 How is information analysed and reported?

Needs assessments will inform a *Joint Health and Wellbeing Strategy* (JHWS) which will set out how a community's health and wellbeing needs will be addressed. The *National Health Service Commissioning Board*, *GP Consortia* and local authorities will be obliged to commission services "with regard to" the needs assessment and the JHWS.⁹⁸

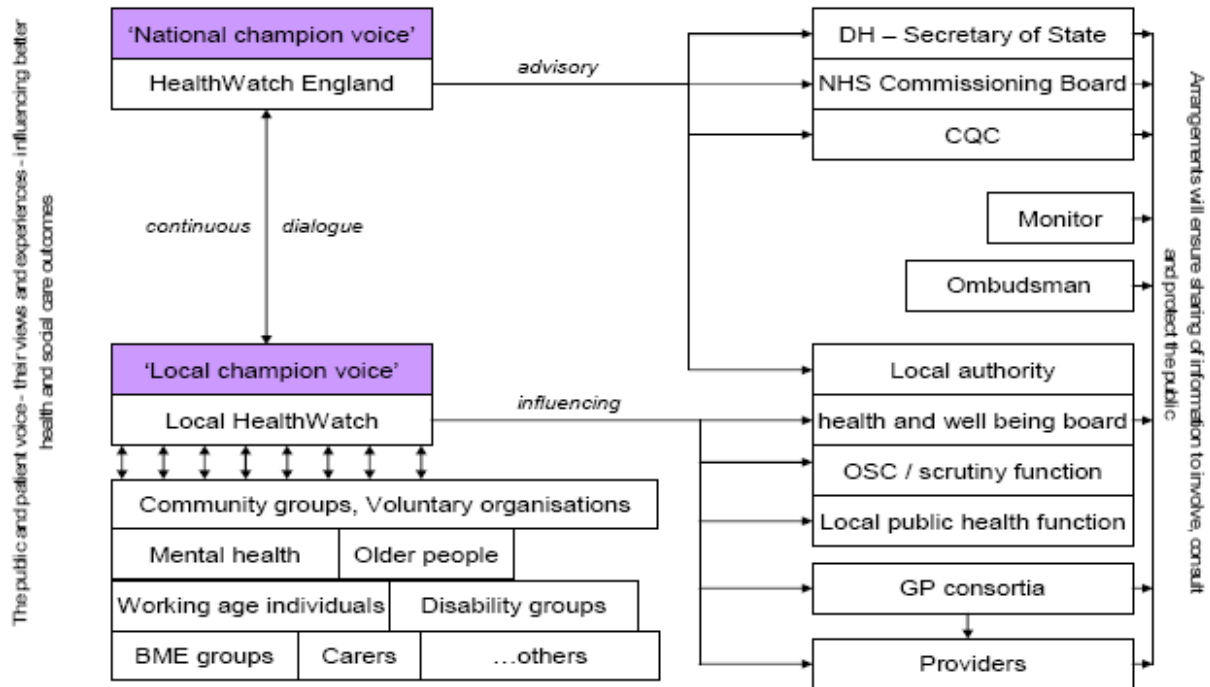
Since 2008, National Health Service organisations have had a strengthened 'duty to involve' and must report on how the views of the public have shaped the decisions they have made in planning and commissioning services.¹⁰⁴ Public scrutiny will become increasingly important in maintaining accountability.

7.4.4 Public accountability

HealthWatch England will be established from October 2012 within the Care Quality Commission. Local *HealthWatch* organisations will replace the LINKs and will facilitate public consultation for regional planning and commissioning, provide advocacy and support to people making health care choices and "provide intelligence for *HealthWatch* England about the quality of providers".⁴³

HealthWatch England will provide leadership, advice and support to Local *HealthWatch* organisations and will advise the National Health Service Commissioning Board, Monitor and the Secretary of State on the findings of local scrutiny, bringing attention to underperforming services.

Figure 7 shows the structure through which *HealthWatch* will inform health decision-making.



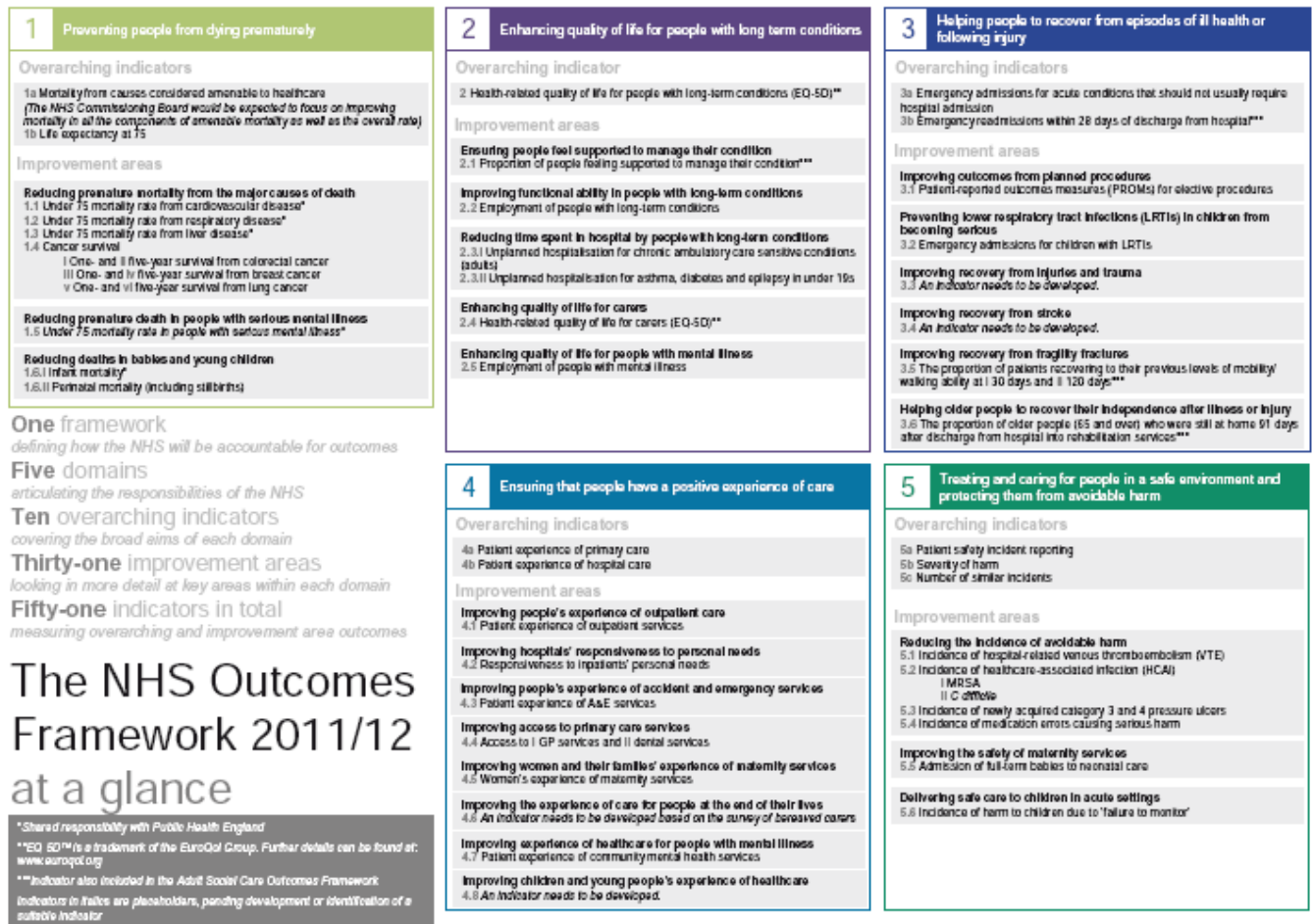
Source:⁹⁷

Figure 7 Structure through which *HealthWatch* is intended to inform health decision-making

7.4.5 National Health Service Outcomes Framework

A feature of the Health and Social Care Bill is an accountability structure based on population health outcome indicators instead of the process measures that had previously been used. The new National Health Service Outcomes framework stipulates the outcomes that the National Health Service Commissioning Board will be expected to achieve.

Figure 8 sets out these outcomes and indicators, although some indicators are currently in development.



Source:⁹⁸

Figure 8 the National Health Service Outcomes Framework which will guide the National Health Service Commissioning Board

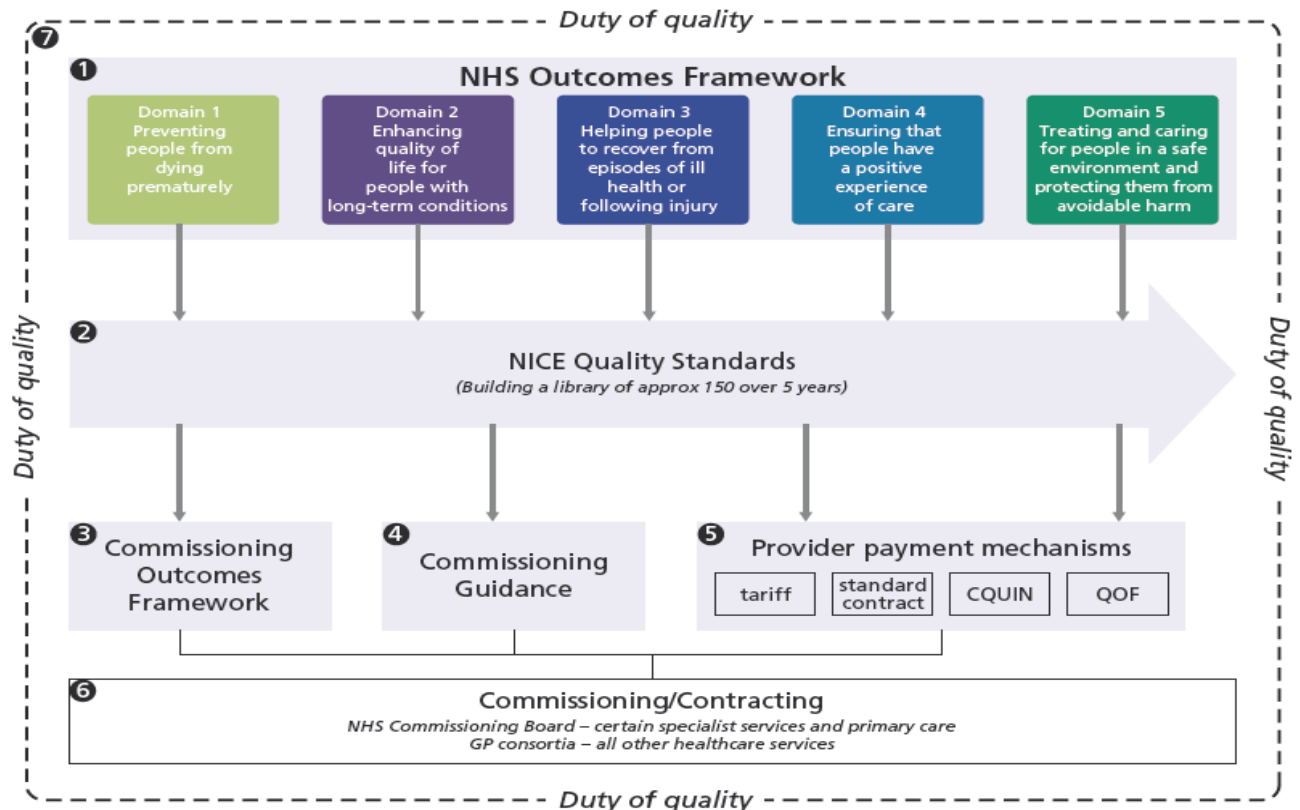
The National Institute for Health and Clinical Excellence (NICE) has been commissioned to create quality standards designed to meet these desired outcomes as well as a Commissioning Outcomes Framework (COF), which is currently under development. The COF will include measures of health outcomes and quality of care, including patient reported outcome measures and patient experience. The COF will provide the basis for holding GP consortia accountable to the National Health Service Commissioning Board and will allow comparison between the achievements of different consortia and the identification of areas for improvement.^{105,106} Figure 9 provides an outline of the proposed Quality Improvement System for the National Health Service.

The GP consortia will be responsible for achieving health *outcomes* but will not be answerable to the Commissioning Board for the *content* of their plans or *how* they achieve these outcomes. The Legislative Framework entails:

The National Health Service Commissioning Board will not have the authority to agree and sign off GP consortia commissioning plans; the planning information that consortia submit to the National Health Service Commissioning Board will focus on financial forecasting, to enable effective pooling of risk. Consortia will be accountable to the National Health Service Commissioning Board, and in turn, the Secretary of State for Health and Parliament; but this accountability will be for the results they achieve – improving outcomes and living within their cash-limit.⁴⁰

A tension between local decision-making and the COF is anticipated by the government in the Legislative Framework.

Respondents highlighted possible tensions between a nationally defined framework and the need to pursue outcomes based on the joint strategic needs assessment...This points to the need for further work, which we intend to pursue with the help of consortia pathfinders and local authorities, to ensure that the Commissioning Outcomes Framework supports the process of identifying local priorities and to allow other local priorities identified through the needs assessment to feed into the developing Outcomes Framework.⁴⁰



Source:⁹⁸

Figure 9 The Quality improvement system in the National Health Service

7.4.5.1 Learnings

The needs assessment and its associated Joint Health and Wellbeing Strategy will be developed by the Health and Wellbeing Boards located within local authorities with the participation of a representative from GP consortia. Needs assessments are intended to guide service commissioning at a local level. However, concerns have been raised in a series of reports from the King's Fund over the accountability of GP consortia to both Health and Wellbeing Boards and to the National Health Service Commissioning Board and the relative influence of the two.^{107,108}

We are particularly concerned about whether the boards will have sufficient engagement from and influence with GP commissioners.... It is not clear, for example, what influence decisions by the health and wellbeing boards on prioritisation of treatment areas as part of the [needs assessments] would really have on resource allocation decisions by GP consortia, which will hold the vast majority of funds for health care.¹⁰⁷

Health and Wellbeing Boards will have the power to scrutinize commissioning plans to ensure that they take due account of needs assessments and the Health and Wellbeing Strategy. A consortium will also have to state in its commissioning plan that the Health and Wellbeing Board agrees that it has had “due regard” to the Joint Health and Wellbeing Strategy. However, given the stronger accountability of consortia to the National Health Service Commissioning Board through the National Health Service Outcomes Framework and policy levers, the King’s Fund¹⁰⁸ concludes that:

It is not clear whether these [Health and Wellbeing] boards will be sufficiently empowered to hold consortia to account, particularly in the context of the relationship between consortia and the National Health Service Commissioning Board, which may involve a strong form of quasi-regulation and/or performance management. Furthermore, if health and wellbeing boards lack (or are perceived to lack) any real influence, they may face significant difficulties in attracting a sufficiently experienced and authoritative membership.¹⁰⁸

7.5 Case examples of additional Canadian provinces

7.5.1 Canada: Newfoundland and Labrador

7.5.1.1 Case study- Eastern Health

In the province of Newfoundland and Labrador, needs assessment is undertaken by regional Integrated Health Organisations. One example, Eastern Health,¹⁰⁹ provides the full continuum of health services to a regional population of 290 000.

Under the Regional Health Authorities Act, Integrated Health Organisations are obliged to perform needs assessments and Eastern Health have embarked on yearly needs assessments at the community level, investigating one community per year sequentially, with the aim of completing them throughout the region by 2011. Needs assessment is focused around the priority areas of the provincial government. In one example,²⁶ an in depth survey of emergency department use was conducted in addition to general consultation.

The process is overseen by a Steering Committee of local health managers and an Advisory Committee of citizens selected by public nomination.

Information is gathered from citizens by phone survey, focus groups, social media, face-to-face interviews and via written, electronic and oral submissions. This information is combined with local data, statistics and a literature review.

The major issues that emerge are prioritized for recommendations, which are made public in the report.²⁶ Other issues are deferred for future strategic planning and needs assessment cycles.

Needs assessment reports and strategic plans are made publicly available on the Eastern Health website.¹⁰⁹ The Eastern Health strategic plan for 2011-2014¹¹⁰ relates each priority area to the provincial government’s priority areas and the needs assessments do not appear to be central to determining a priority. Rather, they appear to influence the details of service provision at a community level.

7.5.2 Canada: British Columbia

7.5.2.1 Case study Vancouver Island

As in Newfoundland and Labrador, Regional Health Authorities in British Columbia consult with their communities and compile regional statistical reports for their regions.

The Vancouver Island Regional Health Authority has a five-year strategic plan,¹¹¹ updated annually. The strategic direction explicitly reflects the priorities of the Ministry of Health Services, but the planning process also reflects population demographics, health needs at the community level, feedback from community consultation, health service use data, and risk assessment. Needs assessment is not identified as a specific activity; rather, it is subsumed in the strategic planning process.

Consultation occurs with the community, partner organisations, and professionals at a regional level, based on a draft report. The plan is reviewed annually based on the consultation and always looks three years ahead.¹¹¹

The authority conducts consultations with specific communities on an 'as needed' basis. The publicly available reports include demographics and epidemiology, and reports of consultation with the public and stakeholder groups. The Salt Spring Island Health Review¹¹² is one example.

The Authority continuously monitors health care data and other information to assess how well the organisation meets its goals and objectives and provides public reports on meeting its performance targets.¹¹¹

7.5.3 Canada: First Nations and Aboriginal Health

In Canada, health services for the First Nations people and Inuit are provided at national level by Health Canada First Nations and Inuit Health Branch. Public health and health promotion, are provided in reserves and communities and primary care services are provided in isolated areas where provincial services are not available.¹¹³ Since the 1980s, control of health services is gradually being devolved to the communities with 79% of First Nations and Inuit communities involved in the transfer process.¹¹⁴ A performance target of a 5% increase over five years has been set for a percentage of First Nations and Inuit communities engaged in the control, design, development and delivery of health programs and services and based on their own identified needs.¹¹⁵

As part of the transfer of control process, communities may apply for funding to perform a needs assessment. They may do this themselves or employ a research consultant.

Sources recommended to assist the needs assessment are:¹¹⁶

- ⇒ First Nations and Inuit Regional Health Survey
- ⇒ service use data from local health facilities
- ⇒ interviews with individuals such as health professionals, service providers, members of community groups, community leaders, police and elders
- ⇒ focus groups with service users, caregivers, illness groups.

It is recommended that those undertaking a needs assessment share their draft report with community leaders and then with their communities for comment and revision.

The needs assessment informs a Community Health Plan, which is used in discussions between the community and the First Nations and Inuit Health Branch in developing a transfer agreement. Once services are established, the needs assessment informs subsequent evaluations and a plan-do study-act cycle.¹¹⁶

7.6 State focus: Needs assessments in South Australia

7.6.1 Policy Context

South Australia Health is undergoing reform at both State and National Level.¹¹⁷ The national reforms build on State reforms of the South Australian health system delivered under *South Australia's Health Care Plan 2007-2016*.¹¹⁸

On 2 August 2011, the Commonwealth Government signed the final details of the National Health Reforms with the States and Territories.⁸³ As part of the reform, on 1 July 2011, five Local Health Networks (LHN)¹¹⁸ were incorporated as hospitals under the Health Care Act, 2008¹¹⁹ to manage the delivery of public hospital and other community based services in South Australia. The portfolio currently consists of the Department of Health, Central Adelaide Local Health Network, Northern Adelaide Local Health Network, Southern Adelaide Local Health Network, Women's and Children's Health Network, Country Health SA Local Health Network and SA Ambulance Service.

The LHNs manage the delivery of public hospital services and other community based health services as determined by the State Government. Each LHN is supported by a Governing Council. A key role of each Network Governing Council is to seek the views of both providers and consumers of health care as well as other members of the community concerning the planning and provision of services.¹²⁰

SA Health views consumers as partners in planning, implementing and evaluating health services. The Consumer and Community Participation Directive¹²¹ aims to ensure that the community is aware of its right to be involved in health service development and is well informed and supported to fulfil this role. The Consumer and Community Participation Guidelines¹²¹ state that effective community participation ensures all people, regardless of health, age, social, cultural, economic, linguistic or geographic backgrounds have the opportunity to participate.

7.6.2 How are needs assessments undertaken?

SA Health has a history of supporting community needs assessment. For example, in 2005, the then Central Northern Health Service prepared a Community and Consumer Participation Framework which established guiding principles for engagement with individual consumers, consumer groups, communities of interest and whole communities.¹²²

In 2008, Health Improvement Plans (HIP) were undertaken to provide a population health and evidence-based approach to the planning, management and evaluation of health services.¹²³ Examples of Regional Needs Assessments conducted concurrently with the HIPs included the Regional Planning Framework and Community Engagement Strategy conducted by the Central Northern Adelaide Health Service and the Community Engagement Strategy conducted by the Southern Adelaide Health Service.

As another example of the different facets of needs assessment, in 2009 the Southern Adelaide Health Service of SA Health released 'Partnering with us', A Guide for Consumer Council Members.¹²⁴

At a rural health level, the Strategy for Planning Country Health Services¹²⁵ provides broad parameters for local Health Advisory Councils to assist in the development of their local 10-year health service plans. Communities and regions are required to work with their communities to develop local 10-year plans for their workforce and services which would deliver local solutions to local challenges as well as taking state-wide needs into account. A focus during 2009-2010 was

implementation of 10-year local health services planning which was undertaken as a collaborative process between Health Advisory Councils, local hospital and health service planning teams, local planning officers and Country Health SA Planning.¹²⁶

At Local Government level, the Local Government Association acknowledges the importance of engagement and consultation with the community as well as the challenges of applying appropriate techniques to particular circumstances.¹²⁷ In 2007, the Association initiated a project on Citizen/Community Engagement with State Government support through the Office of State/Local Government Relations. The project aimed to highlight good practice in SA and develop and promote tools to assist in effective citizen engagement. The second phase of the project resulted in a Community Engagement Handbook (2008) which provided a model framework.¹²⁸

7.6.3 What and how is information collected

Quantitative data for South Australian needs assessments are obtained from a number of sources. Two state level sources include the Health Omnibus Survey, and the South Australian Monitoring and Surveillance System. Both of these surveys collect high quality, representative data at the level of detail which can be used for regional health planning.

In rural areas, the community and stakeholder consultations were led by each local Health Advisory Council. Strategies varied across sites from distribution of questionnaires, letter-box drops, face-to-face interviews, workshops, information booths and public meetings. A country service profile template was developed for the community. Types of data collected includes: current service profile; catchment area; population and demographic information; access to health services; quality and safety reports; activity and health workforce analyses; infrastructure; access to transport and the local budget. Profiles are updated regularly.¹²⁵

A variety of consultation strategies are undertaken. The Strategy for Planning Country Health Services¹²⁵ provides broad parameters for local Health Advisory Councils to assist in the development of their local 10-year health service plans. Communities and regions are required to work with their communities to develop local 10-year plans for their workforce and services which deliver local solutions to local challenges as well as considering statewide needs.

7.6.4 How is information analysed and reported?

Regional Health Services are ultimately responsible for the development and production of Health Improvement Plans, as well as the approval and the implementation of recommendations. Policy staff from SA Health work with regional health services to develop the strategic direction and phases of the planning process.¹²³

In country Health Advisory Councils, the first draft is then reviewed and refined by the local hospital and health service sites in order to consolidate analysis of information with population and demographic data, health service utilisation data, community/stakeholder consultations and existing local/state/national strategic directions and plans. The next step involves review of all draft 10-year plans by local Health Service Executive and the Strategy for Planning Country Health Services in SA Implementation Steering Committee before they are endorsed for public release for consultation by the relevant Health Advisory Council. Feedback is reviewed in the context of the themes and issues raised as part of the needs analysis process.¹²⁵

7.6.5 How are needs assessments utilised to inform policy?

In country SA, thirty-three local health plans have been developed by the Health Advisory Councils and local health services. Country Health SA within the SA Health Department works with the

Health Advisory Councils to find local solutions and share resources to enable final release of the plan.¹²⁵

7.6.6 Learnings

One notable success in the development of the Health Advisory Council plans has been the extensive involvement of volunteers.¹²⁵ The local plans allowed a 'bottom-up' approach to needs assessment. In the future, the use of standardised questionnaires for future community engagement in country SA would allow comparable data.

7.7 State focus: Needs assessments New South Wales

7.7.1 The policy context

NSW has a history of local health reform. In 2004, Planning Better Health¹²⁹ introduced the most significant changes in health administration since 1986. The first step was to combine 17 existing Area Health Services into eight larger ones. Each Area Health Service established an Area Health Advisory Council to achieve greater involvement of consumers, community members and clinicians in the planning, policy development and service delivery.¹³⁰ Area Health Advisory Councils include people with experience in the provision of health services and represent the interests of consumers, health services and the local community. At least one member must have the knowledge, expertise or experience of Aboriginal health.¹³¹ An important component of the role of each Area Health Advisory Council was to maximise the community consultation arrangements by linking with key clinical, community and local health participation groups.

A Health Care Advisory Council, reporting to the NSW Minister for Health and the Director-General of NSW Health, was established as the peak community and clinical advisory group.¹³⁰ During 2007, a review of the Health Care Advisory Council was undertaken which examined its effectiveness and operation.¹³² A principal focus of the review was to align the Health Care Advisory Council with the State Plan and the State Health Plan.

In April 2010, the NSW government entered into the National Health and Hospitals Network Agreement with the Australian Government. Eighteen Local Hospital Networks were to replace the existing eight Area Health Services and, where possible, were to share the same boundaries as Medicare Locals.¹³³

In September, 2010, as part of the National Health Reform Agreement, the NSW Government announced the final boundaries for 18 new Local Health Networks.¹³⁴ Legislation to allow for the creation of the Local Health Networks was passed in October 2010.¹³⁵ The Bill also established Local Health Network Governing Councils of between six and thirteen members to replace the Area Health Advisory Councils. During this time of transition, it was intended that these new groups would be able to draw on the strong community and clinical networks established by the Area Health Advisory Councils.¹³⁴

In March 2011, New South Wales elected a Coalition Government after 16 years of Labor Government. By May 2011, the new Government had reintroduced Local Health Districts, governed by Boards with the stated aim of giving local regional communities a greater voice in the running of their local hospital and health services.¹³⁵

7.7.2 How are needs assessments undertaken?

A NSW policy directive (2005)¹³⁶ required the Area Health Services to develop an Area Healthcare Services plan. This policy directive has a review date of 29 June 2011. However, as at 17 August 2011, its status is still listed as active on the NSW Health website.

Each Area Healthcare Services plan is intended to be a strategic document outlining the medium term priorities for the area with reference to factors affecting the health of the population and delivery of health services (policy directive). A guide for the development of Area Healthcare Services plans was incorporated in the policy directive to assist with the details of the task.

Each Area Healthcare Services plan is the primary strategic document for an Area Health Service which synthesises the current situation, anticipated needs and priorities for action in the short to medium term; and identifies the key strategic directions. Plans are prepared for a five-year period with a broad outlook to 10 years where appropriate. A plan must clearly link overall system goals to local priorities and strategies.

It is a requirement that intentions of the plan are discussed regularly with the NSW Health Department during development. The production of an Area Healthcare Services plan does not replace other local planning processes. Specific Service Plans, Asset Strategic Plans, Workforce Development Plans and Financial Plans inform, and are informed by, the Area Healthcare Services plan over time.

7.7.3 What and how is information collected?

Area Healthcare Services plans are informed by comprehensive data and information including local demographic factors; morbidity and mortality trends; health needs of priority groups and the population at large as well as current and expected patterns of service utilisation.¹³⁶ Whole of population activity, such as immunisation rates and chronic disease factors, need to be included. Each plan also needs to consider policy and practice at the State level as well as strategic issues such as capacity (financial, workforce etc) to respond to demand and the ageing population. Individual service strategies need to be developed for at least the top ten priority clinical specialty services. Additionally, the plan needs to identify significant issues for individual facilities.

An Area Healthcare Services plan is developed with the specific expertise of area managers and planners, health professionals and linked with community leaders through the Area Health Advisory Council.¹³⁶

For example, the Hunter New England Health Area Health Advisory Council¹³⁷ had more than 30 local health advisory councils which provided input into health services at the local level. It held meetings across the area to allow regular face-to-face meetings and also hosted an annual community engagement forum to bring together representatives from various community advisory groups. As a result of feedback, the Hunter New England Health developed several resources including an area Community Engagement Toolkit, and resources to combat childhood obesity. In preparation for the transition to a Local Health Network, the annual planning forum was replaced with two information sessions about National Health Reform.

The value of community input in the Greater Southern Area Health Service was recognised with the formation of a Communication and Community Development Unit reporting directly to the Chief Executive. The role of the Unit is to build a proactive relationship with all who work with the Greater Southern Area Health Service including local government, community participation groups, auxiliaries and service clubs.¹³⁸



7.7.4 How is information analysed and reported?

Area Healthcare Services plans are submitted to the Director-General for approval. A Financial Impact Statement is also required on submission to the Department. A plan is written for an informed audience, most likely people working in health. However, a companion, shorter document may be prepared for the local community.¹³⁶

In addition, Chairs of the Area Healthcare Councils attend meetings of the Health Care Advisory Council, thus providing a crucial communication link between the local structures for community participation and this peak advisory council.¹³⁹

7.7.5 How are needs assessments utilised to inform policy?

The Health Care Advisory Council is the peak clinical and community advisory group that provides advice to the NSW Minister for Health and the Director-General of NSW Health. The Council meets every second month and membership is made up of clinicians, academics as well as consumer, business and professional representatives.¹³⁹

7.7.6 Learnings

One example of the value of community input is demonstrated by the Great Southern Area Health Service, which formed a Communication and Community Development Unit reporting directly to the Chief Executive.¹³⁸ The role of the Unit is to build a proactive relationship with all who work with Great Southern Area Health Service including local government, community participation groups, auxiliaries and service clubs.

At the final Statewide Convention for Area Health Advisory Councils held in October, 2010, outgoing Area Health Advisory Council Chairs and Members had the following advice for new Local Health Network Chairs: 'Keep up the community and clinician engagement and build on what the Area Health Advisory Councils achieved'.¹³⁷