Indicators and Public Health Policy

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This issue includes a paper from the Victorian Department of Human Services, Australia, addressing applications of data on ambulatory care sensitive condition hospitalisations. This work has been very important for Victoria as it provides robust new indicators of access and quality of primary care services that have direct application to current public health policy.

On the surface, this work appears to be the result of a simple set of analyses of routine hospitalisations data; commonplace data that are usually presented in bureaucratic reports that have a life gathering dust on the desks of public sector health administrators. How could such data excite anybody or provoke a practical policy or strategic response?

The answer is in the presentation of information that meets three important criteria: interest, relevance and application. These criteria, often overlooked, provide the key to the practice of successful epidemiology and are vital for meaningful public health research and population health surveillance activities. Thacker and Stroup's definition of surveillance emphasises the essential link between evidence and action in the context of "planning, implementation and evaluation of public health programs" (Thacker & Stroup, 1988). But this link may not be so evident in public health research where accountability can be of a more academic nature, based on process outcomes such as the timely expenditure of research funds and the extent to which peer reviewed publications are generated—more often referred to in grant applications as "track record".

The Victorian Ambulatory Care Sensitive Conditions (ACSC) Study has provided small area level indicators that have particular relevance and application to health planning (Department of Human Services [DHS], 2002a). ACSCs are those for which hospitalisation is thought to be avoidable if preventive care and early disease management are applied usually in the ambulatory setting (Billings et al., 1993). Some examples of ACSC indicators include vaccine preventable ACSCs (e.g., measles, mumps, diphtheria); acute ACSCs (e.g., ENT infections, dental conditions, cellulitis); and chronic ACSCs (diabetes complications, asthma, CCF, angina, hypertension, COPD).

ACSC indicators have been of keen interest to a vast array of stakeholders across the primary health care system in Victoria. These stakeholders comprise individuals and agencies involved in the planning of both central and local public health and primary care services across the Victorian community. More specifically, they include general practitioners, planning officers and public health managers within local government areas, and Primary Care Partnerships (PCPs) in Victoria. PCPs are voluntary alliances of primary care providers that cover two or three local government areas. Their main goals are to improve health outcomes from primary care services, and to appropriately reduce the preventable use of hospital, medical and residential services. This is a major initiative in Victoria designed to improve the communication and coordination among primary health care service providers and the quality of their services. ACSCs indicators have provided an evidence-based platform for community planning and evaluation of this initiative.

From its inception, the study promised to generate a new set of indicators that would potentially assist all PCPs in Victoria (DHS, 2004) to target prevention programs in areas of greatest need across the sector. New information would be provided for each of the state's 32 PCPs in order to support development of strategies to meet a state-wide objective to reduce demand on

hospital emergency departments. Importantly, the study was developed in response to a series of information needs that were identified through an early consultation process. From the outset there was a high level of curiosity and interest in what the analyses might show.

So, from the beginning, this study had a captive, interested audience. But this did not guarantee its relevance or practical application. The relevance was determined in the study's design where analyses were generated at a small area level (geographically defined PCP boundaries) that was of pre-determined practical value to the stakeholders—in this case, health professionals and policy-makers working in PCPs. It would value-add to existing work that was focused on improving access to integrated primary care in community settings across the state. Most importantly it would begin to fill an important gap in the available evidence that could be used to support significant new initiatives in primary heath care service delivery. A good example of an ACSC indicator that has a high level of relevance to such stakeholders is hospitalisation trends for diabetes complications, standardised and presented for all PCPs in the state. These patterns of hospitalisation are highly reflective of the performance and accessibility of local primary care services.

In this context, the Victorian ACSC Study's relevance was determined by the value promised and ultimately provided for those who were responsible for taking practical initiatives in the field; the public health policy-makers, strategists and practitioners. For these professionals, the strength of the study was in its quality as a simple surveillance tool, and the fact that it was a source of indicator data that could be readily understood and used; the data had real practical application! During the dissemination of the findings, important issues were frequently raised by the local stakeholders that reflected their pragmatic thinking about uses of the data. This was particularly true for the 11 PCPs that had been identified with diabetes complication admission rates significantly higher than the Victorian average. The indicators had generated alert signals calling for actions in these PCPs (Choi, Orlova, Issa, Marsh, & Morrison, 2004); for example, there were questions about the causation of patterns of admission for particular problems and what could be done to improve prevention strategies with locally available resources. An active dialogue was generated, resulting in a reappraisal of local priorities in the delivery of selected primary care services and health promotion initiatives.

For those engaged in public health research and surveillance, it is a reasonable expectation that they might take on some accountability for what others do with their data. This simply means that there must be a clear understanding about matters of interest, relevance and application, and a commitment to adhere to these criteria. With this level of accountability, there is an assurance that optimum value for money expended on acquiring new data will be achieved and that the potential for evidence-based policy-making will be enhanced. Conversely, if this level of accountability is not there, it will be more a matter of chance as to whether the information generated will make any practical difference to anyone!

It is worthy to note that these highly practical aspects of public health research and health surveillance have been enhanced in Victoria through the conduct of this work in a public sector setting. Other examples of high-impact epidemiology conducted within the Victorian Department of Human Services include the Victorian Burden of Disease Study (DHS, 1999) and the Victorian Population Health Survey (DHS, 2002b). Both these initiatives have seen a significant shift towards improved use of high quality evidence in the processes of health planning, at a local, regional and state-wide level. It is an increasingly important challenge for epidemiologists and those who fund public health research to ensure there is an appropriate level of accountability in the use of scarce surveillance and health research resources.

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