



Performance Indicators, Key Stakeholders and Data Collection Strategies

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1. Introduction

This section provides more detail on performance indicators, key stakeholders and data collection strategies for the Evaluation and Monitoring Framework for the National Public Health Partnership (NPHP). This section begins with an introduction to some common aspects to these three areas and then looks at each of the key evaluation questions in turn. In each of these areas (performance indicators, key stakeholders and data collection), there is overlap and commonality primarily because the objectives of the NPHP are written broadly and are not mutually exclusive. In the implementation of the evaluation, it is the data collection strategy that will be the most logical place to orient the work of the evaluation around. The evaluation reports will, however, be organised around the key evaluation questions, that is the extent to which the objectives of the NPHP have been met.

1.1 Key questions and definitions

In relation to each NPHP objective we have provided a working definition¹ and asked how the objective will contribute to improved public health and how the Partnership will realise the objective. In each case we have identified pathways to the realisation of the objective and asked how the Partnership's work program, support arrangements and communication strategy will contribute to the realisation of such pathways.

Table 1 provides a diagrammatic representation of the major areas of intersection between the NPHP objectives and the Work Program areas. The crosses designate the areas of the Work Program (including the Partnership Group) that are most central to the achievement of the relevant objectives. Typically, the performance indicators for any objective fall primarily into the identified Work Program area shown in Table 1.

Table 1: Key performance areas for NPHP objectives

Priority Area	Improve collaboration in the national public health effort	Develop better coordination & increased sustainability of public health strategies	Strengthen public health infrastructure & capacity nationally	Facilitate the contribution of all providers of public health services, public health research & education programs & relevant agencies	Establish two-way exchange with key professional, community, consumer, educational & industry interests on the development of national public health priorities & strategies	Enhance the capacity of States/Territories to respond to local priorities
Practice Improvement & Resource Allocation	X		X			X
Information	X		X			X
Legislation Reform	X		X			
Workforce Development	X		X			X
Research & Development	X		X			X
Strategies Coordination	X	X	X			
Partnership Group	X	X		X	X	

¹ Alternative interpretations of objectives are possible to the contested nature of some of the terms used in the MOU.

1.2 Performance indicators

In relation to each objective we have asked two questions: how will we know if the objective has been realised and how will we know if the NPHP has contributed to the realisation of the objective? The answers to these questions have been drawn from the key questions analysis, from the initial terms of reference and outputs of the NPHP Working Groups and from the objectives of the support units' arrangements and the communications strategy.

The performance indicators used in the evaluation will change over the life of the NPHP and will need to be regularly reviewed by the Evaluation Working Group and the evaluation team as the work program evolves and develops. In general terms, indicators will need to become more output focussed as the Partnership goes on.

In addition to performance indicators related to the impact of the Working Groups, a common set of process indicators will be established. These indicators will respond to the question: How will we know if the Working Group operated effectively? Indicators will be that the relevant Working Group

- had established terms of reference;
- met on a regular and planned basis;
- had a stable membership;
- had regular participation from all members;
- maintained minutes of meetings; had a workplan with identified outputs²;
- had appropriate planning, consultation and evaluation strategies in place; and
- tabled required reports to the Partnership Group.

1.3 Key stakeholders

From an evaluation perspective, the key stakeholders involve three overlapping groups: those who have an interest in the outcome, those who are in a position to judge whether the objectives have been met, and those who are involved in the implementation of the NPHP. The term 'key' has been interpreted to mean those stakeholders who the evaluators will actually engage in the evaluation process.

1.4 Data collection strategies

The data collection strategy focuses on internal data collection and review of information generated by the work of the NPHP in years one, two and four. In years three and five this is to be complemented by more primary data collection from sources outside of the Partnership, the Working Groups and the support units.

We have not identified broad data collection strategies for each objective since the strategies will not change significantly, except in relation to the data to be collected and the key stakeholders involved. We have however identified, for each performance indicator, the likely form of data collection, the stakeholders involved and the timeframe. The strategies fall into the three categories of baseline, monitoring and evaluation.

Baseline

Baseline data collection will need to establish current levels of each objective (eg, collaboration) against which the impact of the NPHP can be evaluated. Strategies should include review of current literature and reports on each objective, and of evaluations/reports of recent national strategies, and interviews with selected key stakeholders (including from outside the health sector where relevant). Taking account of the timeframe and resources available, it is not feasible to undertake a comprehensive quantifiable baseline survey. Measurement of change, particularly in relation to external stakeholders, will need to be a matter of reflection in the survey and focus group work carried out in year three.

² Detailed performance indicators on outputs from the initial Working Groups are outlined under the appropriate key evaluation questions, in particular see section 4.2

Monitoring

Monitoring will consist of thematic analysis of minutes and reports of the Partnership, Advisory and Working Groups and it will be useful if Working Groups make progress reports against the NPHP objectives. Reports and evaluations arising from existing and new national strategies will need to be analysed in relation to the NPHP objectives. In addition, there will be analysis of annual reports from members of the Partnership Group and from support units and biannual interviews with Working Group chairs, their support staff and the Director of the Innovation and Support Unit.

Each Partner in the NPHP will be invited to table an annual report of how they have met the roles and responsibilities outlined in the MO. This report will require the Partners to report against each of the items outlined in section 7 (for the Commonwealth) and section 8 (for the States/Territories) of the NPHP Memorandum of Understanding (MO).

Working Groups will be encouraged to have an annual planning/evaluation meeting attended by the evaluators.

The support units of the Partnership will also be invited to report on annual basis as to how they have performed in relation to their own objectives and responsibilities. Clear objectives and responsibilities will need to be agreed and documented as support units are established and these will need to be reviewed on an annual basis.

Evaluation

In addition to the monitoring strategies, evaluation in years 3 and 5 will include:

- a survey of a sample of public health agencies;
- focus group discussions with a sample of providers;
- interviews with key stakeholders, including people from non-health sectors; and
- public invitation to make a written submission.

Data collection instruments (eg, questionnaires, surveys, interview schedules) will be developed by the evaluators.

Case studies

In each of years two to five, two case studies (eight over the life of the NPHP) of public health programs or issues will be undertaken. Each year the Evaluation Working Group will make recommendations to the Partnership Group on the selection of specific case studies using agreed criteria. The criteria for choosing those case studies has been spelt out in section 2.8.3 of the Framework, as follows:

- must relate to an issue of national public health significance;
- must require the development and implementation of a response by Partnership members;
- should include emerging areas as well as established areas in public health;
- should have defined and measurable output; and
- should involve key stakeholders and intersectoral agencies

The case studies will examine the extent to which the NPHP objectives, principles and roles and responsibilities have been carried out. That is, the focus of the case studies will be on the process rather than the outcomes of the program or the issue. Evaluation of the latter are important, but ought to be the focus of evaluations of that particular program or issue.

As with the work program, the data collection strategy for the case studies will be multi-faceted and ought include:

- review of available written material and reports;
- semi-structured interviews with key stakeholders;and
- focus group discussions with practitioners and members of community and consumer groups.

The case study reports should explicitly report against the NPHP objectives (excluding the first objective) principles and roles and responsibilities as described in the MOU.

2. Improve collaboration in the national public health effort

2.1 Working definition and key questions

In the terms of the NPHP, collaboration refers to the relationship between the Commonwealth and the States/Territories. That is, collaboration should be read with the prefix 'inter-Governmental'. This should be distinguished from intersectoral collaboration which refers to a relationship between part, or parts, of the health sector and part, or parts, of another sector (Harris et al, 1995:7).

Collaboration is something of a contested term and definitions abound³ Peck, Sheinberg and Akamatsu (1995:292) argued that collaboration is, 'the process in which several agencies make a formal, sustained commitment to work together to accomplish a common, mutually enhancing mission'. Drawing on business examples, Kanter (1994:105) argued that, 'Active collaboration takes place when companies develop mechanisms - structures, processes and skills - for bridging organisational and inter-personal differences and achieving real value from the partnership.'

How will improved collaboration between the Partners improve public health?

The Health Australia report (NHMRC, 1995) argued the need for a more cohesive public health system and that four aspects of the current system were getting in the way:

- duplication in policy development, leadership and program implementation due to poor articulation and understanding of the roles and responsibilities of the major players (Commonwealth, States/Territories, lead agencies);
- no mechanism to deliver health promotion (or public health) programs in a systematic way across Australia;
- the level of consultation and co-ordination between the Commonwealth and States/Territories, and to a lesser extent their regional authorities, is inadequate; and
- vertical program structures contribute to duplication and an inconsistent approach to addressing population-based or service delivery issues.

Better collaboration between the Partners will mean a more cohesive effort within the public health system, particularly at the Government to Government level, where roles and responsibilities are understood and adopted. This will lead to more effective public health interventions where there are not gaps nor are there duplications and where the available resources are being used to their best effect.

In regard to the pathway to better collaboration Kanter (1994) identified the following eight characteristics of collaborative relationships:

Individual excellence: partners are good in their field and have something positive to add to the relationship.

Importance: the partners have long term goals to achieve and the partnership is important in getting there. Partners want to make this relationship work.

Interdependence: The resources of the partners are complementary. They cannot achieve alone what can be accomplished together.

Investment: Commitment is demonstrated through application of resources (time, equipment, money, facilities) to the relationship.

Information: Partners share information that will help the relationship work.

³ A useful review of the literature in relation to collaboration from both the business and public sectors is provided by Walker, Adam and Lewis (1997)

Integration: Linkages develop between people at multiple levels in large organisations. Shared ways of operating are developed so that work can be accomplished smoothly. Partners learn from and teach each other.

Institutionalisation: The relationship is formalised and responsibilities and decision-making processes are spelled out. It involves additional people to those who started the relationship.

Integrity: The partners behave towards each other in ways that enhance trust. They do not undermine each other or abuse information they gain.

The pathways to better collaboration among the Partners appear to be:

- national agreement of the need for better collaboration;
- agreement around the roles and responsibilities of the Partners;
- national agreement around a set of public health goals;
- sharing of information within the health sector;
- establishment of forums in which information may be shared, negotiations may take place and coordination can develop;
- commitment of resources to the collaboration; and
- adoption of a consultative approach among the Partners.

How will the NPHP improve collaboration among the Partners?

The roles and responsibilities of the partners, as outlined in the MOU, provide support for improved collaboration. In particular, the Commonwealth's responsibilities include:

- facilitating the development of national public health policy in collaboration with government, non-government, professional and community organisations (7a);
- facilitating ongoing negotiations and agreement between Governments on national policy, planning, monitoring, reporting, programs, research, training and evaluation in public health (7c);
- facilitating the development of national consistency in areas where there is agreement that it is needed (7d);
- conduct national programs, in a coordinated fashion with States/Territories, where the need for such programs exists (7g);
- monitor, evaluate and report on the performance of national public health strategies and programs, in collaboration with States/Territories (7h); and
- conduct, in consultation with other partners, Australia's international responsibilities and obligations in public health (7i).

Similarly, the roles and responsibilities of the States/Territories, as outlined in the MOU, also provide support for improved collaboration:

- collaborate in national policy and strategy development and, within this framework determine State/Territory priorities, and develop strategies for implementation within their jurisdictions (8a);
- foster innovation in population health programs in collaboration with the Partnership Group (8c); and
- participate in collaborative efforts at the national level and with other States/Territories, including leading specific projects, and conducting those elements of the NPHP which the particular State/Territory might agree to undertake (8f).

No area of the Work Program focuses explicitly on improving collaboration. The objectives and principles aimed at better collaboration will therefore need to be realised through their implementation within the Work Program.

A common requirement across all Work Program areas will be the need for a collaborative approach within the health sector and with other relevant sectors. Working Groups will need to adopt a collaborative approach in their process and have collaborative mechanisms in place.

2.2 Performance indicators

The performance indicators listed here need to be read in conjunction with the generic Working Group performance indicators outlined in section 1.2 which focus explicitly on process aspects of the Work Program.

How will we know if there is improved collaboration between the Partners?

- major players in the public health field will be able to identify their own roles and responsibilities and those of different levels of Government and other agencies (key stakeholder interviews, baseline & years 3 & 5)⁴;
- Partners will report that other Partners are maintaining their commitment to collaboration and fulfilling their roles and responsibilities (key stakeholder interviews, baseline & years 3 & 5);
- Partners will be able to identify positive and valued contributions made by other Partners (key stakeholder interviews, baseline & years 3 & 5); and
- Partners will support a continued framework for collaboration beyond the life of the Partnership ((key stakeholder interviews, year 5).

How will we know if the NPHP has contributed to improved collaboration between the Partners?

- all members of the Partnership will have signed the MOU (reports from Partners, year 1);
- all members of the Partnership will have maintained formal involvement in the Partnership (reports from Partners & Working Groups, annually);
- all members of the Partnership will have carried out their roles and responsibilities as outlined in the MOU (reports from Partners & Working Groups, annually);
- barriers to participation in the NPHP (eg, relative costs of participation) will have been identified and resolved (key stakeholder interviews, years 3 & 5); and
- alternative arrangements (formal or informal, multilateral or bilateral) to the NPHP have not been established to deal with public health issues (key stakeholder interviews, years 3 & 5).

2.3 Key stakeholders

Partnership Group
NPHP Working Group Chairs
NPHP Support Units

⁴ For each performance indicator, we have identified the major data collection strategy and frequency of data collection, although many indicators will be covered multiple strategies including the case studies.

3. Develop better coordination and increased sustainability of public health strategies

3.1 Working definition and key questions

This objective refers to having a co-ordinated approach across the range of national public health policies, programs and actions. Where the previous objective referred to the Commonwealth and the States/Territories working together at the levels of policy and infrastructure development, this objective refers to a co-ordinated approach across the strategies.

A useful definition of coordination is provided by Alter and Hage (1993:87) who argued that coordination is the "articulation of elements in a service delivery system so that comprehensiveness, accessibility and compatibility among elements are maximised".

Sustainability of strategies refers to adopting common approaches and to learning from one strategy to the next. While sustainability is partly about being able to maintain support for strategies to see them to fruition, it is also about building up systems so that the public health momentum is not lost when the program, and the funding, runs out.

Improved sustainability will mean that interventions are maintained through to desired outcomes and that strategies are not dropped along the way as new issues emerge, or as early gains give way to more intractable problems.

How will better coordination and increased sustainability of national strategies improve public health?

The pathways to better co-ordination and improved sustainability of national strategies appear to be:

- national agreement of the need for better co-ordination;
- agreement around the roles and responsibilities of the Commonwealth, States/Territories, Local Government, statutory authorities, NGOs, universities and service providers;
- national agreement around a set of public health goals;
- a mechanism to deliver public health programs in a systematic way across Australia;
- greater flexibility in program structures to avoid duplication and to allow for a more consistent approach to addressing population-based and service delivery issues;
- establishment of forums in which information may be shared and coordination can develop; and
- adoption of a consultative approach to practice within the health sector.

How will the NPHP provide better coordination and improved sustainability of national strategies?

The NPHP is in itself, in the words of the MOU, "a new working arrangement to plan and coordinate national public health activities". A coordinated approach to public health practice is at the heart of the Partnership.

The only principle directly related to coordination is principle (g) which declares that, "optimising population health outcomes requires effective linkage between public health and health system planning".

The only principle apparently related to sustainability is principle (d) which declares that "a supportive legal and political environment is integral to the public health effort".

The roles and responsibilities of the partners, as outlined in the MOU, provide support for better coordination and improved sustainability. In particular, the Commonwealth's responsibilities include:

- facilitating ongoing negotiations and agreement between Governments on national policy, planning, monitoring, reporting, programs, research, training and evaluation in public health (7c);

- facilitating the development of national consistency in areas where there is agreement that it is needed (7d);
- conduct national programs, in a coordinated fashion with States/Territories, where the need for such programs exists (7g);
- monitor, evaluate and report on the performance of national public health strategies and programs, in collaboration with States/Territories (7h); and
- conduct, in consultation with other partners, Australia's international responsibilities and obligations in public health (7i).
- Similarly, the roles and responsibilities of the States/Territories, as outlined in the MOU, also provide support for better coordination and improved sustainability:
- collaborate in national policy and strategy development and, within this framework determine State/Territory priorities, and develop strategies for implementation within their jurisdictions (8a);
- foster innovation in population health programs in collaboration with the Partnership Group (8c); and
- participate in collaborative efforts at the national level and with other States/Territories, including leading specific projects, and conducting those elements of the NPHP which the particular State/Territory might agree to undertake (8f).

Within the Work Program, the Coordination of the National Public Health Strategies Working Group has an explicit role in developing better coordination and improved sustainability. In particular, the Work Program calls for, "establishment of a mechanism for coordinating across current and new national public health strategies, and a systematic approach to identifying priorities."

The NPHP communications strategy, to be implemented by the Innovation and Support Unit, will also facilitate coordination.

3.2 Performance indicators

How will we know if there is better coordination and improved sustainability of national strategies?

- public health practitioners will report being approached in a more coordinated fashion in regard to their participation in national strategies (survey & focus groups, years 3 & 5);
- public health practitioners will be able to articulate current national health priorities (survey & focus groups, years 3 & 5);
- public health practitioners will be less able to identify duplications and gaps in the health system (survey & focus groups, years 3 & 5);
- public health practitioners will report being able to easily obtain public health information (survey & focus groups, years 3 & 5);
- public health practitioners will be able to identify forums for coordination in which they participate (survey & focus groups, years 3 & 5);
- public health practitioners will report being approached to work in partnership more regularly (survey & focus groups, years 3 & 5); and
- public health agencies will have adopted the NPHP's objectives and priorities as guiding policies for their own work program (surveys and focus groups, years 3 & 5).

How will we know if the NPHP has contributed to better coordination and improved sustainability of national strategies?

In regard to policy coordination:

- States/Territories will have acted upon decisions taken by the Partnership (Partner & Working Group reports, annually);
- joint policy forums, including with other policy sectors, will have been established on a range of emerging public health issues (reports from Partners, annually);
- within each Work Program area, States/Territories will have adopted shared policy objectives and instruments (reports from Partners, annually);
- the Strategies Coordination Working Group will have:

- produced a mapping of national public health strategies (Working Group reports, annually);
 - developed coordination mechanisms through cross-membership and linkages between strategies (Working Group reports, annually);
 - identified best practice in national strategy development and implementation (Working Group reports, annually);
- the Evaluation Working Group will have developed strategies to monitor impacts and outcomes of joint policy efforts (Working Group reports, annually); and
 - Chairs of national strategies will have established forums for communication (key stakeholder interviews, years 3 & 5).

In regard to administrative coordination:

- all members of the Partnership will have carried out their roles and responsibilities in relation to coordination as outlined in the MOU (reports from Partners, annually);
- Commonwealth and States/Territories will be able to demonstrate effective linkages between public health divisions and other parts of the health system (reports from Partners, annually);
- channels for sharing information between jurisdictions will have been established (reports from Partners, annually); and
- shared structures (eg, joint ventures between States and Territories, inter-governmental contracting) for achieving public health objectives will have been established (reports from Partners, annually).
- shared structures (eg, joint ventures between States and Territories, inter-governmental contracting) for achieving public health objectives will have been established (reports from Partners, annually).

3.3 Key stakeholders

Partnership Group
 NPHP Advisory Group
 NPHP Coordination Of National Public Health Strategies Working Group
 Chairs Of National Strategies
 Public Health Practitioners
 Community And Consumer Groups

4. Strengthen public health infrastructure and capacity nationally

4.1 Working definition and key questions

The MOU defines public health infrastructure as, "Identifying infrastructure needs such as workforce, training and development, and information systems. This also involves ensuring appropriate legislative and regulatory frameworks are in place." In addition, the NPHP has taken the view that infrastructure includes public health research. Infrastructure refers to institutions and systems which exist to support and develop the technical capacity of public health practice.

How will strengthened national public health infrastructure and capacity improve public health?

Strengthened national public health infrastructure and capacity will support more effective public health interventions through: a more skilled, flexible and informed workforce; research and development leading to more effective intervention techniques; improved measures of processes and outcomes providing feedback on progress towards a healthier society; access to appropriate funding; and appropriate support from legislation and regulations.

The pathways to strengthened national public health infrastructure and capacity appear to be:

- development of new national measures of public health policies, resources, outputs and health-related indicators;
- a stronger academic research base for public health;
- development of intervention and dissemination research;
- a targeted program of enhanced research training; o an enhanced capacity to deliver evidenced-based policy advice;
- a framework for evaluation of the national public health effort;
- enhanced specialist and continuing education in public health;
- additional support for professional development opportunities; and
- strengthened support for community and consumer involvement.

How will the NPHP provide strengthened national public health infrastructure and capacity?

A number of the Partnership principles are directed towards strengthened national public health infrastructure and capacity.

Principle (d) declares that, "a supportive legal and political environment is integral to the public health effort".

Principle (e) declares that, "improvements in knowledge about current and emerging health determinants and risks are vital to effective public health efforts".

Principle (f) declares that, "priority setting and decision making should be based on scientific evidence as far as possible and on criteria that are open to public scrutiny and debate".

Principle (g) declares that, "optimising population health outcomes requires effective linkage between public health and health system planning".

Principle (h) declares that, "an ongoing capacity to scan and monitor the social and environmental trends likely to impact on future health status is essential for long term planning to prevent ill health".

The roles and responsibilities of the partners, as outlined in the MOU, also provide support for strengthened infrastructure. In particular, the Commonwealth's responsibilities include:

- facilitating ongoing negotiations and agreement between Governments on national policy, planning, monitoring, reporting, programs, research, training and evaluation in public health (7c);
- foster innovation, and initially finance innovation, in population health programs, in conjunction with States/Territories (7f);

- through AIHW - develop and collect public health data, set standards for data quality, produce public health statistics and undertake research and analysis to inform and improve public policy and practice (7j); and
- through the NHMRC - develop timely expert advice, assess best practice in public health interventions, and stimulate strategic research in public health (7k).

All seven of the Work Program priorities are directed to some aspect of strengthened national public health infrastructure and capacity.

4.2 Performance indicators

How will we know if there is strengthened national public health infrastructure and capacity?

- there will be more consistent and harmonised regulatory frameworks across jurisdictions (reports from Partners, annually);
- participation in training, continuing education and professional development programs will have increased (surveys, years 3 & 5);
- the public health workforce will have a greater proportion of people with higher degrees (surveys, years 3 & 5);
- the amount of public health research will have increased (surveys, years 3 & 5);
- the public health workforce will report greater access to training opportunities (surveys, years 3 & 5);
- public health agencies will report greater use of information systems (surveys, years 3 & 5); and
- public health agencies will report greater participation in research and development projects (surveys, years 3 & 5).

How will we know if the NPHP has contributed to strengthened national public health infrastructure and capacity?

The performance indicators listed here need to be read in conjunction with the generic Working Group performance indicators outlined in section 1.2 which focus explicitly on process aspects of the Work Program. Data collection for all these indicators will be primarily based on the minutes and reports from the Working Groups and interviews with Working Group Chairs and support staff.

the Planning and Practice Improvement Working Group will have:

- developed a classification framework for public health activities;
- developed standards for delivery of core public health functions;
- developed performance management tools for use by jurisdictions;
- identified benchmarks and best practice in public health;
- examined and characterised methods of financing public health;
- evaluated the efficiency of methods of financing public health;
- assessed the potential for financing mechanisms to contribute to improved outcomes; and
- analysed the relevance of alternate funding mechanisms.

the Information Working Group will have:

- established a national public health information plan;
- stimulated mechanisms for public health information collection and application, with specific emphasis on National Health Priority Areas;
- investigated the development of a surveillance system; and
- developed nationally consistent standards and protocols for public health information.

the Legislation Reform Working Group will have:

- clarified and articulated the role and function of public health legislation and regulation;
- identified areas and means by which public legislation can be more consistent and efficient across Australia; and
- identified means by which public health legislation can effectively advance public health.

the Workforce Development Working Group will have:

- developed a national public health workforce strategy; and
- identified public health workforce development priorities.

the Research and Development Working Group will have:

- developed a national public health research and development strategy;
- mapped public health research and development activity;
- identified public health research requirements and their relationship to policy and practice;
- developed an approach to priority setting in research and development;
- developed an approach to research and development investment; and
- developed an approach to institutional arrangements for research and development.

the Coordination of National Public Health Strategies Working Group will have:

- mapped national public health initiatives and strategies; and
- developed coordination mechanisms for national strategies.

4.3 Key stakeholders

Partnership Group
NPHP Advisory Group
NPHP Working Group Chairs
NPHP Support Units
Lead Agencies
Universities
Public Health Practitioners.

5. Facilitate the contribution of all providers of public health services, research and education programs and relevant agencies, and establish two-way exchange with key professional, community, consumer, educational and industry interests on the development of national public health priorities and strategies.

For the purposes of the evaluation framework, we have chosen to deal with these two objectives together.

5.1 Working definition and key questions

Together, these objectives refer to the public health field and other sectors being participants in the decision making processes of the NPHP. These objectives refer to the involvement of public health agencies and to professional and community and consumer groups (organised as such) being part of decisions taken by the Partnership about priorities and strategies.

How will facilitating the contribution of public health providers and other sectors improve public health?

This broad contribution to the work of the Partnership will have benefits both "up" and "down". Broad contribution to the Partnership's work will help ensure that the Partnership is well informed in relation to local needs, practice issues and research findings. Participation in decision making by providers and others will ensure that new initiatives are grounded within the realities of current demands and capabilities.

Broad contribution will also help build a constituency of support within the sector for the work and the initiatives of the Partnership. Successful implementation of the Partnership's strategies will rely on the support of the public health field and that support is more likely to occur where the field feels some ownership of the work of the Partnership.

In relation to intersectoral collaboration, its importance is in the recognition that health status is determined by complex and interrelated factors, many of which lie outside the health sector. The Health Australia report argued that collaboration was central to many of Australia's most successful public health interventions and argued that, "it is only by working intersectorally that some of the greatest gains in population health status are likely to be possible" (NHMRC, 1995:193).

The Health Australia report also argued that, "There is strong evidence that community participation in the development of policies and programs is a key factor that contributes to their successful implementation." (p. 199) Legge et al (1992, 1996) have also argued that a pre-condition for best practice is local collaboration and community and consumer involvement.

The Health Australia report argued that there were few formal processes that linked community groups to policy development and that community groups often did not have sufficient resources to effectively participate.

Health Australia argued that intersectoral collaboration could be improved through the following steps:

- establish a structure to identify opportunities to work with other sectors;
- develop instruments that help to develop understanding of the relationship between decisions made in other sectors and their impact on population health (eg, municipal public health plans);
- initiate training for policy-makers and practitioners within the health and other sectors in working intersectorally; and
- support community organisations to participate in intersectoral action.

The pathways to broad participation are:

- a sharing of information within the public health sector;
- timely sharing of information with local communities by the health sector;
- the establishment of regional, Statewide and National forums in which information may be shared and contributions gathered;
- community participation in the management of health services;
- the adoption of a consultative approach by the Partnership to practice within the public health sector;
- training for policy-makers, practitioners and community and consumer representatives in working collaboratively; and
- support for community and consumer organisations to participate.

How will the NPHP facilitate the broad contribution of the public health field and other sectors?

The NPHP is in itself, in the words of the MOU, "a new working arrangement to plan and coordinate national public health activities". A coordinated and collaborative approach to public health, one that embraces the public health field and other sectors, is therefore central to the Partnership.

As previously noted, the NPHP principles place an emphasis on collaboration and coordination. The adoption of those principles in the work of the NPHP and throughout public health practice will lead to a broader contribution from the public health field and from other sectors.

Principle (a) declares that, "each community or population sub-group should have access to strategies, services and activities which optimise their health." Principle (b) declares that, "each community or population sub-group should have access to a healthy and safe environment including clean air and water, and adequate food and housing."

Implicit in these principles is the capacity of local communities to identify local priorities in relation to public health and for those priorities to be articulated and taken account of. Implicit in principle (b) is a role for public health in ensuring access to a healthy and safe environment including clean air and water, and adequate food and housing. Since public health agencies do not have control over the areas of air, water, food and housing, public health will need to negotiate intersectoral collaborations to influence these areas.

Principle (c) declares that, "public health efforts must proceed in partnership with non-health sectors and in collaboration with international partners."

Principle (g) declares that, "optimising population health outcomes requires effective linkage between public health and health system planning".

The roles and responsibilities of the partners, as outlined in the MOU, also provide support for broad contribution.

In particular, the Commonwealth's responsibilities include:

- facilitating the development of national public health policy in collaboration with government, non-government, professional and community organisations (7a);
- conduct, in consultation with other partners, Australia's international responsibilities and obligations in public health (7i);
- through AIHW - develop and collect public health data, set standards for data quality, produce public health statistics and undertake research and analysis to inform and improve public health policy and practice (7j); and
- through the NHMRC - develop timely expert advice, assess best practice in public health interventions, and stimulate strategic research in public health (7k).

Similarly, the roles and responsibilities of the States/Territories, as outlined in the MOU, also provide support for broad contribution:

- undertake State/Territory specific intersectoral collaboration, particularly in facilitating whole of government approaches and in working with Local Government, State/Territory based non-government organisations, and education and research institutions (8e).

No priority area of the Work Program focuses explicitly on facilitating the contribution of the broad public health field, therefore this objective will need to be realised through the processes of all the Working Groups and the Support Units. In particular, the implementation of the communications strategy by the Innovation and Support Unit will be central to facilitating this broad contribution.

A common requirement across all Work Program areas will be the need for processes which facilitate contribution. This will be reflected in Working Group membership by participation of people from a range of jurisdictions and parts of the public health sector. It will also be reflected in the way Working Groups carry out their activities which will need to be open, informative and consultative.

5.2 Performance indicators

How will we know if the contribution of the broad public health field and other sectors has been facilitated?

- public health agencies will make greater use of national policy and planning documents in their local planning and practice (surveys & focus groups, years 3 & 5);
- members of the public health field will be able to describe how national policy is developed and will know of opportunities to contribute to policy development (surveys & focus groups, years 3 & 5);
- the public health sector will be able to demonstrate training opportunities in collaboration that are being taken up by policy-makers and practitioners (key stakeholder interviews, years 3 & 5);
- the public health sector will be able to demonstrate new or further developed, negotiated partnerships with other sectors (key stakeholder interviews, years 3 & 5);
- States/Territories will have protocols in place for consulting with local communities (reports from Partners, annually);
- regional and Statewide processes involving community representatives will be occurring (reports from Partners, annually);
- training systems for working with communities will be in place and will be used by public health policy-makers, practitioners and community representatives (key stakeholder interviews, years 3 & 5);
- States/Territories will have programs in place to assist in the resourcing of community and consumer organisations (reports from Partners, annually);
- interest groups and other sectors will report being involved in positive relationships around national public health issues (key stakeholder interviews, years 3 & 5);
- interest groups and other sectors will be able to identify actions and outcomes arising from their participation in national public health issues (key stakeholder interviews, years 3 & 5); and
- interest groups and other sectors will be able to identify and will be taking up training opportunities that support two-way exchange (key stakeholder interviews, years 3 & 5).

How will we know if the NPHP has facilitated the broad contribution of the public health field and other sectors?

- stakeholders outside the Partnership will report being able to make constructive input to the Work Program (key stakeholder interviews, years 3 & 5);
- members of the Partnership will have carried out their roles and responsibilities, as outlined in the MOU, which will contribute to facilitating broad contribution (reports from Partners, annually);
- Partners and the Working Groups will have established forums to engage contributions from the broad public health field (reports from Partners & Working Groups, annually); o

that NPHP Support Units and Working Groups will be able to demonstrate examples of input from consumers and the community (reports from Working Groups & Support Units, annually);

- the Innovation and Support Unit will have produced and widely distributed a newsletter on a quarterly basis and will have established and maintained a website; and (reports from the Innovation & Support Unit, annually);
- Working Groups will be able to point to examples of consultative process (consultative style, forums, information sharing) in their work (reports from Working Groups, annually);

the Planning and Practice Working Group will have:

- identified best practice models and benchmarks of collaboration and local responsiveness;
- developed standards on collaboration and local responsiveness;
- developed performance measurement tools in relation to collaboration and local responsiveness; and
- developed planning protocols for States/Territories that support collaboration and local responsiveness (reports from Working Group, annually).

5.3 Key stakeholders

Partnership Group
NPHP Advisory Group
NPHP Working Group Chairs
NPHP Support Units
Community And Consumer Groups
Professional Organisations
Lead Agencies
Universities Public Health Practitioners
Industry Groups.

6. Enhance the capacity of state/territories to respond to local priorities

6.1 Working definition and key questions

In the context of the NPHP, the construction of 'local' in this objective means State or Territory rather than neighbourhood, municipal or regional. The interpretation here is that the NPHP will not take away from priority-setting by States/Territories and should add value to their actions.

How will enhancing the capacity of States/Territories to respond to local priorities improve public health?

The Health Australia report argued that while the States/Territories have a responsibility for operationalising programs to address agreed national priorities, they must also have room to address state and local issues (or population groups) that are not of national priority. This acknowledges the significant differences between States and Territories and that the public health issues they face will not always be the same.

The pathway to improved State/Territory responsiveness to local priorities includes:

- a systematic surveillance and research capacity to identify emerging local issues;
- established working relationships with other sectors to allow for the cooperative development of policies and programs;
- a planning system that is able to identify and respond to local priorities;
- an effective program delivery capacity; and
- State level infrastructure capable of responding to workforce, training and development and information needs.

How will the NPHP enhance the capacity of States/Territories to respond to local issues?

While the delivery of public health at the local level is the responsibility of States/Territories, the actions of the Partnership, particularly in relation to infrastructure development, will bear on the capacity of States/Territories to respond locally. An example is the way in which public health data may be collected and made available and the importance of organising such collection and dissemination so that local variations can be identified and responded to.

A number of the partnership principles support the objective of local responsiveness:

Principle (a) declares that, "each community or population sub-group should have access to strategies, services and activities which optimise their health."

Principle (b) declares that, "each community or population sub-group should have access to a healthy and safe environment including clean air and water, and adequate food and housing."

Principle (f) declares that, "priority setting and decision making should be based on scientific evidence as far as possible and on criteria that are open to public scrutiny and debate".

Principle (h) declares that, "an ongoing capacity to scan and monitor the social and environmental trends likely to impact on future health status is essential for long term planning to prevent ill health".

The roles and responsibilities of the States/territories, as outlined in the MOU, also provide support for local responsiveness:

- develop and implement State/Territory specific policy, programs and regulatory frameworks for public health (8b); and

- undertake State/Territory specific intersectoral collaboration, particularly in facilitating whole of government approaches and in working with Local Government, State/territory based non-government organisations and education and research institutions.

None of the Work Program areas directly addresses this objective. However, the outcomes of the Working Groups addressing infrastructure issues will be central to enhancing local responsiveness. These Working Groups will need to bear in mind this objective and balance it against the requirement for an improved national public health infrastructure.

6.2 Performance indicators

How will we know if the capacity of States/Territories to respond to local issues has been enhanced?

- local interest groups and public health practitioners will report increased responsiveness by State/Territories to local issues (surveys & focus groups, years 3 & 5);
- local interest groups and public health agencies will report improved access to local public health information (survey & focus groups, years 3 & 5);
- State/Territory public health plans will include local issues as priorities (reports from Partners, annually);
- States/Territories will be able to demonstrate a systematic surveillance and research capacity to identify emerging public health issues (reports from Partners, annually);
- States/Territories will be able to demonstrate working relationships with other parts of the health system and other sectors (reports from Partners, annually);
- States/Territories will be able to demonstrate planning systems that respond to local issues (reports from Partners, annually);
- States/Territories will be able to demonstrate an effective public health delivery capacity (reports from Partners, annually); and
- States/Territories will be able to demonstrate local infrastructure capable of responding to workforce, training and development and information needs (reports from Partners, annually).

How will we know if the NPHP has enhanced the capacity of States/Territories to respond to local issues?

Outputs of the NPHP Working Groups will have been taken up by the States/Territories, including:

- adoption of a national classification system for public health practice;
- adoption of national standards for public health delivery;
- use of NPHP developed performance management tools;
- use of benchmarks and best practice identified through the NPHP;
- use of funding models developed by the NPHP;
- adoption of nationally consistent standards for information collection and dissemination; and
- adoption of nationally consistent public health legislation (reports from Partners, annually);

States/Territories will have identified local workforce development priorities within the NPHP national framework (reports from Partners, annually);

States/Territories will report improved access to local public health data arising from the NPHP Information Working Group (reports from Partners, annually); and

States/Territories will have developed local research and development strategies within the NPHP national strategy (reports from Partners, annually).

6.3 Key stakeholders

Partnership Group
 NPHP Advisory Group
 NPHP Working Group Chairs
 Community And Consumer Groups
 Local Public Health Agencies.

7. References

Alter C, Hage J (1993), *Organisations working together*. Sage, Newbury Park.

Harris E, Wise M, Hawe P, Finlay P, Nutbeam D (1995), *Working together: intersectoral action for health*. AGPS, Canberra.

Kanter RM (1994), Collaborative advantage: *The art of alliances*. *Harvard Business Review*. July-August: 96-108.

Legge D, McDonald D, Benger C (1992), *Improving Australia's Health: The role of primary health care*. NCEPH, ANU, Canberra.

Legge D, Wilson G, Butler P, Wright M, McBride T, Attewell R (1996), *Best Practice in Primary Health Care*. Centre for Development and Innovation in Health, Melbourne.

NHMRC (1995), *Health Australia: Promoting Health In Australia, Discussion Paper*.

National Public Health Partnership (1997), *A Memorandum of Understanding to Establish a National Public Health Partnership for Australia*.

Peck J, Sheinberg M, Akamatsu N (1995), Forming a consortium: A design for interagency collaboration in the delivery of service following the disclosure of incest. *Family Process*, 34:287-302

Walker R, Adam J, Lewis B (1997), General Practice Projects: Collaborative Structures and Processes, *Health Systems Research Report No. 8*, La Trobe University, Melbourne.