Submission to the

National Health Performance Authority Indicators Review

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Background

The Performance and Accountability Framework Indicators are intended to support reporting on the performance of hospitals and health care services at the local level and are grouped in two sets: local hospital networks and primary health care organisations. The Performance Authority has identified five existing indicators that might constitute a third set of indicators 'healthy communities and hospitals' where outcomes can be influenced by primary health care organisations and hospitals or local health networks.

The scope of the review is limited to the indicators only and will not consider the conceptual framework underpinning the indicators, nor any other element of the framework. Given this scope, AHHA offers the following comments on the indicators and their proposed treatment.

1. Hospital Indicators

For hospital indicators the Performance Authority proposed to be retained with or without modification, indicators 1, 3, 4, 6, 7, 8, 10, 16, 18, 19, 20

1.1 We question the usefulness of retaining indicators 1, 10, 18, 19, 20 when they have not been previously reported by the Authority, they aren't reported by all hospitals and they require methodological development to create accurate, consistent information. In particular, the inability to define indicator *1: access to services by type of service compared to type of need* is non-specific and the establishment of a consistent definition of need is problematic. The experience of defining and collecting elective surgery waiting times that are nationally comparable and consistent has taken years and the costs of developing this indicator have been significant. The benefit versus the administrative burden of measuring 'need' for multiple, as yet unidentified services needs to be considered before retaining these indicators.

Recommend placing these in the category: consultation on possible deletion or substitution.

1.2 Indicator 10: *measures of the patient experience with hospital services* is collected and used by some States and Territories. Hospital Boards or local health service governing bodies use these data (where they exist) to help drive the quality agenda. It may not be feasible in the short term for all hospitals to use the same measurements of patient experience, as some states have invested in collecting these data and report trends using a time series. The additional benefit to patients would need to justify the costs of changing current survey techniques.

Recommend deletion or placing this in the category: indicators where the PAF needs to be developed.

1.3 Indicator 19: *death in low mortality diagnostic related groups*. These deaths require local review, analysis and follow up. The statistical significance of changes in low prevalence conditions is largely misunderstood. It is important for local reviews to take place, but we question the relevance of reporting these nationally. What action should be taken at this level and when? Using explanatory footnotes to caution readers about statistical significance does not ensure correct interpretation of the results.

Recommend deletion.

1.4 It appears that these three indicators in particular do not conform with the selection criteria for indicators in the Framework, e.g. relevance for policy makers, relevance to the national health reform agreement, valid, reliable, comparable and administratively simple and cost effective.

1.5 Indicators 18 and 20 could be placed in the category: consultation on possible deletion or substitution

1.6 We support the recommended treatment of hospital indicators 9, 15, 17 which is to delete or substitute these.

2. Primary healthcare organisation indicators

For primary health care organisation indicators the Performance Authority proposed to be retained with or without modification, indicators 22, 24, 26-32, 34-37, 40, 41, 48, 50, 52-55

2.1 Indicators 22, 26, 27, 28, and 35 are at least partially dependent on BEACH data and therefore will not be reportable from 2016 when these data are not available. Reliance on ABS survey data which is based on self-reported information and is infrequently administered is problematic for assessing service performance at the local level. MBS and PBS data may not provide substitute data that are fit for purpose or reliable.

Recommend including these in the category: indicators where the PAF indicates 'to be developed'.

2.2 Indicators 30, 31, 36 have not been previously reported by the Performance Authority and unless more specificity is created for indicators 30: *waiting times for community health* services and 36: rates of contact with primary mental health care by children and young people they will remain uncollectable. These indicators in part do not conform with selection criteria for indicators in the framework, e.g. relevance to the national health reform agreement, valid, reliable, comparable and administratively simple and cost effective.

Recommend deletion.

2.3 We support the recommendation for the following primary care organisation indicators to be deleted or substituted: 33, 38, 39, 45, 46, 47, 49, and 51.

3. Healthy Communities and Hospitals

The proposal to measure the integration and coordination of services through the development of indicators common to both is supported in principle. Five existing indicators have been allocated to this category and we note that the Performance Authority has limited access to data about care and outcomes across the sectors. Specific comments about each of the chosen indicators are included below.

3.1 Indicator *12: rate of community follow up within the first seven days of discharge from psychiatric admission.* We understand that this has not been reported by the Performance Authority. Data can be collected in some states but is derived from hospital and community mental health services, rather than from hospitals **and** primary care organisations. If the intention is to collect this as a process

indicator across sectors, another data source will be required and it is likely to require data linkage for most states.

3.2 Indicator *14: relative stay index for multi-day stay patients in hospitals.* This is an indicator of hospital practices, although limited access to primary care (and other factors) could impact on LOS in hospital. By itself it provides non-specific data about the health care system and needs to take into account the services that may or may not be accessible in the community if it is to accurately reflect service integration.

3.3 Indicator *21: unplanned hospital readmission rates for various conditions.* We note this has not been previously reported by the Performance Authority and would require data linkage between hospitals (public and private) as well as general practices to provide useful analysis. It would be a useful indicator to measure cross sector integration/communication but may not be feasible other than by using costly research methods.

3.4 Indicator *25: primary care-type emergency department attendances.* Given that the data source used for this indicator relies on a survey and self-reported information about whether a person 'thought their care could have been provided by a GP on the most recent occasion' we would question the reliability of these data for the purpose of monitoring the performance of the health system at a local level as intended. The Patient Experiences Survey weighted estimates show that only 14.3% of those surveyed needed to go to hospital, so the respondents included approximately 3900 records (fewer because of other exclusions) and these were used to estimate ED attendance across all hospitals. We question the sample size and its validity for this indicator. More work is needed to develop the data sources to adequately report this indicator.

3.5 Indicator *56: 5 year survival proportions of selected cancers.* The Performance Authority has not previously reported this but we note that the AIHW publishes a number of reports such as Cancer in Australia 2014 and the Australian Cancer Incidence and Mortality (ACIM) books that report cancer survival. It is unlikely to be feasible to report five year cancer survival for a local area health services each year.

4. Conclusion

4.1 AHHA has welcomed the opportunity to contribute to the discussion about the intrinsic value and usefulness of indicators in monitoring the performance of the primary health care and hospital sectors and their integration.