



australian healthcare &  
hospitals association

*the voice of public healthcare®*



**AHHA response to Hospital/Facility Level Public  
Reporting and Senator Griff's Health Insurance  
Legislation Amendment (Transparent Patient  
Outcomes) Bill 2021**

March 2022



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## OUR VISION

A healthy Australia, supported by the best possible healthcare system.

## OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

## OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective  
Accessible  
Equitable  
Sustainable  
Outcomes-focused.

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## BACKGROUND

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide feedback on hospital/facility level public reporting and Senator Griff's Health Insurance Legislation Amendment (Transparent Patient Outcomes) Bill 2021.

The proposed Bill would enable the Minister for Health to establish public databases of surgical procedures and patient outcomes, with the aim to allow consumers who are considering a particular procedure to make an informed choice about their practitioner.

## WHO WE ARE

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

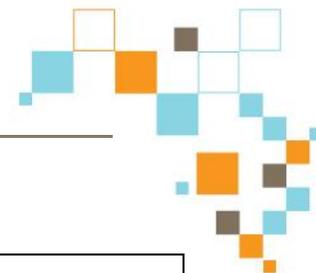
## ACHIEVING HEALTH REFORM

To achieve a healthy Australia supported by the best possible healthcare system, and as outlined in AHHA's blueprint for health reform<sup>1</sup>, AHHA recommends Australia reform the healthcare system over the next 10 years by enabling person-centred, outcomes-focused and value-based health care. This requires:

1. A nationally unified and regionally controlled health system that puts people at the centre;
2. Performance information and reporting that is fit for purpose
3. A health workforce that exists to serve and meet population health needs
4. Funding that is sustainable and appropriate to support a high quality health system.

It is within this context, and the context of the initiatives in the [National Health Reform Agreement \(NHRA\) – Long-term health reforms roadmap](#), that the following feedback has been provided.

This response was prepared drawing on the expertise of our members in the short timeframe available. We would welcome opportunities to engage further on this critical proposed piece of legislation.



## RESPONSE

Question	Input (please use more space if required)
<p><b>What is your view of Senator Griff's Bill?</b></p>	<p>The AHHA supports the Bill's intentions to enable transparency of patient outcomes to increase consumer choice. However, we view the Bill in and of itself as insufficient to meet this goal without causing harm and resulting in unintended consequences. We would support this Bill if it existed within a well-resourced and long-term policy reform package, outlined in the following.</p> <p>Publishing information on health system performance can improve clinical outcomes for patients and benefit the entire system. This occurs in two main ways; (1) increased consumer knowledge of healthcare provider performance can help consumers make informed choices (with low-performing providers losing market share and making meaningful changes to improve performance in response); and (2) increased healthcare worker knowledge of their own performance can motivate them to provide better care.</p> <p>However, performance reporting can potentially:</p> <ul style="list-style-type: none"> <li>• drive risk-avoidance behaviour by services; this will need to be properly managed to ensure an overall positive impact (Chen 2010; Campanella et al. 2016);</li> <li>• impact the reputation of surgeons or cause unnecessary conflict within hospitals by reducing levels of trust between surgeons and hospital administration (Canaway et al. 2019), or limiting opportunities for trainees; and</li> <li>• result in unintended consequences for disadvantaged groups by widening access and equity gaps.</li> </ul> <p>To protect against these risks, the AHHA strongly advocates for this Bill, or similar, to only be introduced as one part of a long-term, multi-stage strategy to design and implement patient outcomes measurement in Australia. To maximise the benefits of transparent patient outcomes and minimise negative and unintended consequences, we need a staged approach; first, beginning with the development of measures of patient outcomes through consultation and evaluation; second, implemented and reported back to practitioners and providers only; and lastly, with patient outcomes data made available to consumers.</p>



	<p>Thus, our support for this Bill is dependent on its context within a wider policy reform platform supporting whole-of-system health performance information and reporting that is focused on health outcomes and facilitates achieving value in health care and transparency of performance. Leadership is needed to establish a system where data accurately reflect care outcomes and are in the right format, timely and of sufficient quality to discern critical relationships between investment and results, as appropriate, for different audiences and purposes.</p>
<p><b>2) Does the Bill require any amendments?</b></p> <p><b>a) If so, what amendments would be required?</b></p>	
<p><b>b) How could more public reporting of health outcomes data at the hospital/facility level be supported?</b></p>	<p>We propose the following action in our <a href="#">blueprint for health reform</a> to achieve performance information that is fit for purpose:</p> <ul style="list-style-type: none"> <li>• <b>Short-term (within 2 years):</b> A strategy is developed for a standardised national approach to measuring value-based, person-centred outcomes and is reported at different levels of the healthcare sector, and to different audiences. This includes setting clear objectives, defining target audiences, developing transparent principles and methodology through broad consultation, and timely monitoring and evaluation of unintended consequences.</li> <li>• <b>Medium term (within 5 years):</b> Benchmarking performance against standardised sets of value-based patient-centred outcomes is introduced with:             <ul style="list-style-type: none"> <li>○ anonymous public reporting across and within health systems</li> <li>○ reporting back to providers of their relative performance, with a focus on learning and continuous improvement</li> <li>○ validated methodologies for outcomes tracking and risk-adjustment.</li> </ul> </li> </ul>



	<ul style="list-style-type: none"> <li>• <b>Long-term (within 7-10 years):</b> Outcomes data that empowers patients to make informed choices about treatment options and providers is made accessible to the public and includes data on the outcomes that matter most to each patient.</li> </ul> <p>For transparency in the public reporting of outcomes to be a positive move, it must be embedded within a quality management and improvement framework. Any public reporting scheme needs to be accompanied by strategies to help providers improve – this includes capability building, funding enablers, and so on.</p>
<p><b>3) What are the enablers and barriers to more public reporting of health outcomes at the hospital/facility level?</b></p> <p><b>a) How could these barriers be addressed?</b></p>	<p><i>Need for consensus on how to measure patient outcomes:</i></p> <p>Currently there is no consensus on how to measure patient outcomes. In the context of surgical procedures, measures that do not capture the complexity of a patient’s condition will be misleading to consumers. Expected outcomes and post-op functionality are highly variable from patient to patient for the same procedure depending on age, comorbidities, expectations etc.</p> <p>AHHA supports the development of comprehensive patient reported outcomes measures (PROMs) to better understand patients’ experience of care and to facilitate the delivery of value-based health care. There should be a shared development of PROMs between consumers, clinicians, researchers, regulators and policy makers. This shared approach is to ensure that the outcomes captured span the range of purposes to which they could be applied and to ensure that they are not purely clinically focused and retain an appropriate patient centric approach.</p> <p>There is increasing interest across the health system in applying patient-reported experience measures (PREMs) and patient-reported outcomes measures (PROMs) to safety and quality improvement, but patterns of collection in Australia are highly variable (Centre for Health Service Development, AHSRI 2016). These are used widely in clinical trials and other research settings; however, their use to improve the safety and quality of healthcare is still emerging.</p> <p>There is some activity in this sphere being led by government entities (e.g., through the NSW Agency for Clinical Innovation), by public health providers (e.g., Dental Health Services Victoria), and across public and private health providers (e.g. in the Continuous Improvement in Care cancer pilot trial in Western Australia).</p> <p>There is increasing implementation of approaches based on the relevant International Consortium for Health</p>



Outcomes Measurement (ICHOM) standardised sets of value-based patient-centred outcomes. The ACSQHC has been scoping an appropriate role for the measurement and reporting of patient-reported experiences and outcomes to support the health system to deliver patient centred care.

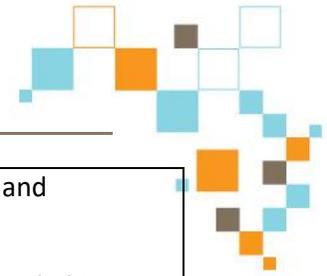
*Data quality:*

Currently, we do not collect data of the quality needed for patient outcomes to be publicly reported without causing harm or consequences. We only measure very high level and usually administrative data. Measures like mortality can be misleading and cause anxiety to patients; and can be especially misleading if the cause of death and co-morbidities are not known. To effectively implement a transparent patient outcomes policy, significant government resourcing would be required to allow high quality data collection or registries to be established and appropriate measures to be designed.

A major data challenge in the reporting of outcomes is adjustment to reflect case-mix. Importantly, the data needs to be weighted so practitioners and units that treat the very complex patients are not penalised. In the UK, a lot of “trial by media” occurred when it created league tables that had little to do with quality. In addition, it is difficult to collect quality, longitudinal data and to make sense of it without a lot of resources (at the moment most clinical registries are voluntary and under- or un-funded). Health literacy is a big issue in Australia, and so another challenge is reflecting complexity and case-mix in outcome measures, whilst ensuring that these can be effectively communicated to and understood by patients.

Despite the importance of health information and reporting, and the substantial data currently being collected, Australia has not implemented a long-term strategic plan to coordinate and direct national health information interests.

Recognising the need for a comprehensive national approach, the Australian Institute of Health and Welfare (AIHW) commenced development of a National Health Information Strategy (NHIS). Broadly, the NHIS aimed to overcome information gaps and barriers in the current system; drive investments in health information; and provide an enduring framework to achieve coordinated, integrated, efficient, effective and timely collection and development of health information. Its scope was expected to cover governance, infrastructure, national health data, analysis, and reporting (AIHW 2020). However, with the COVID-19 pandemic, and COAG being



replaced with the National Federal Reform Council, funding and governance is no longer assured, and development of the NHIS appears to have stalled.

Further, data standards, digital health architecture, and analytical and reporting capabilities are needed to support systematic tracking of health outcomes, relevant risk-adjustment factors, segment-specific interventions, corresponding costs of care and other relevant dimensions of health system performance (WEF 2016).

*Understanding unintended consequences:*

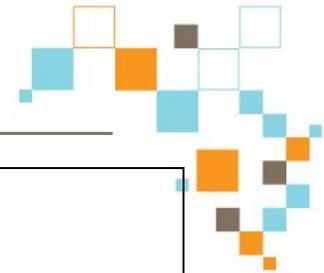
This kind of “catch all” legislation can easily have unwanted consequences. Considering the dangers of transparent patient outcomes outlined above, which have played out in other jurisdictions like the UK, consultation and evaluation is required to mitigate against negative effects and unintended consequences for the health system and vulnerable groups.

The evidence on the impacts of public reporting of outcomes measures is mixed. Most of the research in this space showing positive impacts on outcomes has often been around mortality and been limited to limited areas (cardiology) (Campanella et al. 2016). Our stakeholders have highlighted awareness of international evidence (particularly Hampshire, Bristol and Morcombe Bay NHS Trusts) that publishing outcomes data can result in staff not reporting risks, incidents and “near misses”, as well as the cancelling/closing of services thought to be too high risk rather than improving them. In addition, stakeholders are aware of various reports, inquiries and commissions into those services showing that publishing data had no impact on consumer behaviour (e.g., consumers don’t move to services perceived or reported as “safer”).

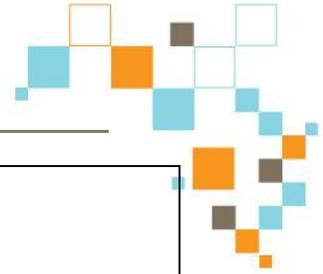
As mentioned, a major challenge is benchmarking outcomes against case-mix. Otherwise, we may have the unintended outcomes we get in mental health, where patients are excluded from services because they are less likely to achieve good outcomes. In mental health, this is unintended and unconscious, but if we look at the data, we have patients who are rejected from public care (often due to social determinants of health meaning they have difficulties with access) and excluded from private for being too complex, or unable to afford services.



	<p>We need to learn from international and domestic experiences and pursue transparency in a staged approach (in question three to avoid repeating policy failures and to avoid foreseeable and unforeseeable consequences).</p>
<p><b>4) Some mature national clinical quality registries are currently publicly reporting risk adjusted health outcomes data at the clinic/hospital level.</b></p> <p><b>a) What are the enablers or barriers to a more systematic approach to public reporting of mature clinical quality registry data at the hospital/facility level?</b></p> <p><b>b) How could these barriers be addressed?</b></p>	<p>Clinical quality registries provide an effective mechanism for capturing and reporting process and outcomes data for specific clinical conditions or treatments and enabling comparisons. However, there is significant variation between existing clinical registries (Woolcock 2019).</p> <p>Continued and coordinated pursuit of national clinical quality registries is needed. Data must capture patient-reported outcomes, with collection embedded in routine clinical practice. Feedback to clinicians must be appropriate and timely to support patient care. The use of clinical quality registries must also be embedded in strategies to inform post-marketing surveillance and disinvestment decisions (Woolcock 2019).</p> <p>To achieve the clear clinical and economic benefits, AHHA is supportive of the <a href="#">National Clinical Quality Registry and Virtual Registry Strategy</a> recognising the importance of:</p> <ul style="list-style-type: none"> <li>• Governance, including coordination of national and state efforts and collaboration between clinical and stakeholder leadership; and</li> <li>• Data, including requirements for providers to contribute data to approved registries, investment in infrastructure to support data collection and considerations for public reporting (Ahern et al. 2018).</li> </ul> <p>However, registries must be appropriately resourced. Funding consideration is necessary, including for approval process for new registries and evaluating existing registries, models that identify multiple sustainable public and private funding sources, and support for provider participation in registries.</p> <p>Some Australia exemplars to consider is the Palliative Care Outcomes Collaboration and Prostate Cancer Outcomes Registry, which both collect data on patient-reported health outcomes using standardised instruments, with summary reports returned to service providers to support benchmarking and quality improvement (AIHW 2018).</p>



<p><b>5) Could existing national administrative data collections be expanded to provide health outcomes data for public reporting at the hospital/facility level?</b></p> <p><b>a) What are the enablers or barriers to expanding existing administrative systems to provide health outcomes data for public reporting at the hospital/facility level?</b></p> <p><b>b) How could these barriers be addressed?</b></p>	
<p><b>6) Could the use of the Individual Health Identifier help support public reporting of health outcomes data at the hospital/facility level? (For example, for care that covers more than one episode or provider?)</b></p> <p><b>a) What are the enablers and barriers to using the Individual Health Identifier to help support public reporting of health outcomes data at the hospital/facility level?</b></p>	<p>AHHA supports the collection of Individual Healthcare Identifiers (IHIs) to facilitate innovative models of care and associated funding mechanisms.</p> <p>Moving the health system from the funding of episodic activity towards a more holistic view of a patient’s journey of healthcare will require the ability to trace a patient across multidisciplinary cycles of care, over time and potentially across jurisdictions.</p> <p>The recent assessment by IHPA of the opportunities and challenges associated with the introduction of bundled payments for maternity care is insightful in this respect. The routine collection of IHIs is also important for the collection of patient reported outcomes measures (PROMs) and as part of a move towards pricing and funding for value-based health care.</p>



<b>b) How could these barriers be addressed?</b>	
<b>7) Do you have any further comments?</b>	<p>As referenced in AHHA’s Blueprint for Health Reform, reorienting Australia’s healthcare system to patient outcomes and value requires a series of short-, medium- and long-term actions. Performance information and reporting that is fit-for-purpose is a one of the four pillars in the blueprint.</p> <p>Through the Australian Centre for Value-Based Health Care, and in collaboration with supporters and partners, we aim to enable the transition to value-based health care, focused on outcomes and person-centred models of care. This response was prepared drawing on the expertise of our members, but given the short timeframe on which to engage, we would welcome opportunities to engage further on this critical piece of legislation.</p>



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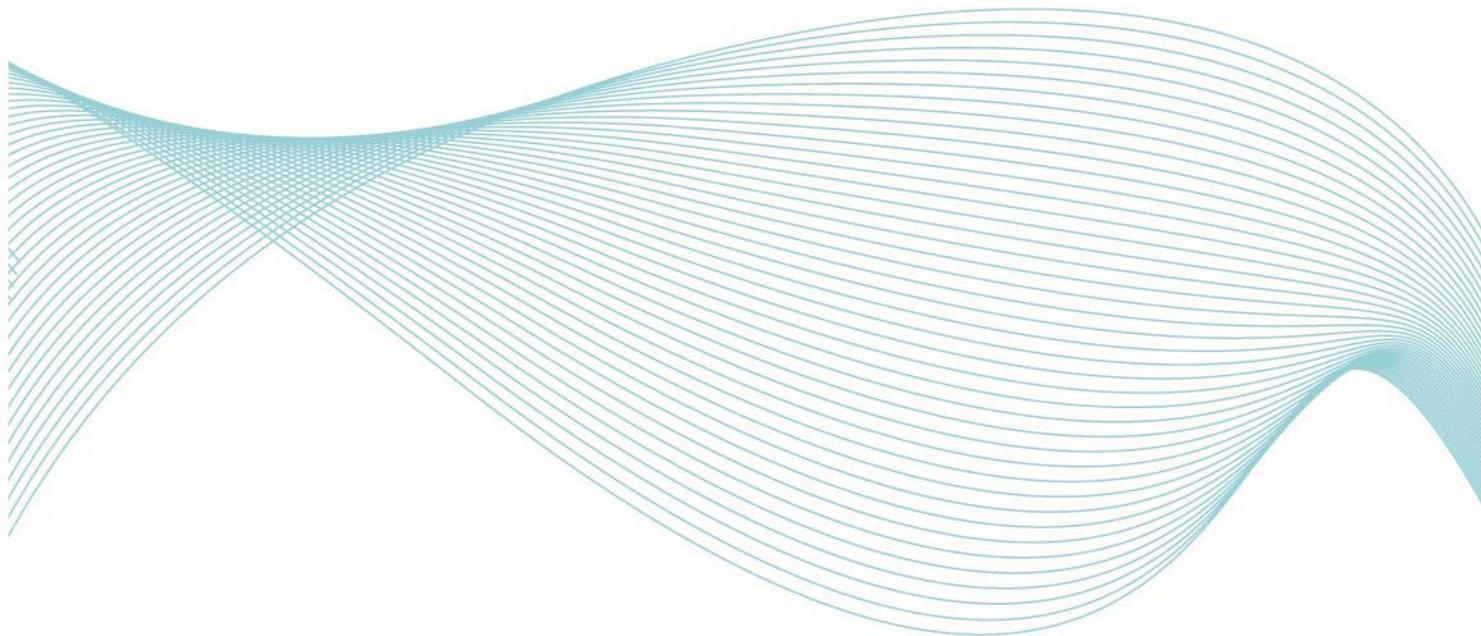
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