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Issues Paper

National Health Reform

Performance and Accountability Framework

Australian Healthcare & Hospitals Association Response

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1. Introduction

The **Australian Healthcare and Hospitals Association (AHHA)** welcomes the opportunity to comment on the Performance and Accountability Framework (following on from earlier comments we provided in relation to the National Health Performance Authority).

1.1 About the AHHA

The AHHA is the independent peak body and advocate for the Australian public healthcare system. The Association is *the voice of public healthcare*.

1.2 Guiding principles for reform

The AHHA offers seven Guiding Principles to govern development, implementation and evaluation of the National Health Reforms:

1. Clear political accountability to the community for funding and health outcomes including sufficient funding for areas and populations of need;
2. Clear provider accountability to funders and consumers for efficiency and health outcomes, including safety and quality;
3. Integrated planning and coordinated delivery of care within and across jurisdictions, healthcare settings and professional groups;
4. Use of incentives to ensure the most appropriate care setting with the providers best suited to treat each unique patient;
5. Use of appropriate data and analysis to inform healthcare planning and delivery and to provide the basis for transparent public reporting;
6. Consumer and community involvement as active and informed participants in healthcare planning and delivery; and
7. Workforce education and training informed by best models of care and partnerships between researchers, employers and educators.

1.3 The National Health Reforms (NHR)

The AHHA views the NHR as a timely opportunity to address these guiding principles and the Performance and Accountability Framework is one vehicle to achieve some of these goals. For more information on the AHHA's position regarding the full package of reforms, see **attachment 1**.

1.4 Nationally consistent performance standards and reporting

The AHHA supports the establishment of national bodies that will drive consistent standards across jurisdictions leading to public reporting of outcomes because, in theory, these initiatives should lead to clearer accountability for the safety, quality and efficiency of healthcare delivery in all settings.

Providers also need a performance system that is useful and meaningful and that provides reliable data and analysis against which the performance of a health service is assessed and which can lead discussions on how to improve that performance where necessary.

This is only possible if the performance system itself provides that information, comparing like with like and not in the form of an arbitrary league table where large services with greater capacity have an advantage in presenting themselves and consequently being rewarded.

Challenges to meeting these goals are:

- administrative data on how health services are delivered and counted, both between and within states/territories, needs to be standardised before data can be interpreted nationally and used for other purposes such as setting a national efficient price (currently the significant differences obstruct national analysis and use);

- linking patient-centric activity data sets between the Commonwealth Department of Health & Ageing, the Australian Institute of Health and Welfare and the new national bodies will be essential for the interpretation of service utilisation within and across sectors and states/territories; and

- the significant challenges to setting health outcome indicators need to be overcome to achieve national conformity while also being sufficiently flexible to guide continuous improvement at the service delivery interface. Performance should be measured, not only by quantifiable outcomes, but also in terms of learning and improving, taking into account the views and feedback from the community[1]. Preferably, health services should have the capacity to put the service user first with the flexibility to meet local goals through continuous improvement. There is a danger that use of easily quantifiable standards which focus on visible parts of the system (eg. emergency departments and elective surgery), while managing political risk, will create perverse incentives and less than optimal outcomes.

2. Earlier AHHA comments on the NHPA

In the context of now having seen the draft of the Performance and Accountability Framework to which we are here responding, the AHHA is keen to reiterate and elaborate on its concerns expressed in the short submission to the House of Representatives Inquiry in the *National Health Reform Amendment (National Health Performance Authority) Bill 2011*:

- the Commonwealth Government failed to involve the states and territories in developing the legislation to establish the NHPA, first introduced into the Commonwealth Parliament on 3 March 2011. If continued and applied to other reform elements, this lack of consultation will lead to suspicion and angst amongst key health services and stakeholders, and could undermine the whole reform process; and

- the draft legislation fails to recognise the formal role of **state/territory governments as majority funders and system managers of public health services** including overall responsibility (statutory and politically) for the performance of LHNs, public hospitals and state/territory primary health care services. These are complex areas of service delivery in which states/territories have considerable knowledge and expertise. As a result, the draft legislation has a number of critical flaws which would reduce the Authority's capacity to fulfil its role. This, in itself, is not in the interests of the Commonwealth Government. In particular, areas which must provide for involvement of states/territories and currently do not are: strategic planning; developing performance indicators to assess quality; and dealing with underperforming hospitals when necessary.

[1] 2010. Neville, Ann. Implementation Challenges: performance management through KPIs. Policy Briefs 9; Crawford School of Economics and Government, ANU.

The AHHA recommends that:

- *immediate attention be given to amending the Performance and Accountability Framework and National Health Reform Amendment [National Health Performance Authority] Bill 2011 to take account of the formal role of states and territory governments as majority funders and system managers of public health services; in particular (but not limited to), giving them a role in strategic planning, developing performance indicators and dealing with underperforming hospitals;*

- *more specifically, the AHHA recommends the following amendments to the Framework:*

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  8.1 Hospital Performance report

  First point: add the underlined words below:

  - *provide clear and transparent reporting on the performance of every LHN, the hospitals within it, and every private hospital on at least a quarterly basis unless agreed otherwise by the Minister for Health* ***and Ageing and the State Ministers for Health.***

  Last sentence: add the underlined words below:

  - *Hospital performance reports will be published through MyHospitals site* ***as agreed by the Minister for Health and Ageing and the State Ministers for Health.***

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  10.1 Accountability framework for Local Hospital Networks and private hospitals

  Amend as follows:

  The Minister for Health and Ageing ~~may~~ ***will*** *provide ~~both~~ confidential ~~and, in the case of persistent and/or unsafe poor performance, public~~ warnings to the state and territory ministers of the need for remediation* ***and, in the case of persistent and/or unsafe poor performance, may provide public warnings in consultation with the relevant state Minister****.*

- *the NHPA be required, in collaboration with AIHW, to undertake in its first year:*

  - *a stocktake/evaluation of current data collections (first recommended by the AHHA in 2008);*
  - *immediate application of some well-developed indicators which can be used for performance monitoring and benchmarking;*
  - *a process for further developing data collections and analysis.*

3. AHHA National Data and Benchmarking Policy (2008)

In 2008 the AHHA invested significant effort, at the request of the Minister for Health and Ageing, Nicola Roxon MP, in developing a National Data and Benchmarking Policy which held many of the critical elements of the Performance and Accountability Framework with some important differences.

Here we reiterate some of the recommendations made in that Policy (the full document is appended at **attachment 2**).

There is presently insufficient recognition of the difference between using data and reporting for the purposes of accountability versus performance/quality improvement. This Framework should aim to achieve both objectives. The data collected and how they are reported must enable health services to focus on how they improve their performance (if necessary) in real terms – otherwise it is at best a neutral and at worst a punitive framework that will not actively result in improved quality and access to health care at the local level. Therefore the Framework requires a finer detail of health service and local area data that is not currently reflected in the proposed 'top-down' political indicators. Indeed, such indicators may have the opposite effect on health services in that they will be under pressure to achieve considerably higher level targets without reference to their local circumstances or need for flexibility in responding to the changing needs of their communities.

There is also no discussion in the Framework of benchmarking as a tool to help health services work together to share practice and improve their processes. The latter is an oft-repeated intent in the Framework that so far includes no indication of how such dissemination of good practice might occur.

The AHHA recommends that overarching objectives across the continuum of care are essential to guide the development of relevant indicators and benchmarks that will, in turn, determine the requirements for data collection and analysis. These processes of performance monitoring will ultimately drive improvements in services, work processes and management practices (use of resources, delivery times and operational efficiency/effectiveness) as well as informing the funding relationships between the Commonwealth and states/territories.

The AHHA is convinced that Australia must have a *balanced scorecard* of key performance indicators (KPIs) for the health of the entire nation encompassing:

- health status and outcomes;
- determinants of health; and
- health system performance.

The 'scorecard' should not only consider the National Health Performance and/or Report on Government Services dimensions within individual health services and between like services. It must also measure the dimensions as a patient moves through various health services, jurisdictions and funding programs (for example, across Local Hospital Network and Medicare Local 'boundaries').

Although enabled by policy reforms, change only occurs at service delivery levels. There is little value in producing outcome reports unless the information is able to be utilised at the place of service delivery as well as at higher levels within the system – area/region, state/territory wide and national. This requires multi-level reporting that facilitates clear analysis of the comparative data for the purpose of motivating, supporting and assisting units and whole health services to implement improvements at their level.

In addition, formal mechanisms must be introduced at the service delivery level to enable the monitoring of local process and outcome indicators that reflect the often unique circumstances of that location and environment. It is essential that health services receive timely feedback in direct response to their data submissions – that is, information for health services to assess internal quality improvements and to compare their performance with like services.

In this regard the AHHA therefore considers it to be essential that there are more formal relationships and links between the NHPA, the Independent Hospital Pricing Authority, the COAG Reform Council, the Australian Commission on Safety and Quality in Health Care and individual accreditation bodies. Collaborative national bodies will ensure a greater degree of understanding of the health system and how to tailor reporting for best use at the health service and community levels.

4. Performance and Accountability Framework

The AHHA largely supports the concepts and principles in the document subject to comments below. Further detail on any of these comments can be provided if required.

4.1 Performance Indicators

The draft framework presents a range of indicators that predominantly focus on activity and inputs (productivity) with little that reflect progression of health outcomes or improvements in population health. The framework is very similar to that used in the UK NHS up until the change of government and focuses too heavily on technical efficiency. It would be very beneficial if the Transition Authority obtained some information from Canada on health service performance reporting, particularly that available for British Columbia as this presents a more balanced view into the relative effectiveness and outcomes achieved for health services.

Ann Neville[2] identifies a particularly problem with the use of high level indicators when they often result in the reduced capacity of service delivery organisations to respond flexibly to individual need.

If the "established" indicators on pages 13-18 were put through rigorous analysis, it would be apparent that many have significant problems ranging from data quality, differences in definition used and population demographic issues that need to be considered before any one of these measures can be used as a "ruler" to measure the performance of a health service (particularly in comparison to others). A number of the proposed indicators would not currently meet the performance indicator criteria over pages 10-11.

For simple measures like ED waiting times significant variation occurs in how well this is measured. For example, there are differences between real time systems and retrospective data capture, use of nurse assessment to reduce the time to being seen, richer and poorer demographics and private sector options that will impact on hospitals achieving these targets. When looking at indicators like readmission following heart failure or AMI, there are variations in criteria used to apply the code and same day separation counting.

In summary, none of the indicators should be "grandfathered" into the framework until they have been assessed. Where significant performance variation is found some on-the-ground validation is required to confirm that the differences are due to practice that can be attributed to real health service performance and not to other factors.

4.1.1 Continuous evolution and evaluation of indicators

It needs to be recognised that indicators will and should change. International experience demonstrates this. In particular, after some time, compliance with a particular indicator may approach or reach 100% which makes it less of a valuable measure as that level becomes expected.

Provision needs to be made for the Framework to be formally evaluated periodically and for the results of these evaluations to be fed back to improve the Framework. There must also be regular mechanisms for reviewing the inclusion/exclusion of indicators, which the AHHA understands will be a process undertaken between Health Ministers to ensure collaboration and agreement. There also appear to be other mechanisms for reviewing specific indicators that the AHHA would like to see 'enshrined' in the Framework as part of its ongoing work, perhaps through an established committee structure. An

[2] ibid

example is the Expert Panel that has been established to review the appropriateness of the emergency department and elective surgery waiting time targets and National Access Guarantee.

The community would like to know that they are getting value for their tax dollars in terms of outcomes and effectiveness as opposed to statistical reports that show fractional numerical improvement. These are things that mean a lot to hospital and health service management as well as governments, but not to consumers. For example, in WA a lot of time was spent with the Health Consumers Council developing a report card for consumers and the content and focus were substantially different from what the system thought was appropriate for reporting.

4.1.2 Equity of access

The issue of reporting equity of access is moot and reflective of both the use of the ROGS framework and the productivity approach suggested in the draft. For example, the entire state of Tasmania is classified "rural and remote" including the capital city. Moreover, equity of access under the proposed measure is not balanced with safety and quality and the now more-or-less national commitment for services to be as close as possible to where people live balanced with a requirement for said services to also be safe and sustainable.

The equity and access measures at section 5.2.3 are productivity statistics without a balancing qualifier of capacity measurements or clinical appropriateness. This reduces the meaning and impact of the measures and the Authority's reports, and in the worst case may lead to misuse and misinterpretation of the data by politicians and the media in particular.

4.1.3 Measure of effectiveness

The proposed measure for effectiveness (5.2.2) is limited to measures of the patients' experience. The fact is that the patient's health may be adversely affected by the treatment they receive but their experience may be very positive. The reverse may also be true when treatment has been to the highest standard within agreed acceptable times but the patient may still be dissatisfied. Canada has some examples of better indicators in this area.

4.1.4 Measure of efficiency

The Framework proposes using the cost per weighted separation as a measure of efficiency. What is counted in costs varies wildly due to different counting practices between the jurisdictions and unavoidable jurisdictional variations in labour and structural costs (power, water, materials etc). These costs are not inefficiencies but unavoidable operational costs involved in delivering services in a particular jurisdiction. This is therefore not a useful measure of LHN/ML efficiency as it is not comparing like with like.

4.2 ROGS framework

There are also concerns with the ROGS framework providing a fair and reasonable basis for comparison. Given the counting and capacity differences between States and Territories, it is a matter of public record that the ROGS frameworks do not provide a wealth of information that could be used for organisational performance measurement and improvement. Moreover they are inherently political and used in that way. It would be more in the public interest if the Framework provided data and benchmark comparative analysis that could be used by LHNs to monitor and improve their own performance.

4.3 Accountability framework

Section 10 on the accountability framework is misnamed – it is a reporting framework as there is no indication of who is accountable and how they are made accountable in this reporting process. Given

that the performance measures are largely productivity based, the reference to poor performance is not relevant to patient outcomes.

The AHHA is very concerned that the proposed sanction of recommending and taking action for poor performance rests entirely with the Commonwealth Minister for Health and Ageing. Given that states and territories are system managers, majority funders and that hospitals and LHNs are established under state legislation, the AHHA questions how this sits legally and constitutionally. What authority does 40% of an "efficient price" buy the Commonwealth Minister and under what authority can action be demanded? We strongly recommend that the Solicitor General provide comment on this section.

The AHHA also recommends that, like Medicare Locals, the judgement of Local Hospital Network performance is "contextualised with regard to varying and unique socio-economic circumstances" (p 26).

4.4 Relative capacity of LHNs and MLs

There is a real risk in the proposed Framework insofar as there is no consideration of the relative capacity of the LHNs or Medicare Locals. As we know, COAG has provided such flexibility in developing the model that there is wide divergence between what are supposed to be comparable entities. For example, there are three LHNs proposed for Tasmania that combined would still not have half the capacity of a metropolitan LHN in Sydney or Melbourne. The same can be said of the relative densities of general practitioners per capita across Medicare Locals. The local system capacity has a profound impact on the ability of the entity to perform within the proposed regime of indicators. For example an LHN with 1 ICU bed per 15,000 population will simply not have the capacity to undertake the same volumes of complex elective surgery as an LHN with 1 ICU bed per 5,000.

If an LHN is operating to 100% capacity as many of our hospitals are, they will simply not be able to "improve" their performance against other health services that have capacity (however small) to increase their productivity. If there are to be national reports as proposed and judgements made on relative performance, a balancing item needs to be developed to reflect the performance of an entity relative to their own capacity as well as the performance of their peers.

5. Performance measures for Medicare Locals

The AHHA believes that a significant amount of developmental work is required on indicators in the primary health care sector. This includes indicators around population and individual health outcomes, as well as process indicators that will tell us whether Medicare Locals are achieving the optimum levels of engagement and coverage of their local providers and community.

In our 2008 National Data and Benchmarking Policy the AHHA indicated that we need better information about GP and specialist services. The Commonwealth spends more on the MBS than it does through the National Health Reform Agreement with states and territories, yet there are almost no data available to monitor or benchmark the performance of community-based health services (except those funded and provided by the states and territories).

We would endorse additional indicators measuring the strength of partnerships developed by Medicare Locals as a core element of their responsibilities, such as:

- Proportion of health services in ML catchments that are members/partners;
- Time and nature of contribution by partners;
- Frequency, mode and nature of communications between partners; and
- Frequency and type of information/data exchanges between partners.

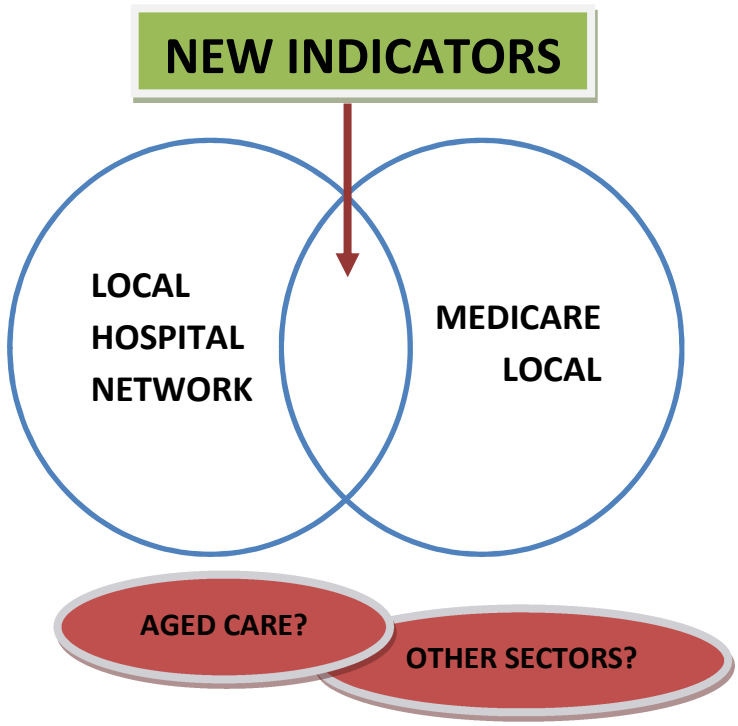
6. Performance measures that address integrated care

Presently there are very few available examples of indicators or data that connect sufficiently between acute, primary/community and aged care health service delivery. This is a major issue because it means we do not really know how the activities of one type of health service are impacting on others, and nor can we have a well-informed discussion about whether care is being provided in the 'best setting'.

In the AHHA's 2008 policy, we suggested that KPIs should "represent the reciprocal and sequential dependence of each element of the system". Put another way by Ann Neville, "governments tend to focus on easily quantifiable indicators (for reasons of control) and usually do not elaborate sequences of outcomes, some of which may be hard to quantify"[3].

In the Victorian Department of Health's submission on Medicare Locals, they suggest that "it will be important for Medicare Locals to work closely with local health services to establish common clinical pathways, service coordination protocols and common planning frameworks"[4]. This approach may provide a foundation for the development, over time, of 'common' performance measures and, in the shorter term, better delineation between Local Hospital Networks and Medicare Locals as to their areas of individual and shared responsibility, and indeed an informed discussion about the best settings for different types of care (see figure 1 below).

Figure 1: Representation of indicator domains



[3] ibid

[4] 2011. Department of Health. Victorian Response: Medicare Locals – primary health care. State of Victoria: Melbourne

In the context of considering data sets that would contribute both to an understanding of integrated care and drive the integration/coordination of care, the AHHA strongly recommends the development of nationally (and internationally) consistent evidence-based clinical pathways.

There are also indicators that could be developed in specific areas, such as palliative care, that would enable the NHPA and local bodies to begin work on 'shared responsibility indicators' that reflect more than raw process data. For example, there are international examples of indicators that measure the quality of dying that report the percentage of people dying at home rather than in hospital. In the jurisdiction and reporting of Medicare Locals, an example of an indicator might be the percentage of Advanced Care Plans that are adhered to. The AHHA believes that it must be part of the responsibility of the NHPA to develop more sophisticated patient pathway and outcome indicators and data sets over time.

7. Performance measures for national bodies

There is no mention in the Performance and Accountability Framework of the type of indicators that might be used to monitor the performance of the national bodies – to put another way, "who polices the police?" While there are mechanisms indicated for these bodies to receive government intervention in their operations, the fact is that the NHPA, IHPA, CRC and ACSQHC will have impacts on how health services operate and ultimately the types of services that are available to the Australian public.

The AHHA would like to see work undertaken to develop some performance indicators that will enable ongoing evaluation of the effectiveness of the national bodies in undertaking their duties. This would also include mechanisms for stakeholders and the community to have regular input to how the bodies evolve over time and remit their responsibilities. Periodic evaluation or review will not be sufficient if there are significant effects from, for example, poorly set national efficient prices for specific DRGs.

8. Providing access to confidentialised data

One of the greatest improvements could, if allowed, be the opening up of detailed data repositories to health service/policy and medical researchers. There are examples in other major data collections where confidentialised unit record files (CURFs) are available to approved universities and institutions to undertake new research on specific issues.

The work of the health services and policy research community in Australia would be greatly enhanced by having this type of access to the unit record data that will be held by the National Health Performance Authority. The quality research that would emanate from this access would be an additional tool to help health services, governments and consumers understand the health system and where there might be great innovations or gaps in access and delivery.

9. Specific comments by page number

The AHHA has the following additional comments and recommended amendments:

Page 4

Figure 1

Recommendations of whether to pay reward funding should not come from inter-jursidictional comparison.

Comparisons at national, jurisdictional, area and hospital/service level need to link better and must always be done cooperatively with the states and territories.

Paragraph 2

How will the indicator set and/or Framework ensure perverse incentives are avoided?

Page 5

Figure 2

While recognising the limitations of current data collections, the AHHA would like to see an increased focus on individual health outcomes which would help build up data sets on *pathways of care*, rather than relying on unconnected episodes or global population health outcomes.

Page 8

Paragraph 3

The NHPA and Health Ministers revising performance indicators in isolation from the functions of the IHPA and other national bodies may cause the indicator sets to be at odds with the funding mechanisms. There must be some way of linking the activities of the IHPA and other national bodies with the NHPA to ensure a loop of advice that provides the best evidence for the respective development of prices, indicators and health system improvements.

Page 9

Paragraph 1

There must be an absolute guarantee that, when Medicare Locals move to more actively mapping primary health care activity and 'filling gaps' that this does not result in unnecessary duplication of services. This would be of particular relevance where a Medicare Local may not have fully understood the primary health care services provided by a Local Hospital Network. This is a key reason to ensure that Medicare Locals have a performance indicator included in their set that measures the organisations' proportion of local engagement with health services in their region. There must also be inclusion of some community health indicators in the LHN indicator set due to the fact many LHNs will continue to provide community health services.

Page 11

In table - Attributable

The third description of the 'Attributable' criterion is "[t]here is adequate scientific evidence **or professional consensus**…". Who will determine this and how will it be measured?

In table – Administratively simple and cost effective

The final description, "[u]tilise existing data sets wherever possible", should be an overarching intent for the entire performance indicator set and Framework.

Page 20

Last paragraph

Where the CRC is expected to highlight examples of good practice, the AHHA perceives that this will be difficult if routine data are not collected on *how* service meet targets.

Page 22

Paragraph 3

While the AHHA welcomes the inclusion of private hospitals and health services in the Framework, questions remain based on the paper as to the real level of comparability that can be achieved with the public sector. While private hospitals will be required to report *some* common indicators, some of the most critical information around patient-level clinical data and financial data will be missing from the private hospital collection. This will limit the extent to which an accurate understanding can be reached on the comparable performance of public and private hospitals undertaking the same clinical work.

Page 23

Second-last paragraph

Consideration over time should be given to consolidating the reporting of health service data across all settings/sectors on the one website for ease of consumer navigation.