NATIONAL HEALTH REFORM
Performance and Accountability Framework
1. INTRODUCTION

The August 2011 Council of Australian Governments (COAG) National Health Reform Agreement (NHRA) outlined COAG’s objectives for national health reform, including:

• improving performance reporting through the establishment of the National Health Performance Authority (the Authority); and
• improving accountability through the Performance and Accountability Framework (the Framework).


The Framework is designed to support improved local level performance assessment to contribute towards the achievement of these objectives.

The key objective of the Framework is to support a safe, high quality Australian health system, through improved transparency and accountability.

A robust performance reporting framework is critical to ensuring extensive information is available for patients and clients, health providers, and health system managers.

The Framework will underpin reporting across three domains – equity, effectiveness and efficiency of service delivery in health care.

By publicly and transparently reporting on these domains of health system performance, the Framework will help to drive improvements in health system delivery and hence the achievement of broader health system objectives.

The Framework has been designed to facilitate the achievement of key national health policy objectives, such as:

• the ongoing improvement of the safety and quality of the health system;
• ensuring efficiency and sustainability through a rigorous data collection, monitoring and reporting system;
• improving integration between the primary health care and hospital sectors; and
• enabling comparisons between all sectors of the Australian health system including comparisons across the public and private sectors to assist both the public and private sectors’ improving performance.

The Authority established under Commonwealth legislation began operations on 21 October 2011. In part, the Framework establishes the conceptual basis for the Authority to fulfil its role in developing and producing reports on the performance of hospitals and health care services, including primary health care services. Specifically, the purpose of the Framework is to ensure that, through clear and transparent performance reporting:

• members of the public have access to relevant, up to date information about health care providers (both public and private), to allow them to make informed choices;
• Local Hospital Networks (LHNS), hospitals, clinical units, Medicare Locals and health services are provided with comparative clinical performance data to foster continuous quality improvement;
• governments and governing bodies of private hospitals are provided with additional data to ensure robust accountability and oversight of the health system; and
• existing reporting mechanisms are supported and coordinated, such as the COAG Reform Council processes.
In addition to underpinning the performance reporting of the Authority, the Framework incorporates the performance monitoring and assessment role of the COAG Reform Council (CRC) established under the National Healthcare Agreement (NHA). The Framework has also been designed to integrate seamlessly with the existing frameworks such as the National Health Performance Framework, the Review of Government Service Provision process and the Aboriginal and Torres Strait Islander Health Performance Framework, and are discussed later in this document.

The Framework has also been designed to integrate seamlessly with the revised National Health Information Agreement (NHIA), to be agreed by the Australian Health Ministers’ Advisory Council (AHMAC) in late 2011. The NHIA will incorporate the data management arrangements in the Framework to the extent necessary, and build on them with its underpinnings for collaborative national development, collection and use of health data.
2. POLICY PRINCIPLES

In undertaking its functions the Authority will not act in a way which is inconsistent with the following policy principles:

• the Authority’s activities provide Australians with information about the performance of their health and hospital services in a way which is both nationally consistent and locally relevant.

• in assessing performance under the Performance and Accountability Framework (the Framework), the Authority should take into account i) the role of the relevant system managers and ii) the responsibilities of the relevant system managers for managing the performance of the entities for which they are responsible:
  - states and territories – as system managers of the public hospital system;
  - the Commonwealth – as system managers of Medicare Locals; and
  - the governing bodies of private hospitals – as system managers of their respective entities.

• the Authority should publicly report on the performance of all LHNs, public and private hospitals and Medicare Locals.

• the Authority should not publicly report on the performance of individual clinicians.

• the Authority should resolve questions relating to data with the relevant system manager.
3. COVERAGE OF THE FRAMEWORK

3.1 Scope

The Framework encompasses and expands upon existing CRC reporting, and outlines a role for the Authority. The Authority’s role will complement the analysis of the CRC, bringing a more local focus to the national and jurisdictional outcomes examined by the CRC. Both agencies will draw on the enhanced safety and quality standards set by the Australian Commission for Safety and Quality in Health Care (ACSQHC). (A more detailed discussion of the respective roles of the Authority, the ACSQHC and the CRC under the Framework is set out in Section 7 - Performance Reporting Bodies.)

3.2 Other Frameworks and elements

As shown in Figure 1, there are elements of health system performance reporting that are not currently captured by the Framework. These include:

• reports produced by the Australian Institute of Health and Welfare (AIHW) under the National Health Performance Framework (discussed further in section 4.2);
• ongoing Review of Government Service Provision comparisons of the efficiency and effectiveness of Commonwealth, state and territory government health services as part of the holistic Report on Government Services;
• specific, targeted reporting on national mental health reform through the annual National Mental Health Report;
• specific, targeted reporting on the health status of Indigenous Australians through the Aboriginal and Torres Strait Islander Health Performance Framework; and
• performance reports issued by states and territories.

As the Framework matures following the establishment of the Authority, further consideration will be given as to how these elements link with the Framework given likely overlaps in objectives, data collection and usage and indicator sets for example.
Performance and Accountability Framework

Figure 1: Scope and Coverage of the Framework

Other reporting:
- AIHW flagship reports
- RoGs annual comparisons
- Aboriginal and Torres Strait Islander Health Performance Framework
- Public reporting by state and territory governments
- National Mental Health Report

Pre-existing reporting incorporated by the Framework
Established by or with the creation of the Framework
Reporting outside of the framework
4. THE FRAMEWORK’S CONCEPTUAL UNDERPINNING

4.1 Key conceptual principles

The objectives of the Australian health system are delivered through multiple decision makers, multiple funding streams, multiple service providers and multiple data agencies.

The indicator set included in the Framework is designed to cover this broad spectrum of activity, whilst ensuring that perverse incentives are not created by encouraging activity that addresses the Framework indicators to the exclusion of other important outcomes.

The Framework includes a new accountability regime and therefore, for accountability purposes, it includes a set of indicators that are sufficiently attributable to the organisations that will be held accountable for the relevant outcomes. It also includes some indicators that cannot be used for accountability purposes, but that provide useful contextual or planning information.

Any new indicators that are to be added to the Framework, and that are used to hold hospitals, LHNs or Medicare Locals to account, will need to be clearly attributable to the performance of those organisations.

Across the areas of activity within scope for the Framework, performance will be measured through a combination of service delivery outcomes and population health outcomes. Whilst health performance frameworks can include measures of individual outcomes, such outcomes are not within the scope of the Framework, which is aimed at reporting performance information at an organisational level in a way that supports individual choice rather than focussing on individual outcomes themselves. Figure 2 illustrates the interaction between these outcomes.

Figure 2: Health Systems Outcomes
4.2 The National Health Performance Framework

In 2001, the National Health Performance Framework (NHPF) was developed by the former National Health Performance Committee under AHMAC. The Framework helps Ministers to understand and evaluate the health of Australia's population from the perspective of three domains: the health status of Australians, the determinants of Australians' health and the performance of the health system. The Framework focuses on the third domain. The other domains are addressed by reports issued by the AIHW, the Australian Bureau of Statistics (ABS) and a range of other bodies.

The Framework draws on the overarching principles of the NHPF in its consideration of health status with regard to the performance of Medicare Local communities, and health system performance with regard to Medicare Locals and hospitals. A key point of difference between the NHPF and the Framework is that the NHPF has been ultimately designed to measure the health status of the population, whilst the primary focus of the Framework is to measure health system performance at the local level.

4.3 Report on Government Services (RoGS) Framework

The Review of Government Service Provision provides information on the effectiveness and efficiency of government services in Australia. One of the main tasks of the Review is to develop agreed national performance indicators for government services, which are published in the annual Report on Government Services (RoGS).

The RoGS framework is outcomes focused, supplemented by output measures. Indicators are considered under three domains – equity, effectiveness and efficiency – which include assessment of inputs in producing desired outputs and outcomes (see Figure 3 below) to meet the overarching objectives being sought. This ensures that comparative information is available to governments and the public about the equity, effectiveness and efficiency of government services. The RoGS framework aims to present a holistic and balanced picture of performance through a comprehensive suite of indicators but also strives for conciseness, for example, by drawing out headline indicators. The RoGS framework assists in identifying gaps in assessing performance due to an absence of appropriate indicators or where there are potentially too many indicators being used to measure the one domain. This approach has therefore been used to design the initial set of indicators to be included in the Framework. Any future indicators to be added to the Framework are expected to be considered against these domains, as well as the performance indicator selection criteria set out in section 5.
The RoGS framework reflects the service process or sequence of steps involved in transforming inputs into outputs and outcomes in order to achieve the desired policy and program objectives. The service process is shown below (Figure 4).

The RoGS Framework distinguishes outcomes and outputs by classifying outputs as the actual services delivered whilst outcomes are the impact of a service on the status of an individual or a group and on the success of the service achieving its objectives. This construction provides good fit for assessing the delivery of health services by providers (hospitals, LHNs and Medicare Locals) through the domains of equity, effectiveness and efficiency - the primary focus of performance reporting under the Framework.
5. UTILISING THE RoGS FRAMEWORK TO SELECT INDICATORS

The Framework directly applies the RoGS framework definitions of equity, effectiveness and efficiency (and cost effectiveness) to measure performance as follows.

Equity indicators measure how well a service meets the requirements of particular groups in society with special needs. Indicators may reflect both equity of access, whereby all Australians are expected to have adequate access to services, and equity of outcome, whereby all Australians are expected to achieve similar outcomes arising from service use.

- **Equity** is further defined to distinguish between horizontal and vertical equity:
  
  **horizontal equity** - the equal treatment of equals, demonstrated when services are equally accessible to everyone in the community with a similar level of need.
  
  **vertical equity** - the unequal but equitable (‘fair’) treatment of unequals, demonstrated when services account for the special needs of particular groups in the community and adjust aspects of service delivery to suit these needs. This approach may be needed where geographic, cultural or other reasons mean some members of the community have difficulty accessing a standard service.

- The equity domain as envisaged and utilised by the RoGS framework needs to be adapted for use within the context of the Framework. Whilst recognising the importance of the equity domain, the purpose of the PAF is not to provide detailed indicators in relation to access at the individual level, but to report on indicators of access at a more aggregate level.

- The Framework addresses the equity domain by recognising that access to health services by disadvantaged groups such as Indigenous Australians and people in rural and remote areas is especially important to ensure an equitable health system.

Effectiveness indicators measure how well the outputs of a service achieve the stated objectives of that service. The reporting framework groups effectiveness indicators according to characteristics that are considered important to the service. These characteristics include access, appropriateness and/or quality.

- Associated with quality is safety. Having quality health services delivered safely is paramount as it ensures public trust and confidence in the health system, and will often be a key determinant of patient outcomes. A continuous improvement culture that drives high quality health services is the foundation of health service delivery.

- The Framework addresses this domain by ensuring that safety and quality data are collected, analysed and fed back for improvement, as well as comparison and accountability purposes. In addition, the Framework includes a number of patient outcome and patient experience indicators, as a measure of the health system is the benefit it provides the community and individuals.

Efficiency indicators (the relationship of inputs to outputs) measure how efficiently the outputs of a service were achieved. Technical efficiency indicators measure how well services use their resources (inputs) to produce outputs. Government funding per unit of output delivered is a typical indicator of technical efficiency. Allocative efficiency considers the use of resources across different care/treatment domains and strategic options, including in hospitals and primary care settings. Whilst indicators of allocative efficiency are not currently well developed in health care, they will be a focus for future development.

The Framework addresses the efficiency domain through the inclusion of efficiency and financial performance indicators as well as recognising that, over time, the indicator set for LHNs and Medicare Locals should be progressively revised by the Authority and Health Ministers to measure the integration and coordination of services through the development of indicators common to both an individual LHN and its relevant Medicare Local(s).
Cost-effectiveness indicators (the relationship of inputs to outcomes) measure how efficiently the outcomes of a service were achieved. Although no cost-effectiveness indicators are currently reported, a theoretical example would be government funding per life (or ‘quality adjusted life year’) saved through breast cancer screening.

### 5.1 Assigning responsibility under the Framework

Whilst a general framework can be applied across a spectrum of activity in the system, the different elements being reported on (in this case LHNs, public and private hospitals and Medicare Locals) will have differing levels of control over factors which may impact upon the performance being measured. Therefore the indicators chosen for performance accountability purposes recognise an appropriate degree of control so as to make them meaningful for this purpose.

As Medicare Locals evolve over time, they will be given greater responsibility and be able to exert greater influence on how services are delivered in the local area. To reflect this, performance reporting on Medicare Locals will initially focus on the input and process part of the service process chain in terms of how they are run, and how well they map out the availability and distribution of primary care services in their area. However, over time, as Medicare Locals receive funding to coordinate and plan services in the community, the output part of the service process will become the focus of performance reporting.

Initially, the performance of Medicare Locals will be measured through the efficiency domain in terms of how they manage the setting up of their structures and processes. The equity and effectiveness domains will start to be measured and related back to performance once Medicare Locals begin to coordinate and plan services.

Section 6.3 lists the initial indicators proposed for Medicare Locals and their communities noting that for the above reasons they will become more refined over time once Medicare Locals become more established in their communities. The indicators are mapped diagrammatically back to the performance domains – equity, effectiveness and efficiency, but there is a clear distinction between what the Medicare Local is being assessed against and the performance of its community (which currently cannot be attributed to the Medicare Local). As such, population health outcomes for the area for which the Medicare Local is responsible will initially be measured for context setting and planning purposes, rather than for accountability.

Performance reporting for LHNs and hospitals using the RoGS framework is more straightforward given there is already an established framework, and there is broad endorsement and acceptance of it and its indicators. Section 6.2 lists the initial indicators proposed for LHNs and hospitals under the Framework and maps them diagrammatically back to the performance domains – equity, effectiveness and efficiency, which thus allow for a systematic assessment of the performance of hospital care.
6. PERFORMANCE INDICATORS

The selection criteria for performance indicators draw on principles contained in the Intergovernmental Agreement on Federal Financial Relations, the Aboriginal and Torres Strait Islander Health Performance Framework, and work previously done by Heads of Treasuries, the Productivity Commission and the CRC. Not all indicators are expected to meet all criteria in all cases, but should be chosen where they are a 'best fit'.

Table 1: Selection criteria for the Authority performance indicators

<table>
<thead>
<tr>
<th>Performance indicator criteria</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Policy</strong></td>
<td></td>
</tr>
<tr>
<td>Relevance and appropriateness for policy makers</td>
<td>The performance measure covers an area or subject of key importance in terms of: the impact on health outcomes, and/or a significant area of health system policy focus. Reporting against the indicator is likely to help decision makers identify opportunities for improvement across both public and private sectors.</td>
</tr>
<tr>
<td>Avoidance of perverse incentives</td>
<td>The measure has been tested for unintended consequences. Ensure that, as far as possible, the measure avoids encouraging perverse incentives. Where appropriate, this may be done by balancing complementary indicators.</td>
</tr>
<tr>
<td>Relevance to NHHN agreement and the NHRA.</td>
<td>Performance indicators should be targeted at one or more of the agreed criteria on what should be measured under the NHHN reforms. Presently, these are captured in the NHRA and relate to: • access to services; • quality of service delivery; • financial responsibility; and • patient outcomes and experience Further, new service and financial performance standards should draw on National Healthcare Agreement indicators and the work of the ACSQHC where possible.</td>
</tr>
<tr>
<td><strong>Scientific soundness</strong></td>
<td></td>
</tr>
<tr>
<td>Valid</td>
<td>The measure accurately reflects the event or activity it purports to measure. Changes in the performance indicator are able to be quantified in a scientifically sound manner.</td>
</tr>
<tr>
<td>Performance indicator criteria</td>
<td>Description</td>
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<tr>
<td>Reliable</td>
<td>There are no data gaps. Results do not vary because of unrelated factors such as who has performed the data collection. Data is able to be collected in the same way from the same sources. There are not significant data delays that compromise the usefulness of the data. Data agencies and relevant experts are in agreement that the indicator can be reliably and accurately measured and reported.</td>
</tr>
<tr>
<td>Attributable</td>
<td>The measure reflects outcomes that are substantially attributable to the component of the health system being assessed. A healthcare provider with higher (or lower as appropriate) performance against the indicator would be considered a high performing provider. There is adequate scientific evidence or professional consensus supporting a link between the performance of the indicator and the overall outcome being measured.</td>
</tr>
<tr>
<td>Comparable</td>
<td>The measure readily allows for comparisons: • over time (see ability to measure progress over time); • at the desired levels of disaggregation (e.g. allows comparisons to be drawn between hospitals, across LHNs, etc.); • between target groups (e.g. by Indigenous status); and • across the public and private sectors.</td>
</tr>
<tr>
<td>Ability to measure progress over time</td>
<td>Indicator is sensitive enough to provide meaningful information about performance between reporting periods. Data will be comparable and remain useful over time, including that baseline data is available. Data is collected at intervals that align with the required reporting frequency.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Assess the costs of data collection, collation and interpretation. Consider whether the expected benefits of reporting against the indicators outweigh the administrative burden and costs of data collection. Consider whether other measures may offer the same or similar information relating to performance for a lower cost. Utilise existing data sets wherever possible.</td>
</tr>
</tbody>
</table>
6.1 **Indicator specifications**

Where an indicator is chosen based on an assessment against the selection criteria, it should be developed so that:

1. The indicator is stated in an unambiguous manner.
2. It is clear what is being measured.
3. Data definitions are widely accepted and explain:
   - what the measure is intended to show and why it is important;
   - the data source;
   - collection arrangements;
   - measurement frequency;
   - statistical techniques for calculating performance, including baseline or historical data; and
   - data limitations, including those outside of the control of government.
4. Where a survey is used, the following is documented:
   - the method for selecting the sample size;
   - size of sample;
   - response rates; and
   - the margin of uncertainty in the reported level of performance.
5. Publication of the indicator is a statistically valid result at the level at which it is reported.
6. Publication of the indicator result does not result in inadvertent privacy breaches by implicitly or explicitly identifying individuals.

The Authority will work with relevant stakeholders on the design and functional definitions of the indicators. Indicator development by the Authority will include the agreement of nationally consistent definitions and methodology for the indicators to ensure valid comparisons can be made.

Over time shared indicators across both LHNs and Medicare Locals that assess service integration, collaboration and coordination in patient care will be developed and introduced.

6.2 **Initial indicators for hospitals and Local Hospital Networks**

Note: All indicators for hospitals and local hospital networks will be reported by Indigenous and non-Indigenous status where statistically possible. Further, indicators will all require varying degrees of data development work. When reporting on Private Hospitals the indicators will need to respect issues of commercial sensitivity.

6.2.1 **Effectiveness - Safety and quality**

6.2.1.1 Hospital Standardised Mortality Ratio

6.2.1.2 Death in low-mortality Diagnostic Related Groups

6.2.1.3 In hospital mortality rates for:
   - Acute myocardial infarction;
   - Heart failure;
   - Stroke;
   - Fractured neck of femur; and
   - Pneumonia.
6.2.1.4 Unplanned hospital readmission rates for patients discharged following management of:

- Acute Myocardial Infarction;
- Heart failure;
- Knee and hip replacements;
- Depression;
- Schizophrenia; and
- Paediatric tonsillectomy and adenoidectomy.

6.2.1.5 Healthcare associated Staphylococcus aureus (including MRSA) bacteraemia.

6.2.1.6 Healthcare associated Clostridium difficile infections.

6.2.1.7 Rate of community follow up within the first seven days of discharge from a psychiatric admission.

6.2.2 Effectiveness - Patient experience

6.2.2.1 Measures of the patient experience with hospital services.

6.2.3 Equity and effectiveness - Access

Note: Access indicators can be used to measure equity of service provision where data is compared across localities. However, access is also an important, absolute measure of LHN and hospital performance:

6.2.3.1 Access to services by type of service compared to need;

6.2.3.2 Emergency Department waiting times by urgency category;

6.2.3.3 Percentage of Emergency Department patients transferred to a ward or discharged within four hours, by triage category;

6.2.3.4 Elective surgery patient waiting times by urgency category; and

6.2.3.5 Cancer care pathway – waiting times for cancer care.

6.2.4 Efficiency - Efficiency and financial performance

6.2.4.1 Relative Stay Index for multi-day stay patients;

6.2.4.2 Day of surgery admission rates for non emergency multi-day stay patients;

6.2.4.3 Cost per weighted separation and total case weighted separations; and

6.2.4.4 Financial performance against activity funded budget (annual operating result).

Note: further financial indicators to be developed by the Authority, subject to COAG agreement.

A set of indicators for the measurement of the performance of LHNs with more specialised roles, such as specialist children’s hospitals, long stay mental health facilities and subacute facilities will need to be developed. In addition an indicator set for private hospitals will be developed, based on the initial indicators listed above for LHNs.

Figure 5, overleaf, illustrates the application of the RoGS process model to hospital/LHN indicators.
Figure 5: Application of the RoGS process model to hospital/LHN indicators
6.3 Initial indicators for Medicare Locals

Note: All indicators for Medicare Locals will be reported by Indigenous and non-Indigenous status where statistically possible.

As the Medicare Locals will be newly established independent corporations a large number of indicators will require data development work and it is envisaged that the indicators below will be introduced progressively over time. However, some primary care data is already collected, including through the Divisions of General Practice’s National Performance Indicators framework.

6.3.1 Effectiveness - Safety and quality
6.3.1.1 Selected potentially avoidable hospitalisations;
6.3.1.2 Percentage of diabetic patients who have a GP annual cycle of care;
6.3.1.3 Percentage of asthma patients with a written asthma plan;
6.3.1.4 Aged standardised mortality of potentially avoidable deaths; and
6.3.1.5 Five year survival proportions of selected cancers.

6.3.2 Effectiveness - Patient experience
6.3.2.1 Measures of patient experience.

6.3.3 Equity and effectiveness - Access
6.3.3.1 Access to services by type of service compared to need;
6.3.3.2 GP type service use;
6.3.3.3 Allied health type service use;
6.3.3.4 Specialist service utilisation;
6.3.3.5 Waiting times for GP services;
6.3.3.6 Waiting times for community health services;
6.3.3.7 Screening rates for breast, cervical and bowel cancer;
6.3.3.8 Vaccination rates for children;
6.3.3.9 GP service utilisation by residents of Residential Aged Care Facilities;
6.3.3.10 Proportion of children with three year old developmental health check;
6.3.3.11 Number of women with at least one antenatal visit in the first trimester;
6.3.3.12 After hours GP service utilisation;
6.3.3.13 Primary care-type Emergency Department attendances;
6.3.3.14 Percentage of the population receiving primary mental health care; and
6.3.3.15 Rates of contact with primary mental health care by children and young people.

6.3.4 Efficiency - Financial performance
6.3.4.1 Financial performance against budget.

Note: further financial indicators to be developed by the Authority.
6.3.5  **Population health outcome measures: included in healthy communities reports to provide context for the interpretation of Medicare Local performance indicators**

Note: Initially these measures are expected to provide contextual and planning information for Medicare Locals. Over the long term, and as the Framework and measures become more sophisticated, relative changes in these measures may be used to assess Medicare Local performance.

6.3.5.1  *Incidence of selected cancers;*

6.3.5.2  *Incidence of ischaemic heart disease;*

6.3.5.3  *Prevalence of diabetes;*

6.3.5.4  *Prevalence of smoking;*

6.3.5.5  *Prevalence of overweight and obese status;*

6.3.5.6  *Incidence of end stage kidney disease;*

6.3.5.7  *Estimated life expectancies at birth;*

6.3.5.8  *Infant/young child mortality rate; and*

6.3.5.9  *Proportion of babies born with low birth weight.*

**Figure 6**, overleaf, illustrates the application of the RoGs process model to Medicare Local indicators.
Figure 6: Application of the RoGS process model to Medicare Local indicators
6.4 Assessment of Indicator Measures

The assessment of performance based on indicators measured by the Authority will include the following:

- an assessment of the measure against the standard;
- an assessment of the progress of the performance of LHNs and Medicare Locals over time; and
- an assessment of the performance of peer group organisations.

Whilst the achievement of standards is the primary goal of all LHNs and Medicare Locals, the non-achievement of standards is not necessarily a concern if there is demonstrable evidence of improvement in performance over time and progress towards the standard is evident.

Assessment comparisons will be based on peer-group comparisons so as to provide a reasonable basis of comparison based on organisational size, role and location.

The Authority will recommend definitions of acceptable performance against the indicators outlined above to the Standing Council on Health (formerly the Australian Health Ministers Conference (AHMC)) for approval in the case of safety and quality indicators and COAG in the case of other indicators.

The Authority will also recommend to the Standing Council on Health clear objective criteria for determining poor performance.
7. NATIONAL PERFORMANCE REPORTING BODIES

States and territories, some private hospital operators and some primary care providers already provide some public reporting of the performance of the health care organisations under their responsibility. The transparency of health care organisational performance will be enhanced at the national level through the establishment of the Authority which will complement the existing role fulfilled by the CRC and the ACSQHC.

7.1 National Health Performance Authority

The main role of the Authority is to report on the performance of the health system at the local level, including trends over time.

The Authority will:

- report on the performance of hospitals (public and private) and LHNs through Hospital Performance Reports and on Medicare Locals through Healthy Communities Reports covering:
  - service and financial performance standards and targets agreed by COAG (drawing on NHA indicators where possible);
  - the National Access Target and National Access Guarantee, and any new National Standards Agreed by COAG; and
  - National Clinical Safety and Quality Standards developed by the ACSQHC and endorsed by Health Ministers
- identify:
  - high-performing organisations, to facilitate sharing of innovative and effective practices; and
  - poorly performing organisations to the Commonwealth, states and territories, to assist with performance management; and
- provide a comparative analysis of the performance of hospitals, LHNs and Medicare Locals across jurisdictions and across the public and private sectors, in order to identify best practice and ensure focus on the achievement of results.

The emphasis of the Authority’s reporting will be on the longitudinal performance of LHNs and Medicare Locals, with a focus on improvement over time.

The initial set of indicators for the Authority was agreed by COAG in December 2011. However, as an independent statutory authority, the Authority, following extensive clinical and community consultation, will recommend changes to the indicator set that it deems appropriate. Indicators selected for the measurement of safety and quality in healthcare will be developed by the ACSQHC. Changes to the indicator set must be agreed by Australian health ministers. In providing recommendations to Ministers, the Authority will have regard to the following:

- where appropriate, indicators should address access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience; and
- indicators should be few in number and supported by data which meets the selection criteria set out in Table 1 – Selection Criteria for Indicators.

The Authority will not report on the performance of individual clinicians.

7.2 COAG Reform Council

The Intergovernmental Agreement on Federal Financial Relations tasks the CRC with reporting of national trends and comparisons of performance across jurisdictions.
Under the Framework, the CRC will report on the performance of all jurisdictions against:

- existing performance indicators set out in the NHA and relevant National Partnership Agreements, including highlighting examples of good practice;
- new National Standards agreed by COAG (this currently includes the National Access Target and National Access Guarantee); and
- national clinical quality and safety standards developed by the ACSQHC and agreed by Health Ministers.

In addition, it will provide advice to COAG to improve NHA performance reporting. Further information about the CRC, including its mission and objectives, can be found at: www.coagreformcouncil.gov.au

7.3 Australian Commission on Safety and Quality in Health Care

The National Health and Hospitals Network (NHHN) Act 2011, establishes the ACSQHC as a permanent, independent authority from 1 July 2011. The role and functions of the ACSQHC are defined in the NHHN Act enabling the continuation of the ACSQHC’s important work.

The ACSQHC will play an important role in developing, validating, supporting implementation and monitoring the effectiveness of national clinical safety and quality standards and guidelines. It will work with clinicians, other health professionals and the National Health and Medical Research Council (NHMRC) to identify best practice clinical care to support the appropriateness of services delivered in a particular setting.

The ACSQHC will provide advice to the Commonwealth, and state and territory Health Ministers about which standards are suitable for implementation as National Clinical Safety and Quality Standards.

The ACSQHC will also collect, analyse and report on national performance against the National Clinical Safety and Quality Standards developed by the ACSQHC and endorsed by Health Ministers.

The Authority will need to work in close cooperation with the ACSQHC to ensure that assessments of safety and quality performance undertaken by the Authority are appropriate for the service being assessed.
8. SETTING STANDARDS AND PERFORMANCE MEASUREMENT

The development of performance standards should precede the development of appropriate performance targets and indicators to measure performance against the standard.

Standards for the clinical safety and quality of health services will be developed and approved by the ACSQHC, and agreed by Health Ministers. Standards that do not involve safety and quality measures (for example, efficiency and access standards), will be approved by COAG in accordance with the NHRA.

Standards will apply across both the public and private sectors where appropriate and will allow valid comparisons to be made across both sectors.

8.1 Local Hospital Networks

Some states and territories already have service standards in their own performance and accountability frameworks.

The ACSQHC has developed ten National Safety and Quality Health Service Standards for safety and quality in hospitals for the consideration of Health Ministers across the following safety and quality domains:

• governance for safety and quality in health service organisations;
• partnering for consumers;
• preventing and controlling Healthcare Associated Infection;
• medication safety;
• patient identification and procedure matching;
• clinical handover;
• blood and blood product;
• preventing and managing of pressure injuries;
• recognising and responding to clinical deterioration in acute health care; and
• preventing falls and harm from falls.

Each of these standards includes performance indicators to be assessed against the standard. Many of these performance indicators are included in the initial indicator set for LHNs proposed in section 6.2 – initial indicators for hospitals and Local Hospital Networks.

The National Partnership Agreement on Hospitals and Health Workforce reform already commits participating states and territories to a range of acute care access targets which will be reflected in the targets for LHNs. Furthermore, the National Partnership Agreement on Improving Public Hospital Services commits participating states and territories to targets relating to elective surgery, emergency department care and access to sub-acute beds.

The measurements currently used to assess hospital efficiency currently vary greatly between states and territories.

8.2 Medicare Locals

The development of standards and targets for the evaluation of the performance of Medicare Locals will require extensive consultation with the primary health care sector prior to consideration by COAG given the current absence of such standards. This should not preclude the measurement of the performance of Medicare Locals by the Authority whilst standards are under development.

Some targets of relevance for Medicare Locals are already prescribed in the NHA and are reflected in the initial Medicare Local Performance indicator set.
9. PERFORMANCE REPORTING: NATIONAL HEALTH PERFORMANCE AUTHORITY

9.1 Hospital Performance Report

Hospital Performance Reports are a key product of the Framework that will be published by the Authority. The reports will:

- 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;
- be developed and agreed by COAG in the first instance, and thereafter reviewed by Health Ministers; and
- contain service, staffing, financial and clinical performance information on every LHN and every hospital.

Reporting will be based on the performance indicators set out in section 6.2, which capture National Standards agreed by COAG and National Clinical Safety and Quality Standards developed by the ACSQHC.

Hospital Performance Reports will be published through the MyHospitals site.

9.2 Healthy Communities Report

Healthy Communities Reports are a key output of the Framework, facilitating, for the first time, monitoring and reporting of performance of primary health care at the local level, with reporting focused on Medicare Locals. Given the extensive data development required in primary health care, and other interdependencies such as the establishment of Medicare Locals and the Authority, the level of sophistication will grow over time.

The Healthy Communities reports will:

- ensure accountability by promoting transparency through making performance information on Medicare Locals publicly available;
- drive quality improvement by supporting:
  - evidence-based funding and strategic planning by governments, Medicare Locals and health care providers to focus performance improvement effort;
  - knowledge-led continuous self-improvement by encouraging innovation through comparative analysis and examples of good and poor performance;
  - the connection and integration of health services by identifying service gaps and underutilised services; and
  - the smart use of data, information and communication by building an integrated data platform for primary health care.

Healthy Communities Reports will be published in a similar manner to Hospital Performance Reports. This is likely to include the establishment of a website similar to the MyHospitals website – which will host the Hospital Performance Reports.

Reporting will be based on the performance indicators set out in section 6.3. In addition, they will provide contextual information about each local area, allowing comparisons with Australian averages. This could include demographic information drawn from the Census, population health indicators such as the prevalence of lifestyle risk factors, and clinical and administrative information from health registries (e.g. the Bowel Cancer Screening Registry).
9.3 Reports to governments

The Authority will report regularly to the Commonwealth Government and the states and territories on the performance of Local Hospital Networks and Medicare Locals.

High performing organisations will be acknowledged regularly and their experience shared formally both nationally and internationally.
10. DATA MANAGEMENT AND DATA FLOWS

The NHHN Agreement reshaped the flow of data by providing a new mechanism by which states and the Commonwealth are required to provide data to the Authority. Clause B93 of the Agreement requires that “the Commonwealth and the States provide the national bodies (including the Authority) with the data the national bodies determine is required to carry out their functions in accordance with their data plans”.

In order to streamline the data reporting obligations of the states and territories, private hospitals and Medicare Locals, existing data sources and existing data supply pathways will be utilised as much as possible. The Standing Council on Health will continue to rationalise reporting required from the states, territories, private hospitals and Medicare Locals.

10.1 Roles and responsibilities of the Commonwealth

10.1.1 Australian Bureau of Statistics

The Authority requires data from the ABS including health-related datasets such as the Patient Experience Survey and other demographic data that will be used to add context to the Reports. Thus, the Authority will seek this data from the ABS.

10.1.2 Australian Institute of Health and Welfare

The AIHW has been the central repository for health data that has been submitted by the states under the National Health Information Agreement (NHIA).

The AIHW will continue to be responsible for producing the health-related publications it currently produces, including the biennial Australia’s Health publication that analyses health-system performance at the jurisdictional level. The AIHW will also continue to provide performance indicator data for the CRC, to report performance indicators for Health Ministers using the Health Performance Framework, provide indicators and/or data for the Report on Government Services and to produce and publish Australian Hospital Statistics. It is expected that the AIHW will also provide an extensive range of data to the Authority to ensure that there is an efficient utilisation of existing data sources.

10.1.3 Department of Health and Ageing

The Department of Health and Ageing collects a number of datasets that the Authority will need to have access to. This includes the Medicare Benefits Schedule, the Pharmaceutical Benefits Schedule, the Private Hospital Data Bureau and a number of Aged Care and Mental Health datasets.

10.2 Roles and responsibilities of the states and territories

10.2.1 Departments responsible for health and hospitals

In accordance with the NHRA, the Commonwealth, states and territories are responsible for the provision of data necessary for the Authority to report on LHN and hospital performance according to the agreed performance indicators. The Commonwealth and the states and territories have also agreed that the assessment of the agreed performance measures must be supported by data which is delivered in a timely manner. The current state hospital data collection and hospital reporting systems vary greatly across the Federation in terms of their timeliness, ranging from real-time reporting of some health data to annual reporting systems. Thus, the changes to health data collection and reporting practices resulting from the NHRA will vary across states.

The states and territories will provide patient-level and hospital-level data, financial payment and other financial information in line with the indicators outlined above according to a timetable to be determined.
by the Authority and agreed by Health Ministers. To the greatest extent possible the Authority will use existing data sets via existing data agencies such as the AIHW so as to minimise the duplication of data reporting obligations.

The states and territories will have access to the data collected by the Authority on LHN performance, subject to the agreement of the Authority. This will assist states to manage their health systems, facilitate the process of performance improvement in LHNs, and support the dissemination of best practice across the health system.
11. ACCOUNTABILITY FRAMEWORK

The celebration and recognition of outstanding performance is an opportunity for the community to focus on the opportunities for improvement across the health system. The Authority will provide annual advice to the Commonwealth Minister for Health and Ageing and state and territory health ministers and governing bodies of private hospitals on the organisations it has identified as performing well above Authority expectations. Hospital Performance Reports and Healthy Communities Reports will also identify those organisations that are performing well.

Judgments of performance of Medicare Locals will be contextualised with regard to varying and unique socio economic circumstances.

In addition to identifying high performing organisations, the Authority will have an important role in the identification of poor performance as an important safety mechanism.

11.1 States and territories remain the system manager for public hospitals and other state and territory funded services

The establishment of the Authority reinforces the ongoing role of states and territories as public hospital system managers. The establishment of the Authority enhances the information available to state and territory governments and the community for the assessment of the performance of LHNs within each state and territory.

The Authority will provide regular public assessments of the performance of LHNs to state and territory governments through Hospital Performance Reports. The role fulfilled by state and territory governments as public hospital system managers means that state and territory governments decide what response is required to each of the assessments provided by the Authority in the case of LHNs.

11.2 Accountability framework for Local Hospital Networks and private hospitals

States and territories are responsible for the safe, high quality delivery of accessible public hospital services within their jurisdiction.

As system managers, states and territories are responsible for responding to Authority assessments of public hospital and LHN performance. Likewise, the governing bodies of private hospitals are responsible for responding to the Authority’s findings regarding the private hospitals they manage.

Whenever the Authority’s report indicates poor performance on the part of an LHN or public hospital, the relevant state or territory health minister must be consulted on the draft report prior to its finalisation and publication. In circumstances where there has been persistent poor performance, or where unsafe performance has been identified, the Authority must consult the relevant state or territory health minister prior to finalising and publishing its report. Specific arrangements for this consultation are set out in the legislation governing the Authority. Only after these provisions have been complied with may the Authority issue its public report. States and territories will consult the relevant LHN governing body before finalising its response to the Authority. Decisions on the nature and timing of remediation actions are matters solely for state and territory health ministers.

The governing bodies of private hospitals are responsible for the quality of care provided by these hospitals. The Authority will monitor and assess the performance of private hospitals using a set of indicators that will be similar to that used to monitor LHNs. This indicator set will be developed in consultation with the private hospital sector prior to implementation in 2012.

The Authority will publish regular Hospital Performance Reports on the performance of private hospitals. The Authority will also provide these Hospital Performance Reports to the governing bodies of private hospitals and the relevant state or territory licensing body on a regular basis. Where a
private hospital demonstrates performance at a level above that expected by the Authority, then that outstanding performance will be acknowledged by the Authority. Where a private hospital exhibits poor or unsafe performance, the Authority will formally notify the relevant governing body as well as the state or territory licensing body. The Authority may provide both confidential - and in the case of persistent and/or unsafe poor performance and where there is a public interest in doing so - public warnings to the governing body of the private hospital and the Minister for Health and Ageing as well as to the relevant state or territory licensing body.

Prior to any publication of assessments of poor performance the Authority must comply with the natural justice provisions in its founding legislation so as to ensure that the relevant state or territory, or relevant governing body for private hospitals, is afforded the opportunity to contextualise data and if necessary, remediate poor performance.

11.3 Accountability framework for Medicare Locals

Medicare Locals will be responsible to their members but will be required to meet minimum performance standards in order to receive Commonwealth funding. Thus, the Commonwealth Minister for Health and Ageing will be responsible for the remediation of poor performance by Medicare Locals. If necessary, in the case of persistent or unsafe underperformance, withdrawal of Commonwealth funding may be required. In the rare event that Commonwealth funding is withdrawn from a Medicare Local, the Minister for Health and Ageing will invite an alternative corporation to fulfil this role. The relevant community will be publicly notified of the Minister’s decision.

The Commonwealth Department of Health and Ageing, as the system manager for primary care and Medicare Locals, will work with Medicare Locals both collectively, and where necessary individually, to drive and support performance improvements.

In the circumstances where the Authority finds poor performance by a Medicare Local that plans and coordinates primary care services provided by a state or territory, the relevant state or territory will be consulted before the Authority issues its final performance report.
12. DATA VALIDATION ARRANGEMENTS

Any performance based management regime incurs the risk of misrepresentation of performance by managers and others.

LHNs are responsible to state and territory governments and are therefore subject to audit by the relevant Auditor General and the relevant internal audit functions of the various departments of health or equivalent.

Medicare Locals will be required to make their performance data available for detailed audit as a contractual requirement for the receipt of Commonwealth funding.

Nevertheless, the Authority will query data that suggests unusually good performance or improvement, in order to provide the opportunity to detail missing contextual information.

Any Authority data queries will be followed up through the pathway through which the data was received. For example, requests for clarification of data provided by LHNs through the states and territories will be followed up through the states and territories.
13. REVIEW AND EVALUATION

This Framework will require regular oversight by the Standing Council on Health. As the health system evolves over time it may be necessary to alter the Framework to ensure that it is still relevant to the needs of the community.

The Authority may recommend changes to the Framework when and if required for consideration by the Standing Council on Health. The Standing Council on Health will evaluate the Framework and recommend any proposed changes to COAG for approval.