Catholic Health Australia

National Health Reform Amendment (National Health Performance Authority) Bill 2011

May 2011

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Introduction

Catholic Health Australia (CHA) supports the establishment of the National Health Performance Authority. Our support is however conditional. We first believe the Authority must demonstrate how it will contribute to improved health outcomes over time, as the contribution it may make is not yet obvious. Our support is further subject to:

1. reaching national agreement on what indicators are to be reported in the Authority's framework, as healthcare performance outcomes have traditionally been based on peer review principles rather than artificially created targets;
2. removing the duplication and minimising the cost of reporting, recognising that almost all the Authority proposes to do is mostly already done by other reporting bodies;
3. treating with caution the proposal for public naming of poor performance, as public naming may result in perverse unintended consequences.

Establishment of Authority Supported

CHA strongly supports the need for greater transparency and accountability in the operation of all health services including hospitals. We also support greater national consistency in reporting on performance - providing the process adopted actually leads to an improvement of system performance.

CHA welcomes the intention to publish on the internet Hospital Performance Reports and Healthy Community Reports. It will be important that these reports are able to communicate to the public meaningful and timely data on the performance of health services. Caution should be used to ensure they are not used to further politicise health care delivery.

CHA considers that the public reporting of data can be a very powerful tool in improving the performance of individual agencies, as well as the performance of the health system as a whole. It does this by *inter alia:*

- empowering consumers to allow them to make choices about the health services they may wish to use (where consumers do actually have an opportunity to make a choice);
- enabling consumers to ask questions of policy-makers, funders and regulators about performance;
- enabling policymakers, funders and regulators to make more informed decisions about the funding, provision and regulation of health services;
- motivating managers and clinicians within health services to increase performance where their peers who provide similar services (with comparable populations, case-mix and resources) are shown to be doing better;
- enabling researchers to study and analyse the reasons for variation in performance which can lead to system improvement – whether at the macro or micro level.

Performance Authority Design

Care will need to be taken in the design of the performance and accountability framework to ensure that unintended consequences are minimised and that the work of the Authority does not result in health services unduly focusing on particular performance indicators to the detriment of their overall performance.

We need, for example, to learn from the recent experience of the Mid-Staffordshire NHS Trust in the United Kingdom, where it has been reported that between 400 and 1200 excess deaths together with appalling lapses of patient care and hygiene occurred between 2005 and 2009 as a result of the local board and hospital management focusing more on meeting performance and cost cutting targets than on actual patient care[1].

The legislation as currently drafted is very broad – indeed vague – on the scope, range and detail of data that will be required to be submitted. CHA is keen to be closely consulted on the detail and acknowledges that the Department of Health and Ageing has had discussions with CHA on the information that will be collected. CHA would like to see this detail set out in regulation – giving the Parliament an ability to exercise oversight over the collection of potentially very sensitive information.

Private hospital data

The Performance Authority will be reporting on private hospital performance. CHA's private hospital members provide high quality and efficient health services and are keen to demonstrate their contribution to the health system.

The Authority will however need to be cogniscent of key differences between public and private hospitals in developing the reporting and accountability framework. In particular, private hospitals operate in a competitive environment – their revenues are not assured and they compete with other providers to attract both consumers (patients) and medical practitioners.

Data relating to health outcomes is an important part of the competitive process. CHA supports the publication of comparable public and private sector outcomes data, but not such a hospital's competitive position might be compromised.

Internal costing and budget information is of critical commercial importance and needs to be treated in a different way to that of the public sector.

[1] Mid Staffordshire NHS trust left patients humiliated and in pain, Guardian Newspaper, accessed at http://www.guardian.co.uk/society/2010/feb/24/mid-staffordshire-hospital-inquiry on 11 March 2011. See also Investigation into Mid Staffordshire NHS Foundation Trust March 2009, Summary Report, Healthcare Commission, accessed at http://www.nhshistory.net/midstaffs.pdf on 11 March 2011.

The private sector currently contributes to national cost collections – this information is published by the Department of Health and Ageing in a de-identified form aggregated to State/Territory level. We believe that level of public reporting is appropriate and should be continued.

We also note that private hospitals are required to negotiate funding contracts with private health insurance funds. Publication of individual hospital financial information may unfairly – from a hospital perspective - upset the current negotiation balance between health funds and hospitals.

CHA believes that costing information for private hospitals should continue to be treated in a commercially sensitive manner and the reporting burden streamlined.

Cost of the information collection and compliance

The collection and reporting of data does cost money – the exact cost will depend on how much data and what frequency it will be required to reported.

The costs of reporting and compliance will need to be accounted for in the setting of an "efficient price" in the case of public hospitals; and potentially in the cost of private health insurance premiums in the case of private hospitals. The costs of setting up the Authority should not result in hospitals having to reduce patient services in order to fund reporting.

Resources

In reporting on performance, it will be important to clarify those areas where health services have little control over factors which will impact on their performance. For example, in most jurisdictions health services have little control over resources such as IT systems; industrial instruments and mandated use of existing state services, such as pathology. Some of these extrinsic factors may contribute to poor performance and should be considered when developing the measures of performance by the National Performance Authority.

Performance is also heavily influenced by resource allocation. CHA would be concerned if health services that are chronically underfunded are simply seen as poor performers. The relationship between funding and performance needs to be taken into account when the metrics for performance are designed.

Need for rationalisation of existing reporting requirements

CHA members are very concerned to ensure that the introduction of a new Authority does not result in a further duplication of reporting requirements for hospitals and health services. It will therefore be very important to ensure there is absolute clarity in setting out the role of this Authority in relation to data collection and reporting vis-a-vis the roles to be played by agencies such as the Australian Commission for Safety and Quality in Health Care, the Australian Institute of Health and Welfare; and the Australian Bureau of Statistics.

One of the aims of the Authority will need to be to rationalise the collection of data from health services in both the public and private sectors to ensure that consistent data is collected once

rather than multiple times in slightly different formats that are required to be sent to agencies at State and Commonwealth levels (as well as to private health funders in the case of private hospitals). As stated above, our support for the establishment of the Authority depends on this factor such that we argue the Authority should in time become the 'one stop shop' for hospital reporting.

Notification for poor performance

The framework proposed to accompany the Authority raises the prospect of hospitals, both public and private, being notified in circumstances of poor performance. Subject to reaching a consensus on the types of circumstances in which notification should be made by the Authority, CHA supports giving to the Authority a role to notify a hospital of it is not meeting agreed performance outcomes.

In designing such a system by which the Authority might notify a health care provider, we suggest the accreditation process of (or something similar to) the Australian Council on Healthcare Standards (ACHS). ACHS uses a '60 Day Survey' process to enable underperforming hospitals to remedy any areas of underperformance prior to their accreditation being downgraded.

The framework also proposes that after the Authority has contacted the health care provider for reasons of poor performance, the Commonwealth Health Minister may publicly name the provider. We do not believe the public benefit of such a power is, on balance, warranted. CHA argues that a public naming power should be approached with caution, and if established, should be accompanied by a commitment to provide resources to enable a public hospital to remedy its poor performance.

The specific risk we see in the Ministerial naming of a hospital is that of long term stigmatisation. Once a hospital has been publicly named, consumers will continue to consider e a hospital as not being up to standard long after any temporary problem may have been resolved. This may have a particular unintended consequence in a town where there is only one hospital. Such a hospital, if publicly named as under performing, may for a long period struggle to win back the trust of local residents who, particularly in regional areas, may have not access to any alternate hospital choices.

Our position on notification of poor performance is therefore:

- that the Authority should be given a role in notifying a health care provider directly of failure to meet nationally agreed outcomes;
- that once the Authority has made its initial notification, that the health care provider should be given a reasonable period within which to remedy any fault;
- that any urgent hospital health risk complaints should be dealt with under current State and Territory hospital licensing arrangements by immediate referral of poor performance by the Authority for consideration of the relevant hospital licensing body;
- that public naming of poor performance by the Commonwealth Health Minister be approached cautiously, and only occur if accompanied by the commitment of financial resources to help public hospital remedy the named poof performance.

Governance arrangements

In relation to the proposed governance arrangements, we note that the Deputy Chair and five other members are required to be appointed with agreement of the States and Territories. At least one Board member will be required to have substantial experience, knowledge and standing in rural health (Section 72 of the Bill).

CHA argues the legislation should be drafted so as to ensure that the governance arrangement reflects the composition of the health system that the Authority will be established to monitor and report on.

Applying this principle, governance positions to be established by the legislation would ideally see members with experience, knowledge and standing in the running of public hospitals, private hospitals and primary health care. The benefit of requiring, by legislative instrument, the construction of a board of governance that is reflective of the composition of those organisations required to report to the new body is that the Authority will be better placed to develop policies and practices that are informed by the realities of diverse setting in which health services are delivered. To ensure independence, specific governance oversight to sufficiently informed consumers should also be assured.

CHA contends that, given the Authority will be reporting on private hospitals, as well as Medicare Locals and health care providers in the community (ie privately operated GP and allied health practices), it is important that at least one of the Authority members should also have substantial standing and knowledge of private or non-government health care provision.

Conclusion

CHA reiterates its view that the performance standards and monitoring framework to be established by the Authority will need:

- Clearly articulated goals and objectives;
- To be designed in a way that avoids unintended consequences;
- Strong clinician, expert and stakeholder input into design, implementation and ongoing evaluation based on Australian and overseas evidence – with pilot testing before rollout to minimise unintended consequences;
- A mix of process and outcome measures (which have been appropriately risk adjusted);
- Incentives to improve performance that will motivate existing best and poorest performers (as well as those in the middle);
- Strategies to identify and report on inappropriate competition, cherry picking and gaming between LHNs and with other health care providers from the introduction of an ABF funding model;

In conclusion, CHA support's the establishment of an independent statutory authority to develop and administer national standards for hospital performance. Our support is however

conditional. The Authority must be designed to demonstrate how it will contribute to improved health outcomes over time. Work must also be undertaken to:

1. reach national agreement on what indicators are to be reported in the Authority's framework, as healthcare performance outcomes have traditionally been based on peer review principles rather than artificially created targets;
2. remove the duplication and minimise the cost of reporting, recognising that almost all the Authority proposes to do is mostly already done by other reporting bodies;
3. Treating with caution the proposal for public naming of poor performance, as public naming may result in perverse unintended consequences.