9

Improving accountability

Whilst it is recognised that health systems must strive at all times for efficiency, it is also true that the basic societal investment in health needs to be at a sustainable level. …it would be of value for this current process to test societal expectations of the health service, and the community's willingness to invest a greater proportion of national wealth in this area.[1]

9.1 Accountability is often linked to a range of concepts including responsibility, responsiveness, regulation and control.[2] In this chapter, the committee examines how the community's high expectations to access high quality affordable heath care can be at odds with the ability of governments to properly resource health care services. The committee also discusses a range of processes that involve the community in decision making about the allocation of health resources and how health service providers can be more accountable to their patients.

Community expectations

9.2 As noted in chapters 3 and 7, the current division of responsibility between the Commonwealth and the states weakens political

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1 Australian College for Emergency Medicine, sub 17, p 2.

2 Mulgan R, *Accountability Issues in the New Model of Governance* (2002), Discussion Paper No.91

accountability to the community for government actions to address health care issues.

9.3 It is also difficult for governments to be accountable for the delivery of high quality affordable health care if there is a clear mismatch between the expectations of the community and the priorities set by governments for the resources allocated to the health system.

9.4 Many inquiry participants noted that the community has high expectations about what the health care system can deliver.[3] These high expectations can relate to different aspects of health care including:

- access — free or affordable health care in a convenient setting;
- quality — effective health care delivered by skilled health professionals in a safe environment;
- timeliness — health care provided according to clinical need, taking into consideration the impact that delaying treatment can have on the ability of community members to participate in community activities; and
- high technology — health care which incorporates the latest technology and advances in medicine.

9.5 High or rising expectations in all of these areas generate significant pressures on the health system. As noted in chapter 7, in most states people face significant waiting times for elective surgery in public hospitals, and in many jurisdictions too much of the elective surgery is not carried out within the clinically appropriate time.

9.6 The difficulties of meeting the community's expectations for public hospital services within a fixed budget were illustrated to the committee by the head of a NSW public health provider:

> I say to people all the time, and my managers in particular, 'We have the budget we have.' If there is a part we cannot control and we must service—such as emergency departments and critical care areas—then we have to do less of the things that are not as clinically urgent or important for health outcomes. There is no simple equation for that; there is

3 Wainwright D, Australian Medical Association, 23 August 2005, p 8; National Health and Medical Research Council; sub 49, p 2; Health Insurance Restricted Membership Association of Australia, sub 6, p 5; Mackender D, Hospital Reform Group, transcript, 29 March 2006, p 6; Australian Doctors' Fund, sub 78, p 25; Mr Anthony Morris QC, sub 72, p 31.

> no magic bullet. That has to be the outcome, and that is a concern.[4]

9.7 The need for rationing, or queuing, is an inevitable outcome in health systems where price is not generally used to limit demand and where there are rising community expectations.[5] The Australian Healthcare Association noted that:

> In social policy, of which health care is an aspect, as we invest and reach a certain benchmark performance, there is a natural inclination for us as human beings to expect the bar to rise, because we can further improve the condition or the conditions under which we live. Therefore, assuming that there is a particular quantum of investment at any point in time, there is always going to be a rationing, according to the way in which that investment is disbursed.[6]

9.8 Several inquiry participants noted the need for governments to better communicate to the community the anticipated effects of current resourcing on access to health care. Catholic Health Australia noted that:

> The political climate for too long has deluded the community into believing that quality health services can be delivered for relatively little outlay. Clearly, community discontent signals that this strategy has run its course.[7]

9.9 The Australian Society of Anaesthetists noted that:

> The general public cannot even enter the debate if they do not understand the problems. Frequently, in every state, you hear talk of the routine eight-week closedown over Christmas and six weeks over Easter. This is because they do not have the budget to fund services through that time. They are not routine at all. They may be now. They have become routine, but they should not be. Until we actually say to the public, 'We do not have enough money to do all the hip replacements, therefore, the waiting list will be three years,' the public cannot even have the debate because they do not understand the problem. Once they understand, they can

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4 Clout T, Hunter New England Health, transcript, 20 July 2006.

5 Ham C and A Coulter, 'Introduction: International experience of rationing (or priority setting', *The global challenge of health care rationing* (2000).

6 O'Conner D, Australian Healthcare Association, transcript, 26 May 2006, p 47.

7 Sullivan M, Catholic Health Australia, transcript, 23 August 2005, p 6.

> then have the debate and decide whether more resources need to be devoted through increased taxation or taking it from some other area.[8]

9.10 The Australian Council of Social Service pointed to the need for resources to be allocated carefully:

> It is uncontroversial that health services should be provided according to need but it is also the case that not all needs can be met. The real resources required to run a health system and in particular the health work force are in limited supply. Running an efficient, effective and equitable health system is therefore about setting priorities.[9]

9.11 The committee supports the need to better communicate with the community about the level and standard of health care that can be provided. The clearer specification of 'acceptable' service standards advocated by the committee as part of the national health agenda (see chapter 3) should contribute to improving community expectations about how resources are linked to outcomes. Possible mechanisms for improving community consultation and responsiveness to community views are discussed later in this chapter.

Public hospital elective surgery waiting times

9.12 While clinical need is used to determine the urgency with which a public patient is treated in public hospitals, patients with less urgent conditions can still experience significant pain and discomfort. Dr Cartmill told the committee that:

> We are told in the public sector to treat category 1 patients or long-wait category 2. Category 3 patients do not get treated.
>
> In urology, category 3 patients have lifestyle problems, such as prostatic disease and bladder outlet obstruction. Those patients have real symptoms, their quality of life is significantly impaired and they are just not getting treated.[10]

9.13 Several inquiry participants noted that there was a need to make access to health care fairer and more transparent, given the lengthy

8 Mulcahy A, Australian Society of Anaesthetists, transcript, 23 August 2005, p 10.

9 McCafie G, Australian Council of Social Service, transcript, 21 September 2005, p 65.

10 Cartmill R, transcript 16 March 2006, p 57.

waiting times for some kinds of elective surgery.[11] One example provided to the committee was the need for a quantitative measurement tool to prioritise patients seeking breast reduction surgery and abdominoplasty (box 9.1). The Doctors' Reform Society (WA) noted that:

> … the state governments ration using waiting lists. It is hotchpotch, it is inequitable and it produces strange results. I think rationing is not only inevitable, it is a good thing, and I think the PBS—and I am not saying it is a perfect system by a long way—is great. 'This is what we fund and this is how we can limit what can be spent on pharmaceuticals.' But it must transparent and it must be coordinated on a big scale.[12]

Box 9.1 Services for breast reduction and abdominoplasty surgery

Evidence shows that breast reduction and to a lesser extent abdominoplasty (more commonly known as a 'tummy tuck') improves patients' general health significantly. This surgery may also play a wider role in illness prevention because it enables people to exercise and have a healthier lifestyle. However, it is often seen as 'low priority' as compared to excision of cancers, but in a longer term view, if it helps to prevent heart disease it is a good investment of health spending.

Because public hospitals have limited resources to treat any non-urgent cases (even though they may result in great health benefit), only a few of these cases are performed each year. Typically, a patient in South Australia will wait between 2 and 10 years from the time they are put on a waiting list.

The introduction of a quantitative measurement tool for patients seeking this surgery would allow fairer prioritisation of patients. It may also be decided by the government that the patients who were given a low priority score by this method would be advised to seek treatment in the private sector. This would free up resources in the public hospitals for those who had significant health problems from their large breasts or overhanging abdomens and mean that those who really needed the surgery could actually receive it. This system would reduce public hospital waiting lists and be fairer.

Source: Flinders Medical Centre, sub 86 and 122; Dean, N and Griffin, P, transcript 2 April 2006, pp 1–13.

11 Flinders Medical Centre, sub 86, p 1; Mackender D, Hospital Reform Group, 29 March 2006, transcript, p 3; Australian Healthcare Reform Alliance, sub 127, p 10.

12 Ralls J, Doctors Reform Society (WA), transcript, 24 August 2006, p 27.

9.14 The committee considers that further effort should be devoted by governments to making waiting lists fairer. The Australian Government — through the National Health and Medical Research Council — should give priority to supporting research that examines how waiting list management systems can be improved.

Recommendation 24

9.15 **The Australian Government, in conjunction with the states and territories, give priority to undertaking research to develop mechanisms to make waiting lists for public hospital elective surgery fairer.**

'Hidden' waiting lists

9.16 Most states report, or are moving to report, information about waiting lists and waiting times for public hospital services, in some cases on a quarterly basis.[13] Such reporting can better inform the community about the capacity of the health system and also provide information to clinicians about how to best care for their patients.

9.17 Nevertheless, there can be 'hidden' waiting lists comprising patients who experience delays in seeing specialists in outpatient clinics prior to being added to elective surgery waiting lists.[14]

9.18 While it is difficult to measure the number of patients who must wait to be assessed by specialists prior to treatment, it is important that the waiting list information produced by the states reflects delays in accessing health care throughout the whole episode of treatment.

9.19 The committee considers that accountability and transparency can be improved through the development of additional sources of

13 See for example, Victorian Department of Human Services, Your hospitals: A six-monthly report on Victoria's public hospital, January to June 2006, viewed on 9 November 2006 at www.health.vic.gov.au/yourhospitals/yourhospitals0606.pdf; ACT Health, ACT Health Public Services Performance Report Quarter 4 2005-06, viewed on 9 November 2006 at www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1157669065&sid=.

14 Wainwright D, Australian Medical Association, transcript, 23 August 2005, p 10; Flinders Medical Centre, sub 86, p 2; Australian Medical Association Victoria, media release, *Elective surgery waiting list not a true reflection of wait*, 28 September 2006; Victorian Auditor-General, Access to specialist medical outpatient care (2006), p 89; Australian Medical Association Tasmania, media release, *Tasmanian elective surgery waiting lists statistics exposed,* 6 April 2005.

information about the delays that can be encountered in accessing specialists in outpatient clinics.

Recommendation 25

9.20 **In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government provide incentives for the states and territories to report in a consistent manner on patient waiting times for access to specialists in outpatient clinics.**

Responsiveness

9.21 The responsiveness of service providers to local community needs can be an important part of being accountable for the effective and efficient delivery of health services.

9.22 Several inquiry participants noted that there are a range of mechanisms that allow health care services to be responsive to the needs of local communities including:

- governance structures for health providers that provide for community representation on governing boards or consultative committees; and [15]
- local government as an advocate or service provider.[16]

9.23 Another form of community consultation — 'citizens juries' — were suggested by inquiry participants as an alternative for involving the community in decisions about allocating health resources (box 9.2).[17] Mr Menadue noted that:

> My observation is that when community groups are well informed about priorities and the options involved, they invariably put, for example, mental health and aboriginal health at the top of the list well ahead of hospitals and hospital beds. Informed community members usually give

15 Victorian Government, sub 67, p 7

16 Shire of Bruce Rock (WA), sub 152, p 1; Shire of Laverton (WA), sub 147, p 1; Western Australian Local Government Association, sub 34, p 7.

17 John Menadue, sub 140, p 1; Australian Healthcare Reform Alliance, sub 127, p 10; Australian Physiotherapy Association, sub 118, p 13; Australian Health Association, sub 62, pp 13–14; Goulston K, Hospital Reform Group, transcript, 29 March 2006, p 10.

much lower priority to life-extending interventions in the last stage of terminal illness, some fertility treatments and hospital super-specialties. Making choices is hard, but my experience is that when the community is well informed it comes to realistic and what I think are sensible decisions on the priorities of health spending. We must obtain informed advice from the community.[18]

Box 9.2 Informing decision making using citizen's juries

Citizen's juries are a technique designed to enhance the engagement of the community in the making of public policy.[19] They are commonly used in the development of broad policy goals or resolution of particularly challenging issues (for example, issues involving complex ethical or technical questions). They have been used in North America, Europe and Australia across a range of policy areas, including healthcare, roads and the environment.[20]

How do they work?

There are various approaches to running a citizen's juries but the main components usually include:

- the formation of a group to participate in the process (sometimes the group is randomly selected, other times it is drawn from recognised stakeholders);
- the presentation of 'evidence' to the group by various relevant experts;
- an opportunity for the group to discuss the evidence; and
- a vote by the group on the issue/s under discussion.

One of the main objectives of citizens' juries (like other 'deliberative' techniques such as focus groups) is to gain a more advanced understanding of community attitudes than can be expected from more common techniques such as surveys. However, unlike most other deliberative approaches, a key feature of citizens' juries is the presentation of important technical and other information to participants by experts. This means that the information obtained from citizens' juries is potentially more considered and more reflective than that available from other approaches.

(continued over)

18 John Menadue, sub 140, p 1.

19 Curtain C, 'What role for citizens in developing and implementing public policy?', National Institute for Governance Conference: Facing the Future: Engaging Stakeholders and Citizens in Developing Public Policy (2003).

20 Dolan P., R.Cookson and B. Ferguson, 'Effect of discussion and deliberation on the public's views of priority setting in health care: Focus group study', *British Medical Journal* (1999), Vol 318, Issue 7188, pp. 916-919; Mooney G. and S. Blackwell, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia*,(2004), vol 180 , no 2, pp 76-78; Carson L. and B. Martin, 'Random selection of citizens for technological decision making', *Science and Public Policy* (2002), vol 29, no 2, pp 105–113.

Citizens' juries in healthcare policy

Citizens' juries are often proposed for the healthcare policy area because they offer the possibility of clarifying issues that are beyond clinical and other forms of technical evaluation. According to Mooney and Blackwell:

> *Above the level of individual clinical decisions, there are questions of resource allocation and policy that are very much social choices. They still have to be informed by technical information. In between, doctors are faced with many decisions where it is less clear which values should apply. Partly this is because it is difficult to decide where the dividing line should come between professional and social value judgments; partly because some decisions are so technical and complex that citizens cannot make truly informed choices. However, citizens may accept their limitations in some areas of decision making, while insisting on their right to decide in others.*[21]

For example, it is commonly suggested that citizens' juries could make an important contribution to addressing the problem of scarcity of resources in healthcare. The idea is that this approach could both enhance public understanding of the problem and lead to more open and productive debates about how to use finite resources to the best effect.[22]

The evidence—pros and cons

There are a number of studies reporting success in obtaining informed and considered contributions from participants in citizens' juries. For example, participants in Western Australian citizen's juries decided upon more community-focused (as opposed to consumer-focused) approaches to health system priority-setting after being presented with expert evidence and given time to discuss and deliberate.[23] Further, convenors of a British citizen's jury concluded that the public was much more willing to engage in the complexity of issues associated with setting priorities in health care when they have been given an opportunity to discuss the issues.[24]

Nevertheless, citizens' juries are much more resource intensive than most traditional forms of community consultation (particularly in terms of the investment of time and financial resources). There are also crucial issues associated with the design of citizens' juries. For example, a number of studies have shown how such issues as the choice of participants and the framing of the themes under discussion can have significant impacts on the results of a citizens' jury.[25]

21 Mooney G and Blackwell, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia* (2004), vol 180, no 2, p. 77.

22 Baume P, 'A Different 'Health' Debate is needed now', *New Matilda* (2005), 7 December.

23 Mooney G and Blackwell, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia* (2004), vol 180, no 2, p 76.

24 Dolan P, R Cookson and B Ferguson, 'Effect of discussion and deliberation on the public's views of priority setting in health care: Focus group study', *British Medical Journal* (1999), vol 318, Issue 7188, p. 916.

25 Hendriks C, 'Participatory storylines and their influence on deliberative forums', *Policy Sciences* (2005), vol 38, pp 1–20; Carson L and B Martin, 'Random selection of citizens for technological decision making', *Science and Public Policy* (2002), vol 29, no 2, pp 105–113;

9.24 Some of the funding models proposed in chapter 3 support the need for greater community input by providing resources to communities for management on a regional basis. While local governments appear to be well placed to provide a forum for local input in some cases, alternative mechanisms such as citizen's juries also appear to provide a realistic means for community engagement.

9.25 Governments need to better engage with the community about their expectations and priorities in health care. While supporting the intent of citizen's juries and other forms of community engagement, the committee considers that they are no substitute for the political accountability of elected governments. Accordingly, the committee sees a role for consumers in setting the national health agenda (see recommendation 1 in chapter 3).

Safety and quality

9.26 Quality is difficult to define because it is a broad term which of itself has little agreed meaning.[26] The NSW Department of Health has articulated a framework for managing six dimensions of quality: safety, effectiveness, appropriateness, consumer participation, efficiency, and access.[27]

9.27 In terms of accountability for safety and quality, this section is concerned mainly with the reporting to the public and patients of the positive and adverse outcomes of these six criteria.

9.28 The Commonwealth and the states are involved in improving health care safety and quality at a broader level, with the formation of the Australian Commission on Safety and Quality in Health Care in January 2006.[28] The Commission, which succeeded the Australian Council for Safety and Quality in Health Care (ACSQHC), will lead and coordinate improvements in safety and quality in health care in

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Dutwin D, 'The character of deliberation: equality, argument, and the formation of public opinion', *International Journal Of Public Opinion Research* (2003), vol 15, no 3; Zwart I, 'Local deliberation and the favouring of nature', Institute for Social Research (2005).

26 Department of Health and Aged Care, *The Quality of Australian Health Care: Current issues and future directions*, Health financing series occasional paper (2000), vol 6, p 5.

27 Department of Health (NSW), *A Framework Managing the Quality of Health Services New South Wales*, viewed on 12 October 2006 at www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_585.pdf.

28 Department of Health and Ageing, sub 43, p 16.

Australia by identifying issues and policy directions, and recommending priorities for action.[29]

9.29 The Medicare Agreements and Australian Health Care Agreements (AHCAs) (see chapter 7) have played an important part in improving public accountability for safety and quality issues:

- requirements for the states to establish public hospital charters and the establishment of complaints handling bodies to resolve complaints relating to public hospital services were included as part of the 1993–98 Medicare Agreements;[30] and
- requirements to develop indicators relating to adverse events were included as part of the 2003–08 AHCAs, building on the efforts of the ACSQHC.[31]

9.30 Traditionally, the quality of health care has been seen as a natural consequence of a sound medical education and good intentions on the part of medical practitioners.[32]

9.31 The provision of safe and high quality health care in Australia is supported by a range of arrangements including high standards of education and training for students, accreditation and registration arrangements for practitioners, assessments by independent bodies such as the Therapeutic Goods Administration and accreditation of health facilities.

Hospital accreditation

9.32 A key mechanism for improving quality has been the process of hospital accreditation. Although other forms of accreditation exist, the principal accreditation agency in Australia is the Australian Council on Health Care Standards (ACHS), who accredit 74 per cent of all hospitals and 87 per cent of all hospital beds across Australia.[33]

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29 Australian Health Ministers, Joint communiqué, *Australian Health Ministers move forward on new commission on safety and quality*, 18 November 2005.

30 See for example, *Agreement between the Commonwealth of Australia and the State of New South Wales in relation to the provision of Public Hospital Services and Other heath services: From 1 July 1993 to 30 June 1998*, clause 4.1–4.6.

31 See for example, *Australian Health Care Agreement between the Commonwealth of Australia and the State of Queensland 2003-2008*, schedule C, clause 12.

32 Department of Health and Aged Care, *The Quality of Australian Health Care: Current issues and future directions*, Health financing series occasional paper (2000), vol 6, p 3.

33 Duckett S, *The Australian Health Care System* (2004), p 157; Australian Council on Health Care Standards, sub 65, p 3.

9.33 Only in Victoria are all public hospitals required to be accredited, with participation by public hospitals in other states voluntary.[34] In 2004-05, the proportion of public hospital beds accredited by ACHS or another agency ranged from 72 per cent in Tasmania to 100 per cent in Victoria, NT and the ACT (see figure 9.1).

Figure 9.1 Public hospitals and beds – number and proportion accredited, states and territories, 2004-05

		hospitals accredited		beds accredited	
Rank		Number	Percentage	Number	Percentage
1	Australian Capital Territory	2	100	669	100
1	Northern Territory	5	100	570	100
1	Victoria	144	100	11875	100
4	South Australia	74	94	4889	98
5	Queensland	153	86	9585	98
6	New South Wales	181	78	19615	95
7	Western Australia	66	71	4766	97
8	Tasmania	3	11	915	72
	Australia	628	83	52884	97

Source *Department of Health and Ageing, The state of our public hospitals, June 2006 report (2006), p 11.*

The ACHS's most recent report, citing results from 2003 and 2004, noted that there were hospitals where performance needed to improve in a number of areas including:

- The emergency management systems required attention in 173 organisations (26 per cent) to ensure that they were adequately protecting patients and staff;
- Patient care was considered compromised (as indicated by the allocation of High Priority Recommendations) in eight organisations because of the lack of formal clinical processes relating to medical staff availability, credentials and competencies of staff, appropriate resources to perform the clinical service, clinician involvement and responsibilities in care delivery, for example in the consent process; and
- Patients, visitors and staff were at risk … in 10 organisations because of inadequate attention to fire safety.[35]

34 Duckett S, *The Australian Health Care System* (2004), p 157.

35 Australian Council on Healthcare Standards, *National Report on Health Services Accreditation Performance 2003 and 2004* (2005), pp 2–3.

9.34 Public reporting of accreditation reports is not mandatory, although some accredited hospitals — usually those that receive positive reports — do make these available to the public via the Internet.[36]

9.35 The ACHS noted that:

> At present, there is no requirement for health services to disclose the content of their accreditation report or their Quality Action Plan. It is ACHS policy to encourage health services to publish their accreditation report or a modified statement of accreditation performance either on their web site or on the ACHS web site. Few organisations do so; understandably organisations that have received a very positive report are generally happy and willing to do so.[37]

9.36 The committee considers that mandatory public reporting of accreditation reports would give strong incentives to hospital management to quickly address issues identified during the accreditation process. While accreditation is not a panacea to improving quality, nor a requirement of funding arrangements in the current Australian Health Care Agreements, the committee notes that the Commonwealth intends that all privately insured health services will be required to meet accreditation standards set by the Minister for Health.[38]

9.37 The committee considers that all public and private hospitals should be required to be accredited with the Australian Council on Healthcare Standards, or an equivalent accreditation agency, and publish their accreditation reports in a timely manner.

36 Robinson M, Australian Council on Healthcare Standards, transcript, 5 July 2005, p 71.

37 Australian Council on Healthcare Standards, sub 51, p 3.

38 Department of Health and Ageing, *Private Health Insurance Bill 2006 :Guide to the exposure draft* (2006), p 9.

Recommendation 26

9.38 **In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government require all public hospitals to:**

- **be accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and**
- **publish their accreditation reports within three months of being completed.**

Recommendation 27

9.39 **The Australian Government prohibit the payment of private health insurance benefits for hospital services unless the relevant hospital:**

- **is accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and**
- **publishes their accreditation reports within three months of being completed.**

Reporting adverse events

9.40 Several inquiry participants noted a number of cases of adverse incidents in public hospitals, dissatisfaction with the quality of care provided by medical practitioners and claims of a less transparent culture within some hospital administrations.[39]

9.41 Mr Anthony Morris QC noted that in Queensland:

> The institutional reaction to adverse events and crises is consistently the same: first, you deny the facts; secondly, you bury the evidence; and thirdly, you shoot the messenger.
>
> People who are 'trouble-makers' — that is, those (especially clinicians) who raise concerns and identify problems — are subjected to 'trumped up' disciplinary complaints and threats of civil and criminal action; have their honesty, their motives, and their clinical competence challenged; are victimised with

39 John Menadue, sub 140, p 2; Health Group Strategies, sub 116, p 12; Mr Anthony Morris QC, sub 72, p 18; Ms Susan Dale, sub 100; Whistleblowers Australia, sub 93, p 24;

> inconvenient rosters and other workplace impediments; and are otherwise bullied until they are eventually eased (or squeezed) out of the system altogether.[40]

9.42 Informing patients about the quality of care they have received, or may receive, is important in making health practitioners, or the institutions and service providers for which they work, accountable to the community and their patients. The availability of appropriate information about the quality and safety of health care can also drive changes to improve future health care and inform patients about where they should seek health care.

9.43 The states provide a range of information to the community and patients about the safety and quality of public hospital health care. The Victorian Government noted that:

> … public hospitals in Victoria are already highly accountable.
>
> - Through their community consultative structures they are accountable to their local communities.
> - Through their boards, and through their annual reporting requirements they are accountable to the Victorian Parliament.
> - Through the six monthly Your Hospitals report, they are accountable to the whole community.
> - Through the regular provision of information to the Australian Institute of Health and Welfare under the National Health Information Management Agreement they provide a wealth of information available to those who seek a detailed understanding of health care provision.
> - Through their requirement to maintain accreditation, they are accountable for the maintenance of high quality services.
> - Through their internal clinical governance arrangements they are accountable for the reporting and minimization of adverse events and through the Sentinel Event Program Annual Report there is accountability to the wider community, and
> - Through the Victorian budget process and Auditor-General requirements accountability in relation to system financial performance is maintained.[41]

40 Anthony Morris QC, sub 72, p 18.

41 Victorian Government, sub 67, p 7.

9.44 A sentinel event is an adverse event that occurs because a hospital system and process deficiencies and which results in death, or serious harm to, a patient. Examples of sentinel events include:

- procedures involving the wrong patient or body part;
- retained instruments or other material after surgery requiring re-operation or further surgical procedure;
- medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
- maternal death or serious morbidity associated with labour or delivery; and
- unexpected death or serious disability reasonably believed to be preventable.[42]

9.45 The committee notes that health ministers had agreed to publicly report sentinel event data by the end of 2005 in a National Sentinel Events Report.[43] As yet, however, only New South Wales, Victoria, South Australia and Western Australia have publicly reported on sentinel events.[44] The committee notes that Queensland, Tasmania, the Northern Territory and the Australian Capital Territory have not yet regularly reported on the incidence of adverse events, despite Queensland experiencing numerous reports of adverse events in the past few years.

9.46 The committee considers that the transparent reporting of sentinel events by states is important. This would enable development of preventative strategies to ensure improved patient safety. Regular reporting by the states needs to be encouraged, as it should assist in the creation of a more open culture that supports learning and improvement.

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42 Western Australian Department of Health, Office of Safety and Quality in Health Care: Sentinel Events, viewed on 8 November 2006 at www.health.wa.gov.au/safetyandquality/sentinel/index.cfm#definition.

43 Department of Health and Ageing, Sentinel events, viewed on 11 October 2006 at www.health.gov.au/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/$File/sentnlevnt31305.pdf#search=%22sentinel%20events%20report%20victoria%22.

44 Department of Human Services (Vic), *Sentinel event program Annual report 2004–05* (2005), December; NSW Health, *Patient Safety and Clinical Quality Program: Second report on incident management in the NSW public health system 2004–2005* (2005); Department of Health (WA), *Delivering Safer Health Care in Western Australia The Second WA Sentinel Event Report 2005-2006* (2006); Department of Health (SA), *Improving the System: South Australian Patient Safety Report 2003-2004* (2006).

Recommendation 28

9.47 **The Australian Government require all state and territory governments to regularly publish reports on sentinel events occurring in their public hospitals.**

Better information about clinician performance

9.48 Good information about individual clinician performance can support greater choice by patients and provide an important source of feedback to clinicians about the performance of their peers.

9.49 Several inquiry participants noted that the absence of information about clinician performance did not allow patients to clearly differentiate between the quality of services provided.[45] Catholic Health Australia noted that:

> One of the features that distinguishes health care from other goods and services is that consumers suffer a considerable disadvantage in terms of knowledge and access to information about their treatment options and the relative performance of providers (doctors and hospitals) in delivering that treatment. [Catholic Health Australia] strongly supports the rights of consumers to be able to make informed choices about their treatment and choice of provider.[46]

9.50 Information about the individual performance of cardiac surgeons has been publicly available in some jurisdictions in the United States for several years and more recently in the United Kingdom.[47] Public reporting of this information in the United Kingdom has largely stemmed from concerns about the insular and 'club culture' of the National Health Service and the creation of a 'patient centred' system.[48] In the United States, the availability of public reporting

45 Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 67; Health Group Strategies, sub 116, p 36; Catholic Health Australia, sub 35, p 3.

46 Catholic Health Australia, sub 35, p 3.

47 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5.

48 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5, p 266.

systems was expected to allow better informed consumers to demand quality and that poor performers would be disciplined by the market.[49]

9.51 There appear to be concerns from some parts of the medical profession that public reporting of individual clinicians' performance will lead to defensive medicine and an avoidance of high-risk patients.[50] On the other hand, there appear to be benefits to providing more information to patients about a clinician's performance, with the Australian Council on Healthcare Standards noting that:

> With respect to some of the public reporting, there was the New York cardiac reporting where they put up reports on different surgeons in different hospitals and their outcomes. The consumers could not have cared less. They saw it but they did not change their attendance patterns, they did not change their choices. But it made those doctors who were not performing improve their performance. In fact, it did work for the health professionals, but the consumers did not change.[51]

9.52 In Australia, outcome data for individual surgeons are collected by many hospitals and surgeons themselves, but they are not centrally coordinated into a comprehensive database, and no surgeon-specific data are available to the public.[52]

9.53 The committee considers that, on balance, safety and accountability can be strengthened through wider public reporting of clinician performance. However, it is important that reporting is not simply based on crude measures such as death rates, but consider broader issues such as patient mix, complexity and performance standards.

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49 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5, p 267

50 Hughes C and P Mackay, 'Sea change: public reporting and the safety and quality of the Australian health care system, *Medical Journal of Australia* (2006), vol 184, no 10.

51 McDonald H, Australian Council on Healthcare Standards, transcript, 5 July 2005, p 75.

52 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5.

Recommendation 29

9.54 **The Australian Government support the development of hospital and clinician-based performance information systems to better inform patients about the competence of health care providers and strengthen accountability of health professionals and health service providers. Reporting systems should allow, where appropriate, for performance information to be qualified to reflect differences in the type of patients being treated.**

Hon Alex Somlyay MP

Chair