1 INTRODUCTION

PREAMBLE

Australia's health care system is complex and multifaceted. It is also a system which is generally considered effective in terms of health outcomes, consumer satisfaction and cost. The Organisation for Economic Cooperation and Development (OECD) 1994–95 Economic Survey of Australia favourably compares Australia's performance in health care provision with other OECD countries.

It found that 'The health status of Australians had improved significantly over recent decades, helped by the health care system which guarantees universal coverage and yields a large measure of satisfaction among the population at a reasonable overall cost to the economy' (OECD 1995).

Like other OECD countries, Australia is experiencing growth in health care expenditures. Factors influencing this growth are frequently documented and include demand factors such as rising incomes, population ageing and increased access, and supply factors such as improved therapeutic and diagnostic technology, and increased supply of medical personnel and equipment.

Funders of health care services are keen to find sensible solutions to curbing this growth. Increasingly sophisticated incentives—such as casemix funding arrangements—are being trialled to monitor and control this growth.

Efficiency measures should not, however, be introduced without attendant incentives to maintain and improve effectiveness, quality and equity within the system.

Various measures already exist to look at the performance of these elements of the system. However, a national system for defining benchmark performance of the health system as a whole has not previously existed.

The moves by private industry to benchmark with competitors in order to make organisations more competitive in world markets has prompted the health sector to look at the potential of this movement for its own purposes. In this context, the Australian Health Ministers' Conference (AHMC) of March 1994 agreed to the development of nationally consistent benchmarks for the health sector in a number of areas, including efficiency, quality, access and outcomes.

The purpose of developing health sector benchmarks is to provide an incentive for improved efficiency, effectiveness and equity in the health sector through:

- defining an acceptable national standard of performance in health service delivery;
- creating a greater focus on measurement of performance in the health sector; and
- providing governments, other funders and managers with a core

set of management performance information to assist in health sector management and policy development.

BACKGROUND

Origin of the program

As noted above, in March 1994 Health Ministers agreed to the development of nationally consistent benchmarks for the health sector in a number of areas. Ministers also agreed to the establishment of a working group of Commonwealth, State and Territory officers to coordinate the development of the benchmarks. This group, known as the National Health Ministers' Benchmarking Working Group (NHMBWG), first met in August 1994. The membership of the Working Group as at October 1995 is shown in Appendix A.

Relationship to other programs

The work of the NHMBWG relates to that of a number of other groups and programs. A brief description of two of the principal programs and the relationship follows. Appendix B contains a summary of some of the related programs with their objectives.

Council of Australian Governments Review of Commonwealth/State Service Provision

As part of the Council of Australian Governments (COAG) Review of Commonwealth/State Service Provision, a number of working groups were set up in key areas. The Hospitals Working Group, in liaison with the Commonwealth Department of Human Services and Health, developed a set of nationally agreed performance indicators relating to the efficiency and effectiveness of the public hospital system. At the July 1994 meeting of the Steering Committee for the review, it was agreed that the Hospitals Working Group's tasks in respect of performance measurement would be merged with that of the NHMBWG.

The NHMBWG therefore took on the suggested performance indicators to develop them further in the context of its own terms of reference. To avoid duplication, the Hospitals Working Group is represented on the NHMBWG by officers of the Industry Commission (which provides secretariat services to the review) and the Victorian Department of Treasury and Finance (which is responsible for chairing the Hospitals Working Group).

National Hospital Outcomes Program

The National Hospital Outcomes Program (NHOP) replaced the National Hospital Quality Management Program (NHQMP) in July 1995. The NHQMP, an incentive program under the 1993–98 Medicare Agreements, promoted a national approach to the improvement of quality of care and health outcomes of hospital services. The program also addressed priority areas such as the development and use of national clinical and non-clinical indicators of quality and outcomes of care, medical record reform, integrated discharge planning and promoting a stronger consumer focus.

The NHOP builds on the work of the NHQMP and will, over the next three years, develop and implement performance measures for standards of

quality and outcomes of care in Australian hospitals.

The quality of care indicators discussed in this report were initially advanced by the NHQMP (they were originally developed as part of the Australian Council on Healthcare Standards Care Evaluation Program), and the further development and reporting of quality measures under the NHOP is closely linked to the NHMBWG's objectives.

OBJECTIVES

Objectives of the Working Group

The terms of reference of the Working Group identify its objectives as follows:

1. to establish appropriate national indicators of performance in the health sector under the following categories:
   - quality
   - production efficiency
   - outcomes
   - investment utilisation
   - access
   - human resource management
   - business operations;
2. in establishing these indicators, to give due consideration to:
   - the validity of the indicators, in terms of the degree to which they provide clear and direct information about the efficiency and effectiveness of the health sector;
   - the understandability of the indicators; and
   - the ease and cost of the collection of the relevant data;
3. to develop standardised definitions of nominated performance indicators, where required, to ensure comparability of data across all States/Territories;
4. to establish procedures for the ongoing collection of performance indicator data and publication of these data on an annual basis at national, State and local level;
5. to undertake the national coordination of benchmarking activities, including the development of networks to facilitate exchange of information on best practice and the setting of initial benchmarks;
6. to give consideration to linkages with other activities/programs being undertaken in this area, that is:
   - COAG Review of Commonwealth/ State Service Provision;
   - National Hospital Outcomes Program (formerly National Hospital Quality Management Program);
   - Better Health Outcomes for Australians: National Goals, Targets and Strategies for Better Health Outcomes Into the Next Century;
   - the National Demonstration Hospitals project;
   - the national Best Practice Program;

- Schedule I of the Medicare Agreements relating to outcome indicators and measures; and
- the Institute's standardisation of data definitions work; and

7. to establish a methodology for the casemix adjustment of data.

Objectives of this report

This is the first national report on health sector performance indicators, and the objectives of the report are appropriately broad:

1. to present data and analyses for indicators where data are available and of sufficient quality;
2. to provide a status report for indicators where data are inadequate to report at a national level;
3. to introduce the concept of benchmarking in the health sector; and
4. to outline an agenda for further development of health sector performance indicators.

SCOPE

Scope of the collection

Developing performance indicators for the health sector is a complex task, so it is appropriate when starting out to focus on one part of the sector. With the merging of this program with that of the COAG review, it was fitting that the scope of this report be limited to the acute hospital sector. Acute hospitals provide services predominantly to patients with acute or temporary ailments. The term 'acute hospital' is often used synonymously with general hospital or recognised hospital.

Some contextual information (see Chapter 2) is also drawn from beyond the acute hospital sector, and some from outside the hospital sector—notably the large Commonwealth health programs.

For most indicators, the scope is restricted to public acute hospitals, but where balance of care is an issue, private acute hospitals are included.

Period of the collection

Most data sets cover activity in the 1993–94 financial year. Exceptions to this are:

- waiting list data were collected by each State and Territory (except Queensland) for a one-month period between June and September 1994; and
- hospital morbidity data and some demographic data were available only for the 1992–93 financial year.

DATA SOURCES

One of the keys to achieving timely reporting of performance data was to use data already flowing from State and Territory health authorities to Commonwealth agencies. The establishment of new data collections for this report was not possible in the timeframe dictated by the COAG review.

Principal data sets include:

- National Minimum Data Set (NMDS) survey program data, that is, hospital- and patient-level data collected for the Institute's

Hospital Utilisation and Costs Study (HUCS) series;

- casemix data, that is, data supplied to the Department of Human Services and Health (HSH) primarily for the purpose of casemix development;
- data supplied to HSH as part of the Medicare Agreements;
- waiting lists data supplied to the Institute; and
- population and other demographic data prepared by the Australian Bureau of Statistics (ABS).

State and Territory health authorities were also requested to provide data regarding capital asset valuation and related material. These data have not been part of a routine collection by any of the Commonwealth agencies.

Additional information on projects and activities related to the agreed performance indicators was also requested to illustrate indicators for which national data were not available.

Other data compiled for the report include:

- Medicare Benefits Schedule (MBS) services and expenditure, and medical providers receiving benefits under the scheme;
- Pharmaceutical Benefits Scheme (PBS) prescriptions and expenditure, and approved retailers; and
- hours of care under the Home and Community Care (HACC) Program.

DATA QUALITY AND AVAILABILITY

Survey of data quality and availability

In March 1995 the Institute conducted a survey of the State and Territory health authorities that aimed to evaluate the likely availability and quality of data for this report given the current collection parameters (definitions, scope and timetable). The survey took the form of a structured questionnaire addressing each indicator and included a discussion of some of the outstanding definitional and collection issues.

Based on the information compiled from the survey it was evident that much work was required to achieve valid comparative hospital performance measures. The Working Group decided that only a small subset of the agreed indicators be used for comparison purposes, and that the indicators be accompanied by a number of qualifying statements.

Though data on other indicators are available, they are either not available for all jurisdictions or not of sufficiently high quality to use for national comparisons. Where appropriate, these data are used to illustrate the type of reporting possible, or the type of developmental work required to bring the indicator into the arena of national reporting. A discussion of a possible development program is contained in the last section of this report.

Data quality in general

Data quality is usually higher where data are collected according to nationally agreed definitions. Such definitions are published by the Institute in the *National*

Health Data Dictionary (NHDD) and cover data items for some of the indicators (see specific indicators in Chapter 3). The Dictionary has been declared by the Australian Health Ministers' Advisory Council as the authoritative source of health data definitions for Australia.

Even where national definitions exist and are used by the health authorities, they may be inconsistently applied. This inconsistency is difficult to control and correct for, and may affect—to a minor degree—the comparability of indicators constructed from the data.

Data quality is generally seen to improve over time when data are collected and published at a national level. One of the positive outcomes of this report may be that data quality improves as data providers seek to enhance the comparability of data collected.

COMPARING HOSPITAL PERFORMANCE

Data quality and comparing hospital performance

It follows from the discussion in the previous section that comparisons are valid only where data quality (at least in terms of consistency) is high. Where data are extracted from disparate sources and collected for purposes other than national comparisons, some caution is required in interpreting the results.

Although great efforts have been made in this report to standardise the data used to construct indicators, some anomalies among and within States and Territories still exist. These anomalies are stated where they occur, as are the techniques used to standardise the data or control for known differences in the practices of service providers.

The nature of performance indicators

Performance indicators are just indicators. They are an attempt to describe a real aspect of the behaviour or performance of a provider, and are useful for generating questions about such behaviour or performance. Indicators are also useful for establishing baseline levels of performance and monitoring changes achieved as part of a quality improvement program.

Indicators do not necessarily reveal how a system is performing with respect to its stated aims, such as maximising the health gain of the population it serves. This sort of evaluation is beyond the scope of currently available data on health outcomes.

The performance of a provider may appear to be short of desired levels because the indicators used fail to account for certain aspects of the patients treated. For example, none of the indicators reported in full in this report takes account of the severity of illness of patients treated.

Indicators must be developed that avoid biases or make appropriate adjustments.

Benchmarking hospital performance

The application of benchmarking processes in the health sector in Australia is very much in its infancy. Benchmarking requires high-quality data

that are consistent among the benchmarking partners.

State and Territory representatives on the NHMBWG believed that the data quality and availability are presently inadequate to set benchmarks and report against those benchmarks. The data collected and presented in this report are nonetheless useful for motivating health authorities to question and investigate the behaviours of the providers that led to the results.

Chapter 4 contains a more comprehensive discussion of the use of benchmarking in the health sector.

STRUCTURE OF THE REPORT

Following this introduction, information is provided in Chapter 2 that helps put the hospital indicators data in context. Chapter 3 reports the hospital performance indicators for which data are available, and addresses the indicators for which data are not presently available. Chapter 4 contains a discussion of the application of benchmarking in the health sector, and the final chapter attempts to outline an agenda for the development of the hospital indicators, and indicators for the broader health sector.