

BEYOND THE BLAME GAME:

Accountability and performance benchmarks for
the next Australian Health Care Agreements

A Report from the National Health and
Hospitals Reform Commission

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The Hon. Nicola Roxon MP
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister

I am pleased to provide you with advice from the National Health and Hospitals Reform Commission on a framework for the next Australian Health Care Agreements – Beyond the blame game: accountability and performance benchmarks for the next Australian Health Care Agreements.

The Commission has been established to ‘develop a long-term health reform plan for a modern Australia’. Consistent with our terms of reference, this advice represents the Commission’s views on key issues to be addressed in the next generation of the Australian Health Care Agreements and focuses on robust and relevant performance indicators and benchmarks.

As part of our early work, the Commission has developed a set of principles to shape the Australian health system, which we suggest should also be embodied in the next Health Care Agreements.

For the purposes of this advice on a framework for the next Health Care Agreements the Commission reflected on how these principles may be put into action in practical terms by highlighting twelve specific areas of significant opportunity for improvement in health and health care. These twelve areas range from Aboriginal and Torres Strait Islander health to education, training and research; from a healthy start to life to improved end of life care. For each of these areas, the Commission proposes performance indicators and benchmarks to strengthen accountability in the next Health Care Agreements.

We appreciated the opportunity to collaborate with the Australian Institute of Health and Welfare in developing these performance indicators and benchmarks.

There is more to the reform of the health care system than can be encompassed in the next Health Care Agreements, even with their scope broadened. We look forward to harnessing the views and ideas of the broader health sector and the community in our forthcoming consultation and engagement process, as we develop a longer term plan for reform of Australia’s health system.

Yours sincerely



Dr Christine Bennett
Chair

30 April 2008

National Health and Hospitals Reform Commission
MDP 101, PO Box 685 Woden ACT 2606

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EXECUTIVE SUMMARY

The National Health and Hospitals Reform Commission ('the Commission') believes that to overcome 'the blame game' traditionally associated with the Australian Health Care Agreements (AHCAs) and to improve patient care, the next generation of AHCAs must be different. Going beyond 'the blame game' requires a new policy framework, with changes to the three key elements: scope, funding approach and accountability. Other policy processes occurring in parallel with the Commission indicate that this need is understood. This report focuses on the third element—accountability—in keeping with our terms of reference to advise now on robust performance benchmarks across a range of areas (see Appendix A). Benchmarks lack practical force unless someone (in practice, either the Commonwealth or the state* government) is accountable for performance against the benchmark.

We have assumed that the scope of the next generation AHCAs will be broader than hospitals. Our proposals on accountabilities also set a framework for a new funding approach, including incentive arrangements and financial consequences for performance against the benchmarks.

We have suggested an assignment of these accountabilities: states accountable for public hospitals, mental health, maternal and child health and public health, with the Commonwealth accountable for primary care (here we mean all other aspects of care in the community, primary medical care and community health care), prevention, aged care and indigenous health. We will be looking to feedback on this approach over the next months of consultation and further consideration in the lead up to our subsequent reports.

* Throughout this report, state is taken to mean state and territory.

This assignment of responsibilities does not necessarily imply an immediate transfer of functions: states will continue to have an important role in service delivery in areas where we have suggested the Commonwealth exercise greater policy leadership with corresponding accountability.

As a first step in our work, we developed a set of principles or expectations of the health system (see Appendix B) to underpin our thinking about health reform and system design. We are currently seeking comment and input to these proposed principles as part of a broad consultation and engagement process. These principles should shape the design of the entire Australian health and aged care system—public and private, hospital and community-based—and be evident in how the system functions for patients and their carers, and should therefore be incorporated in the next set of AHCAs.

We have also identified twelve health and health care challenges where the need for improvement is well understood and extensively documented. These challenges have been used as an organising framework for improved accountability for the next AHCAs. We drew on the work of the Australian Institute of Health and Welfare to identify one or more performance indicators for each challenge and corresponding benchmarks, although some further work is required.

The proposed accountability framework comprises 44 benchmarks where performance against a target should have a clear and usually financial consequence. We were guided by several criteria in developing this set. The most significant of these criteria in terms of transforming the AHCAs are: the need to move towards a single level of accountability for the effective use of benchmarks; the importance of reciprocal accountabilities and benchmarks on all governments; and the need for benchmarks to be set at levels that encourage real improvement.



INTRODUCTION

The National Health and Hospitals Reform Commission has been established by government to “develop a long-term health reform plan for a modern Australia”. The Commission’s Terms of Reference were released by the Council of Australian Governments and are provided in Appendix A, together with information on the membership of the Commission.

The Commission’s Terms of Reference identify that the first task is to provide advice “on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care”. The AHCAs are but one part of our health system, however their renegotiation is a critical opportunity for change. This, our first, report presents the Commission’s views and advice on key issues relevant to shaping the next generation of the AHCAs, recognising that our views will themselves be shaped over the next months of consultation and further consideration in the lead up to our subsequent reports.

Notwithstanding the focus of this report on the AHCAs, the health care system is about much more than the AHCAs. Our subsequent reports will address our task of fundamental redesign of our health system arrangements. The Commission embraces the need “to go boldly” in creating a vision for the health system of the future, a vision that is achievable and measurable with defined short, medium and long-term actions to drive real improvements in health outcomes and the health care experience of all Australians.

We welcome the input and advice of Australians from all walks of life over the next months in helping us to shape this vision. We are actively seeking to harness and build on excellent thinking, successful innovations and the views of health care

leaders, front-line health professionals and the community on broad reforms to the health system, to inform our subsequent work and later reports.

In this report, we begin by presenting our views on the expectations Australians legitimately have of the health care system (see Section 2). We have developed a set of principles that we believe should shape reform and future directions of the whole health system, as well as being included and used as the basis for the next AHCA.

In the light of the principles we developed, we then identify twelve major health and health care challenges (see Section 3). We were not constrained in this process by only addressing those challenges that might be remedied by revising the AHCA. The AHCA is but one instrument for driving the way the health system works, albeit an important one. What we needed to do was to step back and think about how the whole health system works and what needed to be changed to make it more person-centred and equitable, for example.

In Section 4, we outline our views on accountabilities and performance benchmarks for the health system. Our organising frame here was the list of challenges we had identified: that if the AHCA is to result in an improved health system, we should be able to see that in terms of improved performance against the benchmarks we have identified.

Our starting premise is that clear accountabilities for delivering on improved performance of the health care system are one important mechanism to tackle the health “blame game”. We have identified a set of performance benchmarks (some existing and some yet to be developed) that can be used to track our progress in achieving changes that address the critical challenges facing our health and health care system. These performance benchmarks would expand the scope of the AHCA beyond public hospitals to all health services and identify the shared responsibility of all governments to work in partnership to improve how the Australian health system works.

WHAT DO WE WANT FROM OUR HEALTH CARE SYSTEM?

The Australian health and aged care system has multiple functions. For most Australians, what they want from the system is that it will be there when they need it—from antenatal care and birthing through life to death. Australians expect when someone suffers an emergency, an ambulance will arrive quickly, they will be dealt with speedily on arrival at the hospital and they will get good care and rehabilitation if required. Australians also expect that when someone requires surgery for a condition that is not an emergency, they will be able to get access to a hospital in a timely way. Access to a broad range of primary health services (such as general practitioners, district nursing, allied health services and community mental health services) in the community is another vitally important underpinning and expectation of our health system. For people in poor health with chronic or debilitating conditions, the important expectation is that their condition will be managed effectively, with care provided as close to home as possible, so that they can have normal family, social and working lives. Another expectation is that when they or their loved ones can no longer manage at home, they are able to get support at home or, if necessary, can move into a supported environment. Similarly, when people are dying they expect to receive care and support that maintains their dignity and treats them with respect.

However, health is not “merely the absence of disease”: the health and aged care system has an important function in protecting and promoting health. This ranges from providing services to individuals and groups to broader, whole of population interventions. These health promotion and protection functions include support to people to stop smoking, through prompting by health promotion advertising or primary care encounters, access to groups to reinforce individual decisions, as well as changing behaviour about smoking in public places through legislation. Other examples include early detection services so that disease can be picked up and treated early (breast screening is one example) and organised prevention activities such as immunisation.

At a whole of population level, these public health services also include ensuring a clean water supply and other environmental health initiatives. The health system as a whole is important to our identity as Australians: universal access to health care is an investment in the future productivity and longevity of our fellow citizens and helps to strengthen social solidarity.

The health care system exists in a dynamic environment. This means it has an important role in incorporating new learning and knowledge into current practice. To keep Australia at the cutting edge of health service delivery, the health system must absorb, implement and create new knowledge through clinical, public health and health services research, and evaluate and apply knowledge developed elsewhere through health services research. Leading scientists and clinicians also create new knowledge and technologies through research that must, when proven and appropriate, be incorporated into practice for the health benefit of Australians, while also contributing to our position in a growing global knowledge economy.

Another aspect of the dynamic nature of the health care system is that it needs to ensure that there is an adequate supply of health professionals for the future. The whole health care system has an important role in clinical training, education of undergraduate students and training and research opportunities for post-graduate students embarking on professional specialisations.

Finally the health care system employs about 7% of Australians and this employment role cannot be ignored. Recruiting to, and retaining within, the health system will be vital to capturing the talent and realising the investment made in training of all health professional groups. The health system also provides market opportunities for small, medium and large businesses to supply goods and services, thus contributing to our broader economy.

2.1 Proposed principles for the health care system

Australians and their governments generally share a number of aspirations about how the health care system ought to work in this country, although their precise formulation varies over time. The Commission has developed a set of principles to underpin the design of Australia's future health system in two functional categories: service design principles (generally what we as citizens and potential patients want from the system) and governance principles (generally how the health system should work).

The Commission's recommended service design principles are: people and family centred; equity; shared responsibility; strengthening prevention and wellness; value for money; providing for future generations; recognising broader environmental influences that shape our health; and comprehensive. Our governance principles are: taking the long term view; safety and quality; transparency and accountability; public voice; a respectful and ethical system; responsible spending on health, and a culture of reflective improvement and innovation.

The principles have been previously published on the Commission's website (www.nhhrc.org.au) and are described more fully in Appendix B.

These principles should shape the whole health system, public and private, hospital and community based services. These principles also form part of the framework that should be included in, and shape the negotiation of, the next AHCA's.

TWELVE HEALTH AND HEALTH CARE CHALLENGES TODAY

For most people, the Australian health care system works well: the quality of the health workforce is good and care is available when you need it. But that is not the experience of all and some people find it difficult to access the care they need (for example, people with mental illness, people who are socially marginalised, and people living in rural, remote and outer metropolitan areas).

Taking the long-term view, we also know that there are significant changes impacting on the health of Australians, particularly the ageing of the population and the emergence of the 'epidemic of chronic disease'. These are substantial challenges that already place pressure on the current organisation and funding of Australia's health system.

Considering our task to advise on a framework for the next AHCA's, the Commission commenced its deliberations by addressing this question:

What changes and investments do we need to make to:

- 1) Enhance health promotion and wellness and**
- 2) Make the health care system work better for those who need it?**

From this we identified twelve critical challenges where the need for improvement is well understood and extensively documented. Of course, these are not the only challenges! We expect that as part of our consultation and engagement strategy to hear many views, both on what needs to change and, even more importantly, ideas and examples of and opportunities for innovative solutions to tackle these challenges.

An overarching issue for all these challenges is achieving better health and a better health care system in a financially sustainable manner. In addition to population ageing and the increasing burden of chronic disease, advancing medical technology and

higher consumer expectations of what the health system should be able to deliver create real pressures on our health system. Financial sustainability is embedded in many of the principles that we have developed for future reform, including the need to emphasise prevention and to ensure value for money and responsible spending in how we organise and finance health services.

An important element of financial sustainability has to involve increasing community awareness about how much we spend on health services. With ever-growing demands on health services, there have been projections that state budgets could be totally devoted to health spending, with no spending on schools, roads or other important areas. This is clearly neither sustainable nor realistic. There needs to be better community awareness that health services, like water, are precious resources that we need to use wisely. Some of this will involve taking greater personal responsibility for our own health, while at a system level there needs to be a much stronger focus on prevention, an expanded role for community and primary health services, and a more balanced allocation of resources within the health system.

The twelve health and health care challenges highlighted are:

1. *Closing the gap in Indigenous health status*

An Aboriginal or Torres Strait Islander child born today can expect to live 17 years fewer than a non-Indigenous child. At most ages, the Indigenous population has an age-standardised death rate at least twice the non-Indigenous population, with an Indigenous male aged 35 to 44 almost five times more likely to die than a non-Indigenous male of the same age. The chance of an Aboriginal or Torres Strait Islander male reaching the age of 65 is 25% and 35% for a female, compared to over 80% for other Australians. The same trends are reflected in differences in self-reported health status, recent illnesses, and long-term conditions. Although infant mortality rates per 1000 live births for Aboriginal populations are declining, they are still three times greater than for non-Aboriginal Australians. Birth weights for Aboriginal infants are considerably lower than for non-Aboriginal infants. Aboriginal people have much higher rates of infectious disease and other conditions reflecting poorer physical environments than non-Aboriginal people, and higher rates of substance abuse and many chronic conditions (the latter occurring at earlier ages than in non-Aboriginal people). The outcomes of care are also poorer for Indigenous Australians: non-Indigenous cancer patients survive longer than Indigenous patients and access to interventions such as cardiac catheterisation is lower for Indigenous people.

The causes of these differences are complex and go beyond the health care system. But the health care system has a lead role in working with other service delivery sectors and with Indigenous communities to improve the health of Indigenous Australians. There are proven interventions that work: improving maternal and child health, reducing the incidence and impact of chronic disease and culturally responsive drug and rehabilitation programs.

2. *Investing in prevention*

Prevention has to be core to our health care system. We know that many chronic diseases are preventable and they share common risk factors. Action to improve life chances and choices will improve health status, reduce health inequalities and reduce people's need for health care. People can reach retirement age in better health and delay health interventions further. This requires policy to give at least the same priority to long term gains as accorded the urgent and immediate. Of course, the health system and health professionals cannot be held wholly responsible for our health—it is a shared responsibility and individuals contribute to their own health through the choices they make. We also need to build partnerships across other sectors (including education, housing, transport, workplaces and local government).

3. *Ensuring a healthy start*

People's chances of a long, healthy life are affected even before they are born. The prenatal and early years of life are the foundations of health and development, significantly impacting on a person's physical and mental health throughout their life. For example, babies with low birth weight have an increased lifetime risk of cardiovascular disease and diabetes; and young children subjected to child abuse or neglect face a lifetime of greater risk of mental health problems as well as physical illnesses (such as cardiovascular disease, obesity and diabetes). Investment in this life stage is paramount and provides exceptional value. Access to good health care, particularly primary health care, and community support services for pregnant women, children and parents can help ensure a healthy start to life, as well as provide early identification, diagnosis and appropriate intervention when problems emerge. However, as with many other parts of the health care system, fragmented responsibilities between Commonwealth and state governments and poor communication and sharing of information between hospital maternity care and primary and community care hinders effective provision of services. In many areas, there are also problems with timely access to intervention services to assist children with a disability or developmental delay.

4. *Redesigning care for those with chronic and complex conditions*

People with chronic and complex conditions need access to comprehensive care from medical practitioners, nurses, allied health, social and community support, and often, aged care services. The multiplicity of programs, Commonwealth, state and local government, are complex to navigate and have tight eligibility rules that create program silos with gaps between them. As a result, the health system often fails when patients and their families need it most. The health system does not function effectively when responding to people with multiple health needs that may be provided in different settings and by different health professionals, and where there is a requirement for continuity over time. Care for people with rehabilitation

and personal support needs is a particular gap. With many different programs and services with different rules and funded in different ways, there is little ability for service continuity, responsiveness in planning and implementing local models of integrated care, or use of new communication technologies that are focused on the needs of people in their local communities. There is an opportunity to implement and share successful working models where excellence in the care of people with chronic and complex conditions has been demonstrated, moving beyond trials to introduce best practice and knowledge more broadly.

5. *Recognising the health needs of the whole person*

Medicare was designed in the 1960s, 40 years ago. It focussed on access to doctors and hospitals for once-off acute episodes. But health needs are broader than that; they relate to the physical, mental, emotional and social wellbeing of the individual. Patterns of illness have changed and new approaches to care and treatment have developed, involving a broader range of health professionals often working together in multidisciplinary teams to provide care across different settings that meet the ongoing health needs of individuals. Universal and affordable access to medical care must remain at the heart of Medicare, but the system needs to respond to these and other new developments in health care

Key gaps in access exist today, for example, support for mental health care and dental care. The needs of people with mental health conditions are often poorly met. Problems include variable investment in community-based mental health services (resulting in a reliance on acute hospitals which, in turn, are under great pressure) and MBS rebates that do not adequately address those with serious mental illness and those living in areas where mental health nurses, psychologists and social workers are scarce. In the case of dental care, there is clearly inequitable access, with some people relying on public dental programs of varying coverage. Mental health and oral health care needs should not be treated as separate to the needs of the whole person. Our programs and funding come in neat, well-defined categories, but people's needs do not.

Mental health and oral health are just two examples of how Medicare does not focus on the total person. Another example includes the lack of support for allied health and counselling services to help people better manage risks (smoking cessation, dietary advice, support with exercise). Many Australians also use complementary medicine services as a form of self-management—these services are not evaluated and there are often no linkages with traditional medicine that can impact on the effectiveness of all care provided. Health funding focuses on the acute needs of people in hospitals, while changing health needs mean that many people need greater support while living in the community and for support in promoting good health. Hence, acute requirements such as hip replacements may be provided, but physiotherapy, dressings and walking aids or home modifications receive more limited support through our health system.

6. *Ensuring timely hospital access*

Possibly the most visible challenge relates to long waiting times for elective surgery in public hospitals. There is continued growth in demand for public hospital care, which is expressed as both emergency demand (trauma, medical conditions such as heart attacks and stroke, and the needs of frail elderly people) and demand for elective surgery. In hospitals, as in other walks of life, the urgent takes priority and elective surgery is often squeezed out, so people wait longer than clinically desirable.

Long waiting times for elective surgery are a symptom of an underlying problem of capacity in public hospitals. The current internal organisation of hospitals, with multiple mini-queues as patients pass from one department to another, creates inefficiencies and waste. In the longer term, preventive strategies and a reformed chronic disease management system with improved management of care and information across the many interfaces of care will reduce demand on public hospitals and allow better access to elective surgery. As well, addressing elective access requires changing the way hospitals work (streaming elective from emergency care) and ensuring public hospitals have adequate capacity for the demands placed upon them. Addressing waiting lists requires action in all parts of the health system.

7. *Caring for and respecting the needs of people at the end of life*

As the population ages, so the death rate grows. Over the last few decades, we have increasingly recognised the distinct needs of people at the end of life. Palliative care programs have emerged, often focussed on people with cancer or HIV/AIDS. Hospitals are getting better at listening to people regarding their decisions about care at the end of their lives, although the lack of clarity around advanced care directives remains an issue. Yet still, often interventions are made that deny a person's right to die with dignity, and currently we provide only limited options for support for those dying at home. This is an area where the principle of people and family centred care is particularly important, including through providing care at or closer to home for people who want this option, and a preference for less institutional settings with the option to go to more formal care if there are difficulties coping at home.

8. *Promoting improved safety and quality of health care*

Despite the best efforts of well-intentioned health professionals and implementation of sound policies and protocols, things go wrong in health care settings both in and out of hospital. Between 15-20% of hospital overnight episodes have an adverse event. Adverse drug events, medication management errors and falls are a significant problem across the health continuum, and are particularly relevant to older patients with complex health problems on multiple medications. These examples highlight the need and opportunity for improvements in the safety and quality of health care.

Adverse events and mistakes could cost the health system \$2 billion per annum. Improvements need to tackle systemic, communication and information management issues including better patient identification, handover and decision support.

9. Improving distribution and equitable access to services

We have identified above a number of weaknesses of the health system that apply to city and country alike. But Australia's geography creates other challenges: ensuring an appropriate mix of health and aged care services in regional, rural and remote locations, the workforce to staff them, the support for remote staff, and programs to assist people who need to travel for care. Access for these communities is facilitated with good retrieval services, support with accommodation close to treating facilities and help with transport for visiting family members.

Location can also be an issue within metropolitan areas with the workforce unevenly distributed and with significantly better access to health care in wealthier than poorer areas, while health needs are distributed the other way (the so called 'inverse care law'). For Indigenous Australians, these location issues amplify their disadvantage in terms of access to care and health.

10. Ensuring access on the basis of need, not ability to pay

The three universal programs (Medical Benefits Scheme, the Pharmaceutical Benefits Scheme and access to public hospitals) provide a critical equitable underpinning for health care in Australia. Families are further protected against out of pocket costs by the Pharmaceutical Benefits Scheme and Medicare safety nets. But there are still financial barriers to access, with many people facing sizable co-payments and limited government support for some key elements of the service system including allied health and community nursing services, dental care, and aids and equipment.

11. Improving and connecting information to support high quality care

The way health knowledge and information are created, stored, shared and accessed across health services significantly impacts not just on the efficiency of the health system, but also on the quality and safety of patient care. 'Connected health' allows health knowledge and patient information to move with the patient across the different parts of the health care system, improving patient care, helping people navigate their way through the system, supporting doctors in their decision-making, and improving productivity and efficiency.

To achieve this, information about a person's health and how to optimise it needs to be readily available from reputable and respected sources in multiple and accessible formats, while appropriately managing privacy, security and confidentiality.

Currently, health information networks have been built by different public and private providers and are usually based on inconsistent and incompatible designs, which do not allow for interconnectivity. It is imperative to implement a robust and standards-compliant information management system that enables individuals to authorise access to their vital health details across all health care environments including hospitals, GPs and other health professionals, where they choose to do so, in an agreed privacy regime.

12. *Ensuring enough, well-trained health professionals and promoting research*

Responsibility for the education and training of the health workforce is shared between the Commonwealth (which has responsibility for universities) and states, medical specialty colleges and other professional bodies, in hospitals and community settings. There are critical shortages of many health professionals, often exacerbated by skewed distribution of services and providers, poor morale and retention and rigid adherence to narrow professional roles. Recent initiatives to redress some of these problems involving general practice nurses, remote area nurses, specialist nurse practitioners and allied health professionals within multi-disciplinary care teams are still in their early stages of roll out.

Research, education and training are sometimes seen as an afterthought by health services, which are focused on service delivery. Clinicians who have clinics and operating lists cancelled at short notice are denied their responsibility to teach. Trainees are expected to provide service while the commitment to their own training and that of students can be ignored in the interest of service provision. Trainees still work unhealthy hours, adversely affecting their ability to learn. Access to training opportunities, especially surgical, is also impacted in those specialties where a majority of work is undertaken in the private system (particularly orthopaedics, ear, nose and throat surgery and ophthalmology) and also in general practice due to time and workforce constraints. Schools of nursing and allied health professions are constrained in their ability to expand to meet workforce needs because of the difficulty of finding appropriate clinical placements. When placements are found, they may be withdrawn at short notice because of changed service needs.

Inadequate access to protected time for research, teaching and training, and the supervisors to provide this, is short-sighted and must be remedied. Linking innovative clinical research to new models of service delivery has to be a crucial element of a vibrant and evolving Australian health care system. This is a key role for all health professional disciplines and is at the heart of a learning and improvement culture.

Training institutions such as universities are limited in their ability to offer comprehensive and adequate training for students because of difficulty in obtaining sufficient suitable clinical placements. Primary care also suffers from a lack of teaching infrastructure, yet is expected to be the new teaching domain.

Responding to the challenges

Importantly, this listing of challenges includes many areas not traditionally seen as within the scope of the AHCAs. Important as they are, the AHCAs are simply a funding mechanism, and constraining our thinking to operate within those boundaries may be antithetical to a person-centred health system. Addressing the challenges needs concerted action by Commonwealth and state governments, involving the public and private sectors, hospital and community services, and crossing traditional funding boundaries (such as the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme). Although the AHCAs haven't had that scope in the past, health system reform needs to harness all the potential levers.

This listing of challenges is not meant to be exhaustive and we expect to have other issues identified through our consultation and engagement process. The point of identifying these issues is to focus our minds on how the health system might need to change to create a 'person-centred' system, as articulated in our draft principles.

Although additional or shifting investments will be required to meet some of these challenges, we also need to think differently and create different structures, policies and priorities that allow us to provide care smarter. Mindful of our principle of 'value for money', we have to be cognisant of the fact that resources (money, staff, buildings and other infrastructure) are limited and just asking for more resources is not consistent with creating a sustainable system.

It is not our intention to structure our future deliberations solely around these challenges. While the development of a long-term health reform plan must tackle these challenges, it must also move beyond the challenges of today and take a visionary approach in identifying what the health system should look like over the next twenty years.

The identification of our principles and challenges serves to highlight the directions for reform in which the health system should be moving. We do this so we can have a context within which the AHCAs can be situated: we do not want to provide advice that reinforces the separation of hospital issues from the system within which hospitals are embedded, and the other services to which hospitals must relate. Accordingly, our principles and challenges provide the 'framework' that should be used to guide discussions and negotiation of the next Australian Health Care Agreements. In negotiating the shape of the next AHCAs, government officials should ask in relation to each element:

- Is this proposal consistent with the proposed design and governance principles to shape reform of our future health system?
- Will this proposal drive improvements that address the critical challenges facing our health and health care system?

We have used these challenges to shape our selection of performance benchmarks on the premise that these areas are critical ones in which to see improvement early in the next AHCAs over the next few years.

ACCOUNTABILITY AND PERFORMANCE BENCHMARKS

4.1 Purpose of the AHCAs

Our main task in this initial advice is the development of performance benchmarks for the AHCAs. Historically, the AHCAs have been about implementation of the Commonwealth policy of free public treatment in hospitals. To some extent the Agreements could be characterised as a 'purchasing' agreement where the Commonwealth's financial contribution is purchasing from the states the policy goal of free hospital treatment for public patients. This would imply that there should be accountability by the states to the Commonwealth for providing this free public treatment.

Another characterisation is that states are sovereign entities and that the AHCAs are financial support to sovereign state governments to implement their health policies.

How the AHCAs are viewed has a consequence for how accountability might be framed. If, on the other hand, the agreement is cast as a purchasing agreement, it is logical for the agreement to specify a level of funding that the Commonwealth will pay, related to the specific services that it will purchase or support. If, on the other hand, the funding is characterised as supporting sovereign states to implement a range of services/policies, then the accountability should essentially be through the ballot box at state elections.

The reality has been that the AHCAs have elements of both purchasing and broad support, and so accountabilities have been confused to the benefit of both Commonwealth and state governments. The current Agreements contain very loosely defined policy requirements (such as 'access within a clinically appropriate period'), so it is very unclear what level and type of public hospital services are being 'purchased' by the Commonwealth. In addition, the AHCAs have been largely silent on the wider health system in which public hospital services are delivered, including other major

health and aged care programs. Lack of clarity of accountability and definition of responsibilities creates the environment for a blame game, as each government is able to blame the other for shortcomings attributed to each other's programs. The losers are the public who wait longer for care or don't have their service needs met.

The new AHCA should change this. As a people, Australians need to be clear about what we want to achieve, who is accountable for what services, and what will happen if these agreed expectations are not met. It is important to stress here that these accountabilities should apply to both the Commonwealth and the states, and, where appropriate, to the non-government sector, including the private sector. Disentangling the contemporary complex matrix of responsibilities between governments requires either assumption of full responsibility and accountability for specific aspects of service delivery by one government (either Commonwealth or state), or clarification of precisely how each government's support for joint programs will work or a mixture of both strategies.

4.2 Towards clearer accountability by governments for health services

The Commission believes that the next AHCA should be about the Commonwealth and states jointly sharing responsibility for the health system. Importantly, however, this would occur within a framework where the roles and extent of this responsibility will be clearly specified so there can be clear political (and bureaucratic) accountability for meeting the public's expectations.

The use of performance benchmarks (where parties are held financially and/or politically accountable against these benchmarks) means that accountability for particular health services must be attributed to either the Commonwealth or state governments, but *not both governments*. There cannot be financial or political consequences if accountability for non-performance is not able to be attributed.

We recognise the important interdependencies of the health system. Meeting benchmarks by both Commonwealth and state governments will be facilitated if there is greater collaboration and joint planning. Paradoxically, having clear sole accountability and financial consequences for reduced performance will provide a stronger incentive for governments to move beyond blame shifting to tackling problems jointly, with returns in terms of a better health system.

In developing performance benchmarks, we have formed some preliminary views about the level of government that is best placed to improve performance in the delivery of particular elements of the public health system. We must stress that these views are preliminary and may change. We are fully aware that this issue is likely to be the subject of considerable debate during our consultation process. Nor do we want to pre-empt later analysis on roles and responsibilities that will be integral to designing a long-term plan for a person-centred health care system of the future.

Within this context, our benchmarks are based on state governments having clear responsibility and accountability for public hospital services, mental health, public health, and maternal and child health services, and the Commonwealth government having clear responsibility and accountability for aged care and most other health services, including all primary health care services and prevention.

The assignment of accountabilities for performance benchmarks does not mean that we are suggesting that there should be an immediate transfer of functions between governments where they differ from the current situation. The accountable government does not have to be directly involved in service delivery and there are likely to be advantages in retaining mixed provision of services by public, private and non-government agencies. Nor are we suggesting that any financial support for a function should only come from one government: support for public hospitals (or primary care services) could still come from both Commonwealth and states, but the contributions of each would be clearly specified (for example, as a share of funding or the volume of services purchased).

What we are suggesting is that one government should be held accountable by the public for overall service performance in each area. Australians want to move beyond the blame game with each blaming level of government the other for system failings. Patients and the public need to know to whom they can turn for accountability and redress.

Importantly, we are signalling our view about the desirable direction of the Commonwealth taking a more active role in ensuring adequacy of the full range of primary health care services. This would involve moving beyond general practice to allied health, district nursing, community mental health services and community health services, for example. We believe that there needs to be significant investment in primary health care infrastructure, an objective that the Commonwealth Government has partially set out to address through the establishment of GP Super Clinics. State governments have also responded to this challenge through major programs such as GP Plus in South Australia, HealthOne in New South Wales and Primary Care Partnerships in Victoria. But there is no integrated plan for the development, resourcing and networking of state-based primary health services, general practice and other private or non-government primary health services.

The Commonwealth Government is best-placed to take the lead and be accountable for all primary health care services. It is the major funder, including of general practice through the Medical Benefits Schedule, and of allied health and other community-based ancillary services through the private health insurance rebate. Recent policy decisions have also extended the coverage of payments under the Medicare Benefits Scheme (using the Enhanced Primary Care and similar approaches) to cover almost all registered professionals in caring for chronic and complex disease.

Our allocation of accountabilities for other health services is based on factors including:

- the government with existing major responsibility and experience, and/or
- the need for identified national leadership.

Using the first criterion, we have assumed for the purpose of performance benchmarks that state governments will be accountable for public hospitals, mental health, maternal and child health services, and public health services, while the Commonwealth Government will be accountable for aged care. We have assigned responsibility and accountability to the Commonwealth Government for prevention and Indigenous health on the basis of the need for national leadership in these areas.

We acknowledge that this approach of assigning responsibilities and accountabilities to the Commonwealth or state governments will not be supported by some groups who would prefer to see an immediate recommendation for a single government to be accountable for all health services. The Commission believes that it would be premature to make such a recommendation so early in its work, without the benefit of broad consultation and feedback from across the entire Australian community. Once again, our proposals on assigning accountabilities for health services are made in the environment of being asked to provide advice on benchmarks for the next AHCA.

4.3 Context for the Commission's work on performance benchmarks

The Commission is one of several bodies involved in advising or influencing the next AHCA. Since December 2007, decisions taken, and actions foreshadowed, by several other groups will have a profound influence on the environment in which performance benchmarks for the AHCA will be operating.

While the AHCA may be a 'renovator's opportunity', they are not a blank slate and we have been cognisant of this in developing our advice on performance benchmarks. In particular, we note the following substantial commitments and their implications for our work of setting performance benchmarks:

- COAG has agreed to consolidate specific purpose payments with the creation of a single national agreement on health, covering Commonwealth health payments to the states. This is likely to result in broad banding into the AHCA of a number of other health agreements such as the Public Health Outcome Funding Agreements (PHOFAs). Performance benchmarks in the next generation of AHCA therefore need to move beyond the narrow focus on public hospitals to cover a much broader scope of health services and health experience, both in and out of hospitals.
- Heads of Treasury are working on National Partnership arrangements that will contain incentives for reform and a set of matching milestones and benchmarks. The implication is that performance benchmarks will need to evolve over time to match agreed reform priorities.
- Health Ministers have agreed on the need for "reciprocal public performance reporting", meaning that there will be a comprehensive set of performance measures across the entire health system covering hospitals, GPs and other health services. The implication is that performance benchmarks will need to

extend beyond the services that are *funded through* the new AHCA (such as public hospitals and public health) to other services (such as primary care and Indigenous health) that are *funded outside* the AHCA by Commonwealth and state governments, either individually or jointly.

- Finally, Health Ministers commissioned the Australian Institute of Health and Welfare (AIHW) to provide advice and guidance about developing robust Indicators for the next AHCA. The Institute is consulting broadly on this task and is expected to provide its final suite of proposed indicators to Health Ministers by the end of June 2008. We have been working closely with the Institute to ensure that our parallel work on performance benchmarks and indicators is aligned.

Within this busy space, the Commission has sought to identify where we can add value to shaping the performance expectations of our health services for inclusion in the next AHCA. We believe our unique contribution is to move beyond the narrow focus of individual governments on existing health programs and services to take a person-centred approach in identifying the reform challenges for our health system. This has meant that instead of focusing on the 'nuts and bolts' or the framework of the existing AHCA, we commenced our work by developing principles to shape the reform of the future health system and by identifying a series of critical challenges that will need to be resolved to enhance health promotion and wellness, and make the health care system work better for those who need it.

We believe that these twelve existing critical challenges should be the organising domains against which performance benchmarks are now developed. These performance benchmarks should evolve to meet new challenges as they emerge. Hence, one of our roles is to contribute to shaping the domains or important dimensions for reform of our health system against which performance benchmarks should be set in order to track improvements in health and health care in Australia.

In addition to identifying the reform domains for the development of performance benchmarks, we have:

- Produced a set of guiding criteria that explicitly identify our approach to the development of performance benchmarks (section 4.4), and
- Developed a preliminary set of performance benchmarks to feed into the intergovernmental discussions on the next AHCA (section 4.5).

An issue we have not addressed is the resourcing necessary to meet these benchmarks. We have deliberately not set out to specify how much funding should be incorporated in the AHCA, as this is a political issue. However, the Commonwealth's declining share of public hospital funding does have real implications for the level at which performance benchmarks can be reasonably set, and it will be necessary to ensure that states have the necessary recurrent service provision—adequately funded by both the state and Commonwealth governments—to meet these benchmarks.

Similarly growth of primary care services, complex care and aged care based in the community will require an increasing investment to ensure a balance of care across settings, to avoid unnecessary hospitalisations and strengthen 'person-centred' care at home or in the local community. An allocation of resources to prevention and wellness activities is also likely to be required.

4.4 Guiding criteria for the development and use of performance benchmarks

The following criteria have shaped how we went about developing performance benchmarks and should also, we argue, influence how these benchmarks are used.

These criteria relate primarily to the development of performance benchmarks for governments, as we have been asked to provide advice on benchmarks for the AHCA's. However, we believe that comparable performance benchmarks and indicators should be applied to health services provided in the private health sector, where relevant. For example, we believe that most Australians would expect that both public and private hospitals should be held equally accountable for improving the quality and safety of their health care services. We also believe that, within this framework of accountability by governments, accountability for performance should 'cascade' down to individual health service agencies and providers.

The criteria that we developed on setting and using performance benchmarks are as follows:

1. *Clear distinction between performance indicators, targets and performance benchmarks*

In this report, we have distinguished between three types of measures:

- *Performance indicators* that measure an attribute of the health care system (for example, we may want to use indicators to 'track' changes in health status even if there are not identified targets or clear accountabilities for this measure);
- Some performance indicators will have associated *targets* that can be used to measure performance or set quality improvement goals;
- *Benchmarks* are a subset of these targets, where performance against the target will have a clear consequence (usually financial) in terms of accountability.

To illustrate this distinction, the current Australian Health Care Agreements have many performance indicators (such as the share of public hospitals that are accredited or the cost per casemix adjusted separation in public hospitals). But the Agreement is essentially silent on the targets, or expected standards of performance against these indicators. For some of the performance indicators in the AHCA's, it is not even clear whether an increase or decrease in the indicator constitutes improved performance! Using the example of cost per casemix adjusted separation in public hospitals, should

all states be required to reduce their costs to the level of South Australia (about \$3,300 for each treated public hospital patient)? Or, are higher costs such as in New South Wales at over \$3800 for each public hospital patient better? In the absence of targets for the indicators in the current AHCA, there are also no financial consequences associated with not achieving benchmark levels of performance.

While not every indicator can have an associated target or benchmark (where there are consequences of not meeting the benchmark), the Commission believes that there is a clear commitment by all governments to introduce better accountability through greater use of targets and benchmarks across the whole health system, not just public hospitals.

In this report, our main focus has been on identifying performance benchmarks that can be used to promote enhanced accountability by governments for health services. We recognise that these performance benchmarks will be underpinned by a more comprehensive set of performance indicators that cover a wider range of services and issues. Hence, our work on performance benchmarks will be complemented by the broader range of indicators being developed by the Australian Institute of Health and Welfare for Health Ministers by June 2008. There will also be a continuing need for indicators to track performance in depth on particular issues such as efforts in implementing preventive health care, mental health and Indigenous health.

2. Reciprocal accountabilities and benchmarks on all governments

Consistent with Health Ministers' decision of 29 February, we have developed benchmarks that involve a level of reciprocity in that they include indicators which measure performance of state public hospital services as well as performance for services for which the Commonwealth has principal funding responsibility. This differs from the current AHCA where accountabilities fall only on state governments, with no mutual obligations or responsibilities on the Commonwealth government for the health services it directly funds.

But reciprocal accountabilities impose particular challenges in the context of an Agreement that is principally about the flow of funds from the Commonwealth to the states. Design of financial incentives on the Commonwealth (or accountability consequences for weaker performance) becomes particularly complex in this situation. It may be that consequences are best achieved by the Commonwealth becoming responsible in full for costs, or it may provide additional payments to the states linked to its weaker performance. So, for example, considering the benchmark we have developed relating to primary care type patients in emergency departments (see Section 4.5), there might be two alternative approaches to building in consequences for reduced performance:

- If the Commonwealth were responsible for making a per visit payment for all primary care type patients, the financial consequences for weaker performance would be automatic as the Commonwealth bears the risk. This would provide an immediate incentive for the Commonwealth to improve access to primary health care services in the community.

- Alternatively, the AHCAs could be structured so the Commonwealth makes additional payments to those states if a benchmark is set to reduce the level of primary care type patients, and this benchmark is not achieved by the Commonwealth. This recognises that some primary care type patients will continue to receive care in emergency departments for a variety of reasons. Payment could be for emergency department visits above the benchmark.

The structuring of the accountability consequences for reduced performance against the benchmarks should be a key agenda item for the negotiation of the next generation of AHCAs.

More generally, there are many ways in which accountability consequences can be structured, the most obvious being financial consequences such as incentives, bonuses or penalties. In turn, there are a number of ways in which incentives could be structured. We have not recommended the precise design of how financial incentives might be structured for each benchmark, as this in part depends on how the underlying funding relationship is structured. However, we are clear that the next generation of AHCAs must move well beyond the current situation of indicators that are ‘toothless tigers’—lacking genuine accountability, with many not being publicly reported and no consequences (financial or otherwise) for poor performance.

3. Indicators that are ‘fit for purpose’ and suit the audience

Our advice is mainly focused on the development of performance benchmarks for a subset of the indicators identified by the Australian Institute of Health and Welfare for potential incorporation in the next AHCAs. However, this benchmark development is based on some important pre-conditions about how the underlying indicators are selected and used. First, we believe that indicators must meet the criteria set by groups such as the National Health Performance Committee and the Productivity Commission in defining robust indicators. In brief, this means that indicators must be: measurable, including for diverse populations, relevant to policy and practice; able to be understood by people who need to act; feasible to collect and report; and reflect results of actions when measured over time.

Next, it is important to acknowledge that different indicators can serve different audiences and different purposes. One important distinction is the use of indicators for performance accountability (with associated targets and financial bonuses or penalties) and indicators used for quality improvement purposes. For many quality improvement indicators, the focus is on increasing reporting (for example, it is usually acknowledged that higher levels of complaints partially reflect more awareness of the ability to complain) and using the indicator to promote internal change management. Attaching performance benchmarks to some quality improvement indicators can have perverse incentives (such as under-reporting of complaints).

4. Access to regular public reporting on performance of health services and health status

The Commission believes that following negotiation and agreement on the final set of indicators, targets and performance benchmarks for inclusion in the next AHCA, an important consequence should be regular reporting by all governments to the Australian community. The current situation is that most of the reporting focus now is on public hospitals, with very little information available to consumers and patients about waiting times or the quality of care for other parts of the health system. This must change.

Responsibility for reporting should match the accountabilities for health services and performance benchmarks enshrined in the next AHCA. Under this approach, state governments would be responsible for regular reporting against agreed performance indicators for public hospitals, including at a whole of state level, at a geographic area level, at the level of individual hospitals, and showing outcomes for particular populations for whom the system may not be equitable (particularly Indigenous Australians). The Commonwealth would similarly be responsible for reporting against its accountabilities, including state, local, agency and specific populations. Hence, performance indicators (and potentially some benchmarks) should be able to be disaggregated to show performance for particular populations (Indigenous, rural and remote populations, low socioeconomic status), and in particular facilities (e.g. waiting time performance in particular hospitals) in line with the Commission's principles and benchmarks.

5. Careful selection of a high-value set of performance indicators and benchmarks

Although the AHCA involves transfer of billions of dollars, we should resist the temptation of having a plethora of benchmarks: too many benchmarks will mean each becomes of less importance. We also need to ensure that the health care system does not get "benchmarked out". A multiplicity of indicators will mean that each is less important, and critical indicators will be devalued amongst a ragbag of indicators of lesser importance. Too many indicators increase the 'red tape' for health services, add to the reporting burden, and distract health services from their core business of providing health care services.

6. Value of patient-level data in measuring the patient journey

Our aim has to be to emphasise benchmarks relevant to people and their journey through the health system. This means we have often cast benchmarks differently from the way similar indicators have been defined in the past. An important element of a new approach to indicators is the strong reliance on patient-level data, including linked data, to measure the continuum of a person's health service needs and utilisation patterns over time.

7. *Performance benchmarks and indicators that evolve over time*

Although recognising that there needs to be some stability of benchmarks to give certainty to managers and to allow tracking of performance over time, the AHCA benchmarks should not be enshrined in tablets of stone. Rather, they should evolve over time for two main reasons. First, some critical areas do not have measurable indicators able to be produced across Australian health services at present. As more data development work is done, new indicators and benchmarks can be introduced. Secondly, the health system is dynamic and so what might be a critical performance deficiency in 2008-09 might be resolved in 2010-11, creating room for an old benchmark to be dropped and a new one introduced. This mirrors commitments already made by all governments to add new reform areas through National Partnership Payments and to allow for change to the AHCA's following the Commission's final report on designing a health system for the future.

8. *Benchmarks set at levels to encourage real improvement*

An important issue in setting targets and benchmarks is collecting evidence on what performance improvements can be reasonably expected. When funding is at risk, it is all too common for parties to set benchmarks that are easily achievable rather than 'stretch targets' that constitute genuine improvement. But, of course, this must be balanced by a realistic appreciation of the level of resourcing required to achieve these benchmarks. One approach to setting performance benchmarks is to base them on how well the 'best performers' are doing. In the case of performance benchmarks for public hospital services, this would mean that benchmarks might be set at the level of the best performing state. This would allow competitive federalism (with or without financial incentives) to drive improved performance. Comparisons with performance internationally on similar benchmarks might also be warranted.

4.5 Proposed performance benchmarks

Based on these criteria, the following summary table identifies our proposed performance indicators and benchmarks for the next generation of the AHCA's (see Appendix C for detail). The table is organised around the twelve challenges we identified above. For each challenge, we have identified one or more indicators that should have benchmarks specified. Although some of the indicators could be mapped to several challenges, we have simplified our proposal by showing indicators against only one challenge. As we have argued above, each of the benchmarks should be associated with accountability consequences. For most benchmarks, this should be a financial consequence. The negotiation for the next generation of AHCA's will need to specify the nature of the financial consequence.

Health challenge	Performance benchmark (or tracking indicators) and accountability
1. Closing the gap in Indigenous health status	1.1 Comparative life expectancy at birth: Commonwealth 1.2 <i>Birth weight</i> 1.3 <i>Rates of rheumatic heart disease</i>
2. Investing in prevention	2.1 Potentially preventable hospital admissions per 1000 population: Commonwealth 2.2 Immunisation rates for vaccines in the national schedule: Commonwealth 2.3 Proportion of women in 50-69 year aged group who have had breast screen in last two years: Commonwealth 2.4 Proportion of babies who are low birth weight: Commonwealth 2.5 <i>Proportion of adults and children overweight or obese</i> 2.6 <i>Proportion of people who are daily smokers</i>
3. Ensuring a healthy start	3.1 Proportion of children who have received all developmental health checks: State 3.2 Proportion of pregnancies with an antenatal contact in the first trimester: State 3.3 <i>Proportion of women who consume alcohol during pregnancy</i> 3.4 <i>Proportion of women who smoke during pregnancy</i> 3.5 <i>For children with a suspected disability or developmental delay, waiting time at 90th percentile from referral to diagnosis and/or treatment/intervention</i>
4. Redesigning care for those with chronic and complex conditions	4.1 Waiting time at 90th percentile from referral to aged care assessment: Commonwealth 4.2 Number of nursing home type bed days per 1000 population > 70: Commonwealth 4.3 Waiting time at 90th percentile for access to subacute inpatient care: State 4.4 Proportion of patients) who are discharged from an emergency department to home/nursing home who have evidence of communication back to relevant primary health care service: State 4.5 Patients with psychosis seen by a community mental health professional within 7 days following discharge from a public mental health service provider: State 4.6 Waiting time at 90th percentile from referral for radiation oncology to first treatment: Commonwealth 4.7 Primary care patients seen in emergency departments per 1000 population: Commonwealth 4.8 Proportion of people with asthma with a written asthma plan: Commonwealth 4.9 Proportion of people with diabetes mellitus who have received an annual cycle of care within general practice and proportion with a glycosolated haemoglobin (HbA1c) below 7: Commonwealth

Health challenge	Performance benchmark (or tracking indicators) and accountability
5. Recognising the health needs of the whole person	5.1 Waiting time for admission to a supported mental health place in community: State 5.2 Waiting time for admission to a supported drug and alcohol place in community: State 5.3 Waiting time for mental health emergency community support: State 5.4 Patient experience with being treated with dignity: Jurisdiction relevant to service 5.5 Waiting time for access to public dental health services: State
6. Ensuring timely hospital access	6.1 Elective surgery: State 6.1.1 Waiting time at 90th percentile for cardio-thoracic and cancer surgery 6.1.2 Median waiting time for all other surgery 6.1.3 Waiting time at 90th percentile for all other surgery 6.2 Emergency access waiting times for emergency patients by triage categories: State 6.2.1 Category 1 6.2.2 Category 2 at 80th percentile 6.2.3 Category 3 at 75th percentile 6.2.4 Category 4 at 70th percentile 6.2.5 Category 5 at 70th percentile
7. Caring for and respecting the needs of people at the end of life	7.1 Family experience with care process: State 7.2 Number of emergency department visits and hospital days in last 30 days of life per person: State
8. Promoting improved safety and quality of health care	8.1 Investigation of hospital separations with a diagnosis from agreed national list of complications: State 8.2 Appropriate prescription of antibiotics by GPs for upper respiratory tract infections: Commonwealth 8.3 Appropriate safety and quality measures for primary and community care: Commonwealth
9. Improving distribution and equitable access to services	9.1 Indigenous rate relative to the non-Indigenous rate (each indicator) 9.2 Rate in lowest quintile by socio-economic status of area relative to highest quintile rate (each indicator) 9.3 Rural and remote rates relative to the metropolitan rate (each indication)
10. Ensuring access on the basis of need, not ability to pay	10.1 Patients reporting deferring needed treatment because of financial barriers: Commonwealth 10.2 Proportion of general practice services bulk billed: Commonwealth

Health challenge	Performance benchmark (or tracking indicators) and accountability
11. Improving and connecting information to support high quality care	11.1 Patient experience with being provided with adequate information: Jurisdiction relevant to service 11.2 Proportion of hospital discharge summaries that are provided electronically to the patient-identified general practitioner or other health service: State 11.3 Proportion of referrals made to specialists that are undertaken electronically: Commonwealth
12. <i>Ensuring enough, well-trained health professionals and promoting research</i>	12.1 Number of graduating students in health professions relative to requirements: Commonwealth 12.2 Number of new graduates employed in their field of training, immediately post-graduation: State 12.3 Number of accredited and filled clinical training positions for all professions: State 12.4 Number of undergraduate placement weeks for medicine, nursing and other health service professions per 1000 population relative to national average: State 12.5 Research performance: Commonwealth

For about one quarter of the indicators, we have specified the proposed benchmark. This has generally been where a well-established benchmark has been articulated in the past (or implicitly so). Unfortunately, some important indicators need to be developed: an example being the lack of an agreed national survey of patient experience and health literacy means that we cannot specify particular questions to be used to give us a national picture.

Developmental work for all outstanding indicators needs to occur speedily, and should be completed early in 2008-09, allowing data collection, analysis of comparative performance and development of benchmarks in 2009-10, for use in the 2010-11 Agreement year. Where indicators exist, some will be able to have benchmarks developed in time for use in 2009-10, whilst others may require data collection and analysis prior to use in 2010-11.

The emphasis on performance against benchmarks presupposes a capacity for managers to track and adjust policies and strategies in the light of feedback. Information technology and inter-operable systems will be a key technology and structure underpinning such a system. Ease of use, data gathering and analysis, real time feedback of information to inform on the success or otherwise of interventions, and meeting benchmarks and targets will be facilitated greatly by such technologies.

In all, there are 44 proposed benchmarks, with accountability for 18 assigned to the Commonwealth, 24 to states and, for two, accountability is for each government depending on the type of service (e.g. public hospitals, primary care). In addition, we recommend that there be accountability for the distribution of performance

(Indigenous versus non-Indigenous access, rural versus metropolitan, lower socio-economic status versus higher), and this provides an additional overlay for accountability for the relevant government.

Indicators, targets and benchmarks are all important: they allow us to track our progress, lift our vision and hold to account. Behind the benchmarks there need to be people and systems to ensure that we achieve our vision. The Commission's future work will be about devising better systems for the long term and ensuring we have the right personnel in place. Benchmarks are critical to this: they specify explicitly the standard that we, as Australians, expect. More importantly, specifying these quantitative benchmarks means we are moving beyond vague promises and rhetoric to a focus on measurable accountability that, in turn, should drive measurable improvement.

APPENDIX A:

Background on the National Health and Hospitals Reform Commission

Membership

Dr Christine Bennett (Chair)

Professor Justin Beilby

Dr Stephen Duckett

The Hon Dr Geoff Gallop

Dr Mukesh Haikerwal

Ms Sabina Knight

The Hon Rob Knowles AO

Ms Mary Ann O'Loughlin

Professor Ronald Penny AO

Dr Sharon Willcox

Terms of Reference

The terms of reference were announced by the Council of Australian Governments in its communiqué of 20 December 2007 as follows:

“Australia’s health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.
2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
 - a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
 - b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
 - c. bring a greater focus on prevention to the health system;
 - d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;
 - e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
 - f. improve the provision of health services in rural areas;
 - g. improve Indigenous health outcomes; and
 - h. provide a well qualified and sustainable health workforce into the future.

The Commission’s long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her, to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers’ Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and between four to six part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.”

Further information

The Commission has established a website (www.nhhrc.org.au). This website includes information on the Commission’s engagement and consultation process, including how to make submissions.

For further information about the Commission, please call 1800 017 533.

APPENDIX B:

Proposed principles to guide reform and future directions of the Australian health care system

Proposed design principles

(generally what we as citizens and potential patients want from the system)

1. **People and family centred:** The direction of our health system and the provision of health services must be shaped around the health needs of individuals, their families and communities. The health system should be responsive to individual differences, cultural diversity and preferences through choice in health care. Pathways of care, currently often complex and confusing, should be easy to navigate and, where necessary, people should be given help to navigate the system, including through reliable and evidence based information and advice to make appropriate choices. Care should be provided in the most favourable environment: closer to home if possible and with a preference for less 'institutional' settings and with an emphasis on supporting people to achieve their maximum health potential.
2. **Equity:** Health care in Australia should be accessible to all based on health needs, not ability to pay. The multiple dimensions of inequality should be addressed, whether related to geographic location, socio-economic status, language, culture, or Indigenous status. A key underpinning for equity is the principle of universality as expressed in the design of Medicare, the Pharmaceutical Benefits Scheme and public hospital care. Addressing inequality in health access and outcomes requires action beyond these three programs, including through engagement with other policy sectors (such as the education system, and employment). The health system must recognise and respond to those with special needs (the marginalised or underprovided for groups in society). Special attention needs to be given to working with Aboriginal and Torres Strait Islander people to close the gap between Indigenous health status and that of other Australians.

3. **Shared responsibility:** All Australians share responsibility for our health and the success of the health system. We each make choices about our lifestyle and personal risk behaviours, shaped by our physical and social circumstances, life opportunities and environment, which impact our health risks and outcomes. As a community, we fund the health system. As consumers or patients we make decisions about how we will use the health system and work with the professionals who care for us. Health professionals have a responsibility to communicate clearly, to help us understand the choices available to us, and to empower us to take an active role in our treatment in a relationship of mutual respect.

The health system can only work effectively if everyone participates according to these shared responsibilities, recognising and valuing the important roles of both consumers/patients and health staff. The health system has a particularly important role in helping people of all ages become more self reliant and better able to manage their own health care needs. This includes helping people to make informed decisions through access to health information and by providing support and opportunities to make healthy choices, and by providing assistance for managing complex health needs.

4. **Strengthening prevention and wellness:** We need a comprehensive and holistic approach to how we organise and fund our health services and work towards improving the health status of all Australians. The balance of our health system needs to be reoriented. Our health system must continue to provide access to appropriate acute and emergency services to meet the needs of people when they are sick. Balancing this fundamental purpose, our health system also needs greater emphasis on helping people stay healthy through stronger investment in wellness, prevention and early detection and appropriate intervention to maintain people in as optimal health as possible.

Recognising the diverse influences on health status, our health system should create broad partnerships and opportunities for action by the government, non-government and private sectors; balance the vital role of diagnosis and treatment with action and incentives to maintain wellness; create supportive environments and policies; protect our health; and prevent disease and injury in order to maximise each individual's health potential.

5. **Comprehensive:** People have a multiplicity of different health needs which change over their life course. Meeting those needs requires a system built on a foundation of strong primary health care services, with timely access to acute and emergency services.

6. **Value for money:** The resources available to support our health care system are finite, and the system must be run as efficiently as possible and be positioned to respond to future challenges. Delivering value for money will require appropriate local flexibility in financing, staffing and infrastructure. The health system should deliver appropriate, timely and effective care in line with

the best available evidence, aiming at the highest possible quality. Information relating to the best available health evidence should be easily available to professionals and patients. Introduction of new technology should be driven by evidence and cost-effectiveness. Pathways to care should be seamless with continuity of care maximised, with systems in place to ensure a smooth transfer of information at each step of the care pathway, making effective use of information technology.

7. **Providing for future generations:** We live in a dynamic environment and changing populations. Health needs are changing with improved life expectancy, community expectations rising, advances in health technologies, an exploding information revolution and developments in clinical practice. There are new avenues and opportunities for how we organise and provide necessary health care to individuals, using the health workforce and technologies in innovative and flexible ways. Health professionals need to be able to adapt to future health needs. The education and training of health professionals across the education continuum are a responsibility of the whole health community in partnership with the education sector. Continuing education ensures that health professionals are prepared to meet these changing needs. The important responsibility of the health care system in teaching, training future generations of health professionals for a changing health care sector and roles, participating in research, and in creating new knowledge for use in Australia and throughout the world should be actively acknowledged and resourced appropriately as an integral activity. The health sector's commitment to education and research, and its relationship with the education and training sector, should be planned and implemented in a logical and seamless way involving all relevant sectors: public and private, institutional and community.
8. **Recognise broader environmental influences shape our health:** Our environment plays an important role in affecting our health and in helping us to make sensible decisions about our health. The environment here is taken to mean the global climate, the physical and built environment (air quality, the workplace, planning decisions which affect our health), and the socio-economic environment (people in the workforce generally have better health than the unemployed, better educated people have better health and have responded better to health campaigns and tend to smoke less). Peers and family shape both our health (and development of our children) and our adoption of healthy lifestyles. The health system of the future needs to work at these multiple levels to promote health with many and varying agencies and partnerships. These partnerships must be effective and must involve players from outside the health system, whether they be transport departments, local councils, employers, business and worker organisations, and schools and universities.

Proposed governance principles

(generally how the health system should work)

9. **Taking the long term view:** A critical function for effective governance of the health system is that it acts strategically: that short-termism and the pressure of the acute does not crowd out attention and planning for the long term. A responsible forward-looking approach demands that we actively monitor and plan the health system of the future to respond to changing demographics and health needs, clinical practices and societal influences. This requires capacity to seek input from the community and those within the health sector (providers and managers) to assess evidence and develop and implement plans to improve health and health care.
10. **Safety and quality:** There should be effective systems of clinical governance at all levels of the health system to ensure we learn from mistakes and to improve the safety and quality of services. The first step in ensuring effective clinical governance is that there is a culture that embraces improvement in patient safety and quality. This includes an emphasis on open, transparent reporting. There must be a just and positive culture in dealing with adverse events, mistakes and near misses. All of this requires the development of effective organisational systems that promote safety and quality, including appropriate systems of open disclosure and public accountability for the whole system.
11. **Transparency and accountability:** The decisions governments, other funders and providers make in managing our health care system should become clearer and more transparent. Funding should be transparent. The responsibilities of the Commonwealth and state governments and the private and non-government sectors should all be clearly delineated so when expectations are not met, it is clear where accountability falls. Accountability extends to individual health services and health professionals. Australians are entitled to regular reports on the status, quality and performance of our whole health care system, both public and private, ranging across the spectrum from primary to tertiary care and at local, state and national levels.
12. **Public voice:** Public participation is important to ensuring a viable, responsive and effective health care system. Participation can and should occur at multiple levels, reflecting the different roles that individuals play at different times in their lives. This includes participation as a 'patient' or family member in using health care services, participation as a citizen and community member in shaping decisions about the organisation of health services, and participation as a taxpayer, voter, and, in some cases, shareholder in holding governments and corporations accountable for improving the health system.

13. **A respectful, ethical system:** Our health care system must apply the highest ethical standards, and must recognise the worth and dignity of the whole person, including their biological, emotional, physical, psychological, cultural, social and spiritual needs. A significant focus must include respect and valuing of the health workforce. Those working within the health sector must be aware of ethical considerations throughout their training and in their daily clinical practice.
14. **Responsible spending on health:** Good management should ensure that resources flow effectively to the front line of care, with accountability requirements efficiently implemented and red tape and wastage minimised. Funding mechanisms should reward best practice models of care, rather than models of care being inappropriately driven by funding mechanisms. Funding systems should be designed to promote continuity of care with common eligibility and access requirements to avoid program silos or 'cracks' in the health system. There should be a balanced and effective use of both public and private resources. New technologies should be evaluated in a timely manner, and, where shown to be cost effective, should be implemented promptly and equitably. Information and communication technologies, in particular, should be harnessed to improve access in rural and remote access on a cost effective basis to support and extend the capacity of all health professionals to provide high quality care.
15. **A culture of reflective improvement and innovation:** Reform, improvement and innovation are continuous processes and not fixed term activities. The Australian health system should foster innovation, research and sharing of practices shown to be effective and to improve not only the specific services it provides, but also the health of all Australians. Audit, quality feedback loops, and 'Plan, Do, Study, Act' cycles, supported by information and communication technologies, can enable and drive this. The continuum of basic science to clinical and health services research will underpin this and needs to be embedded.



APPENDIX C:

Proposed performance benchmarks

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
1. Closing the gap in Indigenous health status		
1.1. Comparative life expectancy at birth	Commonwealth	<p>Benchmark: The level of the benchmark will be set and measured as part of the Annual Prime Ministerial statement.</p> <p>Rationale: Responsibility has been assigned to the Commonwealth on the basis of the Prime Minister's announcement on closing the gap.</p> <p>Other indicators: Two other indicators are important in tracking progress towards the benchmark of improved life expectancy. These tracking indicators (not performance benchmarks) are:</p> <p>1.2 Birth weight</p> <p>1.3 Rates of rheumatic heart disease</p>
2. Investing in prevention		
2.1. Potentially preventable hospital admissions per 1000 population	Commonwealth	<p><i>Indicator 2.1:</i></p> <p>Benchmark: The level of the benchmark needs to be identified. Separate benchmarks will need to be set for:</p> <ul style="list-style-type: none"> • Vaccine preventable hospitalisations; and • Potentially preventable hospitalisations relating to chronic disease. <p>The rate for vaccine preventable hospitalisation will be close to zero, while the rate for preventable hospitalisations from chronic disease should be set to measure relative success with lower rates reflecting more effective prevention programs and better primary care.</p> <p>Rationale: The rate of potentially preventable admissions measures the adequacy of primary care and prevention. It highlights the importance of a well functioning primary care system in managing the number of patients who present to hospital.</p>
2.2. Immunisation rates for vaccines in the national schedule	Commonwealth	<p><i>Indicator 2.2:</i></p> <p>Benchmark: 90%</p>

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
2. Investing in prevention (continued)		
2.3. Proportion of women in 50-69 year age group who have had breast screen in last two years	Commonwealth	<p><i>Indicator 2.3:</i> Benchmark: 70%</p>
2.4. Proportion of babies who are low birth weight	Commonwealth	<p><i>Indicator 2.4:</i> Rationale: Preventing low birth weight requires broad social strategies prior to conception. This includes services sitting outside the health system. Other prevention indicators: Two indicators have been identified as significant 'tracking indicators' against which it is important to publicly report progress. These have not been assigned for accountability by a single level of government. They are: 2.5 Proportion of adults and children overweight or obese; and 2.6 Proportion of people who are daily smokers. Further development: There needs to be considerable development in indicators and benchmarks relating to the adequacy of the primary health care system, including its role in prevention.</p>
3. Ensuring a healthy start		
3.1. Proportion of children who have received all developmental health checks (6, 12, 18 months and 4 years)	State	<p><i>Indicators 3.1 and 3.2:</i> Rationale: Although many children might receive developmental checks as part of their primary medical care, we have assigned this responsibility to states as this has been a traditional state responsibility since these programs evolved. Similarly, states have major responsibility for public antenatal care through shared care programs and it is important that continuity of care is achieved.</p>
3.2. Proportion of pregnancies with an antenatal contact in the first trimester	State	<p>Other indicators: Three other indicators have been identified as tracking indicators: 3.3 Proportion of women who consume alcohol during pregnancy; 3.4 Proportion of women who smoke during pregnancy; and 3.5 For children with a suspected disability or developmental delay, waiting time at 90th percentile from referral to diagnosis and/or treatment/intervention.</p>

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
4. Redesigning care for those with chronic and complex conditions		
<p>4.1. Waiting time at 90th percentile from referral to aged care assessment. (The 90th percentile is the point where 90% of people would be assessed within that time)</p> <p>4.2. Number of nursing home type bed days per 1000 population >70</p>	<p>Commonwealth</p> <p>Commonwealth</p>	<p><i>Indicators 4.1 and 4.2:</i></p> <p>Rationale: These indicators are designed to measure the adequacy of access to the aged care system in ensuring speedy assessment and timely admission to residential care. The admission to residential care indicator proposed is nursing home type patients in hospitals (total public and private). This is in part because hospitals act as a safety net or last resort for people unable to access residential care and so the prevalence of nursing home type patients signals underlying problems in residential care. Nursing home type patients also signal problems in patient flow, with some occupying acute beds inappropriately, thus contributing to access issues. It is important to note that all waiting time indicators have been set using the 90th percentile, on the basis that the starting point for their measurement is from assessment. For some indicators this will have a significant impact in setting much higher standards of performance than currently exist.</p> <p>Further development: The nursing home type patient indicator should be replaced by the AIHW recommended indicator of patients assessed as being eligible for residential aged care who are occupying (public or private) hospital beds, if and when the indicator is developed.</p>
<p>4.3. Waiting time at 90th percentile for access to sub-acute inpatient care (geriatric services, rehabilitation). (The 90th percentile is the point where 90% of people would be admitted within that time)</p>	<p>State</p>	<p><i>Indicator 4.3:</i></p> <p>Rationale: This indicator links to the nursing home indicator (and reflects the interdependency of the acute and aged care systems). Provision of sub-acute beds is very uneven across Australia, but better provision of sub-acute care opens up housing options for the elderly and facilitates return to home after an acute event.</p>

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
4. Redesigning care for those with chronic and complex conditions (continued)		
4.8. Proportion of people with asthma with a written asthma plan	Commonwealth	<p><i>Indicator 4.8:</i></p> <p>Rationale: The completion of asthma written action plans is principally completed in primary care. There is evidence that the completion of these plans, in partnership with education and appropriate medication management, will lead to reductions in extra medications, urgent visits to doctors, hospitalisations and deaths.</p>
4.9. Proportion of people with diabetes mellitus who have received an annual cycle of care within general practice, and proportion with a glycosylated haemoglobin (HbA1c) below 7.	Commonwealth	<p><i>Indicator 4.9:</i></p> <p>Rationale: Published evidence that HbA1c levels below 7 lead to improved outcomes. Annual cycle of care is a measure of team based and whole person care.</p> <p>Further development: As evidence suggests that blood pressure control delivers greatest health gains, indicators of cardiovascular risk assessment and management need to be developed as a priority. In addition, there needs to be a shift from measuring disease-specific indicators (such as asthma and diabetes) to measuring the overall management of chronic disease, including the development of care plans and access to necessary services following the completion of care plans.</p>
5. Recognising the health needs of the whole person		
5.1. Waiting time for admission to a supported mental health place in community	State	<p><i>Indicators 5.1 and 5.2:</i></p> <p>Rationale: Although acute patients need admission to acute beds, many acute beds are occupied by people who could be better cared for in community settings. As performance benchmark for acute beds may drive inappropriate investments, the preferred indicator relates to access to community-based services.</p>
5.2. Waiting time for admission to a supported drug and alcohol place in community	State	
5.3. Waiting time for mental health emergency community support	State	<p><i>Indicator 5.3:</i></p> <p>Rationale: Care in the community requires support from community mental health teams available within relatively short time frames.</p>

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
5. Recognising the health needs of the whole person (continued)		
5.4. Patient experience with being treated with dignity	Both Commonwealth and states (for relevant services for which they are accountable)	<i>Indicator 5.4:</i> Further development: Requires development of nationally agreed patient experience survey. The use of Computer Assisted Telephone Interviewing (CATI) instruments is support for further development.
5.5. Waiting time for access to public dental health services	State (potentially Commonwealth)	<i>Indicator 5.5:</i> Rationale: Responsibility for public dental health services is currently with state governments. This is subject to negotiation as the Commonwealth has foreshadowed changes to its support for dental health services.
6. Ensuring timely hospital access		
6.1. Elective Surgery 6.1.1. Waiting time at 90th percentile for cardio-thoracic and cancer surgery 6.1.2. Median waiting time for all other surgery 6.1.3. Waiting time at 90th percentile for all other surgery The benchmarks here mean that 90% of cardio-thoracic or cancer surgery should be treated in 30 days. For all other surgery, 90% should be treated in a year.	State State State	Benchmark: 6.1.1: 30 days. 6.1.2: 90 days. 6.1.3: 365 days. Rationale: The traditional 'categorisation' approach is highly subjective, so we have distinguished cardio-thoracic and cancer surgery, where access expectations are for a speedier admission, from all other surgery. We have included a median waiting time indicator to give recognition to the need for some patients to be admitted more rapidly than others. This indicator is currently measured from acceptance onto the waiting list to surgery. We propose that for the 2011-12 year and beyond this indicator be measured from the date of referral from general practice to surgery with the same benchmark performance. In order to ensure equity of access, waiting time performance for private patients in public hospitals should be no different to the public patient waiting times.

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
6. Ensuring timely hospital access (continued)		
<p>6.2. Emergency Access Waiting time for emergency patients by triage categories:</p> <p>6.2.1. Category 1</p> <p>6.2.2. Category 2 at 80th percentile</p> <p>6.2.3. Category 3 at 75th percentile</p> <p>6.2.4. Category 4 at 70th percentile</p> <p>6.2.5. Category 5 at 70th percentile</p>	<p>State</p> <p>State</p> <p>State</p> <p>State</p> <p>State</p>	<p>Benchmark:</p> <p>6.2.1: 100% seen immediately.</p> <p>6.2.2: 10 minutes.</p> <p>6.2.3: 30 minutes</p> <p>6.2.4: 60 minutes</p> <p>6.2.5 120 minutes</p> <p>Rationale: The emergency department triage category benchmarks are now well accepted. Although we have also recommended a benchmark indicator about the number of category 4 and 5 patients seen in emergency departments (and assigned that to the Commonwealth), if a patient turns up at an emergency department the states should still be accountable for ensuring the patient is seen within an acceptable time.</p>
7. Caring for and respecting the needs of people at the end of life		
<p>7.1. Family experience with care process</p>	<p>State</p>	<p><i>Indicator 7.1:</i></p> <p>Rationale: Palliative care programs have been shown to lead to better family satisfaction with the way the health system manages death. A nationally consistent indicator needs to be developed to measure this construct. A benchmark can then be developed.</p>
<p>7.2. Number of Emergency Department visits and hospital days in last 30 days of life per person</p>	<p>State</p>	<p><i>Indicator 7.2:</i></p> <p>Rationale: Higher rates of emergency department visits and/or hospital days in the last month of life is an indicator of a failure of the home-based care process</p>

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
8. Promoting improved safety and quality of health care		
8.1. Investigation of hospital separations with a diagnosis from agreed national list of complications.	State	<p><i>Indicator 8.1:</i></p> <p>Benchmark: Appropriate system exists to investigate complications i.e. that where there is a higher rate of complications, there is a robust system to investigate the reason for the higher rate and ensure that appropriate action is taken in response to the investigation).</p> <p>Rationale: This is both a flow indicator (patients with adverse events stay longer and consume more resources) and also a safety indicator. The policy objective is clearly to minimise (eliminate) potentially preventable complications. But adverse events occur for a range of reasons. We do not support a name, blame, and shame culture so it is proposed that the benchmark be that systems are in place to investigate and learn from adverse events, rather than report a quantified target level of performance.</p>
8.2. Appropriate prescription of antibiotics by GPs for upper respiratory tract infections	Commonwealth	<p><i>Indicator 8.2:</i></p> <p>Rationale: Upper Respiratory Infections are the most common condition managed in general practice and there is no evidence that antibiotics are required. This indicator is to some extent a proxy for other appropriate prescribing indicators. The role of the National Prescribing Service may be important in developing further indicators related to prescribing.</p>
8.3. Appropriate safety and quality measures for primary and community care (to be developed)	Commonwealth	<p><i>Indicator 8.3:</i></p> <p>Further development: Measurement of quality and safety in primary care (primary medical care and community health care) is very complex, partly because of the lack of routinely collected data about diagnosis or presenting problem, treatment and outcomes. However, most interactions with the health system occur in primary care and priority needs to be given to developing measures of this construct.</p>

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
9. Improving distribution and equitable access to services		
9.1. Indigenous rate relative to the non-Indigenous rate 9.2. Rate in lowest quintile by socio-economic status of area relative to highest quintile rate 9.3. Rural and remote rates relative to the metropolitan rate		Although presented in this table as individual separate indicators, these are in fact attributes of a number of the other indicators. All of the access indicators, for example, should have benchmarks about distribution as well as access for the 'average Australian'. We see no reason why there should be a (statistically significant) difference between these rates for any benchmark. Benchmarks for these rates should be raised over time. Responsibility for the distributional measure should be vested in the government with responsibility for the base measure.
10. Ensuring access on the basis of need, not ability to pay		
10.1. Patients reporting deferring needed treatment because of financial barriers	Commonwealth	<i>Indicator 10.1:</i> Rationale: Some surveys conducted by the Commonwealth Fund have used this measure. A measure of this kind needs to be developed and a benchmark identified.
10.2. Proportion of general practitioner services bulk billed	Commonwealth	<i>Indicator 10.2:</i> Benchmark: 80% Rationale: Bulk-billing is only one measure of access, but it has been commonly measured.
11. Improving and connecting information to support high quality care		
11.1. Patient experience with being provided with adequate information	Both Commonwealth and states (for relevant services for which they are accountable)	<i>Indicator 11.1:</i> Further development: Requires development of nationally agreed patient experience survey.

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
11. Improving and connecting information to support high quality care (continued)		
<p>11.2. Proportion of hospital discharge summaries that are provided electronically to the patient-identified general practitioner or other health service</p> <p>11.3. Proportion of referrals made to specialists that are undertaken electronically</p>	<p>State</p> <p>Commonwealth</p>	<p><i>Indicators 11.2 and 11.3:</i></p> <p>Rationale: These indicators are one measure of the effectiveness of communication across health care providers to facilitate good quality care.</p>
12. Ensuring enough, well-trained health professionals and promoting research		
<p>12.1. Number of graduating students in health professions relative to requirements</p>	<p>Commonwealth</p>	<p><i>Indicator 12.1:</i></p> <p>Rationale: The Commonwealth is responsible for the number of university places in each of the professions.</p>
<p>12.2. Number of new graduates employed in their field of training immediately post-graduation</p>	<p>State</p>	<p><i>Indicators 12.2-12.4:</i></p> <p>Rationale: Although we recognise the importance of training in primary care settings and other sectors of government (e.g. the education sector for speech pathologists), most clinical training is still in hospitals and so accountability for these indicators has been assigned to states as they have primary responsibility for ensuring clinical placements and training opportunities are available in hospitals. Recognition of contemporary approaches to clinical education should be given by including simulation-based positions in the count of training positions.</p>
<p>12.3. Number of accredited and filled clinical training positions for all professions</p> <p>12.4. Number of undergraduate placement weeks for medicine, nursing and other health service professions per 1000 population relative to national average</p>	<p>State</p> <p>State</p> <p>State</p>	

Health challenge/ Performance indicators	Accountability	Benchmarks, rationale, tracking indicators and further development
<p>12. Ensuring enough, well-trained health professionals and promoting research (continued)</p> <p>12.5. Research performance</p>	<p>Commonwealth</p>	<p><i>Indicator 12.5:</i></p> <p>Further development: A new method of evaluating quality of research in the higher education sector is currently being developed. Given the overlap in personnel engaged in research in the health and education sectors, we propose that the way in which research is measured in the health sector should parallel the higher education sector. This measure (and associated benchmark) should be developed when policy in the higher education sector is finalised.</p> <p>Depending on the timeframe for development of the higher education sector process, an interim indicator could be the number of publications related to research conducted within health facilities or the amount of nationally competitive grants for research.</p>