

## CHAPTER 7: USING PERFORMANCE INFORMATION FOR HEALTH SYSTEM IMPROVEMENT

This chapter addresses the issue of the use of performance information for benchmarking within the Australian Health System. The first section provides an outline of initial ideas on how the National Health Performance Committee could address its terms of reference relating to the promotion of benchmarking. The rest of the chapter is devoted to outlining some of the benchmarking initiatives within the States and Territories (Section 7.2) and other Australian organisations.

### 7.1 The role of the National Health Performance Committee in promoting benchmarking

In addition to the development and reporting against a national health performance indicator framework, the terms of reference for the NHPC include the encouragement of benchmarking for the improvement of health system performance (see Box 1.1, Chapter 1). While the focus for the Committee during its first two years has been the development of an indicator framework and the commencement of national reporting, the Committee has also examined the role it could play in encouraging the use of performance information for health systems improvement. This chapter discusses the Committee's preliminary deliberations on this role.

The vision of the NHPC is for a health system that searches for, compares, learns from the best and improves performance through the adoption of benchmarking practices across all levels of the system. Benchmarking has been described as 'the ongoing, systematic process to search for and introduce best practice into an organisation' (NHPC, 2000). Benchmarking is generally used to compare an organisation or service with similar leading organisations or services to provide a catalyst to improve performance. It is important to acknowledge that successful benchmarking requires that performance comparison be followed by activities that seek to understand the practices contributing to superior performance, leading to the spread of those practices across participating organisations.

Benchmarking activities are widespread within the Australian health system in the public and private sectors. Many benchmarking activities are occurring without the direct involvement of Government agencies, while others are the direct result of Government initiatives. Later in this chapter an outline is provided of some of the benchmarking activities currently being undertaken by the States and Territories.

While the Committee has developed preliminary ideas on how it might promote benchmarking across the health system, the intention is to refine these ideas through holding a national workshop on benchmarking in the first part of 2002 in collaboration with relevant agencies and organisations. The workshop will focus on developing strategies that reflect the most appropriate contributions the NHPC could make to the promotion of benchmarking across the system.

In its initial discussions, the Committee has identified four roles it could play:

- promoting the national health performance indicator framework for benchmarking in the health system;
- encouraging the application of benchmarking;
- encouraging the development of expertise in benchmarking; and
- contributing to the development and availability of data for benchmarking purposes.

#### Promoting the national health performance indicator framework for benchmarking in the health system

While the framework has been developed with the intention of structuring reports to Health Ministers on the performance of the health system, it could also provide a useful template for structuring data accessed for a variety of performance reporting and benchmarking activities.

An advantage of the framework is that it prompts attention to the broad and balanced range of performance dimensions, even though these dimensions may not always be applicable to specific performance measurement efforts. The proposed criteria for selecting indicators for the framework also provide a useful check list for ensuring performance measures are identified or developed that will be effective in performance improvement.

#### Encouraging the application of benchmarking across the health system

As mentioned there is an extensive and diverse range of benchmarking activities already undertaken throughout the health system. However, benchmarking activities seem to be more the exception than the rule. More could be done to encourage the spread and application of benchmarking so it is taken up as an intrinsic part of health care delivery. This needs to occur at an appropriate organisational level to achieve ongoing improvements in clinical practice and service delivery.

## Encouraging the development of expertise in benchmarking

In addition to encouraging the use of benchmarking, the practice of benchmarking needs to be of a sufficient standard and rigour to derive benefit. Some attention needs to be given to developing within the health sector people with the necessary skills to support and undertake benchmarking.

## Contribute to the development and availability of data for benchmarking purposes

A potential danger in unduly focusing on comparing performance at the jurisdictional level is that it may evoke defensive behaviours by participating jurisdictions. These behaviours may be antithetical to the promotion of benchmarking. Two ways in which the National Health Performance Committee could seek to avoid this problem include promoting the development of better indicators, and ensuring performance information is available at a level, such as at a hospital level, that will facilitate more meaningful comparison of performance.

Many of the performance indicators currently available reflect information that is readily available rather than ideal measures of performance. While performance indicators always have some limitations, there is the potential for much better measures to be developed. By sponsoring research into refining existing indicators, and proposing more appropriate indicators, the Committee could usefully contribute to ensuring performance data is more likely to be used in benchmarking activities.

As a by-product of developing national performance indicators, the Committee could also ensure that data and information required for meaningful performance benchmarks becomes available and is accessible. Wherever possible, this information should be accessible and relevant down to an appropriate organisational unit, such as the hospital level or even the clinical unit level.

## 7.2 Benchmarking activities within the State and Territory health agencies

### 7.2.1 New South Wales

There has been a strong promotion of benchmarking activities and quality services, in both clinical and non-clinical areas, across NSW Health. Many of these activities were identified in the previous report of the National Health Performance Committee. Over the last twelve months there has been substantial progress in a number of key areas which are mentioned below.

In February 1999, *The Framework for Managing the Quality of Health Services in NSW* (the Quality framework) was endorsed following broad consultation with key stakeholders in health, both locally and nationally. The framework identified various dimensions of quality (which broadly align with the national framework developed by the National Health Performance Committee) for which indicators have been developed. During the last year, in collaboration with the Health Services Research Group of Newcastle University, a set of indicators derived from existing data sources was identified (see Box 7.1 for the appropriateness and effectiveness indicators). Data on these indicators is presented in order to flag issues that may relate to the quality of health care provided and help identify variations in practice potentially useful for follow-up studies. Reports were prepared for all New South Wales Area Health Services. The reports identify the potential gains in the event that each Area Health Service rate moves to the rate of the best 20th percentile for New South Wales. Workshops have been conducted in each Area Health Service to provide opportunities for more focused discussion.

#### Box 7.1 Appropriateness and Effectiveness Indicators

- Caesarean section deliveries as a proportion of all deliveries.
- Laparoscopic cholecystectomy as a proportion of all cholecystectomies.
- Hysterectomy separation rate for women aged less than 35 years.
- Hysterectomy separation rate for women aged between 35 and 59 years.
- Tonsillectomy separation rate for people aged less than 15 years.
- Tonsillectomy separation rate for people aged over 15 years.
- Myringotomy separation rate for people aged less than 15 years.
- Coronary artery bypass grafting separation rate.
- Percutaneous transluminal coronary angioplasty, including stenting separation rate.
- Total knee replacement separation rate for people aged over 65 years.
- Total hip replacement separation rate for people aged over 65 years.
- Diabetes separation rate.
- Lower extremity amputation separation rate for people with diabetes as a diagnosis.
- Asthma separation rate for people aged between 5 and 34 years.

As part of the NSW Government's Action Plan for Health, an Acute Care Implementation Group examined the variation in length of hospital stay and clinical practice evident in data held by NSW Health. Analysis has been undertaken for a range of procedures at the level of the admitting doctor. A number of key measures such as rates of procedures performed on a day only basis, rates of

admission on day of surgery, readmission rates and length of stay have been developed, and arrangements established to allow these measures to be available to clinicians on a routine and regular basis. These measures have been incorporated into the quality measures developed under the Quality Framework.

### 7.2.2 Victoria

A number of themes underpin improvement of quality across the Victorian public health acute and non-acute sectors. They include structural changes to improve quality, development of quality indicators, data system improvements to support monitoring and reporting, and continued improvement of efficiency indicators.

Key initiatives to facilitate quality improvement are:

- enactment of legislation to clarify Health Service Board of Management governance responsibilities for ensuring effective systems are in place for accountable and transparent monitoring and reporting of health service quality outcomes.
- publication of annual *Quality of Care Reports* by Health Services to inform their communities of the quality of care in their services. The Reports also promote changes in systems, clinical practice and continuous improvement.
- establishment of a Victorian Quality Council to review system wide performance, identify issues and advise on strategies for improvement. The Council will also liaise closely with the Australian Council for Safety and Quality in Health Care to ensure that statewide initiatives are consistent with national approaches.
- systemic quality performance monitoring including the establishment of Consultative Councils to examine preventable causes of morbidity and mortality through a focus on details of clinical cases with a view to improving practice at a system wide level.
- implementation of a Quality Framework consistent with the National Health Performance Framework, that provides a context for review, evaluation and continuous improvement of performance indicators to achieve meaningful and sustainable performance monitoring that is balanced across the care dimensions. Funding for quality improvement accompanies the framework and includes bonus components subject to Health Service performance against targets.
- projects to support the intelligent use of data to improve quality of care in the high cost specialties of cardiac surgery and intensive care. These will provide aggregate, hospital specific outcomes data broadly reflective of the quality of intensive care and cardiac surgery. Analysis and review of this data will inform proactive addressing of any quality of care issues that may be identified.
- non-acute services such as primary health, aged care and mental health to continue to focus on the measurement of performance as a priority. A strategy to improve performance measurement, reporting and data collection has been developed and implemented in three stages. It included an initial rationalisation of performance measures and reporting arrangements within the boundaries of existing systems and business protocols. Development of a consistent approach to performance measurement and reporting has also been completed and a third stage of major reform of performance measures, development of new approaches and the identification of opportunities for further strategic development work continues.
- hospital based health services report financial and operating information on a monthly basis which includes data addressing a number of key indicators of efficiency and financial viability. In turn, management information derived from these reports is circulated back to the larger hospitals for comparative review and discussion on a monthly basis. Industry performance reporting is now consolidated as a web based annual *Hospitals Comparative Data* report, which presents information on admitted patient expenditure, total nonadmitted patient occasions of service, and workforce data.

### 7.2.3 Queensland

Using known and projected impacts of the burden of disease and health differentials, Queensland Health has developed a comprehensive and compelling case for a set of Strategic Directions to ensure appropriate development of the State's health services from 2000 to 2010. The Queensland Health Strategic Plan 2000–2010 articulates three principal strategic directions that need to be progressed to optimise health gain through effective balance of investment and adoption of an integrated approach to service delivery. The Strategic Directions for 2000–2010 are:

- addressing the Burden of Disease;
- investing in Public Health (prevention, promotion, and early intervention); and
- improving Indigenous Health.

The Queensland Government has also committed to ensuring that service delivery is aligned with government priorities and positive outcomes for Queenslanders under the State's 'Charter of Social and Fiscal Responsibility'. Consistent with that commitment, Queensland Health has developed a set of Health Outcome Plans and Population Policy Frameworks addressing the three Strategic Directions. The objectives of these plans and frameworks are expressed as a set of key outcomes addressing the National Health Priority Areas of older people, Aboriginal and Torres Strait Islander peoples, women, and child and youth health.

### **Performance reporting**

The Queensland Health Strategic Framework is the basis for coordination of strategic and operational planning, budget development and resource allocation across the organisation. An integrated structure of Outcome indicators and Output performance measures and targets for both external reporting and internal management purposes is incorporated into the Strategic Framework. Queensland Health undertakes a comprehensive annual cycle of evaluation and reporting of financial and non-financial performance indicators.

### **Maintaining the value in performance monitoring**

These developments are all aimed at providing Queensland Health with information to better assess need, manage resources and provide services to improve the health and wellbeing of Queenslanders. For resources to be targeted and delivered effectively, it is essential that Queensland Health identify the areas of greatest health gain. Interventions targeted to address these high gain areas will become core business for Queensland Health and be reflected in planning long-term, system wide patterns of investment in health service development across the acute, non-acute, primary health and community support sectors.

Therefore, development of Queensland Health performance management systems focuses on the following:

- using indicators based on current best practice (for example, the National Health Performance Framework);
- using indicators that motivate for improvement in health service delivery;
- using indicators that make sense at various levels of health service delivery; and
- establishing a cycle of reporting (annual, mid-year, quarterly) to assess performance and assist managers in using performance reports to initiate changes in practice.

In order to progress the establishment of this framework for reporting, the following activities are being pursued:

- identifying the information needs required at different levels of planning, management and reporting;
- determining the relationships between the information at each level;
- setting standards for the gathering, analysis and utilisation of that information;
- design of report format for user-friendly and timely reporting against these indicators; and
- provision of training in management processes to enable effective use of such reports.

### **Meeting public perceptions and expectations**

The Queensland Health Strategic Plan 2000–2010 is a site map on the Queensland Health Internet and intranet sites, and is linked to all associated plans, performance reports and research documentation and to the Commonwealth's Health *Insite* portal.

#### **7.2.4 Western Australia**

Current approaches to performance measurement in the Western Australian Health System reflect the implementation of an Output Based Management framework across the Western Australian State sector and the adoption of a purchaser/provider model for the Health System.

The Western Australian Health System is currently in a period of transition. A recent review commissioned by the Government recommended a number of changes to the structural and organisational arrangements for the Health System.<sup>1</sup> The implementation of these new arrangements will provide the basis for developing and implementing a comprehensive, coherent and robust performance measurement strategy and framework to underpin performance management and accountability within the Western Australian Health System.

<sup>1</sup> Health Administrative Review Committee (2001), *Report of the Health Administrative Review Committee*, June, unpublished.

The Department of Health is funded within the Output Based Management framework. This framework is the principal mechanism by which the Government's expectations and the outcomes sought are integrated with the outputs purchased from the Department of Health. The Department is, in turn, responsible for securing the delivery of outputs from health services that reflect the Government's expectations.

The overall goal of the Western Australian Health System is to promote, protect and restore the health of the people of Western Australia. The Department of Health's model for service planning and purchasing provides an integrated focus on intervention strategies, health conditions and populations. (A reporting framework has been adopted to provide an integrated approach to planning, purchasing and performance reporting.)

The reporting framework has guided the development of a comprehensive set of key performance indicators reported by the Department of Health, and Health Service providers in their annual reports to Parliament and the public of Western Australia.

Work has commenced to review performance measurement, monitoring systems and evaluation processes within the Western Australian Health System. The key aim is to further develop the framework that underpins performance measurement and management. This will support the development of a coherent and integrated set of performance indicators to be used as a basis for reporting and benchmarking across all levels of service delivery.

### **7.2.5 South Australia**

The SA Department of Human Services has developed a Planning Framework to align the various plans that contribute to the achievement of strategic directions prescribed in the Human Services Portfolio Strategic Plan. The development of broad outcome measures and key performance indicators at the various planning levels have been promoted across the portfolio. Measures and indicators have evolved in high order Service Improvement Plans including Moving Ahead (Older Persons), Mental Health, Disability and Aboriginal Reconciliation. Key performance indicators that are relevant to the various business units and programs are emerging in business plans. Progress reports are collated for both levels of plans every six months.

The Department is in the process of reviewing the output classes and measures reported to the SA Department of Treasury and Finance. The revised measures will be reported from 2002–03. Where appropriate, output measures are aligned to the performance information profiles for the respective Service Improvement Plans.

The Department is in the process of rolling out a Service Excellence Framework that was developed in consultation with funded services in 2001. The Framework articulates the Department's expectations of funded services in the context of the Human Services Portfolio Strategic Plan. Eight categories have been defined and a series of sub-elements have been defined in matrix form. The Framework includes a service excellence cycle of planning, controls assurance, continuous improvement and performance management which are integral to the elements. It is intended that services will conduct self-assessment against the Framework and then seek validation by an independent assessor. It is anticipated that the achievements of services will become integral to the annual funding and service level agreement negotiations. Where services are assessed as implementing the organisational learning elements, the assessors will conduct a benchmark assessment of the respective service against 'like' prominent agencies.

The reporting of performance information is currently prescribed in health funding and service level agreements. It is anticipated that the nature of this information may be expanded as the number of services actively assessing themselves against the Service Excellence Framework increases.

### **7.2.6 Tasmania**

The Tasmanian Department of Health and Human Services has adopted the National Health Performance Committee's Framework as a basis for measuring and monitoring its own performance. This reflects an increased emphasis on performance monitoring and improvement through which an annual performance review will be conducted using each of the three tiers of the national framework and from this, performance issues/areas for improvement will be distilled and used as the basis for quarterly monitoring. Like the national framework, there is considerable work to be done around indicator selection and/or development.

The Tasmanian approach has also expanded the framework to accommodate both the broader notions of health and wellbeing together with a health and human services system. The Agency is currently working on incorporating the community developed benchmarks set by 'Tasmania Together' into the

framework. Tasmania Together is a 20 year social and economic blueprint for the future that was developed independent of government influence and through the work of community leaders and extensive community consultation. Government agencies will be required to report annually to an independent body on their performance against a range of population-based indicators and targets. Strategic activity towards the achievement of targets will be monitored through the State Government budget process on both a 3 and 1 year basis.

The approach to benchmarking in Tasmania centres around comparison of State performance with that of other jurisdictions and national averages against a range of indicators sourced from the Report on Government Services, published data from the Australian Institute of Health and Welfare, Australian Council of Healthcare Standards and indicators relating to National Health Priorities.

## 7.2.7 Australian Capital Territory

### Quality and safety

The Australian Capital Territory health care quality strategic and operational plan 'Quality First' has been developed in response to a commitment under the 1998–2003 Australian Health Care Agreement. The primary focus is to address quality within the Australian Capital Territory hospital system. In addition, as hospitals operate as an integral part of a wider health care system, those services at the interface between the hospital and the wider health system which have an impact on hospital services are included in the Plan.

### Significant projects to be implemented based on the Plan include the following:

- The Australian Patient Safety Foundation's Australian Incident Monitoring Scheme (AIMS) is currently being implemented across the ACT Health portfolio. The system will provide a uniform mechanism for capturing details of health care incidents, will guide the development of strategies for reducing their occurrence and will measure the effectiveness of such strategies.
- The two hospitals have implemented a Clinical Health Improvement Program where the aim is to improve patient clinical outcomes by clinician involvement in the ownership of services and care. The program facilitates peer clinicians to develop best practice clinical pathways, measure variation from the pathway and determine the cause of the variation. The objective is to reduce variation and to enable consistent replication of the best possible outcomes.
- The aim of the Falls Clinic project is to reduce fall related injury notably fractured neck or femur by implementing protocols for multidisciplinary risk assessment treatment, of older people at risk of falling, and improved continuity of care. Linkages are to be developed between tertiary and primary care settings and increase awareness of risk factors in both the hospital and community settings.

### Benchmarking

The Canberra Hospital provides data to the Benchmarking Consortium for use in the publication of the Casemix Review which compares data for DRGs and Clinical Service Groups between hospitals in the Group. A 'Report Card' in the Report indicates direct comparisons at a DRG level allowing the hospital to compare its practices with better performing hospitals or to act as a mentor for those hospitals not performing as well. A set of performance indicators including risk, quality access, service efficiency and cost efficiency measures are submitted annually to the South Eastern Australasian Hospital Benchmarking Consortium for inter-hospital data comparisons.

### Purchase agreements with public hospitals

Under the purchase agreement that the Department has with public hospitals is an agreed reporting framework as a schedule to the contract. Monthly reports are required on admitted patient care, emergency department waiting times, elective surgery waiting list and a monthly data bulletin. Quarterly reports are required in line with the Department's obligation under the Australian Healthcare Agreement. A quarterly revenue report is also required.

The reporting framework is compatible with the third tier of the NHPC Framework 'Health System Performance'. Monthly reports against the performance indicators address effectiveness, appropriateness, efficiency, accessibility and responsiveness. The service quality components of the agreements address safety.

## 7.2.8 Northern Territory

The Department of Health and Community Services has strategic goals aimed at strengthening the capacity of Northern Territory non-government and private sector organisations to deliver health and community services and developing a far more robust and diverse health sector. It is anticipated that the Department of Health and Community Services will be replaced as the main service provider over

the next 5–10 years. The Department of Health and Community Services Funder–purchaser–provider framework has been modified by replacing ‘purchasing’ with a ‘service development’ function to achieve the capacity building objectives.

There are a number of initiatives driving a strategic approach to performance measurement across the care continuum:

- the Primary Health Care Access Program through the Department of Health and Ageing. This program provides funding for Health Service Zones in rural and remote areas to overcome access issues and build local capacity to manage health services.
- the reform in the non-government sector to align policy objectives with funding, service plans and monitoring.
- service level agreements for the five public hospitals in the Northern Territory to report on access, effectiveness, appropriateness, quantity, quality and consumer participation.
- the NT Treasury has commenced the introduction of accrual accounting and output based funding requiring development of output measures over 3–5 years.
- requirement for the annual report to provide more quantitative health and costing information related to strategic goals and policies.

The Department of Health and Community Services has adopted the National Health Performance Framework for development of performance measures and reporting in the future. Box 7.2 identifies progress in reporting against the framework.

### Box 7.2: Territory Health Services Performance Measures

#### Health Status and Outcomes

Health conditions	<ul style="list-style-type: none"> <li>* Statutory reporting of communicable diseases quarterly by the Centre for Disease Control</li> <li>* 2001 Report on prevalence and incidence of five Chronic Diseases in the NT based on disease registers and community based research</li> <li>* Report on injury and trauma is in preparation and to be completed by March 2002</li> <li>* Mothers and Babies health status (midwives collection) reported annually (1999 Report in press)</li> <li>* Report on health status of infants to young adults in the NT (1998)</li> </ul>
Human function	<ul style="list-style-type: none"> <li>* Non-fatal burden of disease for injury has been prepared but not published</li> </ul>
Life expectancy and wellbeing	<ul style="list-style-type: none"> <li>* Burden of Disease Study in preparation for the Aboriginal population. To be completed by October 2002</li> </ul>
Deaths	<ul style="list-style-type: none"> <li>* Mortality Report 1979–1997 (published in 1999)</li> <li>* Note: Currently attempting to produce morbidity and mortality by the 21 Health Service Zones.</li> </ul>

#### Determinants of Health

Environmental factors	<ul style="list-style-type: none"> <li>* Water quality monitoring reports by the NT Power and Water Authority</li> <li>* Food Market Basket (Remote areas) cost, availability and quality of fresh fruits and vegetables, assessed and reported annually</li> </ul>
Socioeconomic factors	<ul style="list-style-type: none"> <li>* Education levels reported in the Statistical Report on Chronic Diseases and Infancy to Young Adulthood report</li> <li>* Employment reported in the Statistical Report on Chronic Diseases and From Infancy to Young Adulthood report</li> <li>* Income reported in the Statistical Report on Chronic Diseases and Infancy to Young Adulthood report</li> </ul>
Community capacity	<ul style="list-style-type: none"> <li>* Health Services locations reported in the Department of Health and Community Services Annual Report</li> <li>* Use of services and professionals in CATI Survey report</li> <li>* Others being defined and developed</li> </ul>
Health behaviours	<ul style="list-style-type: none"> <li>* Tobacco and alcohol consumption reported annually</li> <li>* Measures of physical activity under development</li> <li>* Breast feeding reported periodically</li> </ul>

Person-related factors	* Congenital abnormalities reported in the Mothers and Babies health status (midwives collection) reported annually. 1999 Report in press
------------------------	---

---

### Health System Performance

---

Effective	* Reported for hospital sector and for Chronic Diseases and Communicable Diseases (immunisation rates)
Appropriate	* No activity
Efficient	* Relates to Treasury Output Measures * Reported for hospital sector and for Chronic Diseases * More work planned on service costs
Responsive	* Consumer reporting by hospitals * Health Complaints Commission Reports annually
Accessible	* Reported for hospital sector and for Chronic Diseases * Health Complaints Commission Reports annually * Patient Assisted Travel Scheme Reports and Inter-hospital Transfer Reports by activity and cost
Safe	* Reported for hospital sector and for Chronic Diseases * Health Complaints Commission Reports annually
Continuous	* No activity
Capable	* Accreditation rates available but not reported for community health, hospitals, GPs * Health Registration Board reports on qualifications * Workforce Planning Statistics on industry based training and competency frameworks
Sustainable	* Health Research expenditure, Aboriginal Health expenditure, Public Health expenditure, Mental Health expenditure all reported currently

---

## 7.3 Other benchmarking related activities across Australia

### 7.3.1 The Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) Performance and Outcomes Service (POS) was established with the aim of developing measures of the quality of patient care in health care organisations.

The measures, called 'Clinical Indicators', are defined as objective measures of the clinical management and outcome of patient care in quantitative terms. Clinical Indicators are 'flags' which can alert to possible problems and opportunities for improvement in patient care. They lend objectivity and interest to quality activities by allowing for comparison of performance against national aggregate data. Clinical Indicators have been developed in partnership with a wide range of Australian Medical Colleges, Professional Associations, specialist societies, clinicians, consumers and interested parties.

There are three basic principles used to develop Clinical Indicators:

- That they be relevant to practice in the health care industry;
- That the relevant data are available;
- That the measure is achievable.

#### For further information:

<http://www.achs.org.au>  
Phone 02 9281 9955  
Email [pos@achs.org.au](mailto:pos@achs.org.au)

### 7.3.2 The Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) is widely recognised as the arbiter of standards for general practice. As well as setting the standards for general practice training, assessment of competence, and quality assurance, the RACGP also sets the standards for general practices, embodied in *Standards for General Practices*, 2nd edition.

#### Accreditation of general practices

These standards are applied so that accreditation of general practices should:

- aim to attain the highest quality of general practice in an achievable and gradual manner
- provide a publicly recognisable measure of quality in general practice
- be voluntary, but should have tangible benefits
- be for a defined period
- be an educational and developmental process and not a punitive one
- be in the hands of the profession.

#### For further information:

Director, Assessment and Practice Standards, The Royal Australian College of General Practitioners, 1 Palmerston Crescent, South Melbourne, VIC 3205.

Website: <http://www.racgp.org.au>

General Manager, AGPAL, PO Box 2058, Milton, Qld, 4064.

Web site: <http://www.agpal.com.au>

### 7.3.3 Australian Private Hospitals Association

Australian Council on Healthcare Standards accredits the vast majority of private hospitals (78%). By comparison, only 52% of public hospitals are similarly accredited. Therefore most private hospitals are reporting on indicators established by the Council (National Health Performance Committee, 2000).

Health insurance funds are now using the ACHS information to inform their purchasing decisions. This is an issue with private hospitals, as the quality or clinical indicators reported on for the ACHS were intended to be used by facilities to improve care outcomes. Where hospitals are at risk of not being contracted by a major insurer unless, for example, unplanned readmissions to theatre figures are 'good', there is the real risk of data manipulation so as to present the best face to a potential purchaser. This, of course, degrades the potential for outcomes data to be used for its primary purpose – care improvement.

Private hospitals have therefore resisted the provision of clinical, quality and/or outcomes data to non-provider agencies. Consequently there are no standardised outcomes data collections in the private sector.

### 7.3.4 Australian Health Insurance Association

Health insurance funds use a variety of performance indicators to inform their decision making process in relation to hospital contracting. While some funds use, or seek, more sophisticated data than others, most compare data such as cost, readmission rates and average length of stay, and other material drawn from the Hospital Casemix Protocol to allow them to benchmark and compare hospitals. Accreditation by ACHS is used by many funds to determine benefit levels, etc.

Health funds are anxious to obtain more data about hospital performance particularly in relation to outcomes. Private hospitals have been less than enthusiastic about supplying such data, and indeed have opposed any attempt by funds to tie payments to outcome or similar data.

Health insurers believe the provision of quality data is an important component of their funding strategies. This interest in developing systems which promote improved quality in the private hospital sector with a view to encouraging 'health gain' and assist hospitals in improving their own performance is expected to continue. Some progress has been made in discussions relating to psychiatric care, where a committee involving the medical profession, private hospitals, insurers and consumers have agreed on a model for collecting and analysing data relating to outcome measures.

### 7.3.5 Hospital Benchmarking Roundtables and Consortia

The Health Roundtable Limited is a membership organisation structured as a not-for-profit company limited by guarantee. The aims of the organisation are to provide opportunities for health executives to learn how to achieve Best Practice in their organisations; to collect, analyse and publish

information comparing organisations and identifying ways to improve operational practices; and to promote interstate and international collaboration and networking among health organisation executives.

Membership in The Health Roundtable is by invitation to hospital Chief Executives only. The Chief Executives are invited to become personal members, and their hospitals are then invited to become organisational members. Members are organised into 'Chapters' to facilitate ongoing small-group discussions. Each Chief Executive is expected to serve on the Board of Directors of the Chapter of The Health Roundtable to which he or she belongs in order to set the agenda and monitor progress. Members may invite a limited number of guests to participate in activities of The Health Roundtable. The 22 hospitals within The Health Roundtable account for over 20% of all public hospital admissions in Australia and New Zealand, with well over one million inpatient episodes per year.

The Health Roundtable process is based on two major approaches: workshopping key issues and analysing casemix performance. The workshopping process uses face-to-face discussion of key operational issues and innovations involving the Chief Executives, key clinicians, and management staff of each member hospital. Workshops have concentrated on ways of improving the management of clinical processes. In addition, workshops with clinical information and casemix data managers from each hospital have been convened to review the techniques of data analysis and the differences in data practices between hospitals. The Health Roundtable also provides in-depth comparative analyses of casemix performance to all member hospitals every six months.

The members attribute the success of The Health Roundtable to several key factors including:

- voluntary participation by hospital chief executives
- emphasis on practical operational issues with solutions that can be implemented immediately
- direct control of the agenda and priorities by the members themselves
- focus on face-to-face discussion of real data with peers from other hospitals
- active involvement of hospital managers and clinicians from several disciplines
- recognition that all member hospitals have innovative practices to contribute
- confidence that the information shared within the group will not be revealed to others and will not be used to the detriment of any member
- independent, professional analytical support by the benchmarking organisation.

The Health Roundtable's agenda is set by the Board of Directors of each chapter, and modified during the year as new issues emerge. It is expected that the agenda will continue to include comparisons of practices in specific clinical specialties, analysis of key functional areas such as nursing, and increased workshopping of clinical cost comparisons.

#### **For further information:**

Dr Michael Walsh (Alfred Hospital) is the current President of The Health Roundtable Limited.

Dr David Dean serves as the General Manager.

#### **For further information about The Health Roundtable or licensing its methodologies, please contact:**

General Manager  
The Health Roundtable Limited  
PO Box 438  
Turrumurra, NSW 2074  
Phone: (02) 9440 2016  
Email: david.dean@hrt.org.au.

### **7.3.6 Benchmarking in Women's and Children's Hospitals**

Women's Hospitals Australasia and the Children's Hospitals Australasia have a number of initiatives in hand to assist member hospitals in enhancing the health and wellbeing of women, children and neonates. Their benchmarking initiatives are focused on providing information to support clinical improvement. The features of the Associations' program are that it is clinician driven, comprehensively supported by all levels of management and is thus not 'top down' or 'paper driven'.

#### **Key performance indicator development**

Member hospitals are currently identifying a number of key performance indicators that are useful to clinicians in enhancing their clinical practice. The indicators are being developed to ensure that the outcomes of the clinical forum program are measurable and support the concept of enhancing the quality, safety and cost effectiveness of the services provided. The indicators will be included in the national database.

### **Clinical improvement program**

Over the last twelve months, the Associations have conducted successful programs of clinical improvement on the vexed topics of caesarean sections and perioperative issues. A number of initiatives are in hand to ensure that hospitals are able to achieve best current practice.

It should be noted that the Associations comprise the leading women's and children's hospitals, as well as major women's and children's units in general hospitals throughout Australia and New Zealand.

#### **For further information:**

Anne Cahill, National Director, Women's Hospitals Australasia and the Children's Hospitals Australasia, Level 1, 99 Northbourne Avenue, Turner, ACT, 2612, telephone (02) 6230 4400, fax (02) 6230 6699, email: [acahill@wha.asn.au](mailto:acahill@wha.asn.au)