

AIHW consultation: performance indicators for new health care agreements

Purpose of this paper

The Australian Institute of Health & Welfare (AIHW) has been commissioned by the Australian Health Ministers to develop a suite of performance indicators for use in the new health care agreements to be negotiated following expiry of the current 2003-2008 Australian Health care Agreements (AHCAs). The AIHW is required to develop a draft set of indicators in consultation with stakeholders for comments by the NHHRC by the end April, 2008, refine indicators, develop technical specification for indicators and to provide a finalised indicator suite by the end of June, 2008.

AIHW has held consultations with key stakeholders to ensure that the new health care agreements incorporate performance indicators that are supported by stakeholders and inform key health care and health reform objectives. Bill Newton (CEO, GPV) attended one of these meetings with the National Primary and Community Health Network on 9th April 2008 where he conveyed many of the comments in this paper.

This paper documents GPV's initial thinking about indicators for the health system. We are providing it to AIHW but we anticipate there may be further opportunity for input over the next 12 months, particularly in light of the National Health & Hospitals Reform Commission. If our member divisions have comments on the issues raised here, please let us know so we can take them into account in our future advocacy, by contacting policy analysts Lucio Naccarella (l.naccarella@gpv.org.au) or Louise Willis (l.willis@gpv.org.au) or Bill Newton, CEO (b.newton@gpv.org.au).

Background Information: Australian Institute of Health & Welfare (AIHW) consultation

The Australian Institute of Health & Welfare (AIHW) has been commissioned by the Australian Health Ministers to develop a suite of performance indicators for use in the new health care agreements.

To date AIHW has prepared seven papers to support the consultations, including:

- Structure of the health & aged care sector
- Relevant communiqués about indicators for the new health care agreements
- Consultation processes
- Principles & framework for health performance indicators
- Indicator assessment process
- AIHW team
- Early draft of indicator suite for consultation.

Based on early consultations, relevant communiqués and existing literature, the AIHW has developed a draft set of working principles for health performance indicators to guide the work including:

- Universal access to the health system
- Equitable access to the public health system, based on needs not ability to pay
- An increased focus on prevention
- High quality care delivered in all health care settings
- A focus on increasing integration and continuity of care

- A focus on care provided efficiently
- A focus on delivering care that is patient-centred
- A health system which is sustainable

AIHW has also assessed about 150 indicators to produce a suite of draft indicators grouped into ten areas:

- Better health (10)
- Focus on prevention (10)
- Access (9)
- High quality – appropriate (14)
- High quality- safe (7)
- Integration and continuity of care (6)
- Patient centred (8)
- Efficiency (3)
- Sustainable (3)
- Contextual indicators (4)

Summary of GPV comments & issues

GPV's comments have been clustered into five categories:

1. Principles underpinning the AIHW performance indicator suite
2. Structure of AIHW performance indicator suite
3. Standards for access
4. General practice specific performance indicators
5. Detailed comments on AIHW draft performance indicators

1. Principles underpinning the AIHW performance indicator suite

GPV has previously advocated for the development of a primary care policy that addresses the criteria to measure health system performance contained in the National Health Performance Framework.¹ We are therefore pleased to see many of the National Health Performance Framework criteria reflected in the draft AIHW indicator principles. If this is what is intended, an explicit reference to the National Health Performance Framework might be useful, to help maintain a consistent strategy and approach in the development of health performance indicators, given that there are many different stakeholders involved at different levels across Australia.

A key principle underpinning the draft indicators is no. 5. about increasing integration and continuity of care between community / primary care and acute care as well as between acute care and aged care. We believe this principle also needs to include '*Coordination between services within primary care*', given the continual ongoing challenge that arises due to the mix of Commonwealth and state funding arrangements (ie the Commonwealth subsidises provision of general practice services through Medicare rebates, while the state funds all other publicly available primary care services).

2. Structure of AIHW performance indicator suite

Grouping the indicators around the headings access, integration etc is useful but their purpose is only implied in those headings. Each group of indicators needs an objective to make it clear what

¹ See [Policy Issues Paper 22 The need for a primary health care policy](#) at www.gpv.org.au; click on policy; discussion papers.

the purpose of the indicator is. Best practice advocates using several indicators to show whether an objective has been met.

The indicators require several other types of information such as: success criteria (there is no sense of any targets etc in the indicators); likely data source (eg client, patient, organisation surveys or at what level the data source is required); current availability of data source (including the data's quality, and how comprehensive it is).

If the performance indicators are to be used to monitor health system performance, it may be strategic to use a 'systems approach' to think about the different indicators required to monitor the different components of a system. For example when the Canadian Government were looking to reform their primary health care system², they set out to map the system comprising:

- Inputs required (financial and human resources);
- Activities required to occur (eg changes in clinical activities, health care management, and policy & governance);
- Outputs (eg., types and qualities of services);
- Immediate outcomes (eg., reduced risk to patients, inc PHC workforce);
- Intermediate outcomes (eg., health care system acceptability & equity); and
- Final outcomes (eg., sustainable health care; improved pop health etc).

At each of these levels or domains performance indicators could be identified and used to reform and monitor Australia's health system.

More recently Duckett & Ward, M (2008)³ have argued that the choice of frameworks to guide performance indicators and subsequent performance measures need to reflect how the health system works, what is to be valued, and how benchmarks are to be used. They proposed a 'value-cube' framework as a way to ensure that the choice of performance indicators takes into account that the health system is dynamic; includes the diverse perspectives of the patient, clinician and funder; and makes transparent the interrelationships among the diverse perspectives. They also suggest a careful consideration of when we should use process indicators rather than outcome indicators, because, when they are based on good evidence linking the process to a desired outcome, they provide more easily for improvement plans to be implemented in health services, whereas the question of how to improve *outcomes* can be far more complex and it can be difficult to identify the best contribution that health system performance could make to improving the outcome.

3. Standards for access

We suggest that more thought needs to be given to developing indicators for access, and that the AIHW national performance indicators should define 'minimum standards' for access as well as quality. In Victoria, we have experienced the results of examining access and quality in isolation, which has resulted in poorer access to services in some areas. The Victorian Department of Human Services (DHS) uses capability frameworks to enable a range of services to assess themselves against a series of standards for provision of services. The frameworks do not define minimum standards for access and consequently an agency may assess itself as not able to meet the standards at given levels, close that service and require people to travel further to access the same type of service. A better response would be to define minimum standards for access with

² Watson, D (2004), Results-based Logic Model for Primary Health Care, Centre for Health Services and Policy Research. <http://www.chspr.ubc.ca/files/publications/2004/chspr04-19.pdf>

³ Duckett, S and Ward, M (2008) Developing robust performance benchmarks for the next Australian Health care Agreement: the need for a new framework. Australian and New Zealand Health Policy, 5(1): 1-16. <http://www.anzhealthpolicy.com/content/5/1/1>

reference to time, money and distance. Developing standards for quality without the corresponding standards for access should not be an option. Equally, measuring indicators for access with no indication of the target level, is problematic.

4. General Practice specific performance indicators

At this stage, it is likely that the Practice Incentive Payments (PIPs) and Service Incentive Payments (SIPs) along with appropriate MBS items for particular GP activities might provide the best basis for general practice indicators. (e.g. the proportion of people with diabetes who have received an annual cycle of care – draft indicator # 43; asthma 2+ plan.) This is because this information is collected from all practices and available through Medicare Australia. But one of the problems that may arise from basing indicators on Medicare items and Practice Incentive Payments (PIPs) is that these are subject to change. (For example, the PIP for immunisation has been removed in the 2008-09 federal budget. Also, the commonwealth government has announced its intention to review the MBS, which may alter the detail of items such as the Enhanced Primary Care (EPC) items (draft indicator #34).

In the future, it may be more useful to devise indicators related to the general practice indicators that divisions of general practice are contracted to report on to the Commonwealth Department of Health & Ageing. This is because, in the context of a health system funded by both state and commonwealth levels of government:

- General Practice cannot achieve improvements in these areas without efforts from the state funded primary health care system.
- Complementarity between state and commonwealth directions in health system development would be enhanced if the same performance indicators applied to both state and commonwealth sectors
- Given that general practice is the source for the data suggested below, making them into national performance indicators would provide imperatives for:⁴
 - state funded agencies to orient services to address (at least some of) the same health outcomes as general practice
 - state health to consider if they have a role in funding some of the system/capacity development within general practice to get better recording of data
 - divisions to share and monitor data with state health and their primary health care partners eg community health services (CHSs), district nursing, other health services
 - state health to fund building capacity and reorienting CHSs to achieve alignment with general practice.

These indicators for future consideration would build on the type of content in draft indicator #43 (the proportion of persons with diabetes mellitus who have received an annual cycle of care within general practice) and could include:

- Number of patients with diabetes whose last recorded HbA1c within the previous 12 months was less than or equal to 7.0%; greater than 7% but less than or equal to 8.0%; greater than 8.0% but less than 10.0%; greater than or equal to 10.0%; or not recorded
- Number of patients with coronary heart disease whose last recorded blood pressure within the previous 12 months was less than 140/90 mmHg.
- Number and proportion of female patients aged 20-69 whose patient record shows that they have had a Pap Smear in the last two years.
- Average immunisation coverage rates for 60-63 months age group.

⁴ Immunisation is an exception, as we have national database, the Australian Childhood Immunisation Register (ACIR). This is a unique situation.

The alignment of state and commonwealth priorities to enhance the contribution of general practice through jointly agreed indicators would be welcome. However at this stage it may be premature to include the sorts of indicators we have listed here, as there are a range of implementation and data quality issues about collection and transmission of general practice data by divisions of general practice which have yet to be worked through. Divisions are obliged to meet targets for the indicators they collect for the Department of Health & Ageing, through the National Quality and Performance System (NQPS) that forms part of their contracts, so the data would not yet cover all practices and therefore would not yet provide a reliable national picture. For the indicators above on CHD and diabetes, divisions are required to collect data from at least 10% of GPs in the first year.⁵ The national Primary Care Collaboratives project has collected this type of data from the practices involved, and, along with other resources, fed it back to them as an incentive for clinical improvement in the practice. Results of the Collaboratives are very promising, but it is been a resource-intensive program, and also does not involve all practices.

5. Detailed comments on AIHW draft performance indicators

- GPV welcomes the inclusion of draft indicator #30 – proportion of hospitals and GP practices accredited – and draft indicators #51-56 focussing on continuity of care.
- Indicator #24 – RPBS/PBS scripts per person. Does this mean prescriptions completed by doctors, or those that are filled as they may be quite different figures. If written, perhaps this could act as disincentive to GPs to write scripts, which in turn could increase number of GP services per person, if for instance, a patient is sent home with an instruction to return for a script for antibiotics in a number of days if an infection has not cleared up, rather than taking a script with them on that occasion to have filled if necessary.
- Indicator #52 – Proportion of hospital patients with a discharge plan (aged care & rehabilitation) and proportion that are done electronically. This indicator does not include a measure of time such as ‘within 24 hours’. It was noted that the proportion of hospital patients with a discharge plan is only suggested for aged care and rehab patients (#52), and for mental health community care (#54). We suggest it would be better to measure the number of patients with discharge communication sent to GPs within 24 hours for all inpatients, apart from chemotherapy and dialysis patients. An area of ongoing concern for divisions of general practice is the need to improve transmission of discharge information to the patient’s GP, to enable better patient care but this tends to be a relatively low priority for hospitals.
- Indicator #53 – Proportion of people entering residential aged care who have previously accessed community care. Community care needs to be defined more clearly.
- Indicator #56 – Review of medication use – need to clarify which target group this is intended to apply to.
- Indicator #59 – Waiting times for GPs. This is not noted by AIHW as requiring development; but how would this be measured? It is likely to be a complex undertaking, as it is not commonly measured by practices, unlike the other general practice-related indicators that are suggested.
- Indicator #68 & 69 – Health workforce inflows and number of training positions (medical and nursing). We would suggest that it would be useful to include practice nurses as a workforce target within this.

⁵ The draft performance indicators for the divisions of general practice are issued by the Primary Care Practice Support Branch of the Commonwealth Department of Health and Ageing.

Appendix

Knowledge to inform performance indicator development

This section provides a brief summary of several documents relevant to the development of the national performance indicator suites which has informed our thinking so far.

- **Murray CJL, Evans DB, 2003. *Health Systems Performance Assessment: Debates, Methods and Empiricism*. Geneva: World Health Organization.**
http://www.who.int/health_financing/documents/cov-hspa/en/index.html. This WHO work identified key issues needing work when developing performance assessment frameworks, including:
 - the lag between introducing interventions and their impact on outcomes;
 - the ongoing challenges with data quality and availability, especially of long consistent time series;
 - the comparability of data definitions across countries needs improving, particularly in the area of responsiveness;
 - the time frame required for analysis and reporting of performance depends on multiple competing purposes, including policy design for strategic decision-making, program implementation and management, monitoring of outcomes or achievements and evaluation of what works and what does not in health systems;
 - the contribution of poverty to inequality needs more explicit linkage; and
 - the health system performance assessment needs to be directly relevant to health policy.

- **PHCRIS (2004). *Performance Indicators in Primary Health Care*. *Journal Watch*. August 2004.** <http://www.phcris.org.au/publications/ebulletin/archive.php>. This issue by the Primary Health Care Research & Information Service (PHCRIS) provided an overview of performance indicators, clarified their purpose and discussed issues regarding their use. The issue raises several points of importance to the AIHW work including:
 - Performance frameworks should be considered at both conceptual and technical levels
 - Performance indicators can have beneficial and detrimental consequences including: goal displacement, sub-optimisation, short term focus, misrepresentation and gaming
 - Selection of indicators and implementation of performance management systems should be designed to maximise cost-effectiveness of data collection, analysis and communication of results
 - Performance indicators must be worth measuring, be measurable for diverse populations, be understood by people who need to act, galvanise action, be relevant to policy and practice, reflect results of actions when measured over time, be feasible to collect and report, and comply with national processes and data definition
 - Performance is a multidimensional concept. No single indicator is sufficient to assess organisational or system performance
 - Performance indicators can relate to structure, process or outcomes. The value of a process measure depends on the strength of evidence linking it with ultimate outcomes
 - If performance indicators are being used to ensure accountability they should measure aspects of performance over which the organisation has control.

- **Asbroek et al (2004). *Developing a national performance indicator framework for the Dutch health system*. *International Journal for quality in Health Care*, 16(10): 65-71).** This paper reports on a literature review conducted to inform the development of the Dutch health system performance framework. It revealed three main conditions:
 - Performance frameworks must be coherently balanced, covering performance dimensions such as effective, efficiency, quality and equity
 - Performance frameworks need to involve information originating from all sectors in the health care system(prevention, cure, care, and social service)

- Performance frameworks need to link performance of health services to population health using public health data.

The Dutch performance indicator framework is based on a ‘balanced scorecard’ approach, which provides managers with a comprehensive, balanced, yet minimised amount of management information from multiple perspectives, including consumer, financial, internal business processes and innovation perspective.

- ***Sibthorpe B & Gardner, K (2007). A conceptual framework for performance assessment in primary health care. Australian Journal of Primary Health, 13(2). 96- 103.*** This paper reports on the development of the Framework for Performance Assessment in Primary Health Care (FPA-PHC)
 - It is grounded in evaluation theory and it identifies processes of primary health care articulated by WHO.
 - It is based on Donabedian’s structure, process, outcome model for assessment of quality of care.
 - The framework specifies objectives focussed on patients/families/communities and has four indicator levels relating to stewardship, organisational structures and processes, processes of care, and intermediate outcomes
 - The indicators can be mapped to higher order system performance frameworks (eg NHPF)
 - The framework has been adopted for use for the National Quality and Performance System for Divisions of General Practice.

Duckett, S & Ward, M (2008). Developing robust performance benchmarks for the next Australian Health care Agreement: the need for a new framework. Australian and New Zealand Health Policy, 5(1): 1-16. <http://www.anzhealthpolicy.com/content/5/1/1>

This timely paper emphasises that the choice of frameworks and subsequent performance measures is influenced by how we first define and describe the health system (e.g. in institutional terms, like primary and secondary care; in terms of people’s needs for coordinated care, a policy view that gave rise to coordinated care trials in the 90s etc). The paper argues that a system of performance measures needs to focus “not only on the institutions or single components of services but on the interactions between them.” Performance measurement requires a choice about what ‘value’ attributes will be highlighted, and the value can be measured from different perspectives, which are sometimes in agreement and are sometimes opposed.

A ‘value-cube’ framework is proposed as a way to ensure that the choice of benchmarks:

- takes into account that the health system is dynamic,
- takes into account the diverse perspectives of the patient, clinician and funder
- makes transparent the interrelationships among the diverse perspectives.