

Comments on Draft Performance and Accountability Framework

1. Introduction

AGPN has been invited to provide comments on the draft Performance and Accountability Framework prepared by the National Transition Office. Despite short timeframe of seven days for a response initial comments have been drawn from;

- Circulation to Network members, Divisions and SBOs, for written responses. These individual responses will be provided in their entirety to the Transition Office.
- Knowledge and experience of the development of Division and PHCO indicators through the National Network Performance Development project.
- Discussion and comments from AGPN staff and Board members.

Due to the constraints of the consultation timeframe the focus of the comments will be on the value of the overall conceptual framework and approach to the development and use of Performance Indicators. Little attention has been given to the Local Hospital Network (LHN) indicators except where they are shared with Medicare Locals (MLs).

The performance and accountability framework is recognised as a central feature of the health reforms and will be critical to successful achievement of the objectives of MLs. Therefore the Network looks forward to participating more fully in the development of the framework and specific indicators over time. This is particularly important as a number of the proposed indicators and key aspects of the framework are still in the formative stage of development.

2. Overall Approach

2.1 Performance Development and Improvement

Overall, the framework is conceptually sound drawing on the approach of the Report of Government Services and current best practice in the selection and development of indicators.

Significantly it explicitly purports to set performance and accountability within an improvement context over time. The translation of this sentiment into reality is a significant challenge that must be met to lift it beyond the simplistic comparative scorecard. Individual LHNs and MLs are appropriately accountable for their performance however the conditions and support required to achieve and sustain good performance, as well as addressing under performance, cannot be left solely to individual organisations that have significant system responsibilities.

In the case of LHNs the ultimate responsibility for performance improvement is clearly the 'owners', State & Territory Governments, that will utilise the information and analysis provided by the National Health Performance Authority and supporting agencies such as the Australian Commission on Safety & Quality to address issues both individually and collectively. For MLs, the structure to support performance improvement has yet to be articulated as part of the National Health Reform process and therefore there is a significant gap in the draft framework. In respect of under performance of MLs the reliance on the contractual mechanisms available to the funder, DoHA, is a blunt instrument that will do nothing to support a continuous quality improvement approach.

The creation of a national organisation for Medicare Locals was flagged in the Invitation to Apply Guidelines released by the Government in February. Given Australia's particular circumstances whereby government funded organised primary health care organisations are being formed as a network of companies limited by guarantee built on divisions of general practice, AGPN believes that an industry-based national body, including state based functions, is essential to galvanise and build a strong, high performing general practice and primary health care sector through Medicare Locals.

A blueprint for such an organisation has been developed in consultation with AGPN's current members and recently ratified by the AGPN Board. The blueprint will be presented to government in the near future. A fundamental role for the national organisation proposed in the blueprint is to optimise the capacity and capability of the Medicare Local sector to function in a consistent and coordinated manner to fulfil their role as part of the Government's National Health Reform agenda. The blueprint proposes that this would occur through a range of national industry development and quality improvement measures such as organisational standards, competency frameworks, a maturity map and a leadership development program. To make such a regime effective the national organisation needs to be given the authority and mandate to take on such a role.

The way in which performance information is fed back, benchmarked and contextualised needs to be developed in an improvement context and reflected in the reporting regime. A 'league table' of quantitative measures in isolation would not reflect this approach. Although the framework does not suggest this approach there is risk that this would be the outcome in the absence of structures and processes that reflect the ambition of achieving improvement.

2.2 Population Health Data and Performance Information

A significant feature of the overall framework is a separate classification of population outcome/health data to provide context for interpreting ML performance. In principle this approach is fully supported. It is noted that the interplay between these two is dynamic; for example the relationship between the denominator for the Diabetes cycle of care performance indicator (5.3.1.2) and the prevalence of diabetes (5.3.5.3) population outcome measure. Another example is smoking rates that could just as readily be identified as a focus for performance as contextual data. It would be useful to further explore the relationship between the two sets and ML objectives.

Context for ML performance is not solely provided by health status/outcome measures. There is a group of broadly defined socio-economic indicators such as income, employment and educational levels that would be equally if not more usefully described as contextual in terms of performance. Further clarity about the content of the Healthy Communities report may clarify this issue because it appears that these reports will include a further extension of 'contextual' information.

2.3 Performance Targets

Consistent with an overall performance and quality improvement approach the suggestion that improvement from a base line as distinct from absolute targets is preferred in most instances.

The suggestion that not all indicators should be applied immediately but progressive introduction over time is appropriate for newly emerging organisations such as MLs.

3. Performance indicators

3.1 Selection of Indicators

It is recognised that in the selection of indicators there is rarely a situation where all the ideal characteristics are available in one indicator. The availability of data is particularly constraining in the primary health care context.

The work that AGPN has undertaken in this area to develop and pilot performance indicators for primary health care organisations demonstrated these difficulties and the importance of reiterating that performance indicators are just that i.e. an indication and are an adjunct to performance improvement. The draft indicator set developed by AGPN is included at Appendix 1. This set also includes internally, business oriented measures that would not be relevant to a national performance regime. However it is noted that half of the indicators proposed in the draft Framework are the same as those developed in the Network Performance Development project. In addition there are a number focused on similar areas but the proposed measure is different.

A feature of the emerging MLs will be the capacity and mandate to have an impact upon some areas that are implied by the adoption of specific performance indicators. It is vital to make this control and attribution assessment as part of the selection process and recognise where at this stage MLs are contributors and aspire to achieve specific results as opposed to being in control through their own actions. A specific example would be GP waiting times although there are a number of others that fall into this category. The relationship between the indicators and the contracts that MLs will enter into with DoHA to resource action in these areas is critical to the Network.

In terms of the total numbers of indicators the set is probably too large to drive a focus on performance in specific areas as distinct from simply providing information with little or no hope of concentrated action. In the light of subsequent comments about omissions there are number of lower value indicators that could be moved such as 5.3.1.4; 5.3.1.5 or deleted such as 5.3.3.3. The Network would be happy to contribute to a discussion about priorities.

Some specific comments about the proposed indicators are included in a later section but the following gaps were identified:

- Measuring service integration, collaboration and coordination. Shared indicators with LHNs go some way to address this issue but this is only one sector where MLs need to demonstrate effective integration.
- Some indicators should be explicitly shared between LHNs and MLs to align priorities not solely recognition of interdependency.
- A value for money indicator for specific functions could be considered in the financial section. This would need to reflect the variable costs associated with provision of services in rural and remote areas. Given the emerging nature of MLs these could be developed in conjunction with the sector over time.
- Key workforce priorities need to be reflected. Although it is recognised that headcount indicators are generally of little value, consideration should be given to the

ratio of Practice Nurses to GPs as part of the current reform initiative in service redesign.

- It is not readily apparent how the two mental health related indicators would be designed.

3.1 Existing Indicators & Processes

AGPN would support building on and linking with existing frameworks and processes and aligning with and/or using other existing indicators where appropriate. However it is unclear to what extent duplication may occur between some of the existing indicators and whether these are to continue. Where relevant indicators exist, every effort should be made to use these if they are fit for purpose rather than develop other indicators. An assessment of whether the total number of performance indicators is appropriate is dependent upon whether they will subsume other collections or be in addition to these collections.

For MLs the data and performance information requirements through individual programs of funding will also have a bearing on the overall burden of reporting.

In the area of Aboriginal and Torres Strait Islanders there is a significant body of work that may also be applicable to MLs and should be considered in conjunction or as an alternative to the proposed use of an indigenous dimension to all of the generic indicators.

3.2 Medicare Local Objectives

It would be preferable to demonstrate a specific link between the objectives of MLs, performance indicators and health status/outcome measures. This process serves to check the relevancy of the proposed indicator set as well as enabling the Performance Indicators to be clearly embedded in the strategic and operational plans of MLs.

3.3 Comments on Specific Indicators

It is hoped that there can be further input by Network members in the design/ definitional issues inherent in indicator development. In some instances there is insufficient detail in the proposals to make any comments at this stage.

However detailed comments have been made about specific indicators in individual submissions by Network members. The following areas have been noted in a number of submissions:

- If utilisation rates are proposed for GPs and allied health it will require an understanding of what constitutes an 'ideal level' as improvement could be measured in both an increase and decrease of the level (access versus over servicing).
- Proposed financial performance indicator does not measure efficiency
- 5 year survival for cancer and age standardised mortality would be more appropriately classified as contextual.
- Community health service waiting times. Depending on the definitions these may be outside the scope of MLs and may be within the scope of LHNs as providers of these services or State/Territory governments where they fund community health providers directly.
- GP waiting times requires significant industry and professional negotiation in terms of the indicators design, availability of data, relationship to incentives and capacity of ML to influence.

- The policy and design features of a number of 'incentive' programs such as GP services in residential homes, diabetes and asthma cycle of care need to be amenable to change to have an impact upon performance and measure the intended objective.

4. Data Availability

The framework does not make clear the requirements for MLs to have access to data, not only for performance information but in relation to fulfilling the planning and integrating service function at the local level. Agreements need to be concluded between MLs, States/Territories, Commonwealth and other bodies such as Medicare and AIHW to enable timely availability of data. It is vital that MLs can draw upon appropriate and efficient mechanisms to support data capture, retrieval, collation and interpretation to minimise duplication of effort.

MLs will increasingly be required to support the collection of data at a service provider level, particularly for the purposes of quality improvement, service redesign and integration as well as potentially for performance reporting. To enable MLs to capture, retrieve and collate data will require significant resources and expertise.

May 2011