



# The National Health and Hospitals Reform Commission

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## The first report:

Beyond the Blame Game:  
Accountability and performance benchmarks for the  
next Australian Health Care Agreements



## The National Health and Hospitals Reform Commission: The first report

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Included in the terms of reference:

*"By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements, including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care."*



## The National Health and Hospitals Reform Commission: **Initial reflections**

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Transcending 'the blame game' requires a new framework:

- the agreements are one part of the system
- the scope should be broader than hospitals
- being clear about who is accountable for what is fundamental to untangling the web of 'responsibilities' which creates the 'blame game'
- the approach to accountability can shape the funding approach



## The National Health and Hospitals Reform Commission: **Seeing the AHCAs in a broader context**

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What do we want from our health care system?

We have expectations about:

1. what we as citizens and potential patients want (*service design principles*) and
2. how the health system should work (*governance principles*)



## The National Health and Hospitals Reform Commission: **Service design principles**

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- *People and family centred*
- *Equity*
- Shared responsibility
- *Strengthening prevention and wellness*
- Comprehensive
- Value for money
- Providing for future generations
- Recognising that broader environmental influences shape our health



## The National Health and Hospitals Reform Commission: **Governance principles**

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- Taking the long term view
- Safety and quality
- Transparency and accountability
- Public voice
- A respectful, ethical system
- Responsible spending on health
- A culture of reflective improvement and innovation



## The National Health and Hospitals Reform Commission: **Principles (cont.)**

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- The principles should shape the whole health system, public and private, hospital and community based services
- The principles are explained in greater detail at: [www.nhhrc.org.au](http://www.nhhrc.org.au)



## The National Health and Hospitals Reform Commission: **Seeing the AHCAs in a broader context (cont.)**

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In light of the principles, what changes & investments are needed to:

- enhance health promotion & wellness and
- make the health system work better for those that need it?



## The National Health and Hospitals Reform Commission: **Seeing the AHCAs in a broader context (cont.)**

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12 critical challenges where the need for change is:

- well understood and
- extensively documented

There are other challenges – we'll have more to say in later reports



## The National Health and Hospitals Reform Commission: **The 12 critical challenges**

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- Closing the gap in Indigenous health status
- Investing in prevention
- Ensuring a healthy start
- Redesigning care for those with chronic & complex conditions
- Recognising the health needs of the whole person
- Ensuring timely hospital access



## The National Health and Hospitals Reform Commission: **The 12 critical challenges (cont.)**

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- Caring for and respecting needs at the end of life
- Promoting improved safety and quality
- Improving distribution and access to services
- Ensuring access on the basis of need
- Improving and connecting information
- Ensuring enough well-trained health professionals and promoting research



## The National Health and Hospitals Reform Commission: **Responding to the challenges**

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- Challenges act as a 'touchstone' against which we can measure whether our proposals have changed the health system for the better (rather than just moved the deck chairs around)
- They include areas outside the AHCAs' scope
- Addressing them requires action by all players
- We used the challenges to develop domains where we developed benchmarks

## The National Health and Hospitals Reform Commission: **The accountability framework (cont.)**

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Clearer responsibilities between governments:

- single accountability – one government, not both
  - ‘joint accountability’ = no accountability
- but the report is not suggesting a single funding source
- we need to move beyond “shared responsibilities”
  - contributions should be clearly specified (for example, as a share of funding or volume of services purchased)

## The National Health and Hospitals Reform Commission: **An example of the current confusion**

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`The Commonwealth is responsible for ..

- fully funding subsidised primary and community based specialist care ..(i.e. subsidisation of care provided by medical practitioners ... some allied health professionals...and other health programs e.g. ..programs for managing specific conditions such as asthma
- Jointly funding public hospital inpatient, emergency department, outpatient, rehabilitation and step-down services through the AHCAs'

Statement on roles and responsibilities prepared for COAG HAWG June 2008



## The National Health and Hospitals Reform Commission: **The confusion continues...**

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Only one joint accountability:

'The Commonwealth and State/Territory governments share joint accountability for implementing health and aged care system reform where improvements to patient care, safety or patient outcomes can be demonstrated'

(NB: not efficiency?)



## The National Health and Hospitals Reform Commission: **The accountability framework (cont.)**

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Proposed division of accountability:

- state governments being accountable for public hospital services, mental health, public health and maternal and child health services
  - did we get maternal and child health wrong?
- the Commonwealth being accountable for all primary health care services, prevention and aged care
  - did we get community mental health wrong?
- we are not proposing an immediate transfer of functions



## The National Health and Hospitals Reform Commission: **Divided accountability and joint action**

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A clear division of accountability does not mean that both Commonwealth and state governments should act totally independently:

- Paradoxically, better cooperation and joint action might occur if both governments are clearer about what their jobs (and accountabilities) are and
- that both recognise they need to work together as partners to achieve common goals



## The National Health and Hospitals Reform Commission: **Divided accountability, joint action, holding hands and love vs clear reasons to work together (continued)**

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It is not from the benevolence of the butcher, the brewer, or the baker, that we expect our dinner, but from their regard to their own self-interest. We address ourselves, not to their humanity but to their **self-love**, and never talk to them of our own necessities but of their advantages.

Adam Smith *An Inquiry into the Nature and Causes of the Wealth of Nations*  
1776

## The National Health and Hospitals Reform Commission: **Divided accountability and joint action (continued)**

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The need for cooperation or partnership (or, at least, coordination mechanisms) occurs because of interdependence (which remains with divided but clear accountabilities):

- Sequential dependence
  - The output of one is the input of the other
  - **Outpatients (GPs and hospitals)**
- Reciprocal dependence
  - Mutual exchange of inputs and outputs
  - **Patients with chronic disease (GPs and hospitals)**

from J.D. Thompson *Organizations in Action: Social Science Bases of Administrative Theory* McGraw Hill 1967  
(NB not pooled dependence)



## The National Health and Hospitals Reform Commission: **The accountability framework at a glance**

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44 benchmarks that relate to the 12 challenges:

- health system as a whole, not just hospitals
- public and private services
- reciprocal obligations: Commonwealth & state/territory performance



## The National Health and Hospitals Reform Commission: **The accountability framework (cont.)**

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Three sorts of performance measures:

- indicators
- indicators with targets attached
- indicators with targets for which there are real accountability consequences (aka 'benchmarks')

All three are important

## The National Health and Hospitals Reform Commission: **The accountability framework (cont.)**

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Benchmarks that would encourage real improvement:  
e.g. for timely access to hospital care:

- Maximum 30 days wait at 90<sup>th</sup> percentile for cardio thoracic and cancer surgery
- 90 days at median for all other
- 365 days at 90th percentile for all other
- BUT from 2011, clock starts from referral not listing



## The National Health and Hospitals Reform Commission: **The accountability framework (cont.)**

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We have also proposed indicators about equity:

- Indigenous rate relative to the non-Indigenous rate (each indicator)
- Rate in lowest quintile by socio-economic status of area relative to highest quintile rate (each indicator)
- Rural and remote rates relative to the metropolitan rate (each indicator)

## The National Health and Hospitals Reform Commission: **The accountability framework (cont.)**

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We have proposed reciprocal benchmarks (accountability for some falls on Commonwealth and some on states), but this is tricky to operationalise in the context of a Commonwealth to State funding agreement:

- Potentially preventable hospital admissions per 1000 population
- Number of nursing home type bed days per 1000 population > 70
- Primary care patients seen in emergency departments per 1000 population

## The National Health and Hospitals Reform Commission: **But there's more!**

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The first report was cast in terms of specific AHCA issues:

- But we couldn't do that without looking more broadly
- We now need to be more specific about what we think should happen in the long term (with a clear implementation pathway) to ensure the health system better responds to the challenges we (and others) have identified
- for copies of the first report: [www.nhhrc.org.au](http://www.nhhrc.org.au)