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Refining the way we measure health system performance

Grattan Institute response to the Review of Australia’s Health System Performance Information and Reporting Frameworks public consultation paper.

By Stephen Duckett and Lucille Danks

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This report was written by Stephen Duckett, Grattan Institute Health Program Director and Lucille Danks, Associate, Grattan Institute.

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Overview

In 2016 and early 2017, the Australia Health Ministers' Advisory Council (AHMAC) has been undertaking a review of the performance and reporting framework used to track the performance of Australia's health sector. As part of this review, a public consultation paper on the proposed revisions to the existing framework was opened for public comment on the 23rd of January, 2017.

Feedback on the questions raised in the consultation paper was collected by the commission via online at https://consultations.health.gov.au/research-data-and-evaluation-division/review-of-australia-s-health-system-performance-in/. This document collates Grattan Institute's responses to these questions.

What are your views on the proposed framework for health system performance and reporting, including the recommendations on what should be included in the framework?

Is there anything missing from the proposed framework?

Generally, the proposed framework appears to be thorough. The exceptions to this are the absence of the affordability of out-of-pocket expenses from the accessibility criteria, and the incomplete treatment of efficiency and sustainability.

Currently, the framework covers technical efficiency, but overlooks allocative and adaptive efficiency[1]. In the context of the health system, these economic concepts can be understood as the cost efficiency of delivering a given output, the efficiency of the choices of outputs and the efficiency of these choices over time.

These efficiency concepts are often in tension: for instance, "quick fix" solutions are cost efficient in the short term but can increase the total costs incurred over time; and, where groups with extreme healthcare needs are more expensive to serve, directing care to where it is most needed can reduce short-term cost efficiency metrics. Consequently, optimising one facet of efficiency in isolation can reduce the efficiency of the system as a whole.

A complete treatment of the efficiency criterion in the performance framework would include all three types of efficiency. This could be achieved by supplementing the current recommendation of optimising the cost of outcomes and the outputs per input with the pursuit of equal health outcomes across demographic groups, and the maximisation of long term social returns from public, primary, secondary, and tertiary healthcare spending.

The framework's sustainability criterion also appears to be incomplete. Currently, the sustainability criterion focuses exclusively on system capacity. This focus – especially as it relates to ensuring we have the right workforce for future health needs – is important.

However, we suggest that this criterion is expanded to include financial sustainability, and research and development. This is because quality of care tomorrow is related to quality of care choices today through the healthcare system's investment in research and development, and governments' budget positions. Consequently, financial sustainability and research are essential inclusions in a performance framework which views the healthcare system as a dynamic system rather than a snapshot in time.

[1] We note that the importance of considering allocative efficiency is mentioned on page 10. However, this comment is not adequately reflected in the framework proposed.

Moreover, system capacity, financial sustainability, and research and development are – like the three efficiency concepts – competing objectives: innovation can be used to resolve a tension between capacity and financial sustainability, but equally, financial and capacity objectives can constrain research and development. For this reason, it makes sense to consider these issues jointly under the concept of sustainability.

Finally, the criteria of efficiency and sustainability are quite distinct. For this reason, we recommend that these criteria are considered separately. This will also allow each criterion to be expanded upon as recommended above.

What are your views on the recommended principles for indicator selection?

Firstly, the criteria for indicators recommends greater focus on outcome indicators and the use of Patient Reported Experience Measures (PREMs). However, it does not explicitly recommend the use of Patient Reported Outcome Measures (PROMs).

Outcome measures which are not patient-reported are based off outcomes that are unambiguously negative, like death, readmission, or experiencing a complication. However, as PROMs - like reported quality of life and functionality - are reported relative to a patient's goals and expectations, these metrics facilitate patient-centred care in a way that general outcome measures cannot.

The patient-centred nature of PROMs also contributes unique information: measures of whether patient-specific health objectives were achieved complement rather than overlap with the measures of whether unambiguously negative outcomes were avoided.

PROMs are integral to the vision for patient-centred care laid out in the performance framework and complete the representation of health outcomes and are commonly overlooked. It's important that it is explicitly recommended that PROMs are reported, as well as general outcome indicators and PREMs.

Secondly, we recommend that measures of dispersion, like the standard deviation or separate means for key demographic groups, are routinely reported in addition to the overall mean. For a health system striving to deliver equitable care, information about the dispersion of health outcomes is a metric that is of interest in its own right.

The dispersion of health outcomes is also important because it has a substantial impact on whether a population-wide or targeted policy response which is warranted.

Finally, measures of dispersion are essential for properly interpreting the average outcome because, a satisfactory mean outcome can hide the fact that some people are experiencing poor outcomes where great outcomes are possible.

What are your views on the proposed tiered reporting framework for health data?

The tiered reporting framework proposed is a good strategy for ensuring the information is both accessible and useful to audiences with different appetites for detail. However, grouping consumers and researchers into the single category of “the public” does not make much sense in this context: of the groups considered, consumers have the lowest appetite for detail and researchers arguably have the largest appetite for detail.

Australia’s health system benefits from the substantial amounts of research into the health system completed by the university sector. However, the university sector’s capacity to do so is limited by the scarcity of publicly availability of data, and the time investment required to acquire full datasets under the Public Health Act. Given this, we recommend that as much information as possible is made readily available to academic researchers.