

# **BUREAU OF HEALTH INFORMATION CHALLENGING IDEAS SEMINAR SERIES**

## **HEALTH PERFORMANCE REPORTING – PAST, PRESENT AND FUTURE**

**8 DECEMBER 2014**

### **THE BUREAU OF HEALTH INFORMATION – AN ENABLER OF PUBLIC HOSPITAL REFORM**

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#### **Introduction**

- 1 May I commence by expressing my appreciation to Professor Armstrong, and the Bureau of Health Information for inviting me, a mere ghost of the past, to reappear and speak at this seminar today. It is a very real pleasure to be here.
- 2 At this important time in the existence of the Bureau, I thought that some reflection on the past may provide some insight into the future.
- 3 May I commence with what I concluded in November 2008 in my Report, and attempt to tell you how and why I came to that conclusion. I said:

I am firmly convinced that the public reporting of information about the health system and hospital performance is essential for the future of NSW Health. At the least it improves patient choice and encourages improvement in all services. But it does a lot more. It

is the single most important driver (or lever) for the creation of public confidence in the health system, engagement of clinicians, improvement and enhancement of clinical practice and cost efficiency.

## **Precipitation of the Inquiry**

- 4 And now some history, which bears repeating lest it be forgotten.
- 5 My Inquiry was precipitated by the build-up in late 2007 and January 2008, of a number of disastrous clinical cases which were headline grabbing. These cases gave rise to significant public unease about the performance of NSW Health.
- 6 The first case involved a 14 week pregnant patient who arrived at the Emergency Department of the Royal North Hospital experiencing symptoms which indicated that that she may be about to miscarry. Having been assessed by the triage nurse, she was categorised as being needed to be seen within one hour. She did not receive treatment within an hour, and after two hours of acute pain, she miscarried in the hospital toilet in distressing circumstances.
- 7 Her experience received widespread media coverage which included accounts, often harrowing, of other similar events. These reports initiated a wide ranging discussion in the media about the public's fear about access to treatment at public hospitals, and the dissatisfaction of doctors and nurses within the system in which they had to provide care.
- 8 A chronic lack of funding, staffing and beds were complained about, low wages, high responsibilities, long shifts and poor staff relations were identified, emergency doctors complained of dirty facilities, a lack of staff and resources and a disconnect between medical staff and hospital administration. Senior doctors expressed concern that emergency departments were largely staffed by junior and inexperienced locum

doctors, routinely having to make life or death decisions without supervision.

- 9 In January 2008, the NSW Deputy State Coroner reported on the death of a 16 year old patient named Vanessa Anderson. She had been admitted initially to the Hornsby Hospital, and then transferred to the Royal North Shore Hospital, having been struck in the head with a golf ball while playing golf.
- 10 The report of the Coroner made for heartbreaking reading. He identified poor communication between doctors, staffing inadequacies, no or inadequate medical notes, poor clinical decisions, ignorance of protocols and incorrect decisions by nursing staff. The Coroner lamented that in Vanessa's case almost every conceivable error or omission occurred and continued to build on top of one another, leading to her death.
- 11 The Coroner called for a full and open inquiry into the delivery of health services in NSW.

## **The Government's Response**

- 12 Vanessa Anderson's case had come on top of a number of other incidents, which generated significant adverse publicity. Ongoing chronic problems which were encapsulated in daily media stories suggested that the public hospital system was entirely broken.
- 13 At a purely political level, the Minister for Health was being required, almost daily, to defend the indefensible. Clinical reality and clinical challenges had become political liabilities.
- 14 The Premier, and the Director-General of the Premier's Department, had previously been the Minister for Health and the Director-General of Health. They were potentially at risk of continuing adverse criticism. But, more

importantly, they knew enough of the situation to mean that they recognised a singular opportunity for significant reform. They became proponents, and strong ones, for reform.

- 15 So, on the same day as the Coroner made his remarks, the Premier announced the holding of a Special Commission of Inquiry into Acute Care Services in Public Hospitals.
- 16 The peace of my summer holiday in Tasmania was rudely interrupted by a telephone call from the Deputy Director-General of the Premier's Department.

### **The Government's Solution**

- 17 The NSW Labor government had, shortly after coming into government, seen the Royal Commission in to the Police Force conducted, and very successfully so, by Justice James Wood. That Royal Commission had been highly successful in its very public achievements of identifying particular incidences of corruption. But it had importantly been a very real catalyst for both organisational change and public policy reordering.
- 18 As well, the Government had during its time used special commissions of inquiry to investigate two railway accidents in metropolitan Sydney which had led to 14 deaths and over 80 serious casualties on the railway system, the widespread contamination of Sydney's drinking water, and commercial sector disasters such as the collapse of the HIH Insurance Company and the restructuring of the James Hardie Group of companies.
- 19 All of these instances of public inquiry, seduced the government into the view that a public commission of inquiry was useful as an agent of change, as a tool for organisational restructure and as the catalyst for significant public and government policy revision.

20 Whilst the Wood Royal Commission had been conducted by a Supreme Court Judge in an area which directly related to his expertise and lifelong work in the criminal justice system, public hospital reform was a very much bigger ship, and required significantly different approaches.

21 But, the government, comfortable with the experiences of lawyers conducting commission of inquiry, took the view that a content free commissioner who had no past in working in public hospitals, would be suitable.

### **The Nature and Complexity of the NSW Public Hospital System**

22 As the Hospital Quarterly Series overwhelmingly demonstrates, the NSW public hospital system is very large, and enormously complex.

23 There are 251 public hospitals in NSW ranging in size from the major metropolitan hospitals such as Royal Prince Alfred Hospital, to remote multi-purpose services in towns like Wilcannia and Bourke. The task of the Inquiry to recommend reform encompassed all of these hospitals and all of the services which they provided.

24 The workforce of NSW Health consists of over 90,000 full-time equivalent staff. If NSW Health was a publicly listed company, it would probably be the fifteenth largest public company in Australia. It provides health to a population in a geographic area which is significantly larger than the geographic area of Germany, or of England and Wales. When the health system was divided into eight area health services, one area health service provided health care to a geographical area larger than the whole of Pakistan.

25 As well, the population serviced by NSW Health is not evenly spread. The great bulk of the NSW population lives between the coastline and the Great Dividing Range. The Great Dividing Range provides a sandstone

curtain through which qualified health professionals, including doctors and nurses, find it difficult to pass.

- 26 The 251 public hospitals in NSW provide about 19,170 hospital beds which represents approximately one third of the Australian public in-patient beds. Private hospitals in NSW have a further 6,208 beds, which comprise about 24% of the total hospital beds in the State. NSW has a slightly higher ratio of 2.8 beds per 1,000 people than the national average of 2.6. Victoria has an average of 2.3 public hospital beds per 1,000 people.
- 27 Historically, public hospitals were developed by communities as settlement spread across NSW. The communities built hospitals as an important phase in the establishment of the community. All towns of any size had a hospital. The nature of this development did not necessarily reflect the most efficient allocation of resources. The nature of the evolving system of hospital construction and planning was one which reflected compromise rather than rational planning.
- 28 Perhaps the nature and complexity of the public hospital system is best illustrated by understanding a typical day in NSW Health.
- 29 On a typical day in 2014, for NSW Health across the State, there will be:
- an ambulance responding to an emergency 000 call every 30 seconds;
  - over 6,700 patients arriving at Emergency Departments seeking treatment;
  - 5,150 new people being admitted as an in-patient at a hospital;
  - Over 19,000 patients occupying a hospital bed, of whom about 45% are over 65 years;
  - Over 7,800 separate procedures being performed; and
  - Over \$49M being spent on providing care in public hospitals and for the health of the population.

30 Some other features ought to be identified. It is well recognised that demographic changes mean that Australia has an aging population which will require proportionally more care as the population ages. 13.5% of the State's population are aged over 65 years, but patients of that age group make up 45%, nearly one half, of hospital patients.

### **Approach to System Reform by the Inquiry**

31 It became necessary at the very start of the inquiry to identify the steps to reform of the public hospital system, which the Inquiry needed to address. There were six.

32 The first of these was to identify the existing state of NSW Health. By that I mean, the Inquiry needed to learn quickly and as comprehensively as possible, what was actually happening within the public hospital system.

33 To this end, the following program was undertaken: a timetable of advertising for and receiving public submissions; conducting hearings, not in a central location as traditional inquiries do, but rather at public hospitals where staff and patients could easily attend; an intense and widespread program of visiting public hospitals and facilities; and then a targeted program of briefings by various sections which existed within NSW Health; consultations with principal interest groups and professional associations; and the undertaking of self-generated research of the position in NSW and elsewhere. This intense program enabled, over a period of about 6 months, the Inquiry to gain an understanding of, and to identify the existing state of, public hospitals in NSW.

34 The second step was to identify and articulate the blockages to reform. Unless these "enemies" were identified and understood, any proposed reform would be unlikely to ever succeed.

- 35 The first and most obvious blockage to reform, in an organisation the size of NSW Health, is the fear of change itself. People are comfortable where they are, and when they know what they are doing. Political tinkering, or else changes suggested by anyone from “outside” the system are regarded with a high level of suspicion and unstated opposition.
- 36 There were other blockages identified as well, to which it will be necessary to return.
- 37 The third step in public hospital reform is to identify the principle, or principles, to which the end point of the reform should adhere. There is little point in propounding reform without a principled basis for it, and since reform is necessarily a continuing process, one hopes that whatever form it takes, it will adhere to the underlying principles identified.
- 38 The fourth step in the reforming process is to identify and create where necessary the enablers of reform. These are the tools, or levers, by which reform will take place, and will be sustainable. Again, I will return to this topic in some more detail.
- 39 The fifth step, which is the one which gains the most publicity but which is perhaps not so deserving, is to recommend the reforms which are necessary. For a reason which I suspect relates to the media’s appetite for headlines, short stories and short sound bites, an Inquiry’s recommendations for reform seem to attract the most attention. In many ways, the apparent success of an Inquiry is measured by how many recommendations the Government adopts. In my experience, few people ever ask, after 5 years, whether any of those recommendations adopted have been given effect to, and if so, how successful they are. I am pleased to think that the Bureau, in this seminar today, is addressing, in a reflective way, one feature of the Inquiry’s recommendations.
- 40 The final step in undertaking public hospital reform is for the reform process to be mapped out, and then monitored, on a pathway which



permits efficient reform, but which does not interrupt the day-to-day conduct of the existing operations.

## **Blockages to Reform**

- 41 The first significant blockage to reform which I identified in the course of the Inquiry was the fact that good working relations between clinicians and hospital management, had completely broken down. I likened it the Great Schism of 1054. If reform was to take place, trust needed to be restored between these important elements of the public hospital system. There needed to be better communication and understanding between them.
- 42 The second principal blockage to reform was the culture of political and public expectation, which is wholly unrealistic in clinical efficiency terms, that every electorate, every town and every community should have a hospital which can provide all hospital services which may be required from time to time.
- 43 Public outcries by communities about changes to “their hospital” are understandable as an immediate reaction. But these expressions of view, which commonly prevail and are supported by local politicians, are necessary sectional and partisan. For so long as these local views hold sway, significant public hospital reform by shutting of expensive and inefficient hospitals, or else by clinical redesign of services being provided, will not succeed.
- 44 The third blockage to reform was, and remains, the complexity of the funding arrangements for public hospitals in NSW and other states of Australia. In understanding reform of the public hospital sector, it is necessary to have regard to the fact that, at least until recently, public hospitals were funded on historical budgets which did not pay regard directly to workload. Activity-based funding was not, at the time I conducted my Inquiry, widely introduced. Because the funding

arrangements were complex, involving funding from the Commonwealth and the State, and as well different funding arrangements for primary health care in the community and for aged care also being provided in the community, or else in aged facilities, a great deal of time and effort was spent in public hospitals on cost shifting. Public hospitals were reluctant to accept that they provided services ordinarily provided by general practitioners. The demand for beds and aged care facilities, which is growing, could be managed by the aged care sector covertly using strategies to ensure that people stayed in acute care public hospital beds longer than they efficiently might.

- 45 The fourth blockage to reform was what can be identified as the silo or empire building mentality of public hospitals and their staff. Because of the historical development of public hospitals in NSW generally, and the major public hospitals in particular, they saw themselves as single institutions and not part of any state-wide system. Within these silos, individual departments and sections competed to construct empires which enhanced reputations, created bases of influence and became islands of clinical idiosyncrasy. But, the reform with which I was charged was system reform for the whole of the State. Modern health systems deal with networks and the provision of services rationally, not just within individual hospitals which do not connect with any other part of the system.
- 46 The fifth blockage to reform which I identified, was again a matter of historical development. Historically there had been a significant and rigid demarcation between roles and clinical functions, particularly in Emergency Departments, and, as well, between departments in hospitals. But in times of cost pressure, staff pressure and significant demands on the system, reforms could not happen if such historical demarcations were allowed to continue.
- 47 The last blockage to reform was an overly large and bloated bureaucracy and the structure of the head office of NSW Health. In the course of the Inquiry, notwithstanding my best efforts, I did not ever gain an entirely

satisfactory understanding of what all of these staff did, and what benefit they provided to patients. I did get a clear sense that, just like the silo mentality of large hospitals, there was a siege mentality where as much knowledge as possible was held within the central bureaucracy, and only some small part was allowed out, and then, only when necessary, and in a form which was appropriate for that purpose.

- 48 By the time of my Inquiry, this may have been a function of a particular party having been in power for many years, as much as it may have been a function of what I saw elsewhere, as being treasury driven administration being dominant over rational delivery of clinical services.

### **The End Principle**

- 49 I determined that the end principle must be for a public hospital system, that every person who comes to be cared for in a public hospital should be treated with respect by an appropriate skilled clinician, in a safe and cost effective way, to achieve the best possible outcome for the patient.

- 50 But there is a tension between this statement and the economic reality. As Porter and Teasberg said in their seminal text, *Redefining Health Care*:

“Health care is on a collision course with patient needs and economic reality. Without significant changes, the scale of the problem will only get worse.”

- 51 After all, NSW Health receives about 29% of the State budget. It is simply not going to get a greater share of that budget, and nor should it.

### **Enablers of Reform**

- 52 What then were the enablers of reform, which I identified, to address the situation with which I was presented.

- 53 The first enabler of reform was the Inquiry itself, and the report in which it culminated. There are a number of features of this which are not to be underestimated. The first is that because the Inquiry was conducted independently of NSW Health by a non-medically qualified person, it was broadly thought by many staff in NSW Health that a fresh perspective which would not be weighed down by the past, would enable real reform.
- 54 The second relevant consideration was that because the Inquiry went out to hospitals, and heard people in their workplace, it was more accessible to the staff of public hospitals who could come and observe the Inquiry as it took place. As well, there was provision for confidential evidence to be taken in circumstances where the particular witness may feel at risk from the nature of the evidence being given.
- 55 The third feature of the Inquiry, was that by enabling a public airing of concerns, the staff of public hospitals felt that they had been heard and their concerns listened to with respect and as fully as time permitted.
- 56 Finally, the crafting and writing of a report in relatively plain English, and in particular, the inclusion of an overview volume, meant that it was readily accessible and, since it was made available electronically on the internet, able to be read by those who were interested.
- 57 The very fact that an Inquiry was able to, in effect, rule a line and talk about progress from that time and change from that time, meant that, as I discerned it, people were more open to reform and change. In this way the Inquiry and the report was an enabler of reform.
- 58 The second enabler of reform was the promulgation, and acceptance, of an important principle for an economically sustainable system of public hospitals, which can conveniently be called the “critical mass theory”. The notion of critical mass is important because it acknowledges a relationship between volume of patient load and the necessity of safety and quality in the delivery of health service. It puts safety and quality as the principal

determinant. I firmly hold to the view that it is essential to keep safety and quality as the principal determinant of patient care. For example, in some specialised areas of medicine, clinicians need to treat a good number of patients each year in order to maintain their specialist skills and competencies. In NSW, all adult heart transplants are carried out at one hospital. Centralisation of all such cases to one specialist unit has the advantage of attracting interested specialists in a forming a centre of excellence. It also means that greater investment can be made in the facility and equipment than if two or three or four such units had to be supported across the State.

59 However, the concept of critical mass is at odds with having a comprehensive supply of clinical services conveniently accessible at most hospitals in the State. Critical mass theory is now accepted as being a non-controversial element of the modern networking and systems of hospitals.

60 The third enabler of reform is information, or data, about the performance of public hospitals. By that I mean, information in a broad sense. Not just the simple throughput numbers, or length of hospital stay, which are relevant and in some contexts important. But rather intelligent information which was necessary for cultural and behavioural change.

61 Broadly speaking, the received wisdom was, and remains, that public reporting of information and data improves safety and quality. Largely, it is said, in two ways. First, it changes consumer behaviour so that better informed consumers demand quality health care, and poor performance is disciplined by the market. Second, it helps poor performers to identify problems with their processes and improve their performance.

62 But to me, making information or data publicly available goes further than such received wisdom. I am firmly convinced that public reporting of information about a health system and public hospital performance improves patient choice and encourages improvement in all services. It

seems to me that it is the single most important enabler for the creation of public confidence in the health system, engagement of clinicians, and the reduction of top-down dictatorially imposed changes, thereby improving and enhancing clinical practice and cost efficiency.

- 63 In a single unitary government health system from which competition is absent, the widespread availability of information and data creates competition. Enabling a hospital or a unit or ward to compare its performance longitudinally against itself, and then against like hospitals or units or wards, and to obtain a sense of where its performance generally, and its safety and quality in particular, falls on the spectrum of similar performances, is a clear driver of improvement.
- 64 I have never met a professional who likes to think that it is a sufficient performance of their duties not to do as well, if not very much better, than their professional peers. An IT system which enables the delivery into a repository of information, and the collation and dissemination of that information back to the hospitals, units and wards, is the essential tool for the provision of this information. Information that is six months or more out of date is often of little use for timely improvement. In due course there is no reason why information should not be, in effect, almost real time information.
- 65 In my report, I recommended that information and data be collected and made available which addressed each of the following areas:
- Access: namely access to and availability of hospital services including timeliness of the provision of services, and proximity to the patient's home or locality;
  - Clinical: clinical performance including patient outcome, appropriateness of clinical treatment method, the variation, if any, from

protocols and models of care and identified benefits or detriments to the health and well being of the patient;

- Safety and quality: safety and quality of the clinical care and the hospital attendance or admission;
- Cost: cost of the clinical care including representation or re-admission cost and error cost (including provision of additional care, medication, diagnostic tests and/or counselling services and any financial settlement including litigation costs);
- Patient: patient experience and satisfaction;
- Staff: staff experience and satisfaction;
- Sustainability: system impact and sustainability.

66 The fourth enabler of reform is innovation and clinical improvement. The two obvious and essential features of public hospital care in Australia are firstly, that public hospitals are being required to provide more care to more patients within existing resources at an increasing level of sophistication and complexity. Secondly, the cost of doing so is increasing at a much higher rate than the Consumer Price Index. The availability of funds to public hospitals is not increasing at the same rate, nor is it likely that it will ever be able to do so.

67 It is an old story: increasing demand, greater complexity, greater cost and less money available to achieve the task. Besides having a public discussion about the expectation of the public as to what they are getting from their public hospital system, thereby either increasing the amount of money available or, alternatively, reducing the range of services provided, it is the system itself which must take steps to manage the tension existing between these features.

- 68 In my view, it can only do so by providing services in a smarter and more cost-effective way. Better use of IT. Better use of medical technology combined with shorter stays in hospital and staying on the leading edge of developments, with a staff that can continuously be updated as to those developments. All of these combine to be a principal enabler of public hospital reform. But that enabler depends upon information. The basis for improved services is clinically relevant information about existing services.
- 69 It is obvious when one looks across the system, that individual units or wards have devised and implemented very innovative solutions to particular problems, but the issue for a public hospital system is the identification of that innovation, and the implementation of that innovation across the whole system. Information about what is being done, how it is working and how it can be implemented in other hospitals is essential to be gathered, sorted and promulgated. As well, champions of innovation in particular areas need to be identified and empowered. One solution to this issue is to devise and use clinical networks of all health professionals in particular areas whose function it is to be both champions and messengers.
- 70 The fifth enabler of reform is a heavy emphasis on safety and quality. The error cost to any system can be significant. The savings from the elimination of error cost can be dramatic. The savings are clear in monetary terms, in terms of the occupation of beds, in medication terms and in the time and effort of clinical staff to treat the patients who are the victims of error. Importantly, error significantly affects public confidence, and public confidence affects the stability and mood of the workforce.
- 71 A strong safety and quality assurance organisation, which is entitled to require of deliverers of health services or other operating entities, adherence to safety and quality standards and recommendations is essential.



- 72 The NSW public hospital system at the time of my Inquiry, had a hospital acquired infection rate of about 15%. Proper hand washing techniques and infection control techniques are well recognised in the safety and quality field. Unless there are programs to require those techniques to be adopted, supervision of them and publication of their results, there will be no improvement in that area, and the enormous cost to the system of hospital-acquired infection will continue. In some hospitals in the USA, staff are on a mandatory “three strikes and you’re out” requirement with respect to hand washing. If you are observed by independent observers monitoring hand washing to have treated three patients without first washing one’s hands, then that is a sufficient basis for dismissal. The hospital acquired infection rate in that circumstance has plummeted and is now almost zero.
- 73 Whether such an approach would be effective in Australia is beside the point, because what is obvious is that a proper emphasis on safety and quality drives significant improvement in the public hospital system.
- 74 The last significant enabler of reform is education and workforce. The workforce of today is a multi-skilled workforce. Just because a person is training to be a doctor, does not mean that the best person to train them in everything which they will do is a doctor. Think, for example, of how many times a skilled laboratory technician will take blood from an individual. They will do so many hundreds more times than will a doctor. There seems to me to be no reason why the skilled trainer of laboratory technicians ought not to be training doctors, nurses and anyone else who has to take blood in how to do it quickly and efficiently.
- 75 Probably the best person to assess how to bandage a soft tissue injury is a physiotherapist. It is they who should be teaching their colleagues of all kinds, how to do so. I very much doubt that an orthopaedic surgeon would be the best trainer for such a task. Yet, young doctors and nurses and other health professionals who need to know how to do it, need to be

trained and that training must come from the best qualified person, regardless of their profession.

- 76 In other words, reform of public hospitals requires flexibility in, and the combined education of, its workforce

## **Bureau of Health Information**

- 77 From the perspective of my Inquiry, and on the basis of the analysis which was undertaken, it seemed obvious to me, that a body which was capable of being the source of all relevant health information was essential.

- 78 Such a body had to be as independent of NSW Health bureaucracy as is possible within a government system. Independence was essential to ensure that the information and data which was produced was broadly accepted as accurate, and not seen to be controlled or “gamed” for bureaucratic or political purposes.

- 79 The Bureau also had to be independent to ensure its credibility as a reliable source of information upon which it was safe to conceive system improvements. And it had to be independent to assist in the restoration of public confidence in the public hospital system, and to help rationally to put in context reports of individual cases.

- 80 The Bureau also had to be able to make its information broadly available, and in accessible form. This had to occur on a number of levels and in respect of different categories of information.

- 81 First, broad state-wide information about the performance all hospitals individually was of importance to the public and the political process. It was also relevant to enable the case for particular reform to be advocated. If it can be reliably demonstrated to the public, that X hospital is only undertaking a handful of a particular procedure, then it can be more readily

accepted that it is safer, i.e. it has a better outcome for patients, and the service is more cost effective, then the prospects of a clinical redesign which is politically and publically acceptable must significantly increase.

- 82 Secondly, rational peer group comparison of performance, and safety and quality outcomes, must lead to more informed discussion about performance improvement. It makes possible the debunking of claimed idiosyncratic explanations for the performance of particular hospitals, particular units within those hospitals and their patient base. Clarity of these parameters permits internally driven reform, depowers received wisdom which is not evidence based and identifies areas for acclamation, or else, improvement.
- 83 Thirdly, as the world of clinical medicine moves to formulate and improve practice based on evidence, albeit of varying strengths and integrity, so must the world of public hospital performance, both on a system wide basis, and on an individual hospital basis, model itself on available information of accuracy and integrity. And governments, of all political persuasions, must learn that, and be content for, their performance in the delivery of health services will be judged on facts and hard data, and not spin or the controlled disclosure of restricted areas of performance statistics.
- 84 Fourthly, data which reflects and provides tracking down to individual unit, and practitioner level, enables identification of successful innovation in the delivery of health services. From that identification, system wide improvement and innovation in clinical performance can be driven.
- 85 Finally, and importantly, the role of the independent Bureau was necessary to support and facilitate research by academics, system managers, by those who use evidence based performance measures to support innovation, and most importantly, by those who would seek to identify and track demand for services, costs of the provision of services, and thereby seek efficiency.

## A Challenge

86 It would be churlish of me, in the present company, to attempt to give the Bureau a report card at the end of its first five years. And I am not going to do so. It is after all an outstandingly successful organisation, which success is a tribute to its Chairman, its directors, its two Chief Executives and the highly professional staff who work within it. So successful has it been, that the Commonwealth government copied it.

87 But, if I may be indulged, let me set the Bureau a challenge for the next 5 years.

88 By now you have established your reputation as an independent body. You are, and should be, comfortable with your public reporting. Such comfort is to be commended. It means that you have a reliable, accurate and regular reporting role. Base statistics are well established. Trends can be tracked, and must continue to be tracked. Sensible predictions can now start to be made about the future.

89 But remaining comfortable and doing no more than what has been seen to date is to waste your hard work to date, and may fail to seize the opportunities which you have.

90 Some examples will suffice. In 2008, during my Inquiry, at my request, I was given a comparison table of the performance of the 10 largest hospitals in NSW with respect to a particular, relatively routine, surgical procedure – involving a cardiac vessel bypass. The parameters which I asked for satisfied me that I was able to, and was making a reasonable and appropriate comparison. To my surprise, amongst the parameters which I had asked for, there were two principal variances which compellingly called for further investigation. The first of those variations demonstrated that the average stay in hospital for patients ranged between 4 and 10 days. The second demonstrated that the average

medical cost of the procedure varied by a factor of 4 between highest and lowest. I did not require the undertaking of any further investigation, but what that exercise proved beyond doubt to me was that data about health performance down to a unit level can be utilised to identify better, more cost effective practices.

- 91 When reading the latest Hospital Quarterly report published a few days ago, I made these observations with respect to an aspect of the performance of a couple of Emergency Departments:

### **Bulli District Hospital**

I note that Bulli is 15 minutes by car (or 11.3km) from Wollongong Hospital

- (1) There were 1174 Emergency attendances which was the lowest number for 5 years – an average of 13 per day.
- (2) There were no Triage Category 1 patients who required resuscitation, and only 21 patients (or 2%) were in Triage category 2.
- (3) There were 1113 (86%) patients in Triage Categories 4 & 5.
- (4) Of these attendances at Bulli, 5% of the patients were transferred to another hospital, and 94% were treated and discharged (or else left before treatment).

### **Kurri Kurri Hospital**

I note that Kurri Kurri is 21 minutes (or 17km) from Maitland Hospital

- (1) There were 1612 Emergency attendances which was the lowest number for 6 years – an average of 18 attendances each day
- (2) There were 1185 (73%) patients in Triage Categories 4 & 5
- (3) The total of admissions to Kurri Kurri or another hospital was just 8% and 80% of the patients who attended at the Emergency Department were treated and discharged (or else left before treatment)
- (4) There was one Triage Category 1 patient who required resuscitation

- 92 If I was to further mine the databases of NSW Health, I am sure that I could find the average cost of these attendances, and relate that average cost to similar attendances at the nearby facilities which I have mentioned. With that material, a real question should be asked, why are these Emergency Department clinical services being provided at these hospitals. Are there other Emergency Departments in a similar condition. Is the public hospital system, in this respect, sustainable in the absence of sensible clinical rearrangement. Well, I suggest that is not. And I venture to suggest that a report of this kind may provide a proper basis for non-partisan clinical service reorganisation.
- 93 So I pose the question, should the Bureau set out to be more pro-active in its reporting of health system performance? It is within its remit to do so. And I leave it with the challenge, over the next 5 years, to champion improvement and innovation in the health care system by thoughtful and regular identification of the best and worst aspects of the NSW public hospital system.

## **Conclusion**

- 94 Thank you again for your invitation. I strongly endorse all that you have done in the first 5 years of existence to inform the public, and the staff of NSW Health, about their hospitals. I confess to a real sense of pride whenever I receive a copy of one of the Bureau's reports which I read with interest. I encourage you to extend your present work to acclaim the good, and expose the underperformers.
- 95 I look forward to watching closely all of your work over the next 5 years, and perhaps attending another seminar then, when I would hope that my relevance is merely one historic interest.