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GMHBA Limited

30 November 2006.

Dr. Diana Horvath
Chief Executive
Australian Commission on Safety
and Quality in Healthcare
GPO BOX 5480
SYDNEY NSW 2001

Dear Dr. Horvath,

Thank you for the opportunity to review the Discussion Paper on National Safety and Quality Accreditation Standards, and in particular to address the questions posed in the paper.

We commend any process which improves the quality and safety of patient care in both the public and private healthcare settings, and believe that this should be achieved without adding to the overall cost of healthcare provision. We believe that this aim can be achieved through the continuous process of outcome monitoring, analysis and continued improvement, and as such provide the following responses to a selection of the questions posed.

Our response is generally applicable to accreditation of hospitals, however is equally applicable to the medical and allied health community.

- 1. What core processes or systems need to be in place to ensure poor performance is detected? Is this necessarily part of an accreditation process? Where there is system failure, how should the accreditation body respond?**

Our understanding is that the current process audits system processes and the documentation of the processes, with the view that quality is likely to be higher where high level processes are in place. However, our view is that as outcomes are the ultimate result of systems and processes, rather than auditing processes, a facility should have its outcomes audited. If a provider has exceptional outcomes it is likely that they have high level systems and processes. Also, reporting of outcomes is more transparent and reports what consumers/purchasers are ideally concerned about - is the provider safe and efficient.

Outcomes should be risk adjusted to ensure that there is like for like comparisons and to remove the likelihood of high risk patients being refused treatment. We do not subscribe to the notion that this will result in providers refusing to treat high risk patients. If the patient is appropriately risk rated, then outcome comparisons are only made against benchmarked standards on a like-for-like basis.

We also believe that outcomes should be publicly available, and while individual patient outcomes should be de-identified, the facility should be identified. If it was felt that a full listing of facilities would be too lengthy, then an alternative of at the very least outlier hospitals (good and bad) could be adopted.

In the event that a provider has been identified as an outlier, the good providers have a public responsibility to share their processes with all other providers within the comparative group so that all providers can learn from the benchmarked outcomes (and their processes employed to achieve the positive outcomes). In the event that a low outlier is identified, the provider should be provided with access to a mentor (hospital CEO/doctor/medical director/allied health manager/) relevant to the service underperforming for an agreed period of time, after which an audit should be undertaken. In the event that the provider is still an outlier, serious consideration should be given to either replacing management, or removing accredited status for that provider. This can be justified on the basis of the service provider not being safe, and the community should not be subjected to treatment by the unsafe provider.

2. What is essential to ensuring all accreditation processes are open and transparent? What minimum information should be publicly available on the accreditation status of health services?

In relation to hospital accreditation, apart from a certificate usually displayed in a prominent location, the general community would not know what accreditation means, and the implications of being awarded three or four year accreditation.

In addition, recognising that the current accreditation process has a significant compliance cost (ie: is largely documentation focussed and preparation for accreditation audits diverts time away from what providers would consider core business) hospitals who receive accreditation for a limited duration rather than the maximum allowable duration are required to spend additional resources preparing for an additional audit rather than improving their quality and safety outcomes.

Therefore rather than accrediting a facility for a period of time, consideration could be given to providing them with first, second, third class or no accreditation status. It is highly likely that those providers classified as first class will use this status as a differentiator and as such the public will quickly become aware of the accreditation standards.

All hospitals should receive their accredited standard for the same four year period. It could be argued that it will take this long to get evidence based outcome results that highlight a demonstrable improvement in outcomes. This will also reduce the audit burden, and allow providers to spend scarce resources on improving quality outcomes, and not just improving documentation. However, if a hospital believed that they had improved their outcomes and wanted reclassification they should be able to request a re-audit. To facilitate an additional audit, a fee could be considered. As well as funding the additional cost of audit, this would reduce the likelihood of frivolous approaches for re audit and subsequent re-classification.

Considering hospitals may have specialities where they are considered specialists in that field yet may also offer services in other areas where they are proficient, but not industry leading in terms of outcomes, it is also suggested that hospital specialities rather than whole of facility be accredited. That is, they may be a first class facility for general surgery, but second class for cardiac surgery. In this way, the referring community (and the general public) can be aware of the comparative competency of each service offered by the hospitals being accredited.

3. How can accreditation be made more cost efficient and effective?

The Discussion Paper advises that small organisations do not have the resources required to employ a quality manager. This highlights a problem in the system where the quality manager is seen as a cost to the organisation due in some part to the current requirements for accreditation, when ideally the position should be seen as a driver of maintaining or improving quality.

If an organisation is too small to employ such a role, or access an appropriately outsourced solution, it could be argued that if they are not monitoring outcomes then they should not be providing healthcare, as they have no idea of their outcomes. Of course, different standards should apply for different services. As an example, a high risk neurosurgery service would be measuring higher level outcomes than a lower risk private sports-physiotherapy practice.

Also, if the accreditation is outcome based, it will resolve the issue identified in the discussion paper as a culture, particularly among the clinicians & medical practitioners, that safety and quality initiatives are someone else's responsibility. As outcomes are a direct result of their input, it will become their score card, and as such their responsibility.

As highlighted in 2 above, if surveys only occur every 4 years rather than the current more frequent incidence for poorer performers, then the process will be inherently more efficient.

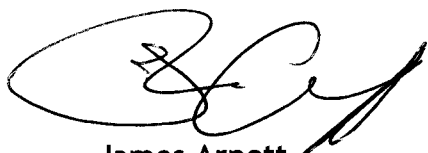
4. That strategies need to be put in place to ensure there is available a sustainable supply of credible and competent surveyors?

The Discussion Paper identifies that there is a problem associated with reliance on what is primarily a volunteer workforce.

Improved quality and safety should be seen as a means to improve medium to long term profitability rather than as a cost. As such, improved quality and safety is highly likely to result in increased adoption of best practice across the industry. This will result in improved effectiveness and efficiency which is highly likely to result in a reduction in the cost of treatment per person treated (all other things remaining equal). In addition to this, and the resultant reduction in audits outlined in 3 above, the resultant "savings" associated with improved outcomes could be invested in employing professional paid auditors.

Once again thank you for the opportunity to comment on the Discussion Paper. If you would like any further clarification on ideas expressed above, please do not hesitate to call me on (03) 5224 8655.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'James Arnott', written in a cursive style.

James Arnott
Executive Manager Health Services

cc: Paul Whelan, Chief Executive