BUPA Australia

BUPA Australia Health Pty Ltd
National Head Office
PO Box 14639
Melbourne Victoria 3001

Tel +613 9937 4307
Fax +613 9937 4162
www.bupa.com.au

National Safety and Quality Accreditation Standards Review
GPO Box 5480
SYDNEY NSW 2001

05 October 2007

The Australian Commission on Safety and Quality in Health Care (ACSQHC) released, in August 2007, a Consultation Paper entitled "An Alternative Model for Safety and Quality Accreditation of Health Care".

BUPA Australia, which operates a private health fund nationally covering over 1 million people, wishes to provide the following comments in relation to the issues that are included in this Consultation Paper.

BUPA Australia welcomes and agrees in broad terms with the approach and alternative model proposed by ACSQHC in the Consultation Paper.

Separation of safety assurance and quality improvement assessment processes

We support the separation of safety assurance from the assessment of quality improvement and the function of developing and setting standards. We also support the registration of accrediting organisations being separate from that of registered organisations assessing and accrediting providers against the developed standards.

We understand that the current system can be confusing and entangled, leading to a lack of clarity for all concerned as to the aim and purpose of accreditation. The present process gives no certainty of expectation or useful information to patients, the privately insured or to the general public. It makes sense to separate the two. Nevertheless, this separation should not lead to an increased compliance burden or cost for stakeholders.

Development of national minimum safety standards

National minimum safety standards other than those suggested could include, among other things, the incidence of falls, adverse events and mortality. An agreed set of standards needs to be developed by the 'National Entity' in conjunction with stakeholders.

BUPA Australia recognises that a wide range of providers may be involved in care, from hospitals to individual providers of particular care disciplines. We support the sensible approach that not all elements of each standard should apply to each level of provider or to each care setting.

We agree that industry standards will need to be developed for services where standards do not currently exist.

We support the approach that the need for registration should be based primarily on the capacity of particular health practitioners not to cause harm.

Agreement on standards meaningful to consumers

BUPA Australia believes it is possible (although not without effort) to reach consensus on agreed core safety and quality improvement standards and on what measures fall under each. These standards must be meaningful from the consumers' point of view. For example, measures could include:

<u>Quality measures</u>
- Waiting times
- IFC
- Risks explained
- Patient satisfaction

<u>Safety measures</u>
- Incidence of falls
- Adverse events
- Infection rate
- Mortality

While some of the suggested safety measures might be considered *quality* issues, they are posed from the consumers' point of view of "how <u>safe</u> is it for me to go to that hospital?"

BUPA Australia would be willing to assist in developing detailed potential safety and quality measures.

Accreditation to national minimum safety standards

The Paper suggests that funders might consider incentives or sanctions for providers to attain minimum safety standards. Reaching **minimum** safety standards is a fundamental must for providers and does not require reward. Similarly, if providers are unable to meet these minimum standards, then funding sanctions should not be an issue, as in our view, the providers should not be allowed to practise in the first place.
BUPA Australia strongly advocates that a provider of any level of care not meeting minimum standards of safety should be immediately prevented from practicing or offering services. This could involve the withdrawal of professional registration, of provider numbers, etc.
Such providers should then be required to demonstrate how they will meet the standards before being allowed to practice again, subject to further assessment as soon as possible.

The cost of meeting minimum safety standards should be a fundamental cost of doing business on the part of providers. Private health insurers would not fund this.

Assessment of non-clinical and technical compliance

The proposal that the alternative model would prevent the duplication of safety standards, regulation and compliance is sensible, efficient and cost-effective for all concerned and should be supported by all stakeholders.

ABN 81 098 309 025
A Registered Health Benefits Organisation

Establishment of a national body to lead and coordinate changes

The proposal suggests that a new national body or bodies be responsible for setting safety standards and for developing a national quality improvement framework.

BUPA Australia asks why the ACSQHC could not fulfil these roles.
While this may require a change to the Commission's Terms of Reference or to legislation, ACSQHC already has the respect of stakeholders and the Commission has a wide range of available experience with Members drawn from the Commonwealth, finance, clinicians and both the public and private health sectors. This would avoid introducing another new organisation and level of control to the proposed processes.

The eventual national body should maintain a register and advise funders of providers' accreditation status. Otherwise funders would need to each develop their own various provider checking mechanisms, which would be administratively expensive and inefficient.

It is plausible that industry funders (including governments, private health insurers and other third party payers) could agree on an appropriate set of available quality indicators from which they (and all stakeholders) would be able to use as few or as many as they wished.
If so, this would make the alternative model more cost-effective and efficient.

Moreover, there is opportunity here for Australia to produce a set of transparent safety and quality indicators available to and used by all stakeholders. The industry should not be deterred from this goal just because work and cooperation would be required from all.

As part of the above, BUPA Australia strongly recommends that the quality indicators achieved by all providers and services against the minimum safety and quality improvement standards, as well as trends in the indicators, should be freely available to all, including consumers, as is happening overseas.

Australians would then have the ability to choose a health fund, provider and services based on comparative information and a more informed basis – a powerful tool and a right that consumers should have.

If Ministers are indeed held accountable by the community for the safety and quality of the health system, then they should willingly support the introduction of legislation to further this goal.

Should a reliable and transparent set of safety and quality indicators be available to funders and to our members, then private health insurers at least may use them without likely need for many other additional measures or duplication.

The concerns of some stakeholders regarding open access to their information is expected and noted – Transparency (Report 2.2). However private health fund data, for example, is already publicly available through PHIAC and comparative information on the PHIO website. Stakeholders may have to overcome their objections in the interests of transparent information to consumers.

Benchmarked hospital level data on private hospital measures for rehabilitation and mental health is already available to insurers and providers, although not yet to consumers.

Indicators already collected by ACHS and ISO, for example, could be used in order to utilise existing data sources as much as possible.

Review of surveyor training

The adoption of the proposed alternative model would result in a clear and improved structure and way forward, which in itself would help the work and recognition of surveyors.

The role of surveyors might then include verifying the accuracy of safety and quality improvement reporting, and checking the process of their collection.

Evidence based care and appropriateness

Whilst this is not specifically referred to in the Consultation Paper, BUPA Australia would be interested in real-time data and variance from quality standards as opposed to spot checks by surveyors. Accreditation is still focused on patient safety with less emphasis on real-time quality improvement and this should change. Evidence based guidelines should inform quality in-patient care and variance from the guidelines, particularly in high volume high cost areas, should be recorded as part of a statistical utilisation review. Variances should be investigated to see if they occur for sound medical reasons. This will need medical record perusal and might be a better use of surveyors. Physician behaviours will also need reshaping to focus on quality improvement, which could be achieved by individual risk rated feedback on their comparative utilisation.

We would therefore like to work with stakeholders to develop accreditation based on:

- Appropriateness Indicators. Quality needs to include appropriateness of care as well as safety and effectiveness. Indicators could include the need for the procedure in the first place, appropriateness of the setting and the type of resources required. A better accreditation system would incorporate such indicators;
- Agreed Practice Guidelines for defined conditions;
- Agreed levels of medical expertise required;
- Statistical Utilisation Review, and;
- Surveyor medical record review.

A pilot model developed with the relevant medical professional bodies would have accepted admission criteria to be agreed by the hospital in a form that can be audited. The right setting and what resources are clinically required could also be agreed. This would all be done in an auditable way so that variances can be detected
Such a model could be developed and piloted along these lines in a demonstration area, such as Caesarean sections, hysterectomy or transurethral prostatectomy.

Ancillary providers

Some of the terminology in relation to ancillary providers needs to be sorted out. In particular, the difference between accreditation, registration, credentialling and recognition (by funders) needs to be made clear.

For example, as a basis on which they may choose to provide funding, as a starting point, it is suggested insurers would look for:

- Registration with a national register maintained by a "national body" as evidence that a practitioner had:
  - (i) an adequate level of insurance cover, and
  - (ii) the qualifications to do the scope of work they do.
- Accreditation of that practitioner's practice, or the practice where they work (and therefore of the services it provides) to the minimum safety and quality standards that apply

Links to research

Finally, the new process should include a link to research and clinical evidence such that pertinent care/treatment findings and information (eg: from overseas, Medical Services Advisory Committee, National Joint Replacement Registry, etc) is fed into whether or not providers are taking notice of and acting on new and valuable clinical information.

In Summary

BUPA Australia recognises the work of the ACSQHC to date, and is willing to assist with further input, particularly in the areas of, but not limited to:

- Mechanisms for public reporting of both accreditation and quality improvement measures;
- The separation of safety assurance and quality improvement assessment process;
- Appropriateness indicators and utilisation review;
- National minimum safety standards, and;
- Associated reforms.

We look forward to further input and collaboration in relation to the Commission's goals in the area of quality and safety. In the meantime, I may be contacted on 03 9937 4432 or via email at **robert.nikolovski@hba.com.au**, should there be any queries regarding this submission.

Robert Nikolovski
Head of Operations