



Adj. Professor Margaret Banks
Policy Team Leader
Review of Accreditation
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
SYDNEY NSW 2001

Dear Margaret

Thank you for the opportunity to provide a submission to phase 2 of the review of accreditation by the Australian Commission on Safety and Quality in Health Care (ACSQHC). On behalf of the Australian Private Hospitals Association (APHA), I have attached a submission addressing the issues and questions raised in the ACSQHC's Consultation paper *An Alternative Model for Safety and Quality Accreditation of Health Care*.

As you are aware, APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

APHA looks forward to further engagement with the ACSQHC on its review of accreditation arrangements.

Yours sincerely

Michael Roff
EXECUTIVE DIRECTOR
5 October 2007

**SUBMISSION BY THE
AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION
TO PHASE 2 OF THE AUSTRALIAN COMMISSION ON SAFETY
AND QUALITY IN HEALTH CARE'S
REVIEW OF ACCREDITATION
INCLUDING COMMENTS ON THE CONSULTATION PAPER
*AN ALTERNATIVE MODEL FOR SAFETY AND QUALITY
ACCREDITATION OF HEALTH CARE***

Key Points

APHA notes that the Alternative Model proposed by the ACSQHC still requires considerable development and further refinement. In addition, there appears to be limited capacity envisaged by the proposals articulated in the Consultation paper for leveraging off the strengths of the current accreditation system.

In APHA's view, the fundamental elements of an alternative model that will be workable and acceptable to a wide range of stakeholders are transparency and consistency. To achieve this end, all aspects of the alternative model, including standards development and setting, accreditation of facilities, monitoring and sanctions must be independent of government, including State and Territory Governments.

Consistency of an alternative model is best achieved through a genuinely national approach to safety and quality accreditation of health care. This does not mean 'national' agreement on a course of action that is then delivered and monitored in a disparate fashion by each State and Territory jurisdiction. This would be an unacceptable outcome of the review process and would achieve little more than entrenching the current system's inadequacies.

APHA and health service providers that are currently accredited expect that the alternative model should be capable of implementation on a cost-neutral basis (at worst), or perhaps even at a reduced cost.

Comments on Options for the Implementation of the Alternative Model

1. Separation of safety assurance and quality improvement processes

The rationale and evidence for the separation of safety assurance and quality improvement processes is not strong. In particular, the envisaged mandatory safety assurance regime being complemented by a voluntary quality improvement framework is a recipe for disaster in APHA's view. It is particularly difficult to understand how such a process will offer a remedy to the "confusion of purpose" of the current system as argued on page 9 of the Consultation paper.

Apart from adding confusion, the mandatory/voluntary split in safety and quality accreditation will inevitably add to duplication, overlap and increased costs of compliance for private hospitals. State and Territory governments and private health insurance funds will quickly move into this 'voluntary' vacuum and seek to mandate their 'own' quality improvement standards and assessment processes for private hospitals. The resulting multiplicity of inconsistent requirements will undermine rather than assure quality improvement.

APHA is at a loss to understand how the Commission could separate mandatory safety standards from an optional quality improvement process. Defining standards that would constitute safety requirements versus quality improvement requirements would result in an arbitrary separation of standards that would not reflect practical application. In addition, by defining minimum 'safety' standards and accrediting organizations against these standards, there is a risk that the community could infer that any organization or individual that meets these standards is 'safe'.

APHA is also concerned that by defining minimum safety standards as distinct from a quality improvement framework could also result in some organizations or individuals working to achieve only minimum compliance rather than commitment to improvement. That is, organisations could meet the standard, but need do no more. This would be a backward step.

Large cost increases could be expected if this proposal is implemented. A multi-stage accreditation process with attendant duplicative compliance costs will consume scarce financial and staffing resources of health care organisations for no clear benefit. The Consultation paper itself envisages this outcome:

“Because funders include governments, health insurers and other third party payers, including patients, there are differences in safety and quality priorities. This may mean that funders will require different levels of quality compliance. If this variation is excessive, it will potentially add costs and inefficiency to the alternative model.”
(page 17).

APHA is not convinced that splitting safety assurance and quality improvement processes will result in improved outcomes for any stakeholders, including patients. In particular, APHA strongly opposes a system whereby safety assurance is mandated and quality improvement is voluntary.

2. Separation between safety standards development and assessment of health services

While APHA does not have a fundamental objection to this course of action, it is yet to be convinced of the need for change. It appears that the recommendation has been made in response to assertions of 'potential' conflict of interest and 'potential' proliferation of standards. Arguably, the potential for these outcomes will not be removed under the alternative model.

The Consultation paper envisages that the proposed National Entity will develop minimum safety standards (or outsource this to another body or collaborative) and that it will oversee the approval of assessment bodies. It is unclear why the National Entity should be prohibited from auspicing a particular organisation to develop standards and approve it also as an assessing organisation, providing that the particular organisation met the required criteria in both areas.

Costs could conceivably be contained if government, via the National Entity, underwrites the costs of standards setting. Health care organisations, as applies now, would presumably continue to meet the costs of accreditation, which could be expected to decrease under this proposal (that is, if the costs of standards development are met by government).

3. Accreditation of all settings of care where services are provided by registered health professionals

APHA believes that all settings of care must be accredited. The fact that gaps exist is an indication of the failure of the current regulatory environment. APHA understands that the accreditation of all settings of care will be a complex and difficult task and proposes that the initial focus of the alternative model adopt the position that the same service be subject to the same safety and quality requirements, regardless of the setting in which the service is provided. For example, chemotherapy provided in the home must meet the same requirements as the same service provided in hospital. Such an approach would address some of the current priority gaps in safety and quality accreditation of health services.

Costs of this initial focus would be expected to be largely borne by those services that are not currently accredited, which would actually improve equity amongst health services.

4. National minimum safety standards that apply across all settings of care

APHA supports nationally consistent safety standards that are applicable across all care settings and, in particular, supports the harmonising of the multitude of safety standards that are currently imposed on private hospitals by jurisdictional licensing requirements, State-based safety and quality bodies and health insurance fund contracting requirements on top of existing accreditation requirements. APHA notes that the Consultation paper proposes that a process of ‘mutual recognition’ will apply so that health services are assessed only once against a particular standard.

Mutual recognition processes have been remarkably unsuccessful in the health sector and APHA remains to be convinced that there are any processes currently in place that will assure the Consultation paper’s envisaged outcome. A prerequisite will be a genuinely national system of safety and quality accreditation whereby all aspects of the alternative model, including standards development and setting, accreditation of facilities, monitoring and sanctions is independent of government, including State and Territory Governments.

The development of national minimum standards will need to commence with a mapping exercise to establish exactly what is in place nationally and to ascertain of these standards: what elements should form part of the national minimum standards, which require revision and also identify any gaps. APHA does not hold a preference as to whether this task is undertaken by the proposed National Entity or a body auspiced by it, however, the process must be informed by the input and collaboration of all relevant stakeholders, which would include private hospitals.

In APHA's view, the development of national minimum safety standards must be accompanied by the development of a nationally consistent quality improvement framework which would also be undertaken or commissioned by the proposed National Entity.

5. Assessment of non-clinical and technical compliance

In APHA's view, mutual recognition of, for example, NATA or AGPAL accreditation processes is a worthy initiative. However, APHA does not support a continuation of the current inconsistencies between different jurisdictions in their licensing requirements nor the development and enforcement of standards that apply in only particular jurisdictions. If any elements of the current State-based safety and quality regimes are judged essential then they should surely form part of the national minimum standards. This is the only way in which duplication can be reduced.

6. Development of a national framework for quality improvement

As noted earlier, APHA does not support the artificial split between safety assurance and quality improvement and in particular, opposes the mandation of safety assurance while quality improvement is a voluntary undertaking. In APHA's view, the development of national minimum safety standards must be accompanied by the development of a nationally consistent quality improvement framework which would be undertaken or commissioned by the proposed National Entity.

7. Establishment of a National Entity to lead and coordinate changes

APHA supports the establishment of a National Entity to lead and coordinate change. Any such body must be completely independent of government. That is, all aspects of the alternative model to be overseen by the National Entity, including standards development and setting, accreditation of facilities, monitoring and sanctions must be independent of government, including State and Territory Governments.

8. Review of surveyor training

Any accreditation system is only as good as the processes in place to assess and measure performance. A crucial element of the process is the surveyor.

Attention is required to the selection processes for surveyors and team leaders. Team leaders perform a key role in the accreditation process and APHA believes that improved processes are required to ensure that appropriate individuals are identified and appointed to these key positions. A straightforward measure that could be immediately adopted is the introduction of confidential assessments by surveyors of the performance of the team leader. These assessments would be programmed shortly after a survey and undertaken on a random basis.

Training of surveyors and team leaders needs to be ongoing. This training must encompass an understanding of the differences between various parts of the health sector and how these differences are accommodated within the standards and the accreditation processes. In particular, surveyors must be cognizant of the prevailing regulatory requirements applicable to the State in which they are surveying.

Improved oversight is required to ensure that surveyors are surveying health services against the standards and are not influenced by their personal views and background. The point above in relation to the regular and random assessment of team leaders would assist here.

In APHA's view, surveyors require a range of essential skills, competencies and attributes, including that they should:

- ✍ Be excellent communicators
- ✍ Be open and collegiate in their approach
- ✍ Have current health care experience
- ✍ Have the capacity to see beyond their personal health care experience
- ✍ Have a willingness and capacity to learn
- ✍ Have good listening skills
- ✍ Have a clear, consistent and analytical approach to surveys
- ✍ Be flexible and adaptable

In order to adequately train and assess surveyors, nationally consistent competencies need to be identified and agreed and core training products and processes need to be developed. Regular assessment of training processes and materials also needs to be undertaken. In addition, the reduction (ideally elimination) of subjective language from all standards, elements and criteria will greatly assist the task of the surveyor, with an accompanying improvement in inter-rater reliability.

9. Associated reforms

Unannounced surveys

APHA supports the piloting of unannounced surveys in a range of care settings which should be accompanied by a transparent evaluation of its strengths, weaknesses and costs.

Tracer methodology

APHA similarly supports the piloting of tracer methodology in a range of care settings which should be accompanied by a transparent evaluation of its strengths, weaknesses and costs.

Developing a best practice guide to standards development and review

APHA supports the development of a best practice guide to standards development and review.

Mapping of standards

APHA regards the mapping of existing standards and all other safety and quality requirements to be a priority for any reform of accreditation. This issue is canvassed in greater detail in the section below on duplication and overlap.

Developing appropriate mechanisms, timing and format for public reporting

This will be a key task of the National Entity and to ensure confidence and transparency, must be independent of government. The development and agreement on appropriate mechanisms, timing and format for public reporting must be informed by work currently underway within the ACSQHC and its Private Hospital Sector Committee.

Developing a process for mutual recognition of accreditation processes and outcomes

APHA supports this process as an essential element of the reform of accreditation.

Duplication and Overlap

APHA acknowledges that the ACSQHC has been tasked by Health Ministers to assess and report on the duplication and overlap of safety and quality measurement and reporting regimes as they impact on private hospitals. APHA fully supports this process. To assist the ACSQHC in undertaking this task, APHA restates below its principal concerns around this key issue.

A central element of any reform of the accreditation systems and processes must seek to alleviate the current burden imposed by disparate requirements of government (State and Federal); accreditation agencies; State-based Safety and Quality agencies; and funders, in particular, private health insurance funds. Rather than a shared endeavour, each of these imposes its own set of requirements to achieve the same end objective of safe and quality health services. The current system of ensuring the safety and quality of health services, of which accreditation is a key component, is anything but systematic characterised as it is by duplication and inefficiency.

Service providers such as private hospitals face ever increasing (and un-recouped) costs of compliance to meet the continued regulatory creep whereby governments, State-based Safety and Quality agencies (such as the Queensland Health Quality and

Complaints Commission); and private health insurance funds each develop and impose their own 'standards' which in many cases overlap and duplicate the requirements of accreditation agencies. A recent assessment indicates that some 900 pieces of legislation, regulation, codes of practice and standards may impact private health care organisations.

Therefore, while integrating and streamlining overlapping accreditation processes is important, the benefits will not accrue unless the approach is broadened to include other regulatory, funding and contractual requirements that purport to ensure safety and quality.

The APHA Safety and Quality Committee has coordinated an assessment of the requirements imposed on private hospitals by health insurance funds to collect and report data relating to safety and quality. The results of this assessment were provided as a confidential attachment to APHA's submission to phase 1 of the ACSQHC's review of accreditation. As the data has been provided to the APHA Safety and Quality Committee in confidence, APHA provides it in confidence for the information of the ACSQHC as an indication of the burden imposed by this duplication of existing accreditation processes.

Of particular concern is that this duplication and overlap, far from ensuring safer and higher quality health care, actually has the reverse effect by redirecting scarce resources (staff and financial) away from the provision of health care to comply with administrative requirements.

Any reform of accreditation must at the outset grapple with this duplication and waste of resources. A partnership approach, whereby the award of accreditation is recognised as a marker of safe and quality health services would be a good starting point.

It should be noted that the hospital sector (private and public) is arguably over-regulated with the myriad of overlapping regimes outlined above. This is in stark contrast to the lack of regulation of many out-of-hospital services which, through advances in technology, can and do now involve a wide range of services and procedures. As noted earlier, this gap in accreditation of out-of-hospital services requires urgent attention.

Priorities for reform

In APHA's view, the key priorities for reform are:

- ✍ establishment of a National Entity to lead and coordinate change. This body must be independent of government;
- ✍ action to address the current gaps in accreditation, and at a minimum to require that the same service is subject to the same standards regardless of the setting in which it is provided;

- ✍ mapping of existing standards, including those safety and quality measurement and reporting requirements incorporated in State and Territory licensing standards, State-specific safety and quality standards, health fund contracting arrangements and existing accreditation systems;
- ✍ development of a coherent set of safety and quality standards agreed to by stakeholders and endorsed by Health Ministers. Undertaking by governments and health insurance funds that compliance with additional standards is not required;
- ✍ mutual recognition of accreditation processes and standards; and
- ✍ review of surveyor workforce capacity, sustainability and training