

# Australian Health Insurance Association Ltd

(ABN 35 008 621 994 – A COMPANY LIMITED BY GUARANTEE – INCORPORATED IN THE A.C.T.)

**PRESIDENT:**  
Mr Terry Smith MBE RFD ED

**NATIONAL SECRETARIAT:**  
4 Campion Street  
Deakin ACT 2600

**CHIEF EXECUTIVE:**  
Hon Dr Michael Armitage

Telephone: (02) 6285 2977  
Facsimile: (02) 6285 2959  
Email: [admin@ahia.org.au](mailto:admin@ahia.org.au)

Professor Chris Baggoley  
Acting Chief Executive  
Australian Commission on Safety and Quality in Health Care  
Level 7, 1 Oxford Street  
DARLINGHURST NSW 2010

Dear Professor Baggoley,

## **Safety and Quality Accreditation of Health Care**

The AHIA welcomes the release of the Commission's consultation paper *An Alternative Model for Safety and Quality Accreditation of Health Care* and the opportunity to lodge a submission.

Our member health funds cover 94% of the 10.4 million Australians who have private health insurance. Private health funds have a keen interest in ensuring that the health care services provided to their members meet high standards of safety, quality and effectiveness. Accreditation of health care services against robust national standards is an important step towards achieving and improving high standards of patient care and outcomes.

### **An Alternative Model**

The AHIA supports the reform of accreditation, including greater clarity and accountability and especially a strong focus on consumers. It is agreed that health care providers should be required to meet national minimum safety standards as a condition of practice and that, in terms of quality, accreditation should drive quality improvement and not just compliance with minimum standards.

It follows that quality assessment should include compliance with good clinical practice, as set out in guidelines issued by professional bodies, and performance against standard indicators of patient outcomes.

### **Separation of Safety Assurance and Quality Improvement**

The AHIA supports the separation of safety standards and assessment from quality standards setting and assessment. This would distinguish between (a) compliance with the standards considered essential for safe delivery of health services and (b) promotion of good practices and patient outcomes which go beyond minimum standards and differentiate providers. This should clarify the purpose and processes of accreditation.

## **Separation Between Safety Standards Development and Assessment**

The AHIA supports the separation of safety standards development and assessment of health services against those standards. It is agreed that safety standards should be developed by a national entity, in consultation with stakeholders, and operate within a national minimum safety standards framework. The national body should accredit organisations to assess health services against the approved safety standards.

Given that there will be a wide range of providers, from major hospitals to individual professionals and carers, not all safety standards will apply to all providers, or at least not in the same way. Sensible decisions will need to be made about the set of safety standards to apply to each type of provider. These decisions should be based on the provider's potential to do harm to patients.

## **Accreditation of Settings where Services Provided by Registered Health Professionals**

Registration of health professionals is taken by consumers as an indicator that a discipline has been reviewed by regulators in terms of its place in the health care industry and that its practitioners have appropriate training and competence to practise in that field. By strong implication, practitioners requiring registration have the capacity to do good or to do harm.

If even one State has found it necessary to register practitioners in a particular profession or field of practice, then all health services providing services in that field should have to meet minimum safety standards. Consumers, legislators and funders should be able to have confidence that, wherever health services are provided in Australia, their interests are protected by appropriate minimum safety standards.

All care settings where services are provided by health professionals who require registration in any State should have to comply with national minimum safety standards.

## **National Minimum Safety Standards**

In setting national minimum safety standards, the national entity should consult with stakeholders including consumers, hospitals, funders, professional bodies and existing accreditation bodies. Forming working groups of stakeholders may be the best way of going about the task so that the interests of all parties, especially consumers, are given appropriate weight. Outsourcing the task to commercial providers, who have interests of their own to protect, may not achieve this end.

The Consultation Paper sets out a number of items which the standards should cover. These include infection control, credentialing of practitioners, medication safety, patient identification and communication. Other items would be falls, adverse events and mortality. In addition, the AHIA suggests that the standards should cover more of the continuum of care and not just hospitals and other acute care settings, such as appropriate practice in assessing health care requirements, clinical handover and post-acute care plans.

The AHIA agrees that the minimum safety standards should be mandated. Any provider who cannot meet the minimum requirements should not be permitted to provide services until they can satisfy the regulatory authority that they can and will meet the standards. Contrary to the suggestion in the paper that funders could offer incentives and sanctions, there is no role for funders in a system of mandatory compliance with minimum safety standards. Compliance – and any costs associated with it – should be regarded as part of normal business for health care providers.

## **Assessment of Non-Clinical and Technical Compliance**

The proposal for mutual recognition, enabling once-only assessment and clearance of safety assurance requirements, including non-clinical regulation and technical compliance, is sensible and is supported.

## **Development of a National Framework for Quality Improvement**

The AHIA supports development by a national body of a national quality improvement framework designed to encourage and support quality improvement activities. This is where the emphasis needs to be if quality processes are to have any real meaning and value. It is agreed that the standards should meet nationally agreed criteria for best practice and consumer focus.

It would be fair to say that current quality accreditation is seen by many as revolving around a formal once-a-year compliance audit process which has little relevance to frontline health workers and limited capacity to drive improvement in health care practices and patient outcomes. That is not to say that quality accreditation has made no worthwhile contribution to improving health care services; clearly it has and still does, but it is time to move on to another level.

Ideally, a set of quality indicators and measures would be agreed by stakeholders and endorsed by the national body for each type of health care service. Accredited organisations would undertake surveys and other assessments of providers' performance against the agreed quality measures. The outcomes should be reported back not just to providers for internal use, but to stakeholder groups convened under the auspices of the national body with the aim of facilitating and supporting quality improvement.

Quality accreditation reporting should not rely wholly on spot checks by surveyors. There should be scope for regular and even real time reporting against quality standards. Evidence based guidelines endorsed by the relevant professional body (or bodies) should inform quality patient care. Variance from such 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 could be good use of surveyors' time.

The AHIA believes that a critical factor in any quality improvement process is public reporting on aggregated patient outcomes from a range of conditions and treatment options. The data should be sufficiently detailed to inform decisions on individual treatment plans, based on evidence of the patient's needs, best practice and both the incidence of treatment regimes and patient outcomes by State and area. This would help to address the question of whether a treatment was appropriate in the first place, not just whether it has been delivered safely and well.

Ultimately, reports against a series of quality indicators and patient outcomes should be published by provider and made available to consumers, as is now happening overseas. This is the best way to empower consumers and improve quality by directing resources to the best providers.

As the paper recognises, funders, whether they be governments, private health funds or other third party payers, will continue to have different priorities and needs for quality assurance and assessment of providers. It may be possible to develop, in consultation with funders and other stakeholders, an overall set of quality indicators and measures from which funders (and other stakeholders) could choose and agree on a set of measures appropriate to their needs. This approach would help make the proposed accreditation model more efficient and cost-effective.

## **Establishment of a National Body**

The AHIA supports the proposal for a national body responsible for the functions set out in the paper.

Rather than duplicate some of the existing resources and expertise, consideration should be given to changing and expanding the Commission itself to perform this role.

The national body should keep records of providers' safety and quality accreditation and make them available online to private health insurers and other parties with a legitimate interest in having the information.

## **Associated Reforms**

In terms of the other reforms listed in the Consultation Paper, the AHIA supports the following reforms in priority order:

- developing a best practice guide to standards development and review;
- developing appropriate mechanisms, timing and format for public reporting;
- developing a process of mutual recognition of accreditation processes and outcomes;
- using unannounced surveys;
- piloting of tracer methodology.

---

The AHIA appreciates the Commission's work on the review of accreditation standards and its willingness to engage with the private health insurance industry. We look forward to continuing involvement in the review and implementation of its agreed outcomes.

Yours sincerely,



**DR MICHAEL ARMITAGE**  
**CHIEF EXECUTIVE OFFICER**

5 October 2007