

D07/8655



AMA

**Submission to the Australian Commission on
Safety and Quality in Health Care on the
National Quality and Safety Accreditation
Standards Review**

October 2007

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AMA Submission in response to the ACSQHC discussion paper on the Review of National Safety and Quality Accreditation Standards

Executive summary

These comments have been prepared by the Australian Medical Association (AMA) in response to the Australian Commission on Safety and Quality in Health Care (ACSQHC) further paper on accreditation, and safety and quality issues titled:

“Consultation Paper: An Alternative Model for Safety and Quality Accreditation in Health Care-July 2007”.

This July 2007 ACSQHC paper follows the earlier November 2006 ACSQHC ‘Discussion Paper’ on issues to do with accreditation. The AMA provided a submission to ACSQHC on the earlier paper. ACSQHC has sought submissions on the proposals in the new paper with submissions due by October 5th.

In this new paper the ACSQHC proposes what it calls “an alternative model for accreditation of the safety and quality of health services in Australia.” (p2). The new paper “primarily recommends high level strategic reforms of the accreditation system together with only a few associated operational reforms” (p7) and the model “aims to reorientate relationships between existing bodies and provide greater accountability and clarity.” (p8).

In these comments the AMA indicates:

1. It supports the further development of evidence based or scientifically proven processes within the Australian health care system that would enhance the safety and quality of care provided;
2. That for issues impinging on medical practice, solutions should be developed through processes that involve equal participation and ownership by recognised, authoritative and representative medical groups. Cumbersome ‘top down’ non-medical government controlled and directed processes are unlikely to reflect what actually happens at the point of care and therefore succeed;
3. The development of such processes has been slow in Australia due in large part to the complex and diverse organisation and funding of the Australian health ‘system’. Doctors already practice within an environment characterized by an array of State and Commonwealth regulatory processes. The AMA believes careful and incremental adaptation of existing regulatory structures to allow evolution of roles is preferred to the imposition of even more regulatory processes and is more likely to achieve real outcomes for patients;

4. The AMA is far from convinced that it is necessary, in the Australian context, to create, in addition to all the other bodies currently involved in accreditation, safety and standards setting, yet another “national body....responsible for developing safety standards that are endorsed by Health Ministers.” (p10). The AMA supports a more targeted, incremental approach and believes there is scope to build on and further refine the many safety initiatives already developed in Australia.

The AMA considers that the new ACSQHC “Consultation Paper” moves a little towards a more realistic, achievable set of goals when compared with the proposals in ACSQHC’s earlier “Discussion Paper”.

Regulatory environment –

- The new paper acknowledges the complex jurisdictional and regulatory environment in which health providers must operate in Australia and the difficulty within this context of defining the roles of, and creating new entities, with responsibilities across the full health system.
- The AMA supports in broad principle the first and key component of the new model: separating the setting of safety standards and processes to measure safe delivery of care from quality standards setting and assessment processes. The AMA notes ACSQHC’s recognition that evidence was often available “to support the development of and assessment against safety standards, while quality was much more subjective and therefore more difficult to measure.” (p9)
- The AMA strongly supports accreditation processes that combine quality assurance with a quality improvement framework for acute care settings where the consequences of adverse events and the costs of care are greatest.
- Efforts to enhance safety and quality must be developed incrementally, in close consultation and cooperation with the medical profession. The AMA is prepared to work constructively on these issues as a key and equal participant.

However, the AMA has strong concerns about the proposal for regulation to mandate compliance with national minimum safety standards. The new ACSQHC paper does not identify the specific weaknesses, or indeed any weaknesses, in the health system that require this measure to rectify them. Further, the paper acknowledges “suitable regulatory mechanisms have not been defined.” (p13)

The AMA is not convinced that, given the existing complex health arrangements in Australia, it is possible to devise “suitable regulatory mechanisms” on a national basis with which to implement the ACSQHC proposals. Agreement across nine jurisdictions on the proposals suggested by ACSQHC may not be easily or readily achieved

There is a significant risk that the provision of health care by medical practitioners will be paralysed by a compliance burden that is onerous and time consuming. Further, even

a relatively minor infringement can very quickly undermine the public's confidence in the health system, as has been seen in recent times with medicines regulation. The AMA cautions the ACSQHC against a heavy-handed regulatory solution to a problem that is yet to be specifically defined.

Also, the proposals come without consideration of the resources (including significant financial resources) that would be required to ensure that these new requirements could be introduced with the support, information, education and other programs that would be necessary throughout all stages of implementation.

In the absence of some fundamental changes to the health system, a more targeted, incremental approach is possibly the only feasible approach. That is, the AMA believes targeted, incremental development of safety and accreditation initiatives should continue.

Background

This new ACSQHC paper proposes major initiatives which would affect all providers of health care in Australia. These proposals would result in Government appointed and dominated entities assuming significantly increased influence and direction in areas where, until now, initiatives have been conceived and largely controlled by professional bodies and by organisations, such as hospitals and other facilities, directly involved in providing care.

The new ACSQHC ‘Consultation Paper’ paper proposes:

1. Separation of safety assurance and quality improvement assessment processes
2. Separation between Safety Standards development and assessment of health services
3. Accreditation of all settings of care where services are provided by registered health professionals.
4. Development of national minimum safety standards that apply across all (similar) settings of care
5. Assessment of non-clinical and technical compliance
6. Development of a national framework for quality improvement
7. Establishment of a national body to lead and coordinate changes
8. Review of surveyor training
9. Associated Reforms.

(“Associated reforms” suggested in the new ACSQHC paper include:

- using unannounced surveys to assess the national minimum safety standards, (after appropriate piloting);
- piloting tracer methodology (patient journey);
- developing a best practice guide to standards development and review;
- mapping of standards;
- developing appropriate mechanisms, timing and format for public reporting; and
- developing a process for mutual recognition of accreditation processes and outcomes.”) (p25)

The AMA supports evidence based and proven measures that will lead to and guarantee enhanced safety and quality in the provision of health care in Australia. The AMA has been closely involved in the establishment of several Australian formal accreditation arrangements.

Australians expect that health care they receive will meet the highest possible standards. The AMA appreciates that various individuals and committees have struggled with the challenge of introducing workable processes for monitoring the safety and quality of health care and for intervening when evidence suggests the need for action.

In considering the issues raised in the latest ACSQHC paper the AMA is mindful that in the last few decades several serious breakdowns have occurred that resulted in harm to patients. In the 1970s this was the case with the deep sleep therapy administered at Chelmsford hospital in Sydney and more recently in allegations relating to some surgical services at Bundaberg hospital in Queensland. It must be remembered that in Bundaberg it was not accreditation standards that failed. The failure occurred when government bypassed the accreditation process. As well as these episodes, public concern has arisen about aspects of obstetric care at the King Edward Memorial hospital in Perth, with some neurosurgical care at the Canberra hospital and with a range of services at the Camden and Camperdown hospitals in Sydney.

In the 1970s the AMA was one of the leaders in the establishment of the (now) Australian Council on Healthcare Standards. The AMA, with other medical groups, remains involved in the governance of that organization. Similarly, in the 1990s the AMA was one of the organisations that participated in discussions that have led to development of the existing system of general practice accreditation in Australia and the AMA remains involved in the governance of AGPAL and of course other accreditation bodies. More recent initiatives have been developed by medical groups. For example, the development and implementation of the Anaesthetic Incident Monitoring System (AIMS) in Australia, based on a specialty based model of incident reporting, is highly regarded internationally. The National Joint Register is another example of doctors initiating a system to collect data in a systematic on-going process aimed at enhancing and improving care.

The AMA is strongly of the view that government and others with involvement and responsibility in this area must put aside any tendency to retreat to discredited, outmoded notions that formal involvement of medical professional organisations in the development of new policy in this area will somehow be corrupted by self interest, a desire to ignore or deny difficulties and resistance to necessary change. Indeed history, particularly at Bundaberg, proves the reverse is the case. On the contrary, the AMA is skeptical that much of value can evolve in this area from committees dominated by non-clinicians and from processes which do not, from the very beginning, appreciate and accommodate the complex professional, legal, organisational and technical factors within which Australian medical practice operates.

Efforts to enhance safety and quality must be developed in close consultation and cooperation with the medical profession. The AMA is prepared to work constructively on these issues as a key and equal participant in the development of proposals. A basic theme in these AMA comments is that progress is dependent on the development of such processes and this submission reflects this view by concentrating more on these general

themes than on providing detailed commentary on this new set of ACSQHC ideas and concepts.

Broader Issues Impacting on Safety and Quality

The AMA also wishes to remind ACSQHC that processes to enhance safety and quality cannot be seen in isolation from other aspects of the health system including, especially, the aggregate resources available within the system. Safety and quality in health care is complex. Improving safety and quality requires a multi-pronged approach, which needs significant and appropriate resourcing.

Clinicians see the over-riding threat to quality and safety in the Australian health system as the lack of sufficient human and other resources at the coalface of clinical care.

Clinicians see major threats to quality arising from factors such as:

- shortages of staff;
- work stresses and conditions which drive people to other jobs;
- emergency departments overwhelmed by demand;
- shortages of facilities for coping with the numbers of acutely ill, particularly elderly people, presenting at emergency departments; and
- closure and downgrading of peripheral hospitals.

Despite a range of proposals from the AMA and other general practice organizations activity within general practice in Australia is still inappropriately distorted by financing arrangements through the Medicare Benefits Schedule that work against the adoption of arrangements more suitable for the needs of an ageing population and the growth in chronic illness.

That is, the AMA does not believe that safety and quality issues can be considered in isolation from other issues, particularly the resources needed to guarantee the provision of safe, high quality care.

The availability of complete and accurate patient information is critical to safe and high quality care. The development of electronic patient records is fragmented, and clinician access to high definition imaging for treatment purposes is very patchy. Patient safety and quality will be greatly improved if these shortcomings are addressed.

Just one example and key indicator of the pressure all around the country on public hospitals is the bed occupancy rate:

Following are some of the stand-outs in 2004-05:

- NSW reports an **average** public hospital acute bed occupancy rate of just over 90%;
- In Victoria, the overall **average** bed occupancy rate is 98.6%;
- In the ACT, it was 92.4%; and
- In the NT, it was over 100%.

Average bed occupancy rates mask particular sites where occupancy rates are extremely high, with serious implications for quality and safety. The available evidence suggests that major metropolitan teaching hospitals tend to have above average rates, while country hospitals are more likely to run below the average. The newly amalgamated Sydney South West Area Health Service reports an overall bed occupancy rate of 94.1% with several major facilities on the wrong side of that average (RPA, Concord, Bankstown and Liverpool).

There is substantial Australian and international evidence that high average bed occupancy rates are not consistent with the efficient operation of public hospitals or with quality outcomes. If average bed occupancy rates are sustained above 85% of technical capacity (the NHS uses a band of 82 to 85%), the impact is felt. One World Health Organisation paper expresses the proposition in the following terms:

“Indeed, we can be fairly confident in making a clear and categorical statement about bed occupancy. In acute hospitals, on optimal average bed occupancy rate lies in the region of 85%; rates much below 80% are clearly inefficient, while average rates of 90% give rise to an increasing probability that, on any given day, the hospital in question may have insufficient beds available to meet random daily fluctuation in demand for care.”

Proposals for more and more cumbersome bureaucratic processes with onerous compliance regimes that would consume even more resources and clinician time for very little gain are not ranked by doctors as high priorities for addressing safety and quality at the point of care.

The Role of ACSQHC

The ACSQHC’s “1 Year Work Plan 2007-2008” and “5 Year Work Plan 2006-2011” lists “Nine Priority Programs.” These are:

1. Patient Charter of Rights
2. Open Disclosure
3. Hygiene (Healthcare acquired infection)
4. Patient Identification Issues
5. Handover
6. Medication Safety
7. National Review of Safety and Quality Accreditation Standards
8. Quantitative and Benchmarking
9. Harness Information Technology and Communication

The new ‘Consultation Paper’ on accreditation is part of the work being undertaken in respect of National Priority Program 7 i.e. National Review of Safety and Quality Accreditation Standards.

The “deliverables” of this program, according to the ACSQHC work plan, are to “provide advice to AHMAC on national accreditation issues and proposed reforms” and the

strategies the ACSQHC will follow in developing this advice are “national consultation and engagement with stakeholders” to “determine a package of accreditation reforms.”

The AMA does not believe that processes that will genuinely enhance the quality and safety of health care in the complex regulatory and funding environment in which Australian doctors work can be developed without the active, on-going and equal participation and cooperation of the organised medical profession.

The AMA has already, in response to the earlier paper (the ACSQHC Discussion Paper- November 2006), questioned the appropriateness of ACSQHC attempting to establish itself as the final arbiter in regard to such important and far-reaching policy issues.

In its comments on the November 2006 ‘Discussion Paper’ the AMA made the following comments which remain pertinent despite the more focused and somewhat less ambitious proposals in the new ‘Consultation Paper’:

“The AMA reviewed the Work Plan of the ACSQHC for the period 2006/2007-2010/2011 as endorsed by Federal and State health ministers. That plan proposes many initiatives. Implementation of the majority of would involve primarily entities other than ACSQHC.

The AMA’s view is that the ACSQHC proposed work plan is practically and politically unrealistic. It goes too far, too fast and, in many areas, goes well beyond the remit of the ACSQHC. The commission should have a more explicit focus and should develop a realistic, achievable and incremental agenda. Australia does not have a ‘health system’ in any structural or legal sense and this is likely to remain the case. Australia has a large number of entities such as public and private hospitals which operate under the laws and requirements of different jurisdictions and which are funded from a variety of sources. It has thousands of privately owned and managed medical practices across a vast range of specialties and geographic locations and which vary greatly in size and which offer a varied range of services. Australia also has a diversity of other settings in which health care is provided and a wide spectrum of health care providers.

Over the decades this system has, in the AMA’s view, been able to adapt with remarkable dynamism as technological innovations emerge and as consumer needs evolve. It concerns the AMA that much of the material emerging from ACSQHC suggests the need for more centralised, directed and controlled regulatory arrangements across the health ‘system’. While such initiatives can be described in warm rhetoric, their implementation can lead to a more restrained, rigid system which becomes clogged in ‘red tape’.”

The alternative model now proposed in the ‘Consultation Paper’ anticipates endorsement by Health Ministers of national minimum safety standards developed within a national minimum safety standards development framework. “All settings of care will be assessed against each national minimum safety standard. Each standard will cover a specific subject area.” (p13)

The AMA has followed the development and scope of activities of the National Patient Safety Agency (NPSA) established in the United Kingdom. The NPSA is able to involve itself, given the structure and centralised regulation of the National Health Service, in a wide range of activities such as improving the safety of blood transfusions, reducing risks associated with high dose morphine injections, identifying and preventing failure to act on radiological imaging, helping prevent medication errors due to poor packaging and ambulance design. The NPSA has just commenced a four year program to address some of the complex reasons behind low compliance with hand hygiene among health service staff. (NPSA Annual Report 2006-2007)

The more centralized nature of the NHS allows the NPSA to exert real influence in these areas. Perhaps what Australia may best gain from the NPSA is information on what programs and projects provide substantial benefits and then seek ways to have these applied within the more diverse and complex Australian health organisational and regulatory arrangements. The AMA also notes references in NPSA publications to its intention and need to cooperate in many projects with organised medical groups such as the royal colleges and the BMA.

That is, the AMA believes ACSQHC would do better to foster and support a more incremental approach which targets key developments where substantial gains are likely rather than proposing a possibly unachievable re-structuring of accreditation and safety and quality arrangements within Australia as a ‘one size fits all’ approach.

The 2006 AMA position paper on safety and quality in health care stated:

“Australia has a high quality health system. Our health system provides more than 230 million medical services each year to Australians at a cost of \$12 billion. In addition we provide 7 million total hospital admissions, 4.2 million of which are in the public hospital system provided at no charge to the patient. The vast bulk of medical training occurs in the public hospitals turning medical students into fully trained and fully fledged medical practitioners ready to practice independently.

Over the last 30 years, we have seen a substantial fall in perioperative death rates through improved anaesthesia management, a substantial decline in death rates from heart attack and stroke, declining death rates from many cancers, improved diabetes management, improved options for mental health care, lower perinatal and maternal death rates and longer life expectancy etc (refer AIHW Australia’s Health 2006, Chapter 2, pgs 15 to 129).

The improvements, we suggest, come about because large numbers of highly trained and motivated people have put their mind to the task over a long period of time putting forward ideas, testing the ideas with peers, gathering the best ideas from colleagues around the world, being well trained and training those following. This has enabled the profession to develop better methods of managing patients to produce better outcomes. It enables the profession to work with new technologies and new pharmaceuticals and improved processes for health care delivery in providing better care for patients.

The vast bulk of improvements in the quality and safety of health care over the long term arises from an adequately resourced, highly trained, and fully credentialed health and medical workforce. For high standards of quality and safety to be assured, the AMA believes it is essential there is strong clinical involvement in and ownership of processes set up to measure and assure safety and quality across the system.

Public hospitals continue to operate under great pressure and this Position Statement acknowledges that resource and capacity restraints have a significant impact on quality and safety and addresses the lack of reliable mechanisms for routine data collection and dissemination. Strategies for developing quality and safety standards can only be derived from robust data sets. It is a common situation throughout the public hospital system that data is collected without input from those directly involved in providing patient care. This immediately compromises its ability to bring about improved patient outcomes.”

The Development of ACSQHC Proposals

It is of interest to consider the membership of the ACSQHC. The AMA believes that the current membership of the Commission, dominated as it is by government employees, means ACSQHC is not always the appropriate body to be making decisions likely to impact on the wide range of small and large, public and private institutions involved in the provision of health care in Australia. These include large and small public hospitals, for-profit and not-for-profit private hospitals, community services, day surgery centers, diagnostic centers and thousands of privately owned and managed medical practices.

The Commission comprises a businessman as Chair, three senior public servants (currently from the Commonwealth, Queensland and NSW Health Departments), an ‘academic clinician’, a ‘clinician’ (currently an employee of the Northern Territory Health Department), the managing director of a large private insurer (BUPA), the CEO of a private hospital (currently the immediate past-president of the APHA), the executive director of the Royal College of Nursing Australia, the manager of a Victorian government health region, a ‘consumer’ representative, and a ‘general practitioner’ (currently an employee of the Western Australian Health Department.)

The first Chief Executive Officer of the ACSQHC was a former manager of a State health department region. The current, interim, CEO has been seconded from the central office of another State health department.

The AMA does not believe that a government appointed and directed committee, dominated by Government employees, can effectively progress the safety and quality agenda within the complex, decentralized Australian health ‘system’. There are two basic reasons for stating this:

- Such “commission” membership and processes does not inspire confidence within medical organisations or among medical professionals. This is particularly so given the never ending political and public debate about the adequacy of funding available for health services. Inadequate funding of some services is, in the view

of the medical profession, a greater threat to quality than the absence of the type of processes being proposed by the ACSQHC.

- Progress in this difficult and complex area of initiatives that impact directly on the medical profession will only be achieved when there is genuine and equal participation of representative medical organisations: many difficult issues have to be worked through. It is simply not sufficient for ACSQHC to “consult” or to appoint individual, selected medical practitioners to committees. Processes must be developed which genuinely engage organised, representative groups if safety and quality initiatives are to successfully developed and implemented across the health system in ways that achieve the broad cooperation of the medical profession.

On this point, the AMA notes the ACSQHC paper “The Report on Initial Stakeholder Consultations: The Review of National Safety and Quality Accreditation Standards (2007)” records (p204) that of 404 persons who participated in focus groups organised to discuss the earlier “Discussion Paper”:

- 154 were “health managers or administrators”,
- 87 were “policy or project officers”,
- 37 were “accreditation surveyors or administrators”, and,
- 17 were “consumers”.

Of the 404 participants 23 recorded their “primary role” as medical practitioner and 4 participants were nursing practitioners.

Clinicians are inherently cynical of processes that provide for a host of officials and administrators to pontificate, by pushing buttons on “interactive audience response technology” (p146) on how clinicians working arrangements should be overseen and regulated and how the health system should be organised. It is hard for medical practitioners not to be cynical about such a use of resources when they must cope daily with greater and greater demands on their time and skills in extremely stressful circumstances, making real (often, literally, ‘life and death’) decisions in the face of inherent uncertainty and risk.

The AMA believes that the make up of the Commission and the prior experience of its staff limit its ability to properly comprehend, must less make recommendations regarding, the organisation and management of the wide variety of settings across which the majority of Australian doctors work. These settings include private medical practices, private hospitals, day centers and public hospitals. Workable and acceptable processes will only be achieved if development is undertaken through processes which allow the organised medical profession to feel that it is an equal partner in their development.

While not endorsing all the views and conclusions of the authors the AMA suggests that the extract below from a recent *Medical Journal of Australia* article by two academic commentators on governance issues pertinent to enhancing the quality and safety at least appreciates some of these issues:

“In the “new regulatory state”, with its increasing privatisation, regulation by government and its agents has become more rather than less common, but the crucial difference from the old “command and control” view is that governments increasingly “steer not row” and are seeking flexible, participatory and devolved forms of regulation. These changes are possible given the changed nature of organisations in the information age, where power flows through networks that are more fluid and complex than older structures of governance

The idea of responsive regulation is that informal interventions to address problems, as well as positive feedback on achievements and strengths, may be all that is required to persuade a health provider. Persistent infractions may eventually elicit repeat inspections and public disclosure of failure to meet standards. But, even at this level, referral to support services or mentoring should be offered. Every escalation up the pyramid should also indicate a path to de-escalation. Continued and serious breaches of the regulatory guidelines may incur financial penalties and result in activities being curtailed. For example, a hospital might be refused public funding for extra elective surgery until a problem is fixed, or a physician might be deregistered. Licence removal or closure are last resorts and signal the failure of both parties to ensure the public is well served.

The tough part about enforced self-regulation is that, unlike voluntary self-regulation, it is enforceable. Hence, if a hospital fails to meet one of the privately written but publicly ratified rules, the organisation and its managers can be sanctioned for that failure. This enforced self-regulation strategy attempts to secure the creativity, flexibility, and cost-effectiveness of moving away from command and control, while simultaneously retaining public enforcement capability.” (*“Designing safer health care through responsive regulation”*: Judith Healy and John Braithwaite, MJA 2006; 184 (10 Suppl): S56-S59)

Background to the July 2007 ACSQHC ‘Consultation Paper’

The ACSQHC website provides some background to the development of its July 2007 “Consultation Paper”:

“The Australian Commission on Safety and Quality in Health Care commenced its review of National Safety and Quality Accreditation Standards in November 2006 with the release of a discussion paper endorsed by Health Ministers. The paper was the basis for the first phase of stakeholder consultations and detailed issues with the current safety and quality accreditation system and its standards. An alternative model of accreditation has been developed by the Commission as the basis of consultation. The alternative model was developed directly from the information collected in the first phase of consultations and proposes a substantial reform of the accreditation system that has the potential for far-reaching change.

A benign interpretation of the above ACSQHC comments is that the new paper reflects a desire of ACSQHC to further develop the extensive proposals in its earlier paper in light

of the significant concerns about the ACSQHC accreditation agenda laid out in the earlier 'Discussion Paper.' The new paper implies that its proposals are a natural evolution following consultation on the earlier 'Discussion Paper'. However, the paper's recommendations are different in many respects from those in the earlier paper and a perusal of submissions and the review of the outcome of consultations published by ACSQHC indicate a stronger degree of disquiet with the earlier proposals than the new paper suggests.

The following comments are from submissions to the ACSQHC on November 2006 Discussion Paper.

The Australian Council on Healthcare Standards (ACHS) commented:

“The tension between ‘continuous quality improvement’ and ‘compliance’ approaches has been a prevailing issue for many years. Research supports the view that whilst there is a place for regulation in a quality performance framework, the best gains are made by encouraging excellence through evidence-based continuous quality improvement. If accreditation is moved more towards a compliance model its value to the health industry and the community will be dissipated and may well be lost entirely. A compliance model can lead to confusion as to who is responsible for performance, particularly when serious service failures occur. Accreditation is one, albeit important, indicator of organisational performance. Accrediting (or performance assessing) organisations rarely, if ever, carry the obligation, right or capacity to make operational improvements. This is the responsibility of those persons with operational management accountability.

It is of great concern that the paper relies heavily on anecdotal feedback from a limited sample of stakeholders and then suggests significant changes on the incorrect assumption that the feedback is representative of industry stakeholders.

A number of ACHS stakeholders have expressed concerns regarding the perceived need for an organisation which will essentially be "adding yet another layer of administration". The basis for that concern is at least three-fold, including that the proposal:

- will involve a further layer of bureaucracy;
- will increase costs; and
- may, inappropriately, be controlled by government as opposed to being truly independent as is the ideal situation.”

The Royal Australasian College of Surgeons commented:

“Despite advances in the area of quality and safety of the health sector over the last 20 years significant questions remain unanswered. A ‘reality check’ is now fully warranted. In many ways the accreditation and standards industry has been captured by interest groups and self professed experts. An enormous amount of time, effort and resource is applied in achieving standards too focused on policies and processes. This may have been appropriate last century when issues of safety and quality were not clearly on the health

sector's agenda. Substantial gains have been made in properly understanding the infrastructure requirements and the importance of reliable processes and policies.”

The Royal Australasian College of Physicians commented:

“The focus in accreditation appears to be shifting from structural frameworks, policies and processes towards performance measurement. In addition the focus within performance measurement is towards development and/or adherence to existing standards. There is less emphasis on performance measurement as it relates to implementation of evidence-based cares in areas in which there are no standards or they may be difficult to quantify – a problem for many of the non-procedural specialties. The role of accreditation in private practice does not seem to have been comprehensively considered within the document. The resource and training implications for physicians (as well as other health care professionals) in hospital and private settings are substantial and need to be further considered in implementing change. Physicians in general, do not have the same level of groups and systems and computerised support for practice that other groups currently have. The overall resources required to implement and maintain accreditation in relation to evidence of its effectiveness has not been demonstrated. Rational evidence based allocation of resources to improve health care outcomes are strongly supported by physicians in general.”

AGPAL commented on the 2006 paper:

“The possible initiatives proposed could be embedded as part of the accreditation process as accreditation has an already established role and acceptability across services and may be in a position to assist in implementation as part of a broader approach. QIP/AGPAL is already in a position to determine the level of performance of practices against standards (including poor performance) so this may be efficient as the resources are already geared. There is otherwise the risk of increased complexity and bureaucracy on an already burdened largely small business primary care system..... Accreditation needs to maintain its focus on education and moving the entire profession forward (i.e. assisting the service response to meeting the standards), rather than being the determining agent of individual non-compliance and consequent sanction action.”

The Australian Health Insurance Association commented:

“The focus groups paid a lot of attention to:

- standardising language and definitions of standards;
- mapping and analysis of existing standards;
- registration of sets of standards (and by whom).

These steps were seen as prerequisite to developing a national set of core standards. It is appreciated that this is a logical process for moving from a somewhat chaotic system of standards and accreditation to a better national one. The trouble is there is a large body of work involved in each of these tasks over an extended period, plus a requirement for a

registration body. The risk is that piling bureaucratic layers on the existing system will only add to complexity and costs without necessarily improving it.”

The Australian College of Health Care Executives suggested:

“The Discussion Paper is seen by some as an unbalanced contribution to an important debate. It concentrates on problems with current accreditation processes which are difficult to resolve and most of which are widely accepted (e.g. inter-rater reliability). The Paper ignores the strengths of current processes (e.g. “fundamental changes are required to sustain accreditation...”), risks (it ignores risk as a concept and the need to manage it) and risk management systems and thus suggests an approach that runs the risk of “throwing the baby out with the bathwater”.

The introduction of unannounced surveys would have a very negative impact on the whole accreditation process. This reinforces the idea that 'Big Brother' is watching and services will therefore spend enormous amounts of time ensuring they are never 'caught out'. This approach goes against the principle of accreditation which is continuous improvement rather than the passes or fails mentality.

Also most services have great difficulty in convincing medical staff to be actively involved in the accreditation program and a large number of services employ Accreditation Coordinators who are usually from a nursing background and are given the responsibility for implementing and coordinating quality programs. These people invariably have a tough time getting other staff to be involved in the programs and there is often a high turnover of staff in these positions.

An issue is whether diversity and choice are important in promoting continuing improvement in the quality of care. If choice and diversity are important then a degree of duplication is inevitable. However, greater coordination between agencies, especially those that are not-for-profit could lead to greater compatibility - rather than uniformity - and sharing of efforts, by acceptance that verification of overlapping standards by an agency would be acceptable by another agency dealing with the same health care delivery unit. There could be a problem in for-profit agencies not being interested in revealing their proprietary standards and or processes.”

The July 2007 ACSQHC Consultation Paper

Below are listed some of the 15 reasons the new ACSQHC lists for the directions now proposed in its new “Consultation Paper”:

- “1. There is no consensus about the purpose of accreditation, and its role in the health system is not clear.
2. The current accreditation processes merge both safety assurance and quality improvement into processes, standards and recommendations which compromise achieving either aim.

3. The accreditation system is currently characterised by fragmentation, lack of coordination and an absence of integration.
.....
5. There is a growing compliance burden associated with safety and quality and there are multiple accreditation processes with significant overlap and duplication.
.....
13. There is a potential or perceived conflict of interest involved in the same bodies developing, owning and assessing compliance against accreditation standards.
14. There is no mechanism for linking accreditation to national safety and quality priorities.
15. Ministers are held accountable by the community for the safety of the health system, but have no formal mechanism to influence the accreditation process and the standards that apply.” p5

The new ACSQHC paper goes on:

“The alternative model cannot address all aspects of duplication in reporting and safety and quality compliance for both public and private health services. In particular, requirements relating to state and territory licensing, and safety and quality reporting mandated by health funds, indemnity insurers and program funding are not included in this review process. Accordingly, these requirements are likely to continue or may increase unless relevant organisations agree that the national minimum safety standards and quality improvement framework meet their needs and that additional measures are unnecessary.” (p5)

“It was apparent that standards and accreditation processes are increasingly used as a solution to a wide range of safety and quality issues facing the health care system. Accreditation has shifted from being a primarily voluntary system to an integral part of access to funding, licensing and meeting accountability requirements of governments.”p9

Safety and Quality developments in the Australian health sector

Debate has not progressed far beyond the situation that existed early in 2006, judging by some summary comments at that time:

“It is hard to escape the conclusion that improvements have been patchy, fragmented and, in many cases, transient — with excellent and instructive projects failing to be sustained and incorporated into lasting system improvements.” (*The safety and quality of health care: from Council to Commission.*” Richard A Smallwood MJA 2006; 184 (10 Suppl): S39-S40)

“To change the nature of health care delivery across the continuum of care, and also within both the public and the private systems, it will need to advocate some powerful levers.The task will be difficult, as it requires the agreement of nine governments along with multiple groups within the health system. It could possibly be achieved with

the cooperation of health insurers to influence good practice in the private health care sector, changes to the Commonwealth and State Health Care Agreements for the public sector, and new private practice incentive payments.”(*Health care safety and quality: where have we been and where are we going?*” Bruce H Barraclough and Jim Birch MJA 2006; 184 (10 Suppl): S48-S50)

Many principles underpinning these AMA comments on the ACSQHC “Consultation Paper” are based on the principles contained in a 2006 AMA position statement on safety and quality issues. A copy of that paper is attached.

Many of the propositions in the latest ACSQHC paper involve principles that are not in accord with established AMA positions. As one example this can be seen by comparing these ACSQHC proposals with the formal AMA position on general practice accreditation:

“The AMA supports a system of general practice accreditation which:

1. is independent of Government;
2. is under the effective control of actively practicing general practitioners;
3. is a voluntary, educational and supportive process;
4. is not punitive;
5. does not interfere with clinical practice or business structures;
6. does not result in a diminution of any existing financial entitlements of a nonparticipating practitioner or their patients;
7. is based on current standards developed by RACGP and supported by the AMACGP; reflects and supports the diversity of general practice; including solo practice;
8. clearly separates the vocational recognition of individual general practitioners from the accreditation of practices;
9. is based on entry level standards, with ongoing accreditation dependent on the implementation by the practice of a process of quality assurance and continuous quality improvement;
10. includes an appeals process independent of the persons conducting, supervising or responsible for the accreditation process;
11. incorporates a mechanism for cost containment; and
12. provides a lead role for general practice profession in the implementation of any significant changes to the evolving process of accreditation.”

The ACSQHC proposals, if implemented, would see a shift from processes initiated, developed and controlled by professional and industry groups towards processes more directly open to control and shaping by government appointed and controlled bodies such as ACSQHC or successor organizations.

The AMA is broadly supportive of the following principles outlined by the ACHS in its submission to ACSQHC on the earlier ‘Discussion Paper’:

“The most important issue is how standards are developed (as opposed to who develops standards). For standards to be useful they must:

1. Address a recognised need
2. Be evidence based (as far as practicable)
3. Be developed through a transparent and consultative process
4. Be outcome focused
5. Achievable
6. Measurable

Accreditation processes should also not be seen as a pass or fail process as this could exacerbate the existing problems with trying to sell the principles of continuous improvement, and also encourage and/or increase concern about perpetuating a culture of blame, shame and punishment.

Although it focused on risk management the following extract from a June 2004 statement prepared by the AMA, the Committee of Presidents of Medical Colleges and the medical indemnity industry is pertinent to the broad points being made by the AMA in these comments on the new ACSQHC paper:

“A more coordinated approach by individual practitioners, colleges, MDOs, medical boards, private hospitals, and state governments and their health systems will help make a good system even better,” Dr Glasson said.

“Doctors currently comply with a range of risk management activities so they can maintain medical registration, College qualifications and access to public or private hospitals.

“Doctors often have to duplicate these activities because of a lack of communication between the parties concerned and because these parties don’t recognise each other’s risk management activities.”

The AMA believes that there are initiatives which could be pursued and which would achieve positive gains without the need for the sort of fundamental change suggested by ACSQHC in its latest paper. The AMA is no way endorsing any of the specific proposals in the following quotations. The AMA has included these to illustrate that opportunities for progress at least worth discussion do exist without the need for the fundamental realignment of powers and responsibilities floated by ACSQHC.

“Last year, the Council commissioned a small advisory group to examine what data might be readily available somewhere in the health system of sufficient quality and importance to make up an initial national dataset. The group proposed that an indicator included in the dataset needs to be:

- strongly and obviously related to quality of care;
- measurable in a systematic, accurate and reproducible manner;
- adjustable for factors outside a provider's control;
- available from routine data sources or, at reasonable cost, from targeted data collections; and, finally
- able to be benchmarked to judge performance.

To get the best return on investment in the collection of quality indicators, it was recommended that priority should be given to areas where high costs are incurred, where the outcome is of major significance, where the consequences of poor care have major implications for survival or quality of life and the cost of subsequent care, and where remedial action is practical." (*The safety and quality of health care: from Council to Commission.*" Richard A Smallwood MJA 2006; 184 (10 Suppl): S39-S40)

There is a vast international literature on issues relevant to the ACSQHC's brief. This literature does provide many useful concepts although often it is not obvious how they can be translated into the Australian context given differences in institutional, financing and regulatory arrangements. As one example, a recent paper from the USA suggests a range of concepts that might be relevant in the Australian context:

- Identify which incentives would encourage doctors to improve patient safety.
- Identify safety standards in office settings, not just hospitals.
- Develop the business case for identifying which interventions in outpatient care are most effective and for which patients in order to make practical improvements in office-based practice.
- Identify and train physician leaders to influence best practices among other doctors.
- Involve local groups in measuring, monitoring, and improving quality by engaging the existing grassroots infrastructure.
- Develop a common language and measures for safety.
- Create safety-related awards for individuals, groups, and societies.
- Put patient safety information in the public domain without compromising privacy or promoting litigation."

(*"The role and responsibility of physicians to improve patient safety,"* by Leslie D. Goode, M.H.S., Dr. Clancy, Harry R. Kimball, M.D., and others, in the October 2002 *Academic Medicine* 77(10), pp. 947-952.)

Conclusion

In this submission the AMA has considered some broader issues than those raised in the ACSQHC 'Consultation Paper' including the role of and processes followed by the ACSQHC. Underlying themes in this AMA commentary are that the AMA agrees that processes can be developed to enhance safety and quality within the Australian health care system, that development of such processes has been slow in Australia due in large part to the complex and diverse organisation and funding of the Australian health 'system' and that cumbersome 'top down' government solutions developed without equal participation and ownership by organised medical groups are unlikely to succeed.

The more positive theme is that the AMA and other organised groups within the medical profession are willing and prepared to cooperate in progressing this difficult, complex and challenging agenda. The AMA believes that there are numerous initiatives which could be considered for possible development in the Australian context and that in the short run on-going incremental work on such possibilities is more likely to bring enhancements to safety and quality.