AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

PROPOSALS ON

AN ALTERNATIVE MODEL FOR SAFETY AND QUALITY ACCREDITATION

AND

MATTERS RELATING TO COSTS AND DUPLICATION OF ACCREDITATION PROCESSES

FEBRUARY 2008

Australian Commission on Safety and Quality in Health Care
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Enquiries concerning this report and its reproduction should be directed to:

Australian Commission on Safety and Quality in Health Care
Level 7
1 Oxford Street
DARLINGHURST NSW 2010

Telephone: 02 9263 3633
Email: **mail@safetyandquality.gov.au**
Internet: www.safetyandquality.gov.au

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AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTH CARE

The Hon Stephen Robertson
Chair Australian Health Ministers Conference
Minister for Health
GPO Box 48
BRISBANE QLD 4001

Dear Mr Robertson

Review of National Safety and Quality Accreditation Standards

On behalf of the Australian Commission on Safety and Quality in Health Care it is my pleasure to submit for the consideration of Health Ministers, both the Final Report on the Review of National Safety and Quality Accreditation Standards and An Alternative Model for Safety and Quality Accreditation.

This Review has been conducted over 12 months and has involved extensive stakeholder consultation. Over 150 written submissions have been reviewed and more than 400 stakeholders have participated in phase one and 200 in phase two of the consultation process. I would like to acknowledge the valuable contributions of all these people during the Review.

The Commission sees this work as an essential plank in the improvement of safety and quality of the Australian health care system. Implementation of this work is a priority that should build on the collaborative national approach to hospitals and health reform adopted by states and territories, and the Commonwealth through the Council of Australian Governments (CoAG) processes.

The Australian accreditation system is mature and well embedded in hospital and general health service delivery. However the complexity and diversity of accreditation approaches, the duplication of safety and quality compliance and ongoing resource demands impact on the effectiveness of accreditation.

Recommendations are being structured to align with current CoAG process underway and will be submitted to the next meeting of the Australia Health Ministers Advisory Committee prior to its consideration by Health Ministers.

I believe that the recommendations will, if adopted, address the fragmentation and duplication of the current system and target priority areas in which standards of expected performance for improving safety and quality can be applied across health services.

I recommend both the Final Report and the Proposals Paper to Ministers.

Yours sincerely

William J Beerworth
Chairman
Australian Commission on Safety and Quality in Health Care

7 February 2008

T: (02) 9263 3633
F: (02) 9263 3613
W: www.safetyandquality.gov.au
E: mail@safetyandquality.gov.au

GPO Box 5480
Sydney 2001 NSW
Level 7, 1 Oxford Street
Darlinghurst 2010 NSW

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Executive Summary

The Alternative Model

The *Alternative Model for Safety and Quality Accreditation* (the *Alternative Model*) is designed to be applied across all sectors of the health care system and implemented incrementally, commencing with services where there is a high risk of patient harm.

This paper provides an overview of how the *Alternative Model* would operate and incorporates recommendations developed following the National Workshop on 30 November 2007.

The *Alternative Model* has the following key elements:

1.1 *Australian Health Standards* developed as a priority in areas that support improvements in the safety and quality of health care in areas of key importance for patient care, that apply to all health services..

1.2 A *Quality Improvement Framework* established to address key corporate, risk and governance areas which support quality processes and are applied to all health services.

1.3 *Expanded scope for accreditation* to services not currently accredited, through staged implementation, starting with those services where there is a high risk of patient harm.

1.4 *National data collection and reporting* to measure performance outcomes and improvements in priority safety and quality areas, to allow credible service comparison and facilitate tracking of the effectiveness of the Australian Health Standards.

1.5 *Mutual recognition of accreditation processes and outcomes* to reduce duplication, minimise the burden of accreditation on health services and promote continuity of care.

1.6 *National coordination* though the establishment of a body to lead, support and coordinate reform of the safety and quality accreditation system, including the development of Australian Health Standards. Such a National Entity would establish a model of collaborative governance that gives a clear role for consumers, clinicians, service providers and other stakeholders.

1.7 *Formal obligations to comply with accreditation requirements and consequence for non-compliance* by Health Services through the use of regulatory mechanisms and clearly described and enforced sanctions and penalties for non-compliance.

Alternative Model Support Projects

The following strategies are recommended as potential mechanisms to support the Alternative Model and the introduction of accreditation reforms.

1.8 *Review surveyor participation* to enable development of strategies ensuring the sustainability of the surveyor workforce with the appropriate expertise to undertake accreditation.

1.9 *Pilot innovative assessment mechanisms* such as patient journey methodologies and short notice surveys prior to consideration of their broader implementation into accreditation processes.

1.10 Facilitate and support a coordinated approach to *research* into safety and quality accreditation.

The Commission considers that AHS are the most effective way of establishing the expected level of service that consumers can reasonably expect across the health system. Accordingly, the Commission believes that all health services should comply with the AHS.

The national implementation of AHS provides an opportunity for the collection of a national safety and quality data set which can be reported publicly. While the frequency and characteristics of reporting will require further discussion with stakeholders, it will be important to involve consumers to ensure that the content of the public report covers those issues of most concern to consumers and the language is appropriate.

Cost of Accreditation

Two further pieces of work are included in this report. The first relates to the cost of accreditation, the second considers the issues of duplication of safety and quality compliance associated with licensing by governments of private health services.

A cost analysis was undertaken in order to establish an indicative baseline cost associated with participating in the accreditation process. Structured interviews were used to collect some data, however it was evident that identifiable data is not routinely collected by health services in relation to costs of safety and quality accreditation.

The findings of the cost analysis indicated that:

- The activities required to achieve accreditation are essentially considered part of core business by many organisations and many of the costs required for compliance with standards would be incurred as part of quality or good practice.
- Activities required for accreditation are inseparable from sound risk management and quality management procedures.
- The overlap of accreditation processes with quality management and continuous improvement means that it would be difficult to separately identify

the costs; and some argue that to do so would run counter to efforts to embed accreditation processes within everyday operations.

- The smaller the organisation the more likely that the task of preparation for accreditation will be burdensome, and that accreditation will be seen as a process diverting resources from income producing or service delivery activities. Smaller organisations are likely to particularly benefit from tools to support accreditation; and
- Accreditation is more likely to be undertaken if there is a direct financial incentive for so doing.
- Some organisations that offer voluntary accreditation e.g. the Australian Psychological Society, RACP and RANZCOG have established incentives to participate in accreditation because of credits gained towards Continuing Professional Development.

A comprehensive report on the review of accreditation costs is available on the Commission's website at www.safetyandquality.gov.au.

Duplication of Standards and Processes

It was evident from the consultation process that there is duplication in standards, compliance and accreditation processes that apply to health services. The Commission recognises the need to minimise duplication in accreditation, particularly as reforms are introduced. Chapter 3 of this Report discusses the current duplication and overlap relating to:

- requirements imposed through state and territory private health facility licensing
- contractual arrangements between health insurance funds and health service providers
- standards applied through different accreditation, certification or compliance processes, which may cover state and territory legislative requirements and mandatory standards.

There is a range of approaches to the scope of licensing of private health facilities across states and territories, which complicates comparison. Nevertheless, there is reasonable similarity in the standards areas covered by accreditation and licensing. In some states where a different license is applied to an accredited facility there is a direct link with accreditation.

Similarly, quality requirements are incorporated into contractual arrangements between health services and health insurance funds. It is difficult to establish the extent of overlap with licensing, accreditation and other standards, but it clear that duplication exists. The Commission is concerned that the degree of duplication is a risk to the successful implementation of the Alternative Model.

Chapter 4 identifies a range of safety and quality related health reforms. They include:

- Council of Australian Government reform of Education and Training Accreditation and the proposed National Health Professional Registration
- review of Private Health Insurance Reforms
- state based safety and quality standards
- expanded scope of accreditation.

The Commission believes the package of reforms proposed has the potential to change the system to improved safety and quality of care for patients and realise savings in part from efficiencies. The recommendations that emerge from the review of national safety and quality accreditation standards follow.

AN ALTERNATIVE MODEL FOR SAFETY AND QUALITY ACCREDITATION

1. AN ALTERNATIVE MODEL OF SAFETY AND QUALITY ACCREDITATION

1.1 Developing the *Alternative Model*

The Commission understands that accreditation is a systematic process and its purpose is to ensure all health service providers in the national health care system provide the highest possible levels of safety and quality to consumers. Accreditation can achieve this through two interrelated processes:

- Developing standards that test and measure the effectiveness, appropriateness, efficiency and quality of care delivered.
- Assessing health service against these standards.

In developing the *Alternative Model,* the Commission has focused on the reasons for reforming the current accreditation system set out in the *Final Report on the Review of National Safety and Quality in Accreditation: March 2008.*

The Commission considers that any accreditation system should primarily reflect the purpose of accreditation - protecting the interests of the Australian public by ensuring all health service providers in the national health care system provide the highest possible levels of safety and quality to consumers.

In exploring options for the *Alternative Model,* the Commission has considered whether the model should focus separately on safety and quality, or address safety and quality in an integrated way. The Commission has concluded that the *Alternative Model* should adopt an *integrated approach,* with safety, non-clinical and technical compliance being considered within a quality improvement framework.

Guiding Principles for the *Alternative Model*

The Commission believes that the identification of principles for the *Alternative Model* would be helpful to both finalise the *Alternative Model* of accreditation and to guide the implementation of reforms. The former Australian Council on Safety and Quality in Health Care developed a set of principles for accreditation reform that were endorsed by Health Ministers in July 2003 and still have relevance. These are listed in Appendix 1. The intent of these has been incorporated into the following principles and is reflected in the *Alternative Model* of accreditation proposed by the Commission.

The Commission proposes the following principles as a clear statement of intent to guide implementation of the *Alternative Model of Accreditation*:

The Accreditation System

1. A system of accreditation of health services is an important and useful safety and quality mechanism.
2. The system of accreditation should be consumer focused.

3. The accreditation process should include a requirement for health services to meet Australian Health Standards (AHS) and encourage continuous quality improvement.
4. Accreditation programs should be simple, transparent, avoid duplication and support mutual recognition to remove duplication.
5. The financial and administrative costs of participation in accreditation processes should be consistent with benefits of ensuring safety and quality for consumers.
6. Any national body established to oversight the accreditation system should include a governance structure and processes which involve collaboration and wide ranging consultation with stakeholders, including consumers, health care providers, funders and regulators.

Australian Health Standards (AHS)

7. AHS should facilitate the delivery of health care that minimises risks and supports optimal health outcomes for consumers.
8. AHS should be formulated in consultation with stakeholders, including consumers and health care providers.
9. AHS should be evidence based (where applicable), focused on measurable clinical outcomes and achievable.
10. Adoption of AHS should support innovation and a focus on continuity of care for consumers.

Application and Implementation of Australian Health Standards

11. All health services should implement AHS.
12. The range of AHS applied to a health service should be relevant to the type of the service, the nature of the health care provided and the risks involved.
13. Systems and mechanisms to measure quality improvement should be flexible and take account of service type and risks.
14. Measurement of compliance with or attainment of AHS in an accreditation process should include independent external review and public disclosure of outcomes.
15. External reviews should be undertaken by well trained and supported assessors and include peer assessors.
16. Sanctions should be applied for persistent non-compliance of the AHS.

Review and Evaluation

17. Information on safety and quality in health care that is generated from accreditation programs should be provided, in an appropriate format, to stakeholders.
18. Research and evaluation should be integral to the ongoing implementation and review of the *Alternative Model* of accreditation.

Benefits of the *Alternative Model*

The *Alternative Model* builds on the strengths of the current accreditation system which are that:

- A high proportion of public and 100% of private hospitals undertake accreditation.
- Involvement of clinicians as surveyors encourages information sharing, an understanding of the application of service standards and exposure to health services in other jurisdictions.
- Accreditation promotes change in health services and supports organisational learning and decision making processes.

The *Alternative Model* of accreditation offers a number of additional benefits including:

- addressing weaknesses such as a lack of co-ordination, fragmentation (section 1.9) and duplication (section 1.6) in the current accreditation system
- providing more active roles and collaboration for clinicians, consumers and other stakeholders, including through their involvement in governance arrangements (section 1.9)
- building in evaluation to ensure that changes to the system deliver improvements and are effective through the national analysis of data (section 1.5)
- targeting safety and quality risks by tailoring quality improvement activities to areas of greatest organisational need (section 1.3)
- targeting safety and quality strengths by identifying outstanding quality practice, the lessons of which could be shared with other health services (section 1.3)
- providing clarity about areas where safety and quality improvements can be progressively achieved (section 1.3)
- identifying priority areas in which standards of expected performance for improving safety and quality should be applied across health services (section 1.2)
- measuring improvements in priority safety and quality areas (section1.5)
- applying AHS across health services with consistency (sections 1.5 and 1.9)
- providing an information base for safety and quality improvement across the health system (section1.5)
- extending accreditation to cover high risk areas and encourage all services to comply with AHS (section1.2)

Whilst the Commission has reviewed international approaches to health care accreditation, there is no international model that addresses all our goals and principles or provides the range of benefits identified above. However, international learnings and best practice have informed the *Alternative Model* where appropriate.

An overview of the model is provided at Appendix 2. At Appendix 3 is the response to specific recommendation on accreditation that were made in the 2005 report on *"National arrangements for safety and quality in health care in Australia"*.

1.2 Australian Health Standards

The *Alternative Model* will establish best practice Australian Health Standards (AHS) in priority areas to support improvements in the safety and quality of health care.

The Commission considers that AHS are the most effective way of establishing the expected level of service that consumers can reasonably expect across the health system. Accordingly, the Commission believes that all health services should comply with the AHS.

Characteristics of Australian Health Standards

The characteristics of AHS are consistent with the work undertaken on national safety and quality standards by the former Australian Council on Health Care in Australia and the recommendations of the Paterson review. It is recommended that AHS be:

- measurable
- definable
- reproducible
- quantifiable
- focused on patient safety and quality
- developed using transparent processes, which involve relevant experts including clinicians, consumers and service providers
- credible
- based on the best available evidence
- freely available to all stakeholders
- applicable or adaptable across health service environments
- externally validated.

Scope of standards

Initial work undertaken by the Commission has identified a number of specific domains where there is evidence that consumers are harmed because of systems failures. The AHS would focus on the development of standards in domains with potential for improved consumer outcomes. They include:

- hygiene and health service acquired infection
- patient identification
- medication management
- clinical handover
- falls.

These areas are also a subset of the Priority Focus Areas (full list at Appendix 4) that the Joint Commission on Accreditation of Healthcare Organisations (USA 2006) has identified as significantly impacting on safety and or the quality of care provided.

Development of standards

The process of setting new standards requires collection and analysis of the evidence, development of a draft standard, consultation, standard verification and an education process to support the implementation of the standard. Therefore, priority areas for AHS will be identified and initial standards developed incrementally. Work underway

in the Commission and jurisdictions and by expert groups will inform and support the development of the AHS and the existence of standards in this area will expedite development. Expert clinical and consumer collaboration will be fundamental to the development of AHS. The emphasis will be on high risk areas where there is potential to deliver improved health outcomes. It will be important for the *National Entity* to work with stakeholders to identify which improvements in health outcomes are being sought, how these will be measured and which AHS will most effectively improve outcomes. Stakeholders have called for the AHS to be limited to core business functions and major organisational risks. Whatever the final agreed set of standards, the data collected will be used to measure the improved health outcomes.

The *National Entity* will be responsible for developing and verifying standards in collaboration with clinicians, technical and other experts including consumers and the Commission. The development process will be transparent and public comment on draft standards will be sought, for example by publishing the draft for feedback on the *National Entity*'s website.

Preventing major systems failures

The AHS will be developed in the specific areas where evidence shows there is the greatest potential to prevent harm to consumers. However, it is important that the *Alternative Model* of accreditation consider how AHS could reduce the likelihood of an accredited service undergoing a significant systemic failure in patient care or serious adverse event.

To prevent major systems failures, the Commission believes that in addition to standards that have a particular focus, the AHS will need to consider standards to measure the integrity of safety and quality systems. Over time, there may also be benefit from developing or endorsing standards specific to areas of care, for example, maternity or primary care practice.

The culture of an organisation is an established determinant of safety and quality of care. Major reviews have identified a range of cultural factors such as a lack of leadership and support, ineffective communication and poor collaborative decision-making, hierarchical structures and limited team training as factors leading to system breakdown. The national coordinating body (the *National Entity*, see section 1.9) will work with stakeholders to identify standards that identify best practice and/or standards to determine the risk factors and early warning signs of major systems failures to prevent their occurrence.

Decisions on standards

Governments and Health Ministers are accountable to the community for the safety of the health system. Thus the Australian Health Ministers Conference (AHMC) has a clear responsibility in the standards setting process.

The *Alternative Model* recognises the AHMC's role is to:

- Endorse AHS priority areas identified by the *National Entity* that have been developed in collaboration with clinicians, consumers, service providers and the Commission.
- Endorse the AHS developed through transparent and inclusive processes by the *National Entity*.

- Receive advice from the *National Entity* on monitoring and reporting against the standards.

Recognition of existing standards as equivalent to Australian Health Standards (AHS)

AHS will be accessible and available free of charge to the health system. There is a recognised need for standards to be applicable to specific services or settings of care and this would be a key component of AHS development.

The Commission recognises the significant investment of professional groups in the development of existing standards. The Commission proposes a mechanism to test existing standards to determine if they are equivalent in scope, content and level of performance to AHS. The process would involve the development of agreed criteria against which standards, such as those produced by standard setting bodies, professional groups or for disease specific services, could be assessed, and if found to be equivalent endorsed or recognised.

The final criteria would be developed by the *National Entity* in collaboration with stakeholders, but indicative criteria might require existing standards bodies to be:

- recognised by a body with international standing, such as Joint Accreditation System of Australia and New Zealand (JASANZ), International Society for Quality in Health Care (ISQua), or an equivalent body (which may include National Association of Testing Authorities (NATA))
- equivalent or requiring a higher compliance than the Nation*al Entity*'s best practice standard
- current
- applicable nationally to similar services.

The benefits of the proposed endorsement process are that it:

- Retains the significant resource investment in standards development made by professionals and service providers.
- Enables the lead time and implementation of the AHS to be streamlined by building on effective aspects of the current accreditation system.
- Leads to more consistency between standards and convergence of standards over time.

Separation of standards setting and assessment

The need for a separation of standards setting from assessment against those standards as a requirement of good governance is widely acknowledged. The establishment of a *National Entity* that has responsibility for the development or adoption of AHS and their endorsement by AHMC addresses the issue of separation of standards setting and assessment.

Reviewing standards

AHS will need to be updated or withdrawn when no longer appropriate or current. Additional standards will need to be developed as priority issues are identified. The proposed governance structure of the National Entity will ensure ongoing collaboration with stakeholders and adherence to the principles for implementation to ensure an appropriate balance is maintained between the safety and quality improvements that new AHS can deliver and the compliance burden for health services.

Application of Australian Health Standards

Health services will only be required to comply with AHS relevant to them. Elements of the infection control standards for patient and health care worker protection are likely to apply in all settings of care, while environmental control standards, such as cleaning, sterilising ventilation and air conditioning are likely to apply variously.

Bodies Assessing Australian Health Standards

It is proposed that the National Entity will have responsibility for authorising accrediting bodies to assess against the AHS. There will be explicit criteria for obtaining authorisation developed in collaboration with stakeholders, including accrediting bodies. It is envisaged that as a minimum an assessment body will be required to:

- Hold JASANZ, ISQua or equivalent recognition (which may include NATA) for assessment processes and processes associated with managing surveyors.
- Demonstrate independence from the health services it assesses and have no conflict of interest in relation to services provided.
- Agree to provide data collected on the AHS to the *National Entity*.
- Agree to provide advice to the *National Entity* on unresolved non-compliance against an Australian Health Standard.

Information about the authorised assessment bodies will be made available publicly, on a website hosted by the *National Entity* or by providing links to relevant sites and organisations. This information could be used by health services to determine which organisations are eligible to provide assessment services and the service types they cover.

The proposal authorising accrediting / certifying bodies to assess health services against the AHS is designed to:

- Provide clarity for both consumers and service providers about the accreditation services available and the health services that they accredit.
- Ensure that all accrediting bodies, assessing against the AHS, meet basic quality and independence requirements.
- Ensure that data on agreed safety and quality outcomes relating to the AHS are provided to the *National Entity* to enable trends and improvement to be identified.
- Ensure that unresolved non-compliance with an Australian Health Standard is reported to the *National Entity* to enable follow up action.

The proposal could broaden the range of accrediting bodies. Initially, high risk services not currently subject to accreditation will be required to comply only with the AHS and progressively the QIF. Assessment against these standards could be undertaken by an existing accreditation assessment body, or alternatively by professional associations or specialist medical colleges which may wish to seek authorisation to assess against the AHS and provide accreditation options to their members. JASANZ, ISQua, NATA or equivalent accreditation processes current requirements and costs are outlined at Appendices 5, 6 and 7.

Assessment processes

The Commission believes that an effective accreditation process should have at least the following characteristics:

- responsiveness
- sensitivity to context
- risk based
- involvement of health care providers
- resource efficiency
- inclusion of a range of methodologies such as short notice site assessment and review of patient journey
- inclusion of effective self assessment processes

The vast majority of current accreditation survey teams are made up of health practitioners, who survey health services part-time or on an ad hoc, infrequent basis. Employers have traditionally supported accreditation through the release of staff from their clinical duties to act as surveyors at other facilities. The cost to employers of releasing staff has been off-set atleast partially, by the benefits of shared learning and exposure to different services. However, a growth in demand for health services and workforce shortages has made it increasingly difficult for employers to release staff to participate in site surveys and for clinicians to leave their patients.

There is a range of assessment mechanisms that can be used in an accreditation process. The Commission considers that there are two essential components to any accreditation process. The first is that all health services are subject to periodic external assessment, as this is considered to be one of the key drivers of organisational change. The second component is that peer review continues to be a characteristic of assessment. The Commission considers that peer review is essential in assessing the effectiveness of a clinical service and providing cross-organisational learning and information sharing.

Assessment processes will need to be matched against the complexity and risk of a service. For example, tertiary acute care facilities warrant a more comprehensive assessment process due to the complexity and high-risk nature of their services, while low risk, small practices, such as a consulting service, could be assessed using a less comprehensive assessment process.

Innovative approaches to assessment will be necessary to ensure the valuable resource of peer review is used most effectively. Assessment processes could include a combination of:

- Self assessment against standards
- Implementation of a quality improvement action plan
- Assessment by external assessors
- Assessment by an external assessor with a specific focus, with selection either random or based on performance. These could be planned or short notice visits.
- Desk top audit of self assessment reports
- Submission of performance indicator data
- Action on recommendations within specified timeframes
- Follow up and focus visits as required. These could be planned or short notice visits.

These options could be applied differently to classes of health service depending on risk and complexity. Whichever option is adopted, it will be essential that systems are established to feed back data from assessments to health services and clinicians as a mechanism for learning or improving practice.

Review of Decisions

The model contains rights of review in two areas.

The first is an additional mechanism to resolve disputes between health services and accrediting bodies. Currently there is no external review body for unresolved accreditation disputes. Unresolved disputes could be forwarded to the *National Entity* for resolution. Initially, the *National Entity* would undertake a robust process of assessment and review to attempt to resolve the matter. The *Alternative Model* could also include dispute resolution procedures and outcomes as one of the issues the *National Entity* could take into account when authorising an accrediting body to assess against the AHS.

The second provides a right of review for accrediting bodies not authorised or re-authorised by the National Entity to accredit health services against AHS. In the short term, this could be achieved by arbitration/mediation by a mutually agreed party. In the longer term, the *National Entity* could explore making its decisions subject to review by the relevant administrative appeals process.

Potential for the standards to contribute to continuity of care in other sectors

Continuity of care across sectors is important for the health outcomes of consumers who access a range of services. The establishment of AHS could improve the continuity of care. The identification of domains and the development of matching suites of standards will provides the potential for AHS to be made available to related sectors such as community care, home care and health services provided as part of aged care services, as appropriate.

1.3 Quality Improvement Framework

The *Alternative Model* for accreditation recognises the importance of health services engagement in quality improvement activities and the need to support and enhance these activities. The proposed Quality Improvement Framework (QIF) would:

- Support and guide health service engagement in quality improvement activities.
- Identify opportunities for improvement and shared learning.
- Provide the opportunity to showcase exemplary practice.

Scope of the Quality Improvement Framework

The QIF will establish an overarching structure for quality improvement activities using the experience and knowledge gained about the content, implementation and effectiveness of the many existing quality frameworks. A national QIF will facilitate links to safety, better practice and clearer benchmarking for quality improvement. The QIF would provide support and facilitate health services making decisions about their investment in quality improvement.

The QIF will focus on quality improvement activities and on areas not specifically addressed in the AHS such as key corporate, risk and governance areas. The structure and content of the QIF will be developed collaboratively with stakeholders as described below.

As suggested in the Paterson Review[1], the QIF would clarify the respective roles and responsibilities of jurisdictions, state-based safety and quality bodies, professional and sector specific bodies (e.g. professional colleges, health funds etc). It would facilitate a coordinated approach to minimise duplication and demonstrate the *National Entity*'s commitment to a consultative and inclusive approach to safety and quality improvement.

The proposed QIF will identify the best practice elements of quality frameworks and advise Health Ministers on compliance requirements for quality improvements by health services. Initially it is proposed, reporting in relation to the National Framework for Quality Improvement will be minimal and limited to confirming that:

- Health services are applying and being assessed against a quality improvement framework.
- The framework complies with 'best practice' requirements as specified by the *National Entity*.

[1] AHMC, National arrangements for safety and quality of health care in Australia: The report of the review of future governance arrangements for safety and quality in health care. July 2005

Development of the Quality Improvement Framework

The Commission considers that all health services should implement an appropriate quality improvement framework as a priority.

The *National Entity* will be responsible for developing the QIF in collaboration with clinicians, technical and other experts including consumers and the Commission. The development process will be transparent and include a public exposure draft.

Implementation of the QIF should involve:

- Developing principles that apply to all QIFs
- Identifying best practice examples of QIFs that could be adopted or adapted by health services.
- Developing tools and support programs to facilitate the take-up and use of QIFs.

The QIF will support health services retaining flexibility in the way local quality requirements are addressed. The National Entity however will need to ensure an effective monitoring system to ensure implementation compliance.

The QIF will be submitted to AHMC for their endorsement.

1.4 An expanded scope for accreditation

The Commission considers that all health services should be required to implement measures to ensure they comply with AHS. The AHS will be consistent with reasonable consumer expectations of safe and good quality care. However system wide accreditation of all health services would be a significant expansion of current practice and not a feasible option in the medium term.

While the Commission sees benefits from accrediting all health services, it recommends that initially only health services with a high risk of patient harm are required to be accredited. The Commission therefore recommends to Health Ministers a staged and risk-based approach to the implementation of accreditation across health settings, focusing on high risk scenarios and carrying out robust evaluation before broader implementation.

Information on service types involved in adverse events, complaints that relate specifically to safety and quality of care, coroner's reports and other data sets that provide evidence of harm to patients will be reviewed before finalising the criteria. The risk rating criteria will be applied consistently to health services whether they are provided by registered or non-registered health practitioners. A service will only be required to meet one of these criteria to be considered high risk and therefore required to undertake safety and quality accreditation.

The *National Entity* will finalise the criteria for classifying high risk services in collaboration with stakeholders and identify health services that fit these criteria and may not be currently accredited. Indicative criteria may include services that:

- Undertake 'invasive' procedures into a body cavity or dissect skin.
- Perform musculoskeletal manipulation.
- Apply biomedical equipment to a consumer with the potential to burn or irradiate.
- Medicate patients to:
  - anaesthetise or sedate,
  - prescribe or monitor anticoagulation therapies, and/or
  - prescribe or monitor methadone.

Implementation of accreditation processes

If Health Ministers endorse the Commission's recommendation for mandatory accreditation of high risk services, due to the diversity of service delivery, legislative requirements and extent of any current accreditation of these health services, the implementation mechanism for particular services may differ.

Many high risk services are already required to be accredited, under funding agreements, contracts with private health insurance funds or as a result of policy decisions by governing bodies. Other services could be required to be accredited using the same mechanisms. For example, health insurance companies could require service providers to demonstrate they are accredited against AHS as part of their enrolment to access funding as a recognised provider. However, some high risk service providers are not captured by these mechanisms e.g. cosmetic surgeons in private rooms providing invasive procedures, in these rooms, that are funded directly

by consumers. Therefore regulatory mechanisms to ensure consistent mandatory accreditation of high risk service providers will need to be pursued.

The Commission does not have direct responsibility for the mechanisms that could achieve this outcome. Health Ministers may wish to consider whether a mechanism to mandate accreditation of high risk services be identified in the remit of the *National Entity*, subject to satisfying any necessary impact assessment. In the meantime, the National Entity could urge organisations with current responsibility for mechanisms to regulate and similar processes to extend accreditation to all high risk services.

Before accreditation is expanded beyond high risk services an evaluation will need to be conducted of the first phase of implementation. This evaluation should include a cost benefit analysis for mandating universal accreditation and an analysis of the applicability and appropriateness of accrediting all health services against the AHS. The evaluation could also consider the basis on which the accreditation system be expanded, should that be recommended.

Mechanisms to address enforceability are addressed in section 1.11.

1.5 National Data Collection and Reporting

Data collection

The *Alternative Model* proposes that data on AHS are collected. These could build on the work being undertaken by the Commission, including:

- identification of existing data sets and the potential for that data to generate safety and quality indicator information.
- identification of gaps in data collection and how they may be addressed.
- identification of up to 50 national safety and quality indicators that will be reported publicly using existing data sets.
- development of data sets and data standards for the collection of new data items.

Data collection is essential to the success of the reforms. It will:

- Enable assessment of the safety and quality of services provided to consumers across the AHS domains.
- Provide information about the rate and coverage of implementation.
- Enable evaluation of the success of the reforms.

This work will provide information to support national safety and quality initiatives, such as clinical handover and infection control and allow for better targeting of accreditation assessments to address any issues identified by the data.

A balance needs to exist between restricting the number of variables collected to minimise the collection burden and maximise accuracy of the data, and obtaining sufficient data to provide meaningful information on the safety and quality of a service. Therefore, wherever possible, data from routine data collections will be used.

The *Alternative Model* proposes that health services will submit data on a regular basis to their authorised assessment body in a format that allows analysis. These data will be forwarded to the *National Entity*. Collection may be annually or more frequently, depending on the type of data, the standard being measured and stakeholder recommendations.

The long term intent for quality improvement is to report on exemplar practice and share learnings that could provide broader system changes and improvements in safety and quality.

In addition to data collected directly from health service accreditation processes, the *National Entity* may use other data sources to verify data submitted to the assessment body and to identify health services requiring more frequent inspection. Such data sources are more likely to be available for large institutional services, e.g. separations data and casemix inpatient information collections.

Data characteristics

The specific data items to be collected will be determined in collaboration with stakeholders as part of the development of the AHS. The trialing of standards through a piloting process will establish the validity, reliability, potential coverage and ease of collection for any new data item. The quality of the data collected, the relevance of that data, the data design, data linkage and timely analysis will need to be defined by the *National Entity* in consultation with stakeholders and data experts.

The data variables should be well-defined and relatively easy to measure and should not be changed unnecessarily from year to year. This will allow for the collection of trend data and comparison between like services. It will be important that data are received in a timely way with minimal lag time between collection and submission.

Collaboration in developing the standards and selecting data elements will ensure that the information generated is clinically meaningful. This will allow health care providers to change or support their practice and consumers, funders and health services to assess the safety and quality of a service.

The Commission is currently working on national safety and quality indicators with the Australian Institute of Health and Welfare. This work aims to identify relevant safety and quality indicators in existing data collections that can be collected nationally. This work will inform data requirements for the AHS and the *Alternative Model*.

Data usage

Self-assessment and reporting against AHS performance indicators could be done in a web-based format to limit the effort associated with data submission. Information generated from the data will be used to:

- Focus accreditation on issues that need detailed review or identifying health services that should be subject to random audit.
- Provide timely reports to health services on performance.
- Inform the development and review of AHS.
- Inform national policy and investment in the safety and quality of health care.

The issue of public reporting on accreditation has been canvassed in detail with stakeholders. They strongly support the public reporting, but not the ranking league tables. The Commission does not intend that the data be used to establish league tables which rank providers. League tables have been introduced in both the United Kingdom and United States of America where there has been a mixed reaction to their use. Supporters[2] [3]suggest league tables stimulate competition, encourage the adoption of 'best practice' and increase the emphasis in health services on quality rather than

[2] Jacobs R, Goddard M and Smith PC. Composite performance measures in the public sector. Centre for Health Economics. University of York, United Kingdom. January 2007 pg

[3] Article. Performance league tables are linked to lower death rates after major heart surgery. Medical Research News. Published 26 April 2007 Website accessed 6 November 2007.

unit cost. Critics[4] [5] however suggest that league tables are not statistically sound or robust, noting:

- It is difficult to disentangle genuine performance variance from statistical random fluctuations.
- The ranking awarded using aggregated data is sensitive to the methodology used and the weighting of data and the 'decision rules' have a significant impact.
- To interpret rankings requires 'indicators of uncertainty' to be made public.
- Alternate tools, such as control charts that monitor and control for variation and can display performance ranking, are more appropriate.

Datasets for multiple purposes

A significant burden for private health services is the duplication that comes from multiple safety and quality data requirements required by health insurance funds of health services as part of contractual obligations, State licensing requirements and State-based Safety and Quality entities, in addition to accreditation requirements. Identifying a data set that is supported by all stakeholders, including service providers and the health insurance industry, will lead to greater consistency, better quality data collected and reduction of the compliance burden. The proviso will be that the data is also both timely and accurate.

Public Reporting

The *Alternative Model* will involve the *National Entity* reporting publicly on the accreditation status of individual services (i.e. accredited or not, similar to current Australian Council on Healthcare Standards practice) and aggregated national data on the safety and quality of health services. In addition, the *National Entity* will produce a national report on performance against the AHS. The frequency and characteristics of reporting will require further discussion with stakeholders. In particular, it will be important to involve consumers to ensure that the language is appropriate and the content of the public report covers those issues of most concern to consumers.

While the *Alternative Model* will not produce a league table of services but will explore ways to enable similar service types to benchmark against each other. The *National Entity* will also need to ensure the integrity of the data to avoid disputes about the accuracy, currency and relevance of information that is reported publicly.

[4] Jacobs R, Goddard M and Smith PC. Composite performance measures in the public sector. Centre for Health Economics. University of York, United Kingdom. January 2007

[5] Adab P, Rouse AM, Mohammed MA, Marshall A. Performance league tables: the NSH deserves better. BMJ. 2002. Vol 324. pg 95-98.

1.6 Initiatives to support mutual recognition

Mutual recognition in the context of accreditation of health services is a mechanism to eliminate duplication of accreditation processes, where services are required to complete multiple separate assessments with different assessment bodies. It does not relate to reducing duplication of other processes, such as reporting of health indicators or service data in different formats to different funding bodies.

The majority of stakeholders supported the proposal to introduce mutual recognition because of its potential to reduce duplication of process and paperwork and decrease the compliance effort. Although not a primary objective of this reform, a more efficient system could increase capacity and the availability of resources to address service demand and safety and quality issues.

The *Alternative Model* will need to ensure mutual recognition does not leave assessment gaps between services. This would require assessing bodies to test the links between services to ensure the risks associated with transferring patients or information on their care does not result in harm. It is at key handover points that there is a greater potential risk of harm to patients because of breaks in information or systems flows. The *National Entity* will need to work with stakeholders, in particular assessing bodies, to ensure this matter is addressed.

There are three specific areas where mutual recognition could be adopted. The first and highest priority area relates to compliance with state, territory, Commonwealth or local government non-clinical regulated areas such as food safety, storage of clinical hazards and fire safety. In each of these areas, where an assessment that is external to the health service is undertaken, it should not be necessary for an assessing body to repeat or duplicate this assessment process.

Secondly, mutual recognition should be sought where accreditation processes establish and maintain quality and safety, but have a secondary role in ensuring accountability of services administered and funded under Medicare. These programs would include accreditation of pathology, diagnostic radiology and nuclear medicine.

The third category is mutual recognition based on individual agreements between assessing bodies. They may relate to specific area of overlap in the work of these bodies or one off agreements. The mechanism to formalise agreements between these bodies could be explored by the *National Entity*, but would be a secondary priority.

1.7 Review of Surveyor Participation

On site assessment by surveyors will remain an important feature of the accreditation process. The consultation process has identified a number of issues, in the participation of health practitioners in surveys, which act as barriers to the continuation of the current accreditation model. The issues of surveyor consistency, objectivity and workforce require consideration if the system is to capitalise on the contribution made by surveyors. Peer review has played a central role in the assessment of services and sharing of information that occurs at accreditation will continue to play a significant role under the proposed reforms. In addition, it will be important to expand opportunities for consumers to participate as surveyors.

The Commission recommends a review of existing arrangements by accreditation bodies for surveyors:

- selection
- orientation
- training
- assessment
- maintenance of competency
- supervision
- performance management
- acknowledgment and support.

The review will seek to:

- Identify and describe ideal surveyor characteristics and processes.
- Examine current literature and practices in relation to surveyor training.
- Identify elements of an effective 'best practice' model of surveyor participation in accreditation.
- Compare the information from the review with the relevant standards used by ISQua, JASANZ and similar bodies in their accreditation processes.
- Describe the characteristics of the surveyor workforce, including:
  - who makes up the workforce by sector, clinical, non-clinical and service type
  - average number of surveys undertaken
  - paid versus unpaid surveyors
  - costs of participation and who is meeting these costs, and
  - trends in participation by surveyors on surveys.

With the reforms proposing a substantial increase in the number of accredited services, this information would be used to determine the sustainability of the surveyor workforce and options for addressing the barriers that are identified.

It is not intended that the *National Entity* will have a long term role in monitoring or assessing surveyor participation in assessment bodies. The review will consider mechanisms for incorporating its findings into existing processes to ensure the uptake of best practice selection, management and support for surveyors. For example, post-review, authorisation of assessment bodies may be dependent on them complying with best practice requirements for surveyor participation.

1.8 Piloting Innovative Assessment Mechanisms

A range of operational reforms have been considered during the consultation process. These reforms detailed below, were supported; some subject to there being additional evidence or testing of the proposal before its wider application.

Mapping of safety and quality standards

This proposal would map standards that were submitted by standards setting bodies for endorsement to the National Entity. The process would determine which standards high risk services (currently unaccredited) should be assessed against and if there are gaps in coverage. This approach is proposed rather than one where all the existing standards are mapped to avoid the issue of the information generated from the mapping exercise becoming outdated and obsolete after a very short time from the ongoing revision of standards.

This reform will be progressed as part of the development of AHS and criteria for endorsing professional and service specific standards. Responsibility for this work would rest with the *National Entity*.

Best Practice Model of Developing Standards

It is proposed that a general framework or best practice structure for standards be developed for use by all standard setting bodies. This will include standardization of language and definitions used in accreditation processes and the development of guidelines for the convergence in format and structure of standards. This work should be undertaken by the *National Entity* in consultation with specialist organisations, such as Standards Australia. It is intended that the AHS and the best practice model be freely available.

Piloting Patient Journey Methodologies (Tracer) and Short Notice Surveys

The Commission recommends that Patient Journey and Short Notice methodologies need to be supported by additional evidence and piloting before being implemented more broadly in accreditation processes.

The Commission strongly supports a greater focus on consumers in the accreditation process and generally supports the introduction of patient journey (tracer) methodologies. However, there was uncertainty about how to use these methodologies to best effect and it was recommended that the methodologies be piloted and rigorously evaluated before inclusion more broadly in safety and quality accreditation processes.

Short notice, rather than unannounced, visits are also supported by the Commission that considers they provide one option in a suite of onsite survey tools. A short notice visit in this context is an onsite external assessment where these is a limited time between scheduling and survey visit. Short notices visits should be timed to create negligible disruption to patient services and provide an opportunity accurately assess a health service's application of the AHS. Stakeholders indicated that if this proposal was pursued, a short notice site visit should have a narrow and specific focus within a service. Further, the factors that trigger a site visit should be clearly articulated. Like

the patient journey methodology, the Commission recommends that short notice surveys be piloted and evaluated before consideration of broader implementation into accreditation processes.

The National Entity could:

- Pilot patient journey methodologies by inviting health services to undertake pilot projects through a tender process.
- Evaluate the use of short notice surveys in current accreditation systems, their effectiveness and limitations, by approaching accrediting bodies and assessing options for broad adoption of short notice surveys.
- Undertake an internal and external evaluation of the pilot projects that included an evaluation of consumers' experience of participation in patient journey methodology pilots.

The objectives of these projects would be to determine the likely application, critical success factors and barriers to the introduction of these methodologies in accreditation.

1.9 Accreditation research

This review process has revealed a paucity of information and lack of coherence in the published literature on accreditation. While research in this area exists, there is a need for greater co-ordination and coherence to maximise resources in areas such as program development, standards development, the effectiveness and critical success factors of accreditation assessment methodologies and cost benefits of accreditation. The *National Entity*, the Commission and research bodies such as the National Health and Medical Research Council all have a role to play in supporting a co-ordinated approach to accreditation research.

1.10 National Entity

Stakeholders have acknowledged that the current accreditation system is fragmented and uncoordinated. It will be difficult to effectively implement the proposed reforms without a properly resourced national organisation to lead, support and coordinate the change. Reforming the system will also require an investment and commitment from a range of stakeholders. Changing the system has the potential to realise savings, in part from efficiencies, but more importantly from improved safety and quality of care for patients.

As part of the *Alternative Model*, the Commission is recommending that a national body be given the task of leading, supporting and co-ordinating reform of the accreditation system. The *National Entity* could be established as a new entity or by giving the role to an existing body.

Characteristics of the National Entity

To ensure the effectiveness and credibility of the *National Entity*, the Commission considers the following characteristics to be key to its success. The *National Entity* should:

- Have a national focus.
- Not be aligned with any particular jurisdiction.
- Report to government but operate independently.
- Demonstrate skills and experience in the functional areas proposed for the *National Entity.*
- Operate in close collaboration with stakeholders but not be comprised of representatives of interest group(s).
- Act impartially and in the public interest.
- Have knowledge and understanding of compliance and enforcement mechanisms.

It is proposed that the functions of the *National Entity* be informed by an advisory committee, made up of stakeholder nominees representing the broad range of interests in accreditation. The governance arrangements will be finalised following resolution of questions such as:

- Will the body be established as a new entity or within an existing body?
- What, if any, powers will the body have to mandate or ensure the inclusion of all services in accreditation?
- What reporting line will exist to Health Ministers?

The following functions would be most appropriately undertaken by the *National Entity*:

- **Standards development**
  - Providing recommendations to Health Ministers relating to the domains across which AHS are developed
  - Developing best practice AHS and criteria against which standards produced by professional groups or disease specific services could be endorsed or recognised
  - Developing and verifying standards in collaboration with technical and other experts
  - Reviewing and maintaining standards
  - Categorising high risk services which will have to comply with AHS in the first phase of implementation
  - Prospective mapping of standards
- **Quality Improvement Framework**
  - Identifying the best practice elements of quality frameworks and advising Health Ministers on compliance requirements for quality improvements by health services
- **Authorisation of assessment bodies**
  - Authorising assessment bodies to assess against AHS and award national accreditation certification
  - Facilitating and formalising mutual recognition agreements between authorised assessment bodies
- **Data collection and analysis**
  - Determining reporting guidelines for health services and authorised assessing bodies, including data elements, definitions, timing and frequency of data to be collected
  - Collating and analysing data from authorised assessment bodies
  - Collating and verifying safety and quality accreditation data with information and trends from data sets
- **Monitoring and reporting**
  - Using of accreditation information to ensure compliance with AHS
  - Monitoring the implementation of the Quality Improvement Framework and reporting on quality health services
  - Measuring performance against the AHS
  - Using information to support and facilitate accreditation research
- **Communication**
  - Managing public reporting on the outcomes of accreditation and the safety and quality of the health system
  - Developing information for consumers on accreditation
  - Establishing a website listing authorised assessment bodies and health services that are accredited
- **Appeals**
  - Providing a mechanism for health services to seek review of recommendations and accreditation decisions
  - Providing a mechanism for assessment bodies to appeal against refusal to be authorised to assess against AHS.

1.11 Formal obligations to comply and consequences of non-compliance

The Commission believes that compliance with AHS should be mandatory and this position is largely supported by stakeholders. The Commission also believes that all health services should be accredited against the AHS. However, there is no consensus from stakeholders on which compliance mechanism should be employed to ensure this occurs. An analysis of the impact of a regulatory model is required before implementation can be progressed. Appendix 8 provides a preliminary analysis of the issues that need to be considered and preliminary responses to the implementation of a regulatory approach to accreditation.

Interest in formal obligations

A significant proportion of stakeholders have expressed support for an accreditation system with mandatory standards and consequences for non-compliance. The Commission, AHMAC members and national workshop participants consider that establishing formal obligations would achieve better safety and quality outcomes from the health sector's investment in accreditation. Some stakeholders have also recommended a regulatory-based approach.

Two regulatory options were canvassed with key national stakeholders at the November 2007 workshop. The first option proposed a single regulatory mechanism that was legislated with mandated compliance and clearly articulated sanctions. The second approach utilised a combination of existing regulatory levers such as funding, legislation and contractual arrangements.

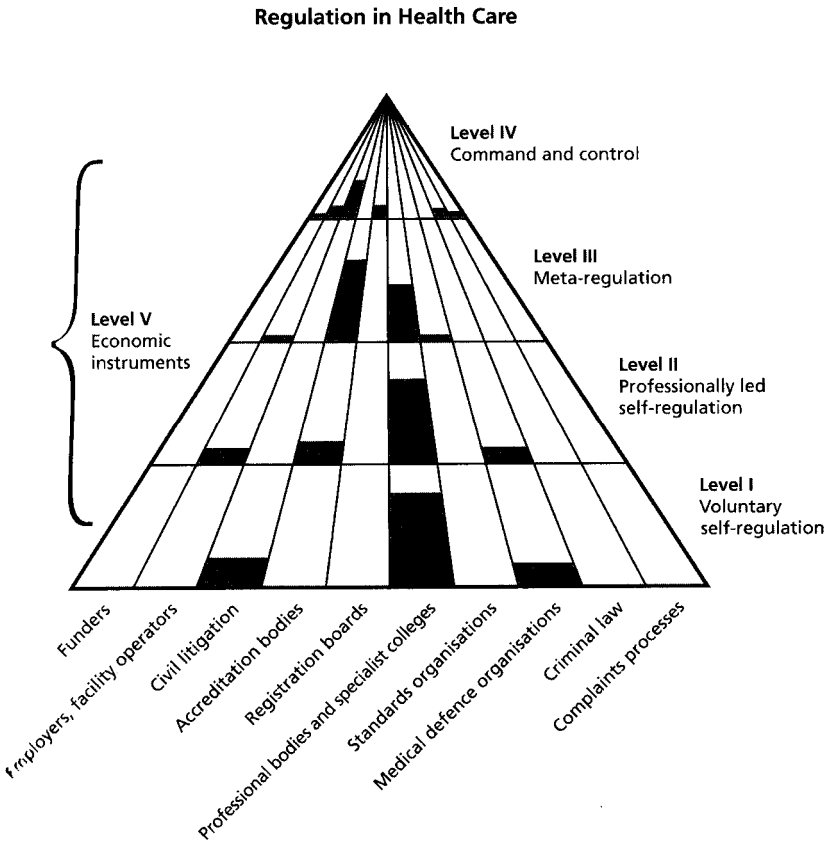
The Commission supports the first option. However to implement the first option there is a need for national agreement on a single regulatory mechanism and a requirement for a detailed regulatory impact assessment. Therefore, the Commission recommends that, in the interim, the second option should be adopted to allow the earliest possible development and implementation of the AHS and reforms to the accreditation system.

Mechanisms to implement formal obligations

Regulation can be considered along a spectrum, from self-regulation to formal compliance obligations, or in a regulatory pyramid as described by Runciman.[6] At the base of the pyramid, self-regulatory mechanisms include voluntary accreditation such as that developed by some allied health professions. At the apex of the regulatory pyramid are requirements applied through legislation or attached to funding access.

[6] Runciman B, Merry A and Walton M. Safety and Ethics in Health Care: A guide to getting it right. Ashgate, 2007 adapted from Braithwaite J, Healy J and Dwan K, (2005) The Governance of Health Safety and Quality. (Canberra: Commonwealth of Australia).

Figure 1:



Source: © Safety and Ethics in Health Care: A guide to getting it right. Runciman B, Merry A and Walton M, 2007, Ashgate.

Accreditation is currently subject to quasi-regulation. Many health providers are required to obtain accreditation:

- to access Medicare payments
- to access funding, e.g. health funds requiring health services to be accredited before a higher level of benefits are payable
- by their governing body e.g. health service owners or State Health Departments may require the services they administer to undertake accreditation.

A possible course of action may be for compliance with the AHS and QIF to be required through existing regulatory bodies. These include health professional registration boards professional associations and colleges, standards organisations, complaints commissions and health insurance funds.

Mechanisms, that could establish a mandatory requirement for health services to be accredited against the AHS and/or formal obligations to comply with AHS and QIF, rest with the jurisdictions. A policy direction requires further deliberation by Health Ministers. Once resolved it will require agreement by the jurisdictions about the regulatory mechanism to be used and appropriate regulatory impact assessment.

Requirement for all high risk services to be accredited against the AHS

As discussed in section 1.4, many high risk services are already required to be accredited, under funding agreements, contracts with private health insurance funds or as a result of policy decisions by governing bodies. For example, health insurance companies require many service providers to demonstrate they are accredited as part of their enrolment to access health insurance payments. However, there are some high risk service providers that are not captured through existing mechanisms. Therefore, regulatory mechanisms to ensure national mandatory accreditation of high risk service providers may need to be pursued.

The Commission does not have any authority over the mechanisms that could achieve accreditation against AHS by all high risk services. In the meantime, the Commission because of its interest in safety and quality will urge organisations with responsibility for compliance mechanisms to consider their use to extend accreditation to all high risk services. For example, Health Departments could direct public sector services to participate in accreditation processes and use private sector licensing legislation to extend accreditation requirements against all high risk services. The National Entity could also liaise with regulators and quasi-regulators to ensure that high risk groups are appropriately covered without duplication.

Requirement to comply with the AHS – the initial approach

The Commission's preferred initial approach to establishing a requirement to comply with the AHS is to:

- Strongly advocate the need for formal obligations to comply with AHS and QIF and raise awareness of the consequences of non-compliance.
- Introduce formal obligations in a supportive way, giving services reasonable opportunities to comply before sanctions are applied.
- Balance opposition to the consequences of failure to comply by promoting the right of consumers to access safe and good quality services.

This initial approach, to oblige compliance with AHS and QIF, is a light touch compliance approach focused on achieving compliance as quickly as possible. The Commission believes that this approach will create a learning culture and simultaneously create an understanding of formal obligations.

It proposes that:

- Assessment bodies would agree to inform the *National Entity* about non-compliance with the AHS and QIF as part of their authorisation to assess against the AHS.
- Where accrediting bodies identify non-compliance, they are required to negotiate with the service to achieve compliance, notify the *National Entity* of the non-compliance and progress to resolve the issue.
- If compliance has not been achieved within an agreed period, to be determined in the development of the AHS and QIF, the accrediting body is required to notify the *National Entity*.

- The *National Entity* will investigate the non compliance (this may include seeking independent peer review) and will negotiate directly with the non-complying service to achieve compliance within an agreed timeframe depending on the issue and urgency.
- Should compliance not be achieved, the *National Entity* will publish details of the issue on its website and notify relevant bodies such as owner, governing bodies and funders.

Bodies which control mechanisms that could establish formal obligations more directly may wish to consider approaches to further embed the formal obligations in their requirements. The Commission will support such developments, and is liaising with DOHA in relation to the implementation of AHS through the Private Health Insurance (PHI) accreditation rules, which would achieve their application to a range of high risk services.

If this approach is not successful in achieving compliance and Health Ministers agree, a regulatory-based approach could be explored through the development of a Regulatory Impact Statement (see Appendix 8). Alternatively, Health Ministers may wish to consider whether a regulatory mechanism to mandate compliance with the AHS should be progressed in the establishment of the National Entity, subject to satisfying any necessary regulatory impact assessments.

Incentives

Many health services have called for incentives, such as those offered to general practitioners, to comply with accreditation requirements. However, funders state that provision of safe services and quality care is core business for health services and should not be subject to incentive payments.

The Commission's position is that best practice be reflected in AHS and the QIF, adopted by health services in their normal operation and that additional incentives should not be required. However, resourcing of health services should be consistent and at a level to ensure the provision of safe and high quality services. This does not exclude funders and providers exploring incentive-based payment options, such as pay for performance where high quality service provision is rewarded.

Sanctions and Penalties

As the long term objective is to implement a mandatory system of accreditation, it will be necessary to consider the sanctions that could apply. Stakeholders did not support a simple pass/fail system, but recognised the need for sanctions, which were graduated and escalating, to apply to services that fail to meet the standards.

It is not proposed that sanctions be imposed on health services in relation to the Quality Improvement Framework.

It has been recommended that sanctions be based on 'a pyramid of responsive regulation' as described by Runciman (see Figure 1) This approach promotes transparency and professionalism by:

- requiring persuasion as the first approach, initially focusing on mediation and remediation rather than punitive action
- using increasingly strong regulatory mechanisms to encourage compliance if persuasion is unsuccessful.

However, the initial application of sanctions and the subsequent involvement of the *National Entity*, need to be balanced against other safety and quality initiatives such as the development of a no blame culture, non-judgmental review and open disclosure following an adverse event.

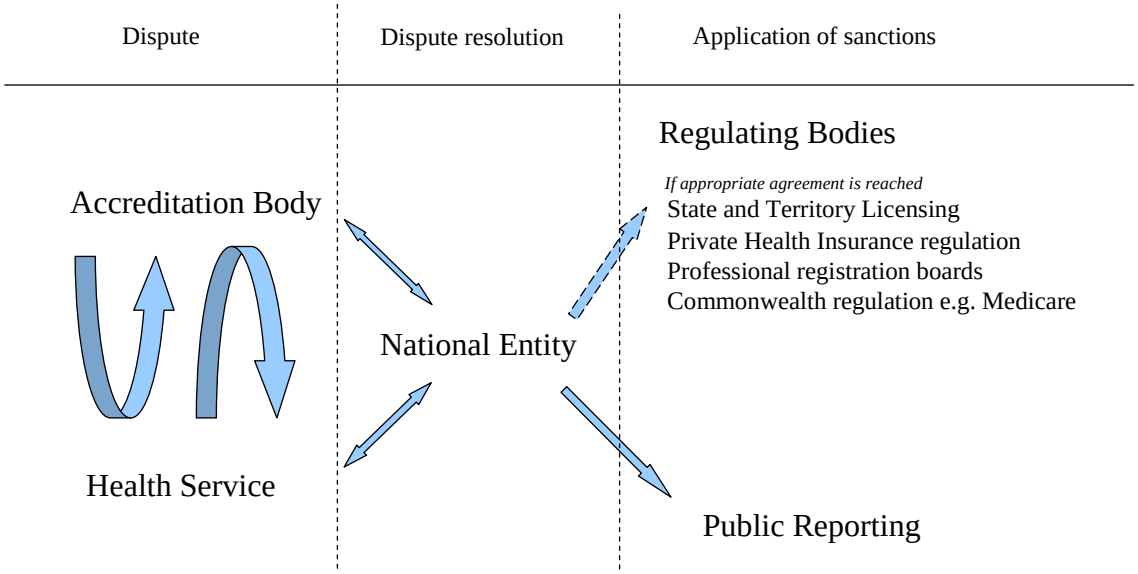
Further, in determining the application of consequences, the following matters could be taken into account:

- whether non-compliance relates to a single issue or more widespread poor performance
- whether non-compliance relates to a minor or serious breach
- whether the breach has occurred for the first time or has occurred before
- whether the breach threatens the health, welfare or interest of consumers
- any element of deliberate non-compliance.

The notification approach proposed will start with persuasion moving to a warning and possible further action.

The National Entity should endeavour to resolve any disputes between health services and the accrediting body about non-compliance. Where the National Entity is satisfied that there has been a significant failure to meet AHS or a continuing failure to meet a standard, after provision of an opportunity to do so, the National Entity may decide to publicly notify the failure and/or, if appropriate, inform any relevant body to consider whether the matter should be formally reviewed and, as appropriate, determine what sanctions should be applied, if any, following that review.

This process is outlined below.



Bodies which might apply sanctions

A call for jurisdictions to retain responsibility for sanctions and penalties was made in the August 2007 AHMAC proposal and in individual State submissions. This option is retained in the *Alternative Model*'s notification approach. Some mechanisms exist for dealing with civil and criminal penalties through licensing, funding and registration systems. Further embedding the formal obligations, for example, through licensing legislation would be a matter for jurisdictions.

A number of professional groups called for sanctions to be applied through professional registration boards. Mechanisms do not currently exist to empower registration boards to apply sanctions for failures by health services to comply with accreditation standards. The *National Entity* may wish to give this further consideration to how this could be developed in collaboration with professional registration boards.

MATTERS RELATING TO COSTS AND DUPLICATION OF ACCREDITATION PROCESSES

2. COSTS OF SAFETY AND QUALITY ACCREDITATION

The Commission has commenced work on identifying the costs and benefits of the existing accreditation processes to gather baseline information to assist in understanding the cost implications of recommended reforms. This information will also be a resource for any detailed cost-benefit analysis of the *Alternative Model* if Health Ministers support its implementation.

2.1 Identification of accreditation costs

Concerns about the cost of reforms to existing accreditation process and the possible costs of the *Alternative Model* were raised throughout the consultation process.

In order to establish an indicative baseline cost associated with participating in accreditation processes the Commission requested consultants undertake a cost analysis of safety and quality accreditation in Australia.

A series of structured interviews were held, across a range of health care providers, to establish quantitative data to enable a cost analysis to be undertaken. It was evident from the interviews that separate, identifiable data is not collected purely in relation to the costs of health service accreditation. This is supported by a review of literature on accreditation, which indicates that little attention has been given to the costs of accreditation.[7]

The structured interviews with individual sites and a range of other key stakeholder groups provided qualitative data on the processes associated with accreditation. While much of this information related to cost and time imposts, nearly all of the participants also volunteered evidence regarding the benefits associated with accreditation processes.

As the reform proposals were being finalised at the time, the study investigated baseline costs as contextual information for the alternative model and a resource for any future cost-benefit analysis of proposed reforms. However, it is significant that in describing the undifferentiated costs of accreditation, many interviewees saw fit to balance these comments about costs against the perceived benefits.

While the specific findings for each category of health care provider differ, the study found a number of common themes. These include the following:

- The activities required to achieve accreditation are considered as essentially part of core business by many organisations and many of the costs required for compliance with the accreditation standards would be incurred as part of quality or good practice.

[7] Geenfield D, Travaglia J, Braithwaite J and Pawsey M. An Analysis of the Health Sector Accreditation Literature. Uni NSW, Centre for Clinical Governance Research in Health. 2007

- Activities required for accreditation are inseparable from sound risk management and quality management procedures.
- The overlap of accreditation processes with quality management and continuous improvement means that it would be difficult to separately identify the costs and that to do so would run counter to efforts to embed accreditation processes with everyday operations.
- The smaller the organisation the more likely that the task of accreditation preparation and compliance will be considered burdensome and that accreditation will be seen as a process diverting resources from service delivery or income producing activities.
- Smaller organisations are likely to benefit particularly from tools to support accreditation.
- Accreditation is more likely to be undertaken if there is a direct financial incentive for so doing.

It should be noted that the range of health care providers surveyed had all undergone accreditation and had agreed to participate in the survey after being approached by the Commission or their professional peak body. For that reason, the survey group was likely to be predisposed towards the concepts of accreditation and generally be more open to recognising the intangible benefits that are expected to flow from the accreditation process.

While several interviewees expressed a degree of frustration with the process itself and the direct cost of accreditation, they understood that overall gains were likely to flow from the preparatory stages, the self assessment, and the discipline provided by the documentation of manuals covering policies and procedures.

One national organisation advised that their basis of accreditation was voluntary but that an incentive to participate had been established because of the credits gained towards Continuing Professional Development. Thus as well as benefits derived for service delivery there may be professional development benefits, although the take-up rate is understood to be low.

Many organisations interviewed, while supportive of accreditation, were frustrated at the extent of overlap and duplication between accreditation and regulatory and contractual requirements. This included having to meet State licensing requirements, accreditation requirements and requirements established as part of contractual arrangements with health insurers. This duplication is considered to involve additional cost.

2.2 Level of cost attribution

Based on the interviews with each group of healthcare providers and some national organisations, it is evident that to date, little empirical information has been collected regarding the costs of accreditation. This is largely to be expected, given that:

- Very few organisations, other than perhaps major hospital groups, have developed sophisticated financial systems capable of recording such costs.
- There is no recognised set of definitions and cost codes by which to identify accreditation costs.
- There has been no imperative or incentive to keep track of accreditation costs
- In many cases, activities that are reviewed during accreditation are undertaken for multiple purposes, only one of which may be accreditation. As a result, it is difficult, perhaps even impossible, to attribute the cost between those purposes, particularly retrospectively.

Accordingly, while it is possible to establish the immediate direct costs such as the accreditation fees paid to an accrediting body, further estimates of the cost of accreditation would appear to be premature at this stage.

2.3 Accreditation fees

General Practitioners

According to accreditation providers, approximately 90% of GP practices are accredited[8]. The following fees were obtained from one of the two GP assessment bodies, QIP/AGPAL[9]:

	Survey Team	Cost basis	Fee
AGPAL			
Accreditation 1st Cycle	NON GP/GP	PER FTE	$1,380.00 + GST
Accreditation 1st Cycle	GP/GP	PER FTE	$1,880.00 + GST
Accreditation 2nd Cycle	GP/NON GP	PER FTE	$1,345.00 + GST
Accreditation 2nd Cycle	GP/GP	PER FTE	$1,815.00 + GST
Accreditation 3rd Cycle	GP/NON GP	PER FTE	$1,260.00 + GST
Accreditation 3rd Cycle	GP/GP	PER FTE	$1,760.00 + GST
GPA Accreditation Plus			Fee information not available

Hospitals – ACHS

A list of health services and organisations accredited by ACHS is available on the ACHS website www.achs.org.au . ACHS conducted 1233 accreditation site visits over the period 2003-2006. ACHS fees are determined through a mutually agreed assessment (between ACHS and the member organisation) based on the size, complexity and geographic spread.

Interviewees provided information in relation to fees paid to ACHS which are determined through a mutually agreed assessment (between ACHS and the member organisation) based on the size, complexity and geographic spread. Respondents reported a range of membership fees from a small rural to a medium metropolitan hospital and from $8,000 to approximately $15,000.[10] In some cases the fees may relate to a cluster of organisations rather than individual services. Respondents were also able to identify separate costs for training, delaying scheduled surveys and other services provided by ACHS.

Hospitals – ISO

A number of certifying bodies are licensed to certify against ISO 9001 and each has their own fee structure. The number of services that are accredited under these standards is unknown. Respondents provided examples of the fees they paid to ISO assessing bodies which varied between $6,000 to $30,000 for small to medium sized facilities[11]. However, services did not all specify what services were included and it is not clear that the figures are comparable or that this is representative of fees charged by certifying bodies assessing against ISO standards.

[8] AGPAL advice November 2007
[9] Website accessed on the QIP/AGPAL website on 16 January 2008
[10] These figures were provided by respondents and have not been verified with the assessing body.
[11] These figures were provided by respondents and have not been verified with the assessing body.

Physiotherapists

QIP is now the sole provider of accreditation services for the Australian Physiotherapy Association Standards for Physiotherapy Practices. Previously accreditation was conducted by the APA. QIP advised that approximately 10% of physiotherapy practices voluntarily participate in accreditation. The fee structure[12] is as follows:

Service description	Type Surveyor	Cost basis	Fee
Registration	Any	Any	$500.00 + GST
Accreditation 1st	Peer surveyor	Per FTE	$990.00 + GST

Optometrists

QIP is now the sole provider of accreditation services for the Optometrists Association of Australia Practice Standards. QIP advised that approximately 10% of optometry practices voluntarily participate in accreditation. The fee structure[13] is as follows:

Service description	Type Surveyor	Cost basis	Fee
Registration	Any	Any	$500.00 + GST
Accreditation 1st	Peer surveyor	Per FTE	$900.00 + GST

Other primary care

The costs of participating in the Quality Improvement Council program vary according to the type of service being offered and the size, configuration and circumstances of the organisation. Fees vary between providers licensed to accredit against the QIC standards. One licensed provider states that the cost for undertaking the process ranges from approximately $1,500 - $30,000 depending on the size, complexity and particular needs of the organisation[14]

Another licensed provider specifies annual fees for organisations of different sizes, commencing from an organisation of 1 – 5 FTEs at a cost of $4,311.00 up to an organisation of 76 – 100 FTEs at a cost of $20 026.00. The provider also offers a range of packages with different pricing.[15]

[12] QIP website accessed on 16 Jan 2008 (www.qip.com.au).
[13] QIP website accessed on 16 Jan 2008 (www.qip.com.au).
[14] (http://www.qms.org.au/index.php?topic_id=54, accessed 17 Jan 2008).
[15] (http://www.ihca.com.au/pdfs/QIC/QMS263_QIC_CostAndBenefits.PDF , accessed 17 Jan 2007).

2.4 Constraints

The cost analysis study found that while there is general support for the principle of accreditation, anecdotally, smaller practices may be reluctant to embed it within established business practices unless there is a direct financial incentive to do so. Most hospitals and larger health services interviewed generally accepted the need for some external review of service quality.

The cost study did not aim to survey non-accredited bodies as they were unlikely to have information on accreditation costs. Presumably, their decision not to pursue accreditation is based, at least in part, on their perception that the costs, both direct and indirect, outweigh the benefits that would accrue from the process. This was the case in the one unaccredited physiotherapy practice that was interviewed.

2.5 Information required for Regulatory Impact Statements

In the event that regulatory impact analysis (see Appendix 8) of any proposed accreditation reforms is required, the report information and outcomes would be a resource for that analysis, given that the report considers both the costs and some of the perceived benefits of accreditation.

The cost analysis study found that there is little information available about accreditation costs. Even direct accreditation costs such as fees are not consistently available. In a number of cases, accrediting or certifying bodies do not make their fees publicly available, nor publish annual reports with details of their gross fee income. Indirect costs are not well-differentiated between accreditation and other purposes.

The cost analysis report suggests that tracking the costs of implementing accreditation in organisations that have not previously participated in an accreditation program could enable greater cost differentiation and a more detailed cost analysis. This could be useful for any future cost-benefit analysis required as part of regulatory impact assessment. Depending on how the impact assessment is undertaken, bodies such as the Office of Best Practice Regulation could also be a useful source of advice.

3. SAFETY AND QUALITY COMPLIANCE DUPLICATION

It was evident from the consultation process undertaken by the Commission over the last 14 months that there is duplication in the standards, compliance and accreditation processes that apply to health services. The Commission recognises the need to minimise duplication in accreditation, particularly as reforms are introduced.

This section discusses the current duplication and overlap relating to:

- requirements imposed through state and territory private health facility licensing
- contractual arrangements between health insurance funds and health service providers
- standards applied through different accreditation, certification or compliance processes, which may cover state and territory legislative requirements and other mandatory standards.

Health services wanted to ensure that accreditation reforms do not add to existing duplication nor pose an unnecessary compliance burden. In addition, there is a desire by many to reduce duplication and overlap in the areas described above.

On first inspection, this task might appear to extend beyond the scope of the Commission's brief to propose an alternative model. However, duplication has the potential to impede progress of any recommended reforms, therefore this section contains relevant contextual information about the extent of current overlap and opportunities that may arise through implementing the *Alternative Model*. For example, it may be possible for AHS to satisfy licensing and private health fund requirements, facilitating integration and consolidation of standards.

3.1 State and Territory licensing of private health services

Intersection of licensing and safety and quality issues

Governments typically use licensing schemes to regulate activities to assure minimum standards are met and protect the public against factors such as the negative impact of adverse health outcomes or information failures, where parties have insufficient information to make informed choices or assess risks.

In the case of private health facilities, legislation in several jurisdictions explicitly states the objective of the legislation. For example, s. 3(1) of the *Private Health Facilities Act 1997* (Qld) provides that the main object of the Act is to provide a framework for protecting the health and wellbeing of patients receiving health services at private health facilities. S. 3 of the *Private Health Facilities Act 2007* (NSW) (yet to commence) provides that the objects of the Act are:

> (a) to maintain appropriate and consistent standards of health care and professional practice in private health facilities, and
>
> (b) to plan for and provide comprehensive, balanced and coordinated health services throughout New South Wales.

In other jurisdictions, the objectives are not explicitly stated in the Act, but can be inferred from the legislation or detailed in the regulations and are similar in purpose to NSW and Queensland.

To demonstrate compliance private health facility licensing typically requires a facility to submit a range of documentation (application for license, renewal etc), comply with legislative requirements including mandatory standards and license conditions and to participate in compliance monitoring, through processes such as self-assessment, reporting, inspection, audit etc.

Licensing schemes impose safety and quality requirements in a range of ways, such as:

- pre-requisites for obtaining a license
- standards with which facilities must comply to retain or renew a license
- reporting/accountability mechanisms

These requirements may overlap with accreditation standards and contractual obligations between health services and private health funds.

In describing the scope of current and proposed state and territory licensing schemes and providing an overview of the standards applied to health services through the licensing process, the Commission is seeking to highlight the different extent to which licensing is used as a safety and quality tool. This difference is demonstrated by the varying requirements and approaches between jurisdictions and the extent of the duplication with safety and quality accreditation requirements.

The following discussion of State and Territory licensing of private health services is based on information provided by States and Territories.

Existing scope of licensing (service type)

There is a range of approaches to the scope of licensing of private health facilities across states and territories. The spectrum extends from licensing of a limited class of facilities that perform specified procedures, for example in the ACT licensing of a broad class of private health facilities where patients are provided with medical, surgical or other treatment such as in NSW. Some jurisdictions have different licensing requirements for different types of facilities such as WA where they license hospitals, day hospitals, day procedure facilities, psychiatric day hospitals, private psychiatric hospitals, private nursing posts and nursing homes. Whilst other jurisdictions focus on the procedures rather than the facility type such as in the ACT .

While the different regulatory approaches complicate direct cross-jurisdictional comparisons, there is reasonable overlap in the scope of licensing schemes. For example, large private hospitals are required to be licensed in all jurisdictions. Most but not all States and Territories require day procedure facilities to be licensed, although all are moving towards this position, some because of amendments to the Private Health Insurance Act due to commence on 1 July 2008 other jurisdictions, including Tasmania to provide more consistent coverage across private sector services.

The scope of regulation of private health facilities is continuing to evolve. Five jurisdictions are currently proposing changes to the scope of private health facility licensing. For example, Queensland proposes to amend its existing licensing legislation to cover procedures involving simple sedation (intravenous sedation) as day hospital services.

The following table provides a broad overview of the current scope of private health facility licensing based on information provided by States and Territories. Although the definitions vary, the table demonstrates the inconsistent coverage nationally, which adds complexity to the operating environment for organisations operating in multiple jurisdictions.

Safety and quality requirements applied through licensing

States and Territories have adopted different approaches to the requirements that private health facilities must satisfy as a prerequisite for licensing or as a license condition. There is a broad range of requirements across areas including:

- staffing
- facility and equipment
- emergency procedures etc.
- patient care
- clinical practice.

Health facilities may need to demonstrate compliance with general safety and quality standards or requirements to be eligible for a license and/or as a license condition. For example, under s. 83 of the *Health Services Act 1988 (Victoria),* when determining whether to register premises, the Secretary must consider whether appropriate arrangements have been made for maintaining the quality of health services and for evaluating, monitoring and improving the quality of health services.

In some cases there are direct links to accreditation. The ACT applies a different type of license to an accredited facility (which involves a reduced compliance activity in recognition of the coverage of accreditation). Under s.48 of the *Private Health Facilities Act 1999*, Queensland requires facilities to be certified under a quality assurance program as a license condition.

Some States require compliance with clinical guidelines, e.g. Victoria expects compliance with specialty guidelines such as Neonatal Services Guidelines.While other jurisdictions focus more on facility and equipment requirements, e.g. SA.

To give an overview of the different approaches Table 1 provides a high level summary of the broad range of State and Territory licensing requirements based on jurisdictional advice.

A preliminary comparison of State and Territory licensing requirements with the standards applied in a common accreditation process (ACHS EQuIP) suggests that there is overlap, particularly in areas such as records management and infection control.

Table 1::Private Sector Licensing Coverage by Jurisdiction 2008

	ACT	NSW	NT*	QLD	SA	TAS	VIC	WA
State and Territory definitions of these terms vary in some cases. This table is based on State and Territory advice about coverage								
Private hospital	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Day hospital	**Yes**	No		**Yes**	**No**	No		**Yes**
Day procedure facility	No	**Yes**		**Yes** Classified as day hospitals	**No**	No	**Yes**	**Yes**
Psychiatric day hospital	No	No		No	**No**	No	**Yes** Day procedure facility providing a mental health service	**Yes**
Private psychiatric hostels	No	No		No	**No**	**Yes**		**Yes**
Private nursing post	No	No		No	**No**	No		**Yes**
Other	**Yes**	No		**Yes**	**No**	**Yes**	**Yes**	**Yes**
	Public hospitals are subject to type 2 licence conditions			Acute hospice and Sub-Acute Medical/ Rehabilitation		Private palliative care hostels	Non-emergency Patient Transport Providers	Nursing homes
	Dental surgeries - Facilities carrying out prescribed medical and dental procedures including administration of certain anaesthetics, endoscopy etc					Private aged care establishments	Stand By Services Persons who operate stand by services for participants at public events who suffer unanticipated illness or injury during the event	
	Other facilities may require a type 1 licence if they provide prescribed medical procedures as defined in the ACT Health Care Facilities Code of Practice							

***** Information not yet provided

Inspection

Audit or inspection periods vary across States and Territories, facility types and standards, with annual inspections common for larger institutions such as private hospitals.

Reporting

All States and the ACT licensing schemes enable some reporting requirements although this is primarily inpatient statistics data not safety and quality data. For example, ACT and SA require an annual report on specified issues. Queensland and Victorian legislation provides for monthly reporting on specified issues. The Hospitals and Health Services Act 1927 (WA) provides that the CEO may direct a hospital service provider to give to the CEO the information specified in the direction The Hospitals Act 1918 (Tas) enables reporting to be required, but arrangements have not been established. Other organisations, such as the Queensland Health Quality and Complaints Commission has legislative powers to require reporting against specific safety and quality standards.

3.2 Health insurers - safety and quality compliance for private health services

Currently private health insurance funds require safety and quality performance reporting by health services as part of contractual arrangements. These requirements include the need to maintain accreditation and often additional requirements, particularly reporting on service performance and activity. As the requirements differ between funds, it is difficult to establish the extent of overlap with licensing, accreditation and other standards but it is clear that duplication exists.

Private health insurance peak industry bodies have indicated that their members wish to establish a systematic and common approach to monitoring and measuring safety and quality outcomes associated with the delivery of health care. They see this being achieved through a collaborative approach that either provides a framework for negotiations with health services or is more prescriptive, providing a quality plan that includes specific clinical indicators and performance measures. Both the Australian Health Services Alliance and the Australian Health Insurance Association have commenced work separately in this area. Both organisations are seeking to encourage the delivery of high quality care to private health insurance fund members and the establishment of mechanisms to ensure continuity of care and effective monitoring of health service performance.

Private health service providers have also called for a systematic and consistent approach to safety and quality compliance to reduce the duplication that currently exists. They have expressed concern about the growing compliance burden associated with multiple assessment and compliance processes and data requests. Private sector health service providers have supplied the Commission with evidence of the existence of wide variation and substantial volume of safety and quality compliance requirements sought by health insurance funds.

The Australian Private Hospitals Association has proposed that if the focus of the delivery of care is safety and quality, then all health services should be required to comply with an agreed common set of standards and report on performance indicators. If health insurers, governments or other bodies consider that additional standards or performance indicators are sufficiently important that a health service is required to measure and report against them, then the APHA have recommended a case should be made for their incorporation in the AHS or its indicator set.

Overlap with accreditation/certification

Governments, private health insurers and service providers seek to ensure that health services are provided at reasonable levels of safety and quality. This concern has resulted in the application of different stand-alone, overlapping mechanisms rather than an integrated approach that meets the needs of regulators and the various private health insurers. Whilst there are now attempts to explore a more integrated approach, the challenge is how to achieve this without imposing unnecessary duplication and overlap between licensing requirements, accreditation processes and additional quality requirements required by private health insurers, which may divert resources into multiple processes and away from a direct investment in safe and high quality patient care.

The overlap and duplication between licensing requirements, accreditation standards and contractual obligations between health services and private health funds has the potential to be exacerbated or reduced by changes to existing accreditation processes and standards.

3.3 Future considerations

The concern about the costs and inefficiencies that result from duplication has been a recurring theme in the review of national safety and quality accreditation standards. The Commission believes that achieving efficiencies in the current accreditation system is dependent on reducing duplication that exists more broadly in relation to safety and quality compliance.

However, the regulatory and contractual aspects of this issue mean that Health Ministers would need to endorse further work and consider the most appropriate body and mechanism to explore reducing duplication. This work would require cooperation and ongoing collaboration with private health insurance organisations, private sector providers and their representative peak bodies. It would also require a more detailed mapping of state and territory licensing and consideration of the regulatory impact of licensing on health services.

The Commission considers that there is overlap between accreditation, licensing and contractual obligations and that the duplication is a risk to the successful implementation of the alternative model.

Health Ministers' support is considered warranted for a detailed review and analysis with a view to:

1. reducing the duplication between state and territory licensing and accreditation requirements
2. decreasing the complexity by harmonising licensing requirements and contractual reporting obligations. Harmonising could be achieved by:
    a. agreeing standardised definitions for service types between states
    b. setting minimum national licensing requirements for service types and standards
    c. determining common reporting obligations
3. Exploring opportunities to work with DoHA, private insurers and private sector providers to streamline safety and quality performance reporting and links to AHS.

4. OTHER HEALTH SERVICE REFORM INITIATIVES

Throughout the review process, stakeholders have been eager to ensure any reforms that arise from the review of safety and quality accreditation are cognisant of other health service reforms underway that relate directly or indirectly to safety and quality. There is a call for better links between the various legislative and bureaucratic programs that impact on consumers, carers, service providers, funders and other professional groups. Other major reform programs include:

Council of Australian Governments Reform of Education and Training Accreditation and the proposed National Health Professional Registration

At its meeting in April 2007, the Council of Australian Governments announced the formation of a new national system for the registration of health professionals and the accreditation of training and education programs for implementation by July 2008. An Inter-Governmental Agreement was completed, but not signed as the former Australian Government sought additional consultation prior to signing. While it is unclear what form changes to professional registration will take, it would appear inevitable that changes will occur.

Stakeholders in the accreditation review of national safety and quality accreditation have highlighted the impact of multiple reform processes on services and health care providers, raising concerns that there may be an additional compliance burden, regulatory requirements or inconsistencies between reform programs and have urged the Commission and Governments to ensure there is consistency and/or no duplication between the education/training and safety and quality accreditation processes.

The Commission believes there is the potential to streamline these processes by:

- recognising the role of registration boards in safety and quality protection of the public and working with them to identify gaps and way to address these
- working with bodies such as professional colleges that both set safety and quality standards and have a role in education and training accreditation to identify and reduce duplication
- where appropriate seeking mutual recognition between accreditation programs.

Review of Private Health Insurance reforms

In 2007 the Australian Parliament enacted the *Private Health Insurance Act 2007*. This legislation presents a significant change for health care providers accessing private health insurance funding as it requires them to meet the standards specified in the Private Health Insurance (Accreditation) Rules to be eligible for private health insurance financing. It is anticipated that health care providers will need to be registered with a professional registration board or a member of a relevant professional association to have been deemed to comply with the rules. The standards therefore will be those set by the profession or applied by states and territories.

The Commission's reform process is seeking to ensure that all health services comply with AHS. They will cover priority areas in which standards of expected performance for improving safety and quality are applied and ensure high risk services undertake an accreditation process that includes an external review. While the proposed Private Health Insurance (Accreditation) Rules go some way toward ensuring safety and quality requirements are met by health service providers accessing private health insurance funding, they do not go as far as the Commission's reforms propose.

The Department of Health and Ageing has indicated throughout the process of revising this legislation and in public discussion documentation that the private health insurance standards and regulations will align with the work of the Australian Commission on Safety and Quality in Health Care. The implementation of the Rules due from 1 July 2008 will be closely followed by Health Ministers' consideration of the reform proposals for safety and quality accreditation in March 2008 and will precede the implementation of any reforms that are supported. Therefore, the Commission will continue to work with the Department of Health and Ageing and review the Private Health Insurance (Accreditation) Rules, if Health Ministers agree on a program of national reform for safety and quality accreditation.

State based safety and quality standards

States and Territories are addressing safety and quality for health services in different ways in response to local needs and objectives. For example, the Queensland Health Quality and Complaints Commission has developed mandatory safety and quality standards which cover the following issues:

- review of hospital-related deaths
- management of acute myocardial infarction on and following discharge
- surgical safety
- hand hygiene
- credentialing and scope of clinical practice
- complaints management
- providers duty to improve the quality of health services

Compliance by all health care services is mandatory under the *Health Quality and Complaints Commission Act 2006* (Qld). The definition of health service is broad and captures primary, community acute and other institutional care settings. NSW has safety and quality accreditation standards for specific services, such as methodone clinics and is implementing a quality system activity statement to measure compliance with safety and quality standards, protocols and guidelines in public hospitals.

Some of these initiatives have overlapping requirements with accreditation associated with the content of the standards, performance reporting and other compliance requirements.

While the impact of the duplication between these initiatives and accreditation will be variable across states, overlap should be considered when overall compliance and options for reducing duplication are reviewed.

Expanded scope of health accreditation

Commonwealth and state governments have moved recently to increase the number of services that are required to participate in an accreditation program. The Department of Health and Ageing is supporting the establishment of an accreditation program in Aboriginal Health Services nationally and is working with medical colleges to implement a mandatory accreditation program for diagnostic imaging services accessing funding through Medicare.

Similarly, the Victorian government have moved to require registration of a number of community care services, including child protection, disability and mental health services. For these services obtaining accreditation is considered equivalent to meeting many of the registration requirements. The impact of these changes is an expansion of the number and type of accredited services.

APPENDICES

Appendix 1 Council Principles for Improvement of the Safety and Quality Accreditation System

Principles developed by the former Australian Council on Safety and Quality in Health Care in 2003.

1. Stakeholder confidence in the rigour of accreditation systems and the reliability of responses to significant non-compliance is enhanced.
2. Accreditation of health care services is supported. Varying regulatory and funding options for achieving greater national consistency are utilised to encourage accreditation of health care services.
3. Effective consumer engagement occurs throughout the accreditation system.
4. The administration of accreditation is efficient.
5. Standards against which compliance is assessed are capable of adaptation to varying health environments – but are firm and credible.
6. Surveying against standards is credible, robust and consistent.
7. Accreditation processes encompass both assessment of compliance with minimum standards and encouragement of continuous improvement.
8. Standards setting and accreditation processes are externally validated.
9. Assessment options are flexible.
10. Responsibility for taking action on accreditation outcomes is clearly defined.
11. Accreditation processes and outcomes are transparent.
12. Information learned from accreditation is used for system wide improvement.
13. The direct and indirect relationship between accreditation and safety and quality in health care is evaluated through research.

Appendix 2: Overview of the *Alternative Model*

The *Alternative Model* of accreditation includes the following key components:

1 Australian Health Standards.

1.1 Best practice Australian Health Standards (AHS) that are established as a priority in areas that support improvements in the safety and quality of health care.

1.2 Standards that are identified and developed in collaboration with stakeholders.

1.3 Drafting, verifying and endorsing of AHS for Health Ministers, funders, consumers, clinicians, service providers, professional bodies, the Commission and a national accreditation coordinating body that is clearly defined.

1.4 A process to recognise existing standards that are considered equivalent in scope, content and level of performance to AHS.

1.5 A process of mapping safety and quality standards prospectively which determines the coverage and gaps of existing standards in the current accreditation system.

1.6 An authorisation process for accrediting bodies that assess health services against the AHS.

1.7 A mechanism to resolve disputes that can not be resolved between health services and accrediting bodies.

1.8 A website that can host information about standards, authorised assessment bodies and accreditation outcomes.

2 Quality Improvement Framework

2.1 A Quality Improvement Framework that can be applied to all health services.

2.2 A Framework that includes key corporate, risk and governance areas.

2.3 A Quality Improvement Framework that is developed in collaboration with consumers, clinicians, technical and experts including the Commission.

3 Scope of accreditation

3.1 AHS that are implemented in all health services.

3.2 Adoption of a risk-based and staged approach to the implementation of accreditation into health services that are not currently accredited.

3.3 Criteria for classifying high risk services that are developed in collaboration with stakeholders.

3.4 Identification of mechanisms that mandate accreditation of high risk services.

3.5 Evaluation of the first phase of implementation prior to the expansion of accreditation beyond high risk service that includes a cost benefit analysis of accreditation and an analysis of the applicability and appropriateness of broader application of the accreditation processes.

4 National data collection and reporting

4.1 Data on AHS that is collected nationally from all accredited health services.

4.2 Specification of data items to be collected that are determined in collaboration with stakeholders during the development of the AHS.

4.3 A web-based format that can limit the effort associated with data submission and analysis.

4.4 Data collection, relevance, design, linkage, timely analysis and reporting that is determined in consultation with stakeholders and data experts.

4.5 Other administrative and clinical data sources that can be used to verify accreditation data and support accreditation processes.

4.6 Information that is used to report on exemplar practice and share learnings to encourage broader system changes and improvements in safety and quality.

4.7 Information that is produced in an appropriate format and reported to stakeholders and to the public.

5 Initiatives to support mutual recognition

5.1 Formalised mechanisms that allows different assessment processes to recognise acceptable performance of other assessment processes.

6 National coordination

6.1 A national body that is established to lead, support and coordinate reform of the accreditation system.

6.2 Functions that include:

- Developing the AHS
- Establishing a National Framework for Quality
- Assessing accreditation bodies
- Collecting and analysing accreditation data
- Monitoring and reporting
- Communicating accreditation outcomes
- Managing appeals.

6.3 A national body that is guided by an advisory committee, constituted of stakeholders representing the broad range of interests in accreditation.

7 Compliance and consequences of non-compliance

7.1 Compliance with AHS be mandatory, with an escalating series of sanctions applying for non-compliance.

7.2 The regulatory mechanism to be applied is a matter for Health Ministers to determine, with existing regulatory levers being utilised.

Further, the following projects are recommended as potential mechanisms to support the introduction of accreditation reforms

8 Review surveyor participation

8.1 A review of existing surveyor participation arrangements by accreditation bodies.

9 Pilot innovative accreditation assessment mechanisms

9.1 Patient journey methodologies be piloted and evaluated to determine critical success factors prior to consideration of broader implementation into accreditation processes.

9.2 Short notice surveys be piloted and evaluated to determine critical success factors prior to consideration of broader implementation into accreditation processes.

10 Research

10.1 Opportunities to support and coordinate research effort into accreditation be explored in collaboration with research funders and centres and other stakeholders.

Appendix 3: Paterson Report: Goals for a reformed accreditation system

The 2005 report on *"National arrangements for safety and quality in health care in Australia"* recommended that a review of accreditation be undertaken and should recommend:

Advice sought	Commission response
• whether a national accreditation body is necessary and, if so, what its role and function should be	Rather than establishing a national accreditation body, the Commission considers a more cost effective and efficient way to achieve similar outcomes of consistency and coordination is to give a body the role of national coordination and establishment of Australian Health Standards, a quality improvement framework and associated processes that will move the accreditation system towards better practice and more consistency and build on the strengths of the current system.
• the best mechanism to review existing standards that apply to the health sector, to determine opportunities for streamlining and reducing duplication	The Commission recommends a multi-pronged approach to this issue: ▪ Establishing best practice Australian Health Standards and an approach to recognise existing standards as satisfying the AHS, encouraging convergence ▪ Encouraging mutual recognition in 3 key areas: o regulatory standards o national health care initiatives e.g. Medicare o bilateral arrangements between accrediting bodies ▪ Streamlining and harmonising other safety and quality compliance requirements, such as safety and quality regulation and performance reporting
• the best way to translate nationally agreed safety and quality improvement policies and standards into accreditation standards as a mechanism for implementation	The Commission believes that the proposed establishment of Australian Health Standards is the best way to translate nationally agreed safety and quality improvement policies and standards into accreditation standards as a mechanism for implementation
• ways to address issues relating to the rigour and robustness of survey processes	The Commission proposes a approach that includes: ▪ a review of surveyor issues, to identify strategies to improve the rigour and robustness of survey processes and the sustainability of the surveyor workforce ▪ piloting of innovative assessment mechanisms ▪ a coordinated approach to accreditation research
• the development of a mechanism to ensure appropriate action is taken in the event that an unacceptable threat to the safety and quality of care is identified by an accreditation agency	The Commission is recommending a new reporting mechanism to ensure any unacceptable threat to the safety and quality of care identified by an assessment agency is reported to the National Entity for further action

Appendix 4: The Joint Commission, USA - 008 National Patient Safety Goals

The following information was accessed from the Joint Commission website: http://www.jointcommission.org/ accessed on 4 February 2008.

The 2008 National Patient Safety Goals cover the following Programs:

- Ambulatory Care
- Assisted Living
- Behavioral Health Care
- Critical Assess Hospital
- Disease-Specific Care
- Home Care
- Hospital
- Laboratory Services
- Long Term Care
- Networks
- Office-Based Surgery

The 2008 National Patient Safety Goals include:

Goal 1:	Improve the accuracy of patient identification
Goal 2:	Improve the effectiveness of communication among caregivers
Goal 3:	Improve the Safety of using medications
Goal 7:	Reduce the risk of health care-associated infections
Goal 8:	Accurately and completely reconcile medications across the continuum of care.
Goal 9:	Reduce the risk of patient harm resulting from falls.
Goal 10:	Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
Goal 11:	Reduce the risk of surgical fires.
Goal 12:	Implement applicable National Patient Safety Goals and Requirements at the component and practitioner site levels.
Goal 13:	Encourage patients' active involvement in their own care as a patient safety strategy.
Goal 14:	Prevent health care-associated pressure ulcers (decubitus ulcers).
Goal 15:	The organization identifies safety risks inherent in its client population.
Goal 16:	Improve recognition and response to changes in a patient's condition.

Appendix 5: ISQua International Accreditation

The following information was accessed from the ISQua website: http://www.isqua.org.au/isquaPages/General.html accessed on 30 October 2007.

ISQua provides international programs based on best international practice standards and principles to assess, survey and accredit in the areas of

- standards,
- organisational performance,
- surveyor/assessor training programs, and
- education and learning programs in quality and safety in health care.

ISQua Accreditation is an external evaluation and recognition award based upon a four-year cycle of

- assessment tools and guidance
- supported development, education and training
- self-assessment and documentation review
- on-site pre-survey review
- independent peer assessment or on-site survey
- full report and recommendations for improvement
- accreditation as a formal recognition of achievement
- opportunities for on-going development

ISQua International Accreditation Program Fees

Access Fee: US $1,200
(information package for ISQua Standards Assessment is sent on receipt of payment)

Standards Assessment: US $2,180 per annum
(fee for service paid via equal instalments over 4 years)

Training Program Assessment: US $1,900 per annum

Organisation Survey: US $2,780 per annum

Organisations with standards: US $4,900 per annum
(includes on set of standards)

Organisations using standards developed by another body: US $3,700 per annum

Additional standards US $1,000 to annual fee

Appendix 6: JASANZ Accreditation

The following information was accessed from the JASANZ website: http://www.jas-anz.com.au/ accessed on 30 October 2006

JASANZ accepts applications for accreditation from Conformity Assessment Bodies in the areas of Management Systems Certification (General Practice Accreditation Scheme and Hospital Accreditation Agencies Scheme), Product Certification, Personnel Certification and Inspection. Accreditation involves five general steps and involves reassessment every four years:

1. Application – submission of application form and payment
2. Systems Assessment – review of documentation against accreditation criteria and report provided back to applicant
3. Assessment – Onsite assessment by team and completion of report with recommendations
4. Review of Assessment Report – JASANZ Accreditation Review Panel review report and make accreditation decision
5. Accreditation Decision – Certificate of Accreditation issued if accreditation is approved. If accreditation is not granted applicant advised of reason.

Regular visits occur to assess ongoing compliance with accreditation criteria.

JASANZ Fees
(Australian Dollars)

Application fee: $2000
(Covers 1 day document review, $125 invoiced per hour for additional reviews)

Program Fee for Management systems: $10,000 per annum (invoiced monthly)

Certificate Fees: Vary per number of certificates issued per annum and details are available on the website.

Appendix 7: NATA Accreditation

The following information was accessed from the NATA website: http://www.nata.asn.au/ accessed on 17 December 2007.

While NATA accepts applications for accreditation from laboratories and facilities operating in many health and health related fields it also accredits reference material producers, proficiency testing providers and inspection bodies.

Accreditation involves five general steps and involves reassessment every three years:

1. Application – submission of application form and payment
2. Advisory visit – an informal review of a facility to examine the major elements of the system and readiness for assessment
3. Assessment – onsite assessment by a team that includes appropriate technical expertise and completion of report with recommendations
4. Review of Assessment Report – NATA Accreditation Advisory Committee review report and confirm accreditation decision
5. Accreditation Decision – Certificate of Accreditation issued if accreditation is approved. If accreditation is not granted an applicant is advised of the reason(s).

Regular visits occur to assess ongoing compliance with accreditation criteria.

NATA Fees (2007/08)
(Australian Dollars)

Application fee: $2070

Advisory Visit and Initial Assessment: Charged at $202 per hour of NATA staff time (technical assessor time not normally charged) plus expenses

Once accredited for the first time an annual fee applies that covers the costs of the 3-yearly reassessment.

Annual fee: Administration fee varies between $1480 - $1775, plus a fee per technical unit that ranges from $1825 - $2190 (the range in fees reflects the varying distances of the accredited facility from the nearest NATA office).

Appendix 8: Justification to explore a regulatory approach

This preliminary analysis provides some indicative reasons for exploring a regulatory approach[16]. The analysis will be developed further if AHMC supports exploration of a regulatory model.

Is regulation needed? What is the problem that requires addressing?	Technically accreditation is a voluntary exercise. There are no clear standards that consumers are entitled to expect from all health services and no consistent sanctions for failure to achieve particular standards or accreditation generally.
Where is the market failure?	A self-regulatory, market based approach has not delivered consistent safety and quality outcomes from the accreditation process and has resulted in the inconsistent application of accreditation requirements and sanctions which creates an uneven playing field and could distort the health care market.
Can it be addressed without recourse to government regulation?	There are no non-regulatory mechanisms readily available to address these issues.
What are the costs, risks or benefits of maintaining the status quo?	Generally, the costs, risks or benefits of maintaining the status quo are: *Costs and risks* ▪ Continued inconsistent safety and quality outcomes from accreditation ▪ Continued lack of clarity about what can be expected from an accredited health service ▪ Continued inconsistent application of accreditation requirements and sanctions ▪ Lost opportunities to improve safety and quality outcomes through accreditation *Benefits* ▪ No costs incurred in developing or implementing a new system ▪ Organisational investment in current processes is unaffected
Regulatory failure Is regulation likely to improve on market outcomes?	Initial analysis suggests that there is potential to increase the effectiveness of accreditation in improving safety and quality outcomes through a regulatory model.
Could regulation lead to worse outcomes?	A regulatory accreditation model is unlikely to lead to worse safety and quality outcomes, but if not carefully developed, could be resource intensive and potentially divert resources from service delivery.
Alternative solutions? What are the alternative approaches to dealing with the problem, including non-regulatory action?	Alternative approaches include: ▪ Improving the current self-regulatory approach through the development of best practice resources such as National Health Standards ▪ Mandate specific safety and quality standards through legislation not linked to accreditation

[16] http://www.pc.gov.au/__data/assets/pdf_file/0006/8727/reglnrev0506.pdf
http://www.obpr.gov.au/publications/external/coag/coag.pdf
http://www.socsci.flinders.edu.au/fippm/ppnsummerconference2007/papers/CarrollFederalism.pdf

Benefits of regulating? What are the likely benefits, including risk reduction, or the proposed regulation?	▪ Clarity for consumers about the standards that accredited health services should achieve ▪ Potential to improve safety and quality outcomes through accreditation ▪ More equitable application of accreditation requirements and sanctions ▪ Improved health outcomes for consumers and a reduction in the costs associated with adverse health outcomes for consumers, providers and governments
Who will reap these benefits and how certain are they?	▪ Consumers will reap the benefit of clarity about standards of accredited health services. This benefit is reasonably certain. ▪ Improved safety and quality outcomes would benefit consumers, services and governments by improving health status and productivity and reducing the costs associated with adverse health outcomes for consumers, providers and governments. This is a potential benefit and the feasibility of achieving it needs to be explored in more detail. ▪ The more equitable application of accreditation requirements and sanctions would benefit health providers and consumers by creating a more level playing field.
Cost of regulating What are the likely costs of the proposed regulation? Who in the community will bear these costs?	The cost of a regulatory model of accreditation would be shared by health providers, consumers and governments. This issue requires further careful assessment.
Public consultation What is the feedback from the public consultation on the points above?	A significant proportion of stakeholders consulted during the review of accreditation supported some equitable application of sanctions for failure to achieve certain key standards of health care or accreditation more generally. Other stakeholders would prefer to maintain the status quo.
Support for regulation What support is there for the proposed regulations, including support from suppliers and consumers and other parties bearing the costs of regulation?	See above. This issue would need further exploration if AHMC supports a regulatory approach.
Impact on competition What is the impact of the proposed regulatory measure on competition, including the introduction of new processes and techniques?	A regulatory model of accreditation could potentially yield competition benefits, by restoring a level playing field.

Appendix 9: Glossary

AACS	Australasian Auditing and Certification Services PL
AAGP	Australian Association of General Practitioners
AAPM	Australian Association of Practice Managers
ACD	Australian College of Dermatologists
ACEM	Australian College for Emergency Medicine
ACHS	Australian Council on Healthcare Standards
ACMI	Australian Midwifery Council Inc.
ACRRM	Australian College of Rural and Remote Medicine
ACSAA	Aged Care Standards and Accreditation Agency Ltd.
ACSQHC	The Australian Commission on Safety and Quality in Health Care
ADA	Australian Dental Association
ADGP	Australian Divisions of General Practice
AGPAL	Australian General Practice Accreditation Ltd.
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Council
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANZCA	Australian and New Zealand College of Anaesthetists
APA	Australian Physiotherapy Association
BC	Benchmark Certification Ltd.
CHF	Consumers Health Forum of Australia
CoAG	Council of Australian Governments
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EQuIP	Evaluation and Quality Improvement Program
GM PL	Global Mark Pty. Ltd.
HACC	Home and Community Care
HAS	Haute Autorité de Santé
HDSC	Health Data Standards Committee
HIQA	Health Information and Quality Authority
HQCC	Health Quality Complaints Commission Qld
IEO	International Electrotechnical Commission
IHCA	The Institute of Healthy Communities Australia Ltd.
IHCA Ltd	Institute for Healthy Communities Australia Ltd
ILAC	International Laboratory Accreditation Cooperation
ISC	International Standards Certification Pty. Ltd.
ISO	International Organisation for Standardisation
ISQua	International Society for Quality in Health Care
JAS-ANZ	Joint Accreditation System of Australia and New Zealand
JCAHO	Joint Commission on Accreditation of Healthcare Organisations
KPI	Key Performance Indicator
MOU	Memorandum of understanding
NAMDS	National Association of Medical Deputising Australia Ltd
NATA	National Association of Testing Authorities
NCSI	NATA Certification Services Inc.

NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NHPC	National Health Performance Committee
NIAZ	The Netherlands Institute for Accreditation of Hospitals
NPAAC	National Pathology Accreditation Advisory Council
OAA	Optometrists Association Australia
OH&S	Occupational Health and Safety
Paterson Report	Review of Future Government Arrangements for Safety and Quality in Health Care
PHIAC	Private Health Insurance Administrative Council
PHISQC	Private Health Insurance Safety and Quality Committee
QHNZ	Quality Health New Zealand
QIC	Quality Improvement Council
QICSA	Quality Improvement & Community Services Accreditation Inc.
QIP	Quality In Program Pty. Ltd. (wholly owned subsidiary AGPAL)
QMS	Quality Management Services Inc.
QPA	Quality Practice Australia
RABQSA	RAB Quality Standards Australia
RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australasian College of Medical Administrators
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RCPA	Royal College of Pathologists of Australasia
RDAA	Rural Doctors Association of Australia
SA	Standards Australia Ltd.
SAC	Severity Assessment Code
SAI Global	SAI Global Ltd.
TGA	Therapeutic Goods Administration
The Commission	The Australian Commission on Safety and Quality in Health Care
Discussion Paper	National Safety and Quality Accreditation Standards Discussion Paper, November 2006
TQCSI PL	TQCS International Pty. Ltd.
Turning Point Keepad	Interactive audience response technology
VCEC	The Victorian Competition and Efficiency Commission
WHO	World Health Organisation

Appendix 10: Definitions

Accreditation	A system to promote and support safe patient care and continuous quality improvement of services through a process of assessment and review.
Assessment Body or Agency	A recognised independent body that assesses and recognises through the award of accreditation status or certification that a healthcare organisation meets applicable pre-determined and published standards.
Clinical / Health / Patient Outcomes	The impact of health care on the well-being and quality of life of patients.
Community Care	The diverse range of services provided to people who require care to remain successfully living in their own home and community.
Consumer	Any person who is a potential user of a health care service. (Source: Standards Australia (SA))
Continuity of Care	The degree to which a series of discrete health care events is experienced by the patient as coherent and connected and consistent with the patient's medical needs and personal context. (Source: RACGP)
Health Care	The prevention, diagnosis and/or treatment and management of illness and the preservation of mental and physical well being through the services offered by health practitioners.
Health Care Provider/ Practitioner	Any person or organisation who is involved in or associated with the delivery of health care to a consumer or caring for a consumers' wellbeing. (Source: Standards Australia)
Health Service	The organised provision of health care including diagnosis, treatment and/or management by a health care practitioner(s) which may occur in an institution, practice, community or residential setting.
Health System	The organisation, structure, method and processes by which health care is provided.
Mutual recognition	Where assessment certification awarded by one accreditation body is accepted by other accreditation bodies and the assessment is only carried out once.
Patient Journey (tracer) Methodology	The tracking of care recipients' experiences throughout an organisation or episode of care. This tracing activity allows surveyors to assess organisational systems and processes that drive care in the organisation and affect the actual experiences of the individuals observed during the on-site evaluation. (Source: JCAHO)
Primary Care	Health care that is provided at the point at which a consumer first seeks assistance from the health care system and/or clinical services provided by general practitioners, allied health practitioners, practice nurses, primary/community health care nurses, early childhood nurses and community pharmacists.
Public reporting	Providing information on outcomes (such as of accreditation and health service performance) openly and in an appropriate format.
Quality	The degree of excellence, extent to which an organisation meets clients' needs and exceeds their expectations. (Source: ISQUA)
Registered Health Practitioner	An individual who has met the requirements of the relevant professional registration board to practice within the scope of care defined by the profession.
Risk	Chance or possibility of danger, loss or injury. This can relate to the health and well-being of staff and the public, property, reputation, environment, organisational functioning, financial stability, market share and other things of value. (Source: ISQUA)
Safety	The degree to which the potential risk and unintended results are avoided or minimised. (Source: ISQUA)
Short notice / unannounced surveys	External assessment visits that are undertaken with minimum or no notice of the visit occurring.
Stakeholders	Those individuals and organisations that have an interest in an issue such as accreditation.
Standard	A desired and achievable level of performance against which actual performance is measured. (Source: ISQUA)
Surveyor / Assessor	External reviewer, who assesses achievement of or compliance with agreed standards, principles and/or criteria. (Source: ISQUA)

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