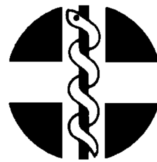

AMA

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

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

Opening comments

In this paper the AMA comments on the recent Australian Commission on Safety and Quality in Health Care (ACSQHC) paper titled Review of National Safety and Quality Accreditation Standards. The AMA appreciates the opportunity provided by the Commission to comment on this paper.

The AMA has not responded in detail to the series of questions posed in the Commission's discussion paper. Rather this AMA paper considers the concept of national safety and quality accreditation standards within the context of the broader, changing and evolving health care system. In 2003 the AMA contributed to a similar exercise undertaken by ACSQHC's predecessor the Australian Council for Quality and Safety when that committee was preparing its paper on 'Standards Setting and Accreditation Systems in Health'.

The AMA has taken this approach because, in preparing its comments, the AMA reviewed the Work Plan of the ACSQHC for the period 2006/2007-2010/2011 as endorsed by Federal and State health ministers. That plan proposes many initiatives such as 'structural changes to improve whole of person care over time', 'assist the development and roll-out of national health records', 'accreditation of all settings of health care', 'identify and recommend to Ministers a core set of safety and quality standards for ambulatory practice settings for agreement with stakeholders', 'maintain a watching brief on registration and accreditation issues', 'credentialing of health professionals for high risk procedures…through an enforceable system' which the AMA believes need to be more fully discussed, debated and agreed across the health sector. Implementation of most of these concepts would involve primarily entities other than ACSQHC.

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

needs to do much more to clearly define (and justify) its proper role within the loose network of providers, funders and regulators that is the Australian ‘health system’.

Over the decades this system has, in the AMA’s view, been able to adapt with remarkable dynamism as technological innovations emerge and as consumer needs evolve. It concerns the AMA that much of the material emerging from ACSQHC suggests the need for more centralised, directed and controlled regulatory arrangements across the health ‘system’. While such initiatives can be described in warm rhetoric, their implementation can lead to a more restrained, rigid system which becomes clogged in ‘red tape’. The AMA hopes that the ACSQHC is not too influenced by thinking developed within the stressed Australian state public health systems or by looking to the UK for examples. It seems to the AMA the UK health system is forever being ‘redisorganised’ by central dictate with the results being more often chaos and a demoralised workforce than real improvements to health care.

What drives quality of health care in Australia?

A highly trained workforce is the main driver of quality health care and the first step should be to consider how ACSQHC can help and encourage the workforce to further improve its performance.

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

Public comment on many health system issues is frequently negative. This creates in the public mind a perception of a low quality health system riddled with adverse events and near misses with litigation the only form of redress available to patients. The reality is that the Australian health system delivers a large number of low cost, high quality medical and health services. This message needs to be reinforced not least because a health system constantly under unjustified attack will promote costly defensive medicine.
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Over the last 30 years, there has been a substantial fall in peri-operative death rates through improved anaesthesia management, a substantial decline in death rates from heart attack and stroke, declining death rates from many cancers, improved diabetes management, improved options for mental health care, lower perinatal and maternal death rates and longer life expectancy etc (refer AIHW Australia’s Health 2006, Chapter 2, pgs 15 to 129).

This has not come about because of the Quality in Australian Hospital Care Study or quality assurance activities at the hospital or as a result of ACHS accreditation or ACSQHC activities. These may impact at the margin. There is a lack of recognition in

the Australian community of the contributions to quality, safety and improved health outcomes from a highly trained adaptable health workforce supported by good research as opposed to the smaller contribution from formal quality measurement and assurance activities.

Aims of ACSQHC paper

The Australian Committee on Safety and Quality in Healthcare paper sets out to:

"a) Review accreditation arrangements in Australia: consider these arrangements in light of international experiences and recommend a revised model for accreditation of health services both public and private across Australia.

b) Provide a discussion paper to Australian Health Ministers Conference (AHMC) by October 2006, outlining the strengths and weaknesses of the current system, the benefits that can be gained in a future system and a process and timetable for recommending an alternative model for accreditation including a national set of standards by which health services would be assessed; and

c) Provide a draft report to AHMC by June 2007 and a final report by December 2007."

There is very little in the paper which constitutes a review of the Australian and International accreditation experience. The decision to keep and extend accreditation systems seems to have already been made. The AMA is unaware of evidence which demonstrates a causal link between accreditation and quality improvement. ACSQHC has the solution but has ACSQHC identified the problem? Is it a problem that can be fixed by the wider application of accreditation systems or are there other more innovative, supportive mechanisms available for enhancing safety and quality?

AMA comments on broad agenda of ACSQHC

The AMA is concerned that two fundamental misapprehensions may arise unless ACSQHC conducts its affairs carefully. It seems obvious to the AMA that the safety and quality of any individual episode of health care depends essentially, and will continue to depend, on the professional dedication and commitment of the doctors, nurses and others involved in actually delivering that care.

Systematic examination of quality and safety issues and outcomes and the development of processes to enhance the safety and quality of care may be useful. However, this will only be the case if those espousing and developing such policies and processes develop carefully considered incremental initiatives which build on existing processes and arrangements. The AMA believes it is appropriate in this submission to raise two fundamental issues . These are:

1. There is a risk that the language and pronouncements emanating from ACSQHC will, if great care is not taken, make the jobs of medical practitioners, nurses and other

dedicated health professionals even harder, and more demoralising, than they are at present. The AMA hears on a daily basis from young doctors who are expected to work unconscionable hours, from GPs struggling to cope with ever growing numbers of patients and from hospital specialists stretched to cope with ever greater demands on their time in an environment of constrained resources, bureaucratic inefficiency and political interference. These broad systemic pressures are, in the view of the AMA, greater threats to safety and quality than any issue for which ACSQHC is ever going to be responsible.

It is easy for a bureaucracy established in comfortable offices well removed from a clinical care setting to propose a more consumer focused health system. However, such rhetoric will actually damage the causes it aspires to promote if all that is achieved is the generation of misapprehension in the community so that people become concerned and suspicious about the health and medical care they are receiving. In Australia the vast majority of patients are satisfied after interactions with the health system. The AMA wishes to stress that it will oppose measures and proposals that would add further pressure and increase demoralisation in the already difficult and fraught environment in which doctors and others work.

2. The AMA believes that the existence of ACSQHC could lead to a false expectation or misapprehension that, simply because it has been established, 'safety' and 'quality' are now catered for. The AMA notes the tendency of political processes to assume that matters are best addressed by establishing a committee which then engages in a complex process of consultation, fact finding, conferences and visits; sub-committees are established and eventually numerous papers emerge. The impression is one of activity and action and problems being addressed. However, the reality can be an entity more likely to satisfy bureaucratic, political and public relations requirements by giving the appearance that issues are being addressed. Whether the entity will seriously shape how things are done in the real world is a completely different matter particularly given the loose network of thousands of independent entities that comprise the Australian health 'system'.

More practical comments on ACSQHC approach in the paper

Since 1995 there has been a string of reports and committees in Australia which have examined and made recommendations on issues associated with safety and quality in health care. However these efforts have produced little effect.

The AMA notes that ACSQHC, like its predecessor, has no executive powers. Although called a 'commission' it is actually only a committee limited to making recommendations to other entities such as the Federal and State governments. The AMA raises this point to stress that many of the specific initiatives contemplated by the Commission in its 2007-2010 work plan, if they were to be implemented, would require complex and protracted negotiations among the regulatory, government, financing and 'provider' entities which would actually implement them.

There is a tendency among modern ‘quality advocates’ to forget that the methods and processes by which care is delivered have evolved over many decades. Countless processes aimed at protecting patients and enhancing quality are built into the day to day activities through which health care is delivered. Anyone actually involved in the day to day delivery of health care, can with a little reflection, think of any number of measures, undertaken virtually automatically, that were developed to enhance the quality and safety of health care. It should not be forgotten that these standard processes evolved over many years of careful observation and change. The AMA remains to be convinced that the establishment of centralised bureaucratic systems will have the same effect.

The AMA doubts the wisdom of jumping straight into a major debate regarding a dramatic extension of the coverage of accreditation systems. Shouldn’t we instead stand back and look more broadly at options to enhance quality and safety? It’s already clear from these AMA comments that the Commission needs to more carefully identify the problem(s) it is trying to address and more carefully address the evidence for the wider application of accreditation systems as the answer to the problem(s) identified.

The AMA is also concerned that ACSQHC proposes solutions which, it seems, are assumed to be cost free with no alternative quality initiative or actual health service delivery application considered given the cost involved. This is not the real world.

The paper is envisaging extending accreditation systems to individual doctors in solo or small group practices including those providing largely consulting services.

Are there already too many hoops for doctors to jump through? There are 15 years of training required for many specialties, medical registration requirements including discipline aspects, College certification and now recertification. There is credentialing in larger institutions, risk management programs offered through medical defence organisations, some licensing of facilities, Federal and State, for procedural practitioners and new approval arrangements proposed by private health insurers for services under Broader Health Cover. Doctors are also subject to oversight by Medical Boards, the Colleges, the Health Insurance Commission, Professional Services Review, State based Complaints Commissions, the Private Health Insurance Ombudsman to name just some. Most importantly doctors are bound to practice according to professional and ethical standards.

Against this background would the further ‘red tape’ inevitably imposed by accreditation be cost effective? There is no consideration of this issue in the paper. The Federal Government recently acknowledged the profession’s legitimate concerns over this maze of regulation by requesting the Productivity Commission to review the processes by which red tape could be reduced. Is there strong public support for accreditation? A cynic might suggest the demand for accreditation is driven largely by the accreditation industry.

Accreditation in different health settings

Are there grounds for considering extending accreditation systems to new clinical situations? Some relevant issues are:

- Economic issues – what might be justified in large institutions with lots of resources may not make sense in other smaller settings. The AMA would need to be satisfied that the benefits decisively outweighed the costs before endorsing extension of accreditation beyond acute care settings.
- Acute care issues – accreditation may be appropriate when patients are at a significant risk of serious adverse outcomes, for example when undergoing complex procedures in acute care hospitals. It may not be applicable when issues are more to do with the competence of practitioners' diagnostic and management skills. In these circumstances competence is better addressed by other processes such as 'maintenance of professional standards' rather than accreditation.
- Complexity – should smaller health settings be expected cope with the complexity and costs of accreditation processes given its unproven benefit?
- Opportunity costs– What other better things could you do with the money either to enhance quality or expand direct clinical care?

There is a case for accreditation in large acute facilities where they can be introduced at reasonable cost with a large span of effect and where there is an important and necessary assurance for the public given the seriousness and technical complexity of the health interventions which take place in these institutions.

The AMA believes no similar case has been made for the introduction of complex accreditation systems in ambulatory care medical settings where the services being offered are largely consultative.

In the case of General Practice, accreditation was achieved in the context of a broader health financing agreement which existed at the time and which was used to induce the parties to agree to implement accreditation systems. The General Practice accreditation arrangements are profession controlled, voluntary and relate largely to the physical facilities of the practice and practice organisational arrangements, not clinical aspects. AMA policy in respect of GP accreditation provides that the accreditation system must be independent of government, is not punitive, provides for appeal and is not linked to medical fees or patient rebates in any way. (See attached AMA policy covering GP accreditation)

There is no equivalent public interest case or similar political circumstance to support the same development occurring in the medical profession beyond General Practice with the exception of the larger corporate diagnostic services practices where there are already separate established processes supported by the profession and utilising standards developed by the relevant professional bodies. Patients access specialist services much less frequently than GP services and access these services on referral from their General Practitioner. Patients generally return to their GP for on-going care and they have a high level of trust in specialist medical practitioners given their length of training, credentialing, maintenance of professional skills etc. This submission has previously

listed the many existing bodies and processes applicable to the medical profession to assure the public.

There is a risk of overlap, overkill and overstretch. There are already complex and expensive accreditation systems in aspects of specialist practice delivered through day procedure centres. Having separate systems in rooms would create unnecessary duplication and cost. Doctors already comply with a multitude of regulatory systems which should and do give assurance to the public of their skill and expertise. Patients are not bonded to them and can exercise freedom of choice in most cases.

There are a large number of medical practices in Australia – approximately 20,000 employing more than 100,000 people according to the most recent ABS survey. If accreditation systems are also to apply to practices involving nurses, physiotherapists, optometrists, psychologists, dentists (as implied in the ACSQHC work plan) then the resource implications are enormous. An accreditation process in a big hospital may have a large impact but in a single doctor practice the impact would be small but the resources consumed large.

Other issues

1. There is a risk of raising unobtainable expectations from accreditation – it cannot substitute for other systems, it is a point in time snap shot. It can not claim to influence outcomes. Systems to enhance safety and quality are more likely to succeed and be accepted if they are developed cooperatively with the practitioners affected and if useful information is provided to clinicians, information which can then be used to adapt processes to improve outcomes.

2. The consequences for a health facility not achieving accreditation need to be declared. Public and private hospitals which have not met accreditation standards continue to receive government and private health insurance funding for the services they provide. While some people may make a decision on the location of care based on the accreditation status of the institution, benefits are payable nevertheless. A stronger link between accreditation status and government or private health insurance funding would be a controversial move and would bring a much more critical focus on the cause and effect relationship between accreditation status and health outcomes.

3. There is no obvious body which is set up to do this work (implement consequences of non accreditation) or which could withstand the sort of political pressure which would be brought to bear if funding was cut or ceased. ACSQHC could not be such a body. Would there be formal appeal avenues? If the consequences of non accreditation were to be so great in an acute clinical (as opposed to laboratory) environment, it would need to be introduced with some years of advance notice to enable systems to evolve to produce compliance and challenge less rigorous aspects of the accreditation systems.

4. What is the role of the private health insurers in accreditation? There is clearly no role for the private health insurers in the delivery of accreditation services. At most, they should be able to use accreditation as one consideration in an array of considerations on whether they pay health fund benefits for a service.

5. Can we learn from the UK and the USA on these matters? Unannounced surveys and Tracer methodology have only a recent history in the USA and UK. There is not enough evidence for Australia to be considering introducing such measures. By proposing such untried processes, ACSQHC risks being perceived, early in its development, as a draconian entity proposing hostile inspectorial, police-like processes rather than an entity focused on supporting and encouraging 'coal face' practitioners to achieve higher quality care. There are a large number of issues to be worked through with either of these initiatives but the main issue is the difficulty of using a single incident to act against a health institution which is responsible for the production of thousands of services and which may have existing unconditional accreditation status for years into the future.

If we stay with current accreditation scope, what sensible adjustments can be made?

Lower costs – the big criticism from medical practitioners and others of the present accreditation systems is that they are very costly in terms of dollars and time. The smaller the institution, the larger the relative imposition. The Commission needs to give consideration to making present accreditation processes more efficient before extending them to new settings. At the end of the day, accreditation costs are borne by patients.

Reasonable competition between accreditation bodies – one mechanism for reducing costs is to introduce a greater element of competition between accreditation providers. If the number and complexity of standards was reduced to the minimum possible level and competition between providers was guaranteed, the cost of accreditation, ultimately borne by patients, would fall and participation would rise.

National systems – the AMA supports moves to develop minimum national accreditation standards to help reduce costs imposed on patients. This would also assist with mutual recognition of accreditation programs.

Better surveyors – the AMA supports initiatives to improve the capacity of accreditation surveyors as they are a key aspect of quality accreditation activities. It is essential experienced clinicians be included in accreditation teams.

Better use of data – this is a key aspect. We need better collections of data which can be used to examine the intermediate, and if possible, final outcomes of care. This data needs to be made available to clinicians and the clinicians need to be supported in analysing the data, publishing the findings and ensuring any key messages percolate through the relevant aspects of the health system in a non confrontational, non alarmist manner.

Does the paper achieve what it set out to achieve?

In the AMA's view, it does not. The paper commences from the position that accreditation systems are the answer before it has established the problem and considered the broader options. In our view, it does not consider the international evidence satisfactorily nor does it make a case for recent international developments having a particular role in the Australian health system.

Conclusion

A highly trained confident and committed workforce is the main driver of high quality health care.

Accreditation has a place but it is most productive in larger institutions such as public and private hospitals which have the resources to cope with the bureaucratic demands of accreditation and where there are major clinical interventions with grave consequences for patients. The 1995 Australian Quality in Health Care Study which has led to various (largely abortive) safety and quality initiatives was limited to an assessment of medical records in public hospitals. It seems somewhat illogical to use this study as a justification for the imposition of accreditation processes in completely different settings. As well, a majority of the 'adverse events' identified in that study were the result of simple, practical mishaps such as falls and were nothing to do with the perhaps more exciting areas in which ACSQHC seeks a role, judging from the commission's work plan.

The case for extending accreditation into smaller services such as medical practitioners in rooms is very weak. Doctors already feel they work in a system clogged with red tape and bureaucracy. The big challenge is to support the clinicians in their quest to provide higher quality services with good data and quicker national roll out of improvements.

Clinicians are already subjected to an enormous number of controls as has been outlined. It would be appropriate to give support and encouragement into the future rather than further controls.

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GP Accreditation

2005

The AMA supports a system of general practice accreditation which:

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

Equity of Access

The AMA supports the concept of equity of access to the accreditation process. There should be no financial or other impediment to the ability of small practices, rural practices, remote practices and/or indigenous practices to access the accreditation system.

Accrediting Bodies

- The AMA must be a member of the independent general practice accreditation body, Australian General Practice Accreditation Limited.
- Accrediting bodies must be managed by practising GPs.
- The general practice profession must drive interpretation of the standards for the purposes of accreditation.
- Accreditation decisions must be consistent.
- The cost drivers of accrediting must be transparent.
- Accrediting bodies must comply with Australian competition laws.
- Accreditation bodies must be free of influence from other commercial organisations

Funding

While accreditation may at times represent a gateway to specific funding or programs delivered by Government and provide an incentive for accreditation, in this context:

- where accreditation is an eligibility criterion for access, such programs or payments must relate to practice infrastructure, not the GPs' clinical practice; and
- accreditation of a practice should not itself attract specific funding.

Surveyors

- GPs must be free to choose whether GP or non-GP surveyors assess their practice.
- Surveyors must be:
  - acceptable to the practice;
  - appropriately trained and experienced;
  - completely independent of any practice they survey; and
  - granted legal privilege
- The inspection of patient medical records by surveyors must comply with the relevant Privacy legislation.

Appeals

- An independent appeals body must exist to provide an independent, formal appeals process agreed by the profession that can be accessed once the accrediting body's appeal process has been exhausted.
- The independent appeals process must be affordable and accessible for all practices, regardless of their size.
- The independent appeals body must be indemnified