Business Council of Australia

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**Submission to**

**Senate Community Affairs Committee**

**on**

**National Health and Hospitals Network Bill 2010**

**August 2010**

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## EXECUTIVE SUMMARY

The Business Council of Australia (BCA) welcomes the permanent establishment of the Australian Commission on Safety and Quality in healthcare (ACSQHC) as a long-overdue development to address issues of patient safety and quality in the health sector. But, it should be seen as a first step in an overall redesign of system governance aimed at improving the performance of the health sector. Future governance reforms will be needed, building on the current round of COAG reforms,

The COAG reforms have the potential to rationalise many program delivery accountabilities between the Commonwealth and the states. They have also established new access and performance targets and associated reporting requirements, including those to be made through the Commission. The establishment of local boards is also aimed at improving governance at the local level, through better matching resources to needs and providing a mechanism for local input, including clinical input to resource allocation decisions.

However these reforms are primarily focused on the public provision and funding responsibilities of governments. Information from public hospitals and state public hospital systems on waiting times will be made available to taxpayers and consumers and a *My Hospitals* website has been commissioned. Data at least initially will continue to be lagged and we are concerned that continued separate existence of both the Australian Institute of Health and Welfare and the ACSQHC may delay or duplicate information collection and analysis.

The sectoral oversight characteristic of other sectors of the economy is missing from this governance design. As a result the primary focus appears to be on accounting for the performance and funding of public institutions rather than providing adequate information to consumers, or taxpayers, about the relative performance of their health sector overall – both public and private providers – and the information they need to make decisions about choice of treatment and provider.

Key functions of government in relation to the performance of sectors include ensuring that consumers have adequate information to enable their choices, together with assurance of the quality and safety of the services and goods on offer. These functions continue to be downplayed or ignored in the design of the reformed governance system. Australian consumers lag their international counterparts in terms of the information they can readily obtain.

The quality assurance function is similarly dispersed shared between the proposed Commission, the national accreditation board and Australian Medical Board and government departments.

For this reason we believe that the establishment of this Commission must be seen as a first step in putting a national system of governance in place for the health sector and that future reforms should move to streamline it and orient it to a more traditional market oversight role that recognises the mixed public and private nature of our health sector and the greater information and support needed by consumers as they are expected to take more responsibility for managing their own health and health costs.

## INTRODUCTION

The Business Council of Australia (BCA) represents the chief executives of over 100 of Australia's leading companies. The BCA develops and advocates, on behalf of its members, public policy reform that positions Australia as a strong and vibrant economy and society. Our vision is for Australia to be the best place in the world in which to live, learn, work and do business.

Having a healthy population and an effective health system is fundamental to achieving this vision. Without health both our economic and social prosperity is harmed, as educational outcomes, workforce participation and productivity are lowered and full participation for individuals denied. Improving our health is a goal which we all share and to which we must all contribute. Health is everybody's business. Accordingly, the BCA has taken a keen interest in the recent health reform debates and has participated in the major reviews that have led to the COAG reforms and the Bill currently before the Parliament.

From our perspective the aims of health reform should be two-fold:

- *Improve Australia's health*.

  Without this, Australians will not enjoy the quality of life we seek

- *Improve the effectiveness and productivity of our healthcare system.*

  The challenges facing the healthcare system are well documented. They include: the sustainability of our healthcare system as demand and expectations increase and health workforce numbers lag need; its slowness to re-configure services to meet a changed pattern of disease and treatment; persistent quality problems and inequitable

health outcomes. Just adding dollars will not solve the problem. Fundamental changes to the way in which health is promoted and healthcare delivered are required to address these challenges in ways that are affordable, equitable and high quality.

As a business organisation we have confined our comments to what we see as the missing economic, strategic and system management elements of the COAG reforms, bringing to bear the expertise of our members in undertaking structural reform, complex system management and building international competitiveness.

We have been struck by the lack of microeconomic reform and systematic productivity improvement within the healthcare sector despite its growing economic significance and the challenges facing the health sector (above). These challenges represent actual or potential market failures, as well as social failings. In our view, then, equal attention must be paid to improving the economic performance of the health sector/market as to the clinical and care issues so well identified by the National Health and Hospitals Commission. A key element of this is designing a governance system that promotes both objectives and in itself facilitates the growth in capacity the sector requires.

## COAG REFORMS A GOOD FIRST STEP

We recognise that the program of reform is one which will take at least a decade, particularly if we are to ensure that the strengths of the current system are not damaged and recognising that many of the building blocks for effective reform, such as system connectivity and good information, are not yet in place. Within this context the current COAG reforms are a good first step and our reactions to these have been presented elsewhere (Business Council of Australia, 2010). In this submission we will focus on governance reforms, of which one is the permanent establishment of the Australian Commission for Safety and Quality in Healthcare (ACSQH).

Our starting point are some principles of good governance – clarity of roles and responsibilities; transparency and timely accountability to all stakeholders; recognition and management of risk; ethical and responsible decision-making; good and timely information to aid decision-making by policy-makers, potential investors and providers, citizens and consumers. These are needed at least two levels: at the level of individual organisations and at a system level.

The COAG reforms seek to strengthen financial and governmental, management and clinical governance through clarifying responsibilities and roles; improving feedback and accountability processes; improving the quality of information and rationalising pricing, service standards and quality processes. For example, the establishment of local hospital boards can work to improve the match between local provision and need and provide accountability to local sand national stakeholders. The establishment of pooled funds between Commonwealth and states, together with the rationalisation of responsibilities for primary and aged care, can improve clarity about the relative roles and responsibilities of the major levels of government, their funding shares and how they are used. The proposed independent pricing authority will also help to reduce cost shifting through its determination powers. The establishment of and reporting on national quality and access targets are also important in setting expectations and providing accountability to give effect to the objective of universality.

The permanent establishment of the ACSQH is a welcome acknowledgement of the need for strengthened arrangements to improve and account for patient safety and so we are pleased to support the current Bill for the reasons outlined in the next section.

## SUPPORT FOR THE PERMANENT ESTABLISHMENT OF THE AUSTRALIAN COMMISSION FOR SAFETY AND QUALITY IN HEALTHCARE (ACSQHC) AS PART OF OVERALL SYSTEM GOVERNANCE

The need to address systematically and systemically the number of medical and medication errors in Australia is strong. The original study in 1995 estimated that some 2% of hospital admissions annually were resulting in serious injury or death and that was from the hospital sector alone. In 2005, a review of progress was unable to conclude that this record had been improved because of the paucity and lack of integrity of data.

The previous Commission's own reports point to the lack of good data and the voluntary nature of implementation of their recommendations for improvement (Australian Commision on Safety and Quality in Healthcare, 2008). The continuing structural division between the different care settings (and the accountabilities these imply) and the slow development of integrated patient information systems means a continued limited capacity to reduce the significant number of errors that flow from inadequate patient hand-over across the boundaries.

The linking of public hospital funding to reporting by the Commonwealth in the past few years has started to improve data collections but the integrity and consistency of that data remains in question (see Auditor-General reports).

Initiatives too by some medical colleges and by medical insurance companies aimed at addressing quality issues have also been undertaken but these too remain largely voluntary. The National Institute of Clinical Studies regularly reviews and finds significant gaps between best practice and actual practice.

The quality and safety issues in Australia are not unique. Since the mid-1990's this area of policy has been addressed by many of our developed country counterparts through a variety of means. It is notable that in many countries, the publication of outcome data by provider for consumers has been given much more emphasis than it has in Australia.

The safety records of many sectors of Australian economy have received considerable policy attention in the past decade, such that there has been significant and documented improvement (eg air safety; building safety). These too have been sectors in which professional judgment has been highly prized and in which there have been complex systems. The injury and death rate associated with road trauma has been similarly tackled, with dramatic reductions in the toll. Yet in the health sector the toll is relatively unpublicised and not subject to compulsory corrective action.

Establishment of the national Commission with appropriate powers to develop national safety standards and report against them and to publish outcome data is an essential and overdue development in Australia.

## RECONCEPTUALISING SYSTEM GOVERNANCE – BUILDING A SYSTEM AND DEVELOPING A SECTOR

However, we believe these reforms are a starting point only. The BCA believes that if the objectives for health reform are to be met, if the economic performance of the sector is to be improved sufficiently to meet our emerging health needs, then the sector's governance and management needs to be strengthened considerably. While the current reforms move to address some of the weaknesses, they are incremental and, in our view, insufficient to trigger the necessary transformation envisaged by the National health and Hospitals Reform Commission (NHHRC). They maintain the traditions of fragmentation and bureaucratic regulation and fail to give adequate attention to the mixed nature of health service provision.

In particular we believe there needs to be more attention to market supervision and stimulus for improved economic performance of the sector at large that will deliver better value for patients. Australia's mix of public and private health services is seen internationally as a strength, at a time when transformation of delivery models and innovation are seen as essential for addressing the challenges outlined above. Yet its 'system' governance is loose and dominated by government oversight of primarily government-owned institutions, together with a series of self-regulating professional bodies. The forms of control tend to limit innovation and investment, yet quality assurance and consumer information mechanisms remain relatively weak and the take-up of best practice voluntary.

Yet a key stated objective of current health reform has been the development of a patient-centric system. Supported by a growing body of international evidence (M. Hofmacher, 2008) the NHHRC and government seek to embed a health system characterised by coordinated models of care tailored to individual patients. Such models of care incorporate community-based resources and acute services as required and are more effective and efficient in addressing the prevention, management and treatment of chronic disease. The current systems, spanning public and private service delivery, lack sufficient connectivity to meet this new standard.

This is not just about a lack of digital connectivity. It reflects a lack of coherence in system 'management' and governance. The fundamental dynamic of a producer/provider-led sector needs to change if the objective of patient-centricity is to become a reality.

Such a change has been assisted in other sectors by multiple interventions: structural changes in the service supply and simultaneously a considerable strengthening of consumer education, information and protection mechanisms. Together they have driven greater responsiveness and consumer benefit and could be used to help effect the patient-centricity desired for the health sector.

But patient-centricity is not just about changing the relative power between providers and patients. It is also about recognising the additional rights of citizens and patients in an era in which people are increasingly being asked to manage their own health as part of our collective goal of improving our health. Patients have always had a responsibility to cooperate with medical advice, but as we understand more about chronic disease and its causes, they will asked to take a much larger role than previously and in quite dispersed

settings. The current reforms envisage that to acquit this role, patients will need greater support and health literacy. We would argue that the lesson from other sectors is that with greater responsibility comes the right to greater information and choice.

## SYSTEM MANAGEMENT AND GOVERNANCE

In other sectors, governments have been clear about their responsibilities for market development. They have sought to ensure that:

- Barriers to entry and exit are appropriate to the sector
- Adequate information is available to stakeholders, including investors, both before and after the operating period
- Adequate and trustworthy information is available to consumers to guide their choices and ensure grievance and complaints processes are in place
- The quality of goods and services meets appropriate benchmarks, including safety benchmarks, and that services are provided by appropriately qualified personnel
- That providers of services and goods meet financial and sustainability standards, comply with all relevant legislation

In the health sector, however, governments' responsibilities extend beyond facilitating a market. Governments are the dominant purchasers and funders of services to meet the needs of citizens. They are also the managers of publicly owned institutions which provide services. These functions generate informational and accountability requirements in their own right.

Currently information to fulfil these functions and to account for them is intertwined with the normal functions of market supervision that investors and consumers might expect. While the reforms promise to improve the information available to consumers and citizens they are heavily dominated by the desire for governments to manage their budgets and their institutions. We suggest that they do not adequately recognise the growing responsibilities consumers and citizens are being asked to take for their own health management nor health costs. Nor are they couched with a view to improving the overall performance of the sector as a whole.

For this reason we have previously suggested (Business Council of Australia, 2009) the establishment of two separate but independent bodies. The first, an independent planning commission, which could provide independent and long-term advice to governments about the nature of projected health needs and the best ways to meet these needs. This body would also provide regular information to the community about the extent to which health outcomes were being achieved and gaps in service being met.

The second body would address the quality assurance and consumer information functions implicit in the market supervision responsibilities outlined above. A health sector regulatory body, Taking on functions similar to those exercised by APRA or ASIC in the financial services sector, would supervise and oversee the health sector to ensure that providers meet appropriate quality and safety standards; that best clinical practices are taken up, and can report regularly to all stakeholders on the relative effectiveness of our system. We believe that such a body could take up the responsibilities currently envisaged for both the ASQCH and the Australian Institute for Health and Welfare. It might also link or incorporate the National Accreditation Board.

Our concern is that the current system governance design remains too fragmented to ensure that the full scope of functions envisaged can be acquitted and the separation of information, monitoring and evaluation functions undermines the accountability sought. What we do know from current experience is that the information to guide purchasing and investment decisions, to evaluate the effectiveness of treatment programs remains dated and inconsistent between agencies. The administrative costs of supplying data is unnecessarily burdensome on providers and while the progressive introduction of electronic information and communication systems will reduce these burdens, the lack of coherence in system management and governance raises the prospect of unnecessary duplication.

## ORGANISATIONAL GOVERNANCE

While the current Bill does not deal specifically with governance at the local level, we would note here that in ensuring that good governance flows from the system and sector at large to the institutions within it, best practice standards need to apply.

First, the desire to achieve a patient-centric system relies on seamlessness between the various subsectors of the health sector and in particular, between primary and acute services. As we have noted above, poor or inadequate information flows across these

boundaries result in errors and unnecessary duplication. For reasons of patient service, efficiency and safety, seamlessness, or integrated patient care is the new international standard. The current reforms seek to strengthen accountabilities for service delivery and local responsiveness but in their current form will make more difficult the achievement of this one over-riding policy objective. The scope of the proposed boards will be confined within existing care setting boundaries (that is, acute care and primary care).

It is possible to construct other integrating mechanisms. For example the careful construction of performance indicators and accountabilities for cross boundary results can seek to overcome this structural divide. We note that in the Marmot Review in the UK it was recommended that local boards be held accountable not only for the normal volume and access targets, but also for health outcomes in the local area and the level of health inequities within those outcomes. It is our view, however, that a structural solution is clearer.

Second, the establishment of the local boards by state governments, coupled with funding by the Commonwealth, mean that those boards will effectively have two masters and two sets of accountabilities. Further these are to be married to the Commonwealth's desire for them to be accountable to their local communities. Ensuring that these accountabilities and related reporting requirements are clear, streamlined and effective will require significant cooperation between the three levels in the initial design stages, but will also require considerable ongoing work, particularly at the local level. It is easy to imagine that in these circumstances the energy available to focus on the patient and local population will be dramatically eroded.

Third, the composition of governance vehicles also needs to accord with best practice. The management of health service and planning and regulatory bodies should reflect the skills required to undertake the roles and functions assigned to them. Industry-specific knowledge is a well-recognised board input, as are financial, commercial, legal and human resource skills. But they should not come with real or potential conflicts of inertest. Again other sectors have addressed these issues and lessons can be learned about the different ways that necessary input to sound decision-making can be achieved.

We support the current work being undertaken by the Australian Institute of Company Directors (AICD) in relation to these governance issues. We also note that there may be other solutions, such as the citizen's juries proposed by the Centre for Policy

Development, ( Centre for Policy Development, 2010) which may achieve the desired outcomes. More discussion about the various structural forms is necessary.

## CONCLUSION

The BCA supports the permanent establishment of the Australian Commission on Safety and Quality in Healthcare as part of a serious attempt to address long-standing issues about patient safety in Australian healthcare. It could ultimately become part of the independent regulatory body that oversees the health sector market and assures consumers, taxpayers and investors alike about the quality and integrity of all providers and ensures the availability of accurate and timely information to underpin their decision-making.

However we also recommend that this been seen as a first step in a larger process of reform of system management and governance that will facilitate the improvements and innovation necessary to address the current challenges facing the sector. By learning from successes in other sectors that have undergone similarly radical transformations to those envisaged for health, we can accelerate that process. This involves reconceptualising the governance system, separating it from (the essential) accountability mechanisms associated with public funding and/or provision and re-orienting it to a market oversight function that provides adequate information and protection for consumers and investors, including taxpayers.

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