CHAPTER 7

QUALITY IMPROVEMENT PROGRAMS

7.1 This chapter discusses the inquiry's terms of reference relating to the effectiveness of quality improvement programs to reduce the frequency of adverse events. While the terms of reference specifically focus on programs for quality improvement much of the evidence received by the Committee discussed quality improvement in general terms. This chapter focuses on these broader issues as the evidence indicated that a discussion of quality improvement cannot be solely restricted to its impact in addressing adverse events given the impact of these programs on other quality of care issues.

7.2 It was highlighted during the inquiry that the community has a right to expect that the quality of care in public hospitals meets the highest standards. While most treatments carry some risk, the hospital system should be organised to minimise those risks and the extent of any injury which might result from an adverse event. A concern for safe, high quality care should permeate the whole public hospital system.[1] While evidence to the Committee indicated that the quality of public hospital services in Australia is of a generally high standard it was emphasised during the inquiry that in several critical areas safety and quality could be enhanced.[2]

7.3 Several Australian studies in the 1990s have focussed on the issue of quality and safety in health care. The 1995 Quality in Australian Health Care Study focussed particular attention on safety issues by suggesting that a higher than expected number of hospital admissions were associated with adverse events. Following the release of the findings of the study, the Taskforce on Quality in Australian Health Care was established in June 1995 to consider the data and report to Australian Health Ministers on measures to reduce the incidence and impact of adverse events in the health care system. The Taskforce reported to Health Ministers in June 1996. In March 1997, the National Expert Advisory Group on Safety and Quality in Australian Health Care was established to provide practical advice to Health Ministers on further steps to improve safety and quality of health care services. The National Expert Group presented its Interim Report to Health Ministers in July 1998 and its Final Report in August 1999.[3]

Definition of quality improvement

7.4 The subject of quality in health care has been described as 'bedevilled with definitional confusion and ambiguities'.[4] Terms such as 'quality', 'quality

---

1 Taskforce on Quality in Australian Health Care, *Final Report*, June 1996.

2 *Committee Hansard*, 21.3.00, p.334 (Dr O'Connor); *Committee Hansard*, 21.3.00, p.369 (RACP).

3 For further details see DHAC, *The Quality of Australian Health Care: Current Issues and Future Directions*, Occasional Paper, Health Financing Series, Volume 6, 2000, pp.3-4.

4 Submission No.6, p.3 (Dr Wilson).

improvement' or 'quality assurance' are often difficult to precisely define and are often used interchangeably. During the inquiry, a number of terms were referred to when describing quality of care issues including 'quality improvement', 'quality management' and 'quality assurance'. 'Quality improvement' in the context of hospitals has been defined as the end result of effective quality management and can be measured in relation to the degree to which practices in hospitals result in the production of known or assumed maximum health status improvement for patients. Quality improvement has three components – identifying problems within hospitals, for the most part identifying system defects; resolving those problems; and measuring the resultant improvement.[5]

7.5 'Quality management' has been described as an umbrella term that includes a wide range of hospital activity designed to produce a 'quality mature' hospital. Quality management includes such activity as quality assurance, risk management, credentialling of medical staff, incident reporting and analysis, adverse events monitoring, quality assessment and quality improvement. A 'quality management program' is defined as an organised, coherent, range of activities that will enable the hospital and its medical staff to improve the quality of care provided.[6] 'Quality assurance' has been described as the process of ensuring that clinical care conforms to criteria or standards and is a subset of quality management.[7] Generally the term 'quality improvement' is used throughout this chapter as it relates directly to the terms of reference and is the term most commonly used in submissions and other evidence to the inquiry.

Nature and extent of adverse events

7.6 There is little data on adverse events in Australia. The 1994 the Quality in Australian Health Care Study (QAHCS) was commissioned by the then Commonwealth Department of Human Services and Health to determine the proportion of admissions associated with an adverse event (AE) in Australian hospitals.[8] This was the first published study in Australia that attempted to identify quality of care problems in Australian hospitals.

7.7 There is no nationally or internationally agreed definition of what constitutes an adverse event. In the Australian context, the Quality in Australian Health Care Study defined an adverse event as 'an unintended injury or complication which results in disability, death or prolongation of hospital stay, and is caused by health care management rather than the patient's disease'.[9]

---

5 Submission No.6, p.4 (Dr Wilson).

6 Submission No.6, pp.3-4 (Dr Wilson).

7 Wilson, L and Goldschmidt, P, *Quality Management in Health Care*, Sydney, McGraw-Hill, 1995, p.xli.

8 Wilson, R *et al*, 'The Quality in Australian Health Care Study', *Medical Journal of Australia*, Vol.163, 6 November 1995, pp.458-71(referred to as QAHCS). The study reviewed the medical records of over 14 000 admissions to 28 hospitals in NSW and South Australia in 1992.

9 QAHCS, p.461.

7.8 The QAHCS study found that 16.6 per cent of hospital admissions were associated with an adverse event and 51 per cent of the adverse events were considered preventable.[10] While in 77.1 per cent of cases the disability had resolved within 12 months, in 13.7 per cent the disability was permanent and in 4.9 per cent the patient died. For the two categories of 'death' and 'greater than 50 per cent permanent disability', the proportion of high preventability were 70 per cent and 58 per cent respectively. There was a statistically significant relationship between disability and preventability, with high preventability being associated with greater disability.[11] The proportion of admissions associated with permanent disability or death due to adverse events increased with age; however temporary disability and preventability were not associated with age or other patient variables.

7.9 A significantly lower proportion of the adverse events were reported for obstetrics (7.2 per cent) and ear, nose and throat surgery (7.9 per cent) than for other specialities, while a higher proportion were associated with digestive (23.2 per cent), musculoskeletal (21.9 per cent) and circulatory (20.2 per cent) disorders.

7.10 The study found that extrapolating the data on the proportion of admissions and the additional bed-days associated with adverse events to all hospitals in Australia in 1992 indicated that about 470 000 admissions and 3.3 million bed days were attributable to AEs.[12] The study also found that the number of patients dying or incurring permanent disability each year in Australian hospitals as a result of AEs was estimated to be – 18 000 deaths, 17 000 cases with permanent disability, 50 000 cases resulting in temporary disability and 280 000 cases of temporary disability.[13]

7.11 A Victorian study recorded an adverse event rate of 5 per cent of separations using inpatient data from all public and private acute care hospitals in that State in 1994-95. Most (81 per cent) were complications after surgery or other procedures; 19 per cent were adverse drug effects; and 1.7 per cent were misadventures.[14] The study has, however, been criticised on the basis of the less rigorous definitions it employed than the Quality in Australian Health Care Study.[15]

7.12 The cost to the Australian health care system of adverse events in hospitals has been estimated at $867 million per year. Over a five year period this would amount to $4.3 billion. This estimate does not include any subsequent hospital admissions and out-of-hospital health care expenses, loss of productivity of the patients involved, and the long term community costs of permanent disability from

---

10 QAHCS, p.459.

11 QAHCS, p.465.

12 QAHCS, p.459.

13 QAHCS, p.465.

14 O'Hara, D and Carson, N, 'Reporting of adverse events in hospitals in Victoria, 1994-1995', *Medical Journal of Australia*, Vol.166, 5 May 1997, p.460.

15 Wilson, R and Harrison, B, 'Are we committed to improving the safety of health care?', *Medical Journal of Australia*, Vol.166, 5 May 1997, p.452.

AEs.[16] The National Expert Advisory Group estimated that the extrapolated potential savings from preventable AEs in 1995-96 would be $4.17 billion.[17]

7.13 Regarding overseas comparisons of AEs, the Australian study found that when expressed as a rate of adverse events per admission, the rate of hospital admissions associated with an adverse events was 13 per cent compared to the rate of 3.7 per cent in the Harvard Medical Practice Study in the United States on which the Australian study was modelled. The study noted that the considerably higher rate recorded in the Australian study may have been due to the fact that the US study was concerned with medical negligence and malpractice, whereas the Australian study focussed on prevention – which may produce different incentives for the reporting of AEs. In addition, while both studies surveyed medical records – the US study in 1984 and the Australian study in 1992 – the quality of the medical records may have improved in the intervening years. These factors suggest that the US study could have underestimated the AE rate.[18]

7.14 The Committee considers that the extent of adverse events highlighted in these various studies are disturbing. The implications in terms of preventable adverse outcomes and the use of health care resources are substantial, especially as the Quality in Australian Health Care study suggests that in up to half of all adverse events practical strategies may be available to prevent them.

Current approaches to quality improvement

7.15 The main quality improvement standard in the Australian health care sector is the Australian Council on Healthcare Standards (ACHS) accreditation and quality improvement program. The Council supports health care organisations in their implementation of quality improvement; develops and reviews quality standards and guidelines in consultation with the industry, professional bodies and consumers; benchmarks clinical care through the collection, analysis and dissemination of clinical indicators; and advises on health care quality improvement.

7.16 ACHS' quality improvement program – the Evaluation and Quality Improvement Program (EQuIP) – is a continuous quality improvement program that provides a framework for establishing and maintaining quality care. EQuIP requires an integrated organisational approach to quality improvement by assisting health care organisations to improve overall performance; develop strong leadership; and focus on a culture of continuous quality improvement with an emphasis on patients and outcomes.[19]

---

16 Taskforce on Quality in Australian Health Care, *Final Report,* Appendix 7.

17 National Expert Advisory Group on Safety and Quality in Australian Health Care, *Interim Report,* July 1998.

18 QAHCS, p.470.

19 http://www.achs.org.au/open/abou01.htm

7.17 ACHS conducts surveys of hospitals and awards accreditation on the basis of the demonstrated ability of a hospital to demonstrate significant and continuous improvement. Participation in the accreditation process is voluntary and larger hospitals are more likely to seek accreditation.[20] As the table shows, in 1995-96, 40 per cent of public hospitals were accredited, representing 69 per cent of accredited public hospital beds. In 1997-98, 47 per cent of public hospitals were accredited, representing 75 per cent of beds in public hospitals.[21]

Table 7.1: Accreditation of public acute care hospitals [(a)] and average available beds, 1995-96

Public Hospitals	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Accredited hospitals	100	55	25	26	38	3	2	–	249
Non-accredited hospitals	73	60	119	61	37	12	–	5	367
Total hospitals	173	115	144	87	75	15	2	5	616
Proportion hospitals accredited	58%	48%	17%	30%	51%	20%	100%	–	40%
'Accredited' beds	13,861	9,410	4,401	3,432	3,098	1,061	769	–	36,032
'Non-accredited' beds	4,300	2,787	5,567	1,439	1,653	174	–	570	16,489
Total beds	18,161	12,197	9,968	4,870	4,751	1,235	769	570	52,521
Proportion beds 'accredited'	76%	77%	44%	70%	65%	86%	100%	–	69%

(a) All acute care hospitals are included in this table whether or not accreditation was sought. Hospitals are included in this table for performance indicator purposes and for some jurisdictions excludes multipurpose facilities, mothers and babies facilities and dental hospitals.

Source: AIHW, *Australia's Health 1998,* Canberra 1998, p.210.

7.18 There are a number of other accreditation systems involved in the health care sector including those related to community health, mental health, aged residential care, and general practice. In addition, a number of other professional accreditation systems exist through specialists' colleges, health professional organisations and the post graduate medical council.[22]

20 AIHW, *Australia's Health 1998*, Canberra, 1998, p.210; Submission No.16, p.17 (QNU); Submission No.63, p.40 (AHA, WHA, AAPTC).

21 AIHW, *Australia's Health 2000*, Canberra, 2000, pp.325-26.

22 Submission No.63, p.41 (AHA, WHA & AAPTC).

7.19 At the Commonwealth level there are a range of activities and initiatives to promote safety and quality of health care, which attempt to promote a national focus and an integrated approach to quality and safety. The Department of Health and Aged Care (DHAC) stated that 'although the Commonwealth does not have responsibility for the day to day running of public hospitals, [there]… are examples of where the Commonwealth is currently working with other stakeholders to support quality and safety improvement'.[23]

7.20 These initiatives are detailed below:

- Australian Council for Safety and Quality in Health Care – the Council was established in January 2000 to act as a national partnership between governments, health care providers and consumers to improve the safety and quality of care. The Council will initiate research and identify strategies to improve the quality and safety of health services and strengthen the link between existing quality improvement programs.[24]
- National Institute of Clinical Studies – the Institute, which is yet to be established, will work with the medical profession to identify, develop and promote best clinical practice across a range of clinical settings, and encourage behavioural change by the medical profession.[25]
- Consumer Focus Collaboration – this organisation was established in April 1997 and is a national body consisting of representatives from consumer organisations, professional associations, State and Territory health departments and the Commonwealth. Its aim is to strengthen the focus on consumers in health service planning, delivery, monitoring and evaluation. The goals of the organisation is to facilitate the provision of information to consumers; to facilitate active consumer involvement in health service planning, monitoring and evaluation; improve health service accountability and responsiveness to consumers; and promote education and training that supports active consumer involvement in health service planning and delivery.[26]
- National Resource Centre for Consumer Participation in Health – the Centre became fully operational in May 2000. Its aim is to assist service providers, such as hospitals, to improve their strategies for involving consumers in developing their services and practices. It has two functions, namely as a clearinghouse for information about methods and models of community and consumer feedback and participation; and in the longer term as a centre of excellence in consumer

23 Submission No.38, p.47 (DHAC).

24 ACSQHC, Terms of Reference.

25 http://www.health.gov.au/hsdd/nhpq/quality/natsafet.htm

26 http://www.health.gov.au/hsdd/nhpq/consumer/concolab.htm

participation where clients can seek assistance to develop, implement and evaluate feedback and participation methods and models.[27]

- Clinical Support Systems Project – the Royal Australasian College of Physicians (RACP) is undertaking a consultancy for DHAC to focus on the measurement and improvement of clinical care through the implementation of clinical support systems. The College is working with innovative and leading clinicians and hospitals to explore whether combining the use of evidence with a systematic approach to clinical practice results in more effective and efficient health care with a view to improving patient outcomes.[28]

- National Demonstration Hospitals Program – NDHP is a Commonwealth funded program designed to identify and disseminate information about best practice models for innovation in acute hospital care. The effectiveness and transferability of these innovations are evaluated through demonstration projects conducted in a range of hospitals. Phases 1 and 2 focussed on innovation in internal processes in hospitals to improve patient care and resource management. Projects in Phase 3 are reaching beyond the immediate acute care sector and are focussing on identifying and developing systems and processes that link and coordinate all services delivered by the acute and related areas of the health sector. [29]

7.21 Further information on these projects is provided in discussion in this chapter on measures to improve quality and safety in hospitals.

7.22 In addition to these initiatives, under the current Australian Health Care Agreements (AHCAs) approximately $660 million is allocated to the States and Territories to fund and support quality improvement and enhancement practices in hospitals. This requires Ministers to agree, on a bilateral basis, to a strategic plan for quality improvement during the term of the Agreement. Progress under each plan will be reviewed during the 2000-01 financial year.[30]

7.23 For example, in Queensland a quality improvement program is being implemented by funding provided under the AHCAs. Under the program over the period from 1999-2004 major activities to be undertaken include requiring all services funded or provided by Queensland Health to have in place quality and continuous improvement systems; ensuring that all services participate in an endorsed accreditation program; implementing systems to assess risk, including the monitoring of adverse incidents and monitoring and evaluating quality performance criteria. The program also aims to provide relevant information to consumers, which allows them to make informed decisions regarding their own health and to measure patient

27 http://nrccph.latrobe.edu.au

28 http://www.health.gov.au/hsdd/nhpq/quality/3quality.htm

29 Submission No.38, pp. 26-27, 53-55 (DHAC). See also DHAC, *The Quality of Australian Health Care*, Occasional Paper, pp.21-2, 43-61; www.health.gov.au/healthonline

30 Submission No.38, p.7 (DHAC); DHAC, Occasional Paper, p.46.

satisfaction and patient experience of health services particularly with respect to outcomes.[31]

7.24 The Committee notes that there is no means of knowing if the quality enhancement funds provided by the Commonwealth are being spent effectively by the States. Under Clause 23 of Schedule E of the AHCAs, each State and Territory has agreed to provide the Commonwealth the following reports within five months of the end of each grant year:

- a statement to acquit the amount of funds provided in the relevant grant year as Health Care Grants under the terms of the Agreements; and
- a certification that the Health Care Grant funding received in the relevant grant year was expended on the provision of public hospital services.

7.25 Under Clause 24 of Schedule E, each State and Territory has agreed that the reports referred to in clause 23 of Schedule E will be in the form agreed with the Commonwealth from time to time. This acquittal form includes separate identification of components of Health Care Grants paid to each State and Territory, including for quality improvements and enhancement.

7.26 However, DHAC cannot provide details of how each State/Territory has spent its quality improvement and enhancement funds in the 1998-99 financial year because they are not required to allocate the quality funding against specific projects or to reconcile this funding at the end of each financial year. It is therefore not possible to determine whether the $660 million provided to the States is being used to drive quality improvements. Unless better financial accountability mechanisms are put in place the ad hoc and unsystematic approach to quality improvements in the Australian health care system will continue.

7.27 A range of activities are also undertaken at the State and Territory levels towards supporting safety and quality in health care. In NSW the *Framework for Managing the Quality of Health Services in NSW Health* was developed in 1998 to provide a comprehensive approach to assessing the performance of Area Health Services in NSW. The Framework which is currently being implemented on a State wide basis identifies a number of dimensions of quality relevant to patients and health providers, in the areas of 'safety', 'effectiveness', 'appropriateness', 'consumer participation', 'efficiency' and 'access'.[32]

7.28 In South Australia, the Department of Human Services has engaged the Australian Patient Safety Foundation (APSF) to provide service infrastructure and monitoring software for a comprehensive package to measure risk and the incidence of adverse events and provide for analysis of these factors. The APSF system has been

---

31 Submission No.41, pp.36-37 (Queensland Government); Additional Information, 10.12.99 (Queensland Government).

32 Submission No.79, p.23 (NSW Government).

trialed and is being introduced across the State.[33] In Tasmania the State Government indicated that it is developing a comprehensive quality plan to address adverse events and other quality issues.[34]

7.29 Evidence to the Committee suggested that current quality improvement programs need to be improved to reduce the frequency of adverse events. The Royal Australasian College of Physicians (RACP), Health Issues Centre (HIC) & the Australian Consumers' Association (ACA), reflecting much of the evidence stated that:

> While there have been extensive efforts at Commonwealth, State and hospital level in relation to quality improvement in hospitals, much of the effort remains unsystematic and ad hoc.[35]

7.30 The Consumers' Health Forum (CHF) also noted that 'effective quality improvement programs are essential to reduce preventable injury and death in hospitals. These programs are currently very ad hoc and "process", rather than "outcome" oriented.[36]

7.31 Dr Lionel Wilson of Qual-Med put the view starkly when he stated that:

> …few if any such programs exist and those that do are largely ineffective…Unfortunately, quality management programs barely exist in most hospitals although sporadic efforts exist to implement a range of quality management projects. It is this absence of program activity that accounts for the fact that current activities are quite ineffective in reducing the frequency of adverse events, or indeed, a wide range of additional quality of care issues.[37]

7.32 Dr Wilson stated that the overall results of this situation are that 'no patient in Australia can be guaranteed high quality of care in any of our hospitals and there are no worthwhile initiatives to reduce or even identify adverse events in most hospitals resulting in high levels of avoidable mortality and morbidity'.[38]

Improving quality and safety in public hospitals

7.33 During the inquiry a number of areas were highlighted where improvements to safety and quality of care in public hospitals could be made. These issues are

---

33 Submission No.60, p.30 (SA Government).

34 Submission No.67, p.10 (Tasmanian Government).

35 Submission No.45, p.30 (RACP, HIC & ACA). See also Submission No.53, p.5 (Professor Duggan); Submission No.32, p.2 (Dr Masters).

36 Submission No.72, p.33 (CHF). See also *Committee Hansard*, 20.11.00, pp.787-59 (Professor Richardson).

37 Submission No.6, p.1 (Dr Wilson).

38 Submission No.6, p.1 (Dr Wilson).

discussed below and include a discussion of the role of the Australian Council for Safety and Quality in Health Care; the need for improvements in data collection on adverse events, the need for pilot projects to find solutions to system failures, the role of financial incentives, improved accreditation processes, improved education and training for health professionals; encouraging best clinical practice; promoting greater consumer participation; and the development of performance indicators.

Australian Council for Safety and Quality in Health Care

7.34 At the August 1999 meeting of Australian Health Ministers' Conference all health ministers agreed to establish the Australian Council for Safety and Quality in Health Care (ACSQHC) to address the need for a national coordination mechanism to improve Australia's health care system and to support action at the local level.[39]

7.35 The National Expert Advisory Group on Safety and Quality in Australian Health Care (the Expert Group) recommended in 1999 that the Council be established to improve safety and quality in health care through:

- providing national leadership and coordination of health care safety and quality activities;
- developing an overall coherent plan for improving the quality of health care services;
- facilitating action by dissemination of information about quality activities and their outcomes through appropriate agencies and organisations;
- promoting a systematic approach to safety and quality within the health care system and within the community at large; and
- providing advice to Ministers and the public about the safety and quality of the Australian health care system.[40]

7.36 The Council's subsequent terms of reference reflect the recommendations of the Expert Group. The Council's stated role is to lead national efforts to promote systemic improvements in the safety and quality of health care in Australia with a particular focus on minimising the likelihood and effects of errors. The aims of the Council are to:

- provide advice to Health Ministers on a national strategy and priority areas for safety and quality improvement;
- develop, support, facilitate and evaluate national actions in agreed priority areas;

---

39 Submission No.38, p.47 (DHAC).

40 National Expert Advisory Group on Safety and Quality in Australian Health Care, *Implementing Safety and Quality Enhancement in Health Care*, Final Report, July 1999, (referred to as the Expert Group report), p.22.

- negotiate with the Commonwealth, States and Territories, the private and non-government sectors for funding to support action in agreed priority areas;
- widely disseminate information on the activities of the Council including reporting to Health Ministers and the public at agreed intervals.

In undertaking these tasks, the Council will:

- work collaboratively with stakeholders, in particular building on the existing efforts of health care professionals and consumers to improve the safety and quality of health care;
- establish partnerships with existing related national bodies and organisations, in particular the National Institute of Clinical Studies (NICS) and the National Health Information Management Advisory Committee (NHIMAC) to facilitate action in agreed priority areas;
- consider and act to improve health care in the priority areas identified as a result of national consultations undertaken by the National Expert Advisory Group on Safety and Quality in Health Care including:
    - methods to enable increased consumer participation in health care;
    - implementation of evidence-based practice;
    - agree a national framework for adverse event monitoring, management and prevention including incident monitoring and complaints;
    - effective reporting and measurement of performance, including research and development of clinical and administrative information systems;
    - strengthening the effectiveness of organisational accreditation mechanisms;
    - facilitate smoother transitions for consumers across health service boundaries; and
    - education and training to support safety and quality improvement; and
- co-opt members with specific expertise, and establish sub-committees and reference groups as required.[41]

7.37 The Council comprises 23 members including experts in the areas of health care quality and safety; education, training and research; and consumer members. Its membership reflects the view of the Expert Group that the Council members be appointed from a range of stakeholders including Commonwealth and State representatives, members of learned Colleges and professional associations, hospitals and consumer representatives.[42] The Commonwealth and the States were asked to

41 ACSQHC, Terms of Reference.

42 Expert Group report, p.20.

nominate members for the Council with the Commonwealth negotiating with the States on the final list of nominees. All Health Ministers agreed on the list of nominees for the Council. Mr Bruce Barraclough, currently President of the Royal Australasian College of Surgeons and Vice Chair of the Committee of Presidents of Medical Colleges was appointed Chair of the Council on 21 January 2000. The Council will receive $5 million in core funding over five years from all governments.[43]

7.38 The Council has identified a number of key priority areas that need to be addressed. These priority areas are to:

- develop a national reporting system for errors that result in serious injury and death of patients;
- address medication errors across the system, including investigating IT support for health professionals;
- provide support for consumer incident reporting and feedback – what goes wrong and what goes right;
- establish mechanisms to review causes of preventable deaths and the interventions that would improve practice;
- establish programs to educate health professionals across the spectrum – undergraduate and postgraduate – about safe practice, quality improvement and communication;
- investigate workforce issues such as skill mix, supervision and workplace constraints across all professional groups;
- examine methods of auditing practice to provide feedback to clinicians about their performance against best practice standards;
- examine a system to track implanted medical devices;
- look at the issue of credentialling and licensing of health professionals with a view to development of national standards; and
- provide support for a national/international conference on safety and quality in health care.[44]

7.39 It is envisaged that the Council will initiate a detailed plan of action on these priority areas by June 2001.[45] The Council has identified three priority areas in which it will focus its efforts in the first instance. These are improvements in data collection and reporting mechanisms; more effective ways to support the safe practices of health

43 Minister for Health and Aged Care, *Media Release*, 21 January 2000, p.1.

44 ACSQHC, *Press Release*, 18 February 2000.

45 Health and Aged Care Portfolio, *Portfolio Budget Statements 2000-01*, p.243.

care professionals; and re-design of systems to strengthen a culture of 'safety improvement' within health care organisations.[46]

Role of the Council

7.40 Evidence to the Committee indicated that there was general support for the establishment of the Council.[47] The Committee of Presidents of Medical Colleges (CPMC) stated that with the establishment of the Council 'we have every hope that we will now get quality, particularly in dealing with adverse events higher on the agenda, and that we will get some effective ways of dealing with that'.[48] The Australian Medical Association (AMA) noted that, in supporting the Council, 'individual doctors and hospitals are putting in an enormous amount of effort to improve quality, yet it needs a national focus that the Council can give'.[49]

7.41 The Centre for Health Program Evaluation (CHPE) stated that an important role of a permanent quality assurance group 'would be the determination of core measurement and performance indicators for each sector and specialisation, and the determination of the validity of these instruments. This suggests the desirability of a capacity to monitor work in other countries and to run pilot studies in Australia'.[50] The Expert Group envisaged that the Council would support a number of pilot programs aimed at establishing national standards and evaluation tools.[51] The nature and extent of pilot programs undertaken by the Council have yet to be considered by Health Ministers.

7.42 Professor Jeff Richardson, Director of the Health Economics Unit, also stated that the Council should be put under 'very close scrutiny' that they are implementing examples from around the world in regard to best practice medicine.[52] Professor Guy Maddern representing the South Australian Salaried Medical Officers Association (SASMOA) expressed the view that while the Council may initiate action at the Commonwealth level there is a concern that initiatives will 'not get down to the state level where in fact most or all of the public hospital dollars are spent'.[53]

7.43 Dr Wilson also added a note of caution in relation to the Council questioning its composition the breadth of its expertise. He noted that, while acknowledging the need for such a national monitoring body on quality issues:

---

46 Australian Council for Safety and Quality in Health Care, *Safety First: Report to the Australian Health Ministers' Conference*, July 2000, p.6.

47 Submission No.45, p.31 (RACP, HIC, ACA); Submission No.72, p.34 (CHF); Submission No.47, p.38 (AMA).

48 *Committee Hansard*, 23.3.00, p.491 (CPMC).

49 Submission No.47, p.38 (AMA).

50 Submission No.46, p.23 (CHPE).

51 Expert Group report, p.23.

52 *Committee Hansard*, 23.3.00, p.601 (Professor Richardson).

53 *Committee Hansard*, 23.2.00, p.197 (SASMOA).

> Unfortunately, what has been established is a reflection what I call the Australian disease: it's full of state representatives, and in some case, their role would be to see that nothing changes the status quo in that state. What is more, apart from some exceptions–notable exceptions–there is a minimum of expertise on that council because they have been chosen for other reasons, and this is a complex area and there is little expertise in this country...What is required of a council like that is not something that addresses the political difficulties between the federal government and the states…but one which applies a good deal of expertise to the problem...I have some hesitation as to whether that council will be terribly effective.[54]

7.44 With regard to composition of the Council, of its 23 members, nine are representatives of Commonwealth and/or State and Territory health departments. This indicates that of the total Council membership some 40 per cent are Commonwealth or State representatives. The Committee shares the concerns expressed by Dr Wilson that this may be an overly large representation of government officials, a representation that would need to be matched by a strong commitment of those representatives to establish an effective partnership between the Commonwealth, the States and other key stakeholders to advance safety and quality issues in Australia.

7.45 As to the perceived lack of expertise on the Council the Committee notes the concerns expressed. The Committee notes, however, that the Council has a number of noted professionals and other experts in the area of quality and safety. The Committee does, however, consider that the composition of the Council and the range of expertise represented should be kept under review.

7.46 The Council's lack of formal links with the health system is also of concern to the Committee. Under the current structure the Council lacks the ability to make sure its strategies are implemented across the health care system. The Council can produce reports and strategies and make recommendations to the Health Ministers but it has no mechanism to directly drive cultural change and institutional reforms.

7.47 The Expert Group considered that the Council and its performance should be reviewed prior to the conclusion its first four year term.[55] The Government determined that the term of the Council would be five years but did not put a formal review process in place. The Committee believes that the Council should be reviewed after two years of operation, and that this review should consider, among other things any change in the structure and composition of the Council and the degree to which its aims and objectives are being met.

7.48 Some evidence suggested that there should be a statutory body established to oversee quality issues. The Australian Healthcare Association (AHA) argued that the most effective way to deal with these issues would be to have an independent statutory

---

54 *Committee Hansard*, 21.3.00, pp.312-13 (Dr Wilson).

55 Expert Group report, p.21.

body at least to oversee the implementation of the Expert Group's report.[56] AHA also suggested that while there are a number of organisations that are involved in various aspects relating to quality 'none of them…have the independence, freshness or breadth in their current brief to be able to do that'.[57] The Committee sees merit in this proposal and believes that a statutory authority should be established to oversee the quality programs.

7.49 The Committee has some concerns at the level of resources devoted to the Council. As noted above, Health Ministers have agreed to funding of $1 million per year over five years ($5 million in total) for operating costs. The Task Force argued that funding of $17.4 million ($4.35 million per year over four years from 1999-00) should be provided, which would allow for a number of targeted research, development and dissemination activities suggested by the Expert Group (as outlined above).[58] The Council advised that Health Ministers would consider additional resources for the Council at their meeting in July 2000.[59] At their meeting, Health Ministers agreed, in principle, to provide $50 million over five years for the Council to lead a 'national program of work to improve the safety and quality of care'.[60] The Health Ministers agreed to provide $5 million for a one year work program and the Council will provide a report to Ministers on progress. Both of these commitments were in line with the recommendations of the Council in its first report to Health Ministers.[61] Further commitment of funds by Health Ministers to the Council will be dependent on the progress and results of this one year program of work.

Conclusion

7.50 The Committee believes that new quality funding arrangements that include financial incentives and penalties linked to agreed national quality targets are required. To be effective the new funding arrangement would need to be supported by an institutional body or authority with the capacity to monitor and report on the achievements of quality and safety outcomes of different health systems. Under the current system there is no body that oversees quality and drives the required reforms.

7.51 Quality improvements are currently limited to pilot projects and consequently there is no overall requirement for the system to commit to quality improvements. Quality improvements will remain an 'optional extra' in our health system until new funding arrangements are developed and implemented that require specific quality measures to be built into the entire system.

---

56 *Committee Hansard,* 11.11.99, p.111 (AHA).

57 *Committee Hansard,* 11.11.99, p.111 (AHA).

58 Expert Group report, p.23.

59 ACSQHC, *Press Release,* 18 February 2000.

60 Australian Health Ministers' Conference, '$50 million plan to improve safety and quality in health care', *Media Release,* 31 July 2000.

61 Australian Council for Safety and Quality in Health Care, *Safety First,* p.1.

7.52 The Committee believes that the Australian Council for Safety and Quality in Health Care has the potential to place quality improvement high on the national health agenda and to provide the essential national leadership and coordination of safety and quality activities. However, under the current funding arrangements State and Territory health systems are not obliged to adopt the Council's agenda. The Council's work needs to be supported by an independent statutory body that sets quality improvement targets and reports on their implementation across the different systems. An independent statutory body would overcome the ad hoc and unsystematic approach that has characterised quality reforms in Australia. Funding for quality programs needs to be made more accountable, especially the funds provided through the AHCAs.

7.53 The Committee considers that the Council should pursue a vigorous and pro-active program of reform aimed at improving the quality of health care across the nation and that this program of reform should be adequately resourced. In this regard, the Committee notes the recent decision of Health Ministers to provide $5 million to the Council for a one year program of work. The Committee notes, however, that this is only a fraction of the funding needed, especially considering that the Taskforce on Quality in Australian Health Care sought $166.3 million over five years when it reported in 1996. It is also only a fraction of the total cost to the health care system of adverse events which has been estimated at $867 million per year. The Committee is concerned that the Council will require increased funding to enable it to fulfil its functions. The Committee also notes the very long time taken for the Government to address the quality agenda. The Taskforce reported in 1996 but the Council was not established until January 2000.

Recommendation 25: That a national statutory authority be established with responsibility for improving the quality of Australia's health system. This authority would be given the task of:

- **collecting and publishing data on the performance of health providers in meeting agreed targets for quality improvements across the entire health system;**
- **initiating pilot projects in selected hospitals to investigate the problem of system failures in hospitals. These projects would have a high level of clinician involvement; and**
- **investigating the feasibility of introducing a range of financial incentives throughout the public hospital system to encourage the implementation of quality improvement programs.**

Recommendation 26: That the mechanism for distributing Commonwealth funds for quality improvement and enhancement through the Australian Health Care Agreements be reformed to ensure that these funds are allocated to quality improvement and enhancement projects and not simply absorbed into hospital budgets.

Recommendation 27: That the Commonwealth Government undertake a review of the structure, operations and performance of the Australian Council for Safety and Quality in Health Care after two years of operation.

Recommendation 28: That Commonwealth and State and Territory Health Ministers ensure that the Australian Council for Safety and Quality in Health Care receives sufficient funding to enable it to fulfil its functions.

Collection of data on adverse events

7.54 Submissions emphasised the need for common systems for the collection of information about adverse events and incidents in Australia. The Australian Health Insurance Association (AHIA) argued that all hospitals should be required to report incidents to a central incident reporting system.[62]

7.55 Infections and medication errors are the two areas that have been identified as the major contributors to adverse events in several Australian and international reports.[63] Figure 7.1 in this chapter indicates that data on 'hospital acquired infection rates' are not yet completed and there is no mention in the chart of data relating to medication errors.

7.56 In the United States in February this year the US President, Bill Clinton, announced reforms to begin to reduce medication errors:

> I'm calling on the Food and Drug Administration to develop standards to help prevent medical errors caused by drugs that sound similar or packaging that looks similar. In addition, we'll develop new label standards that highlight common drug interactions and dosage errors.
>
> Hospitals that have already taken these steps have eliminated two out of three medication errors. This is very significant. We tend to think all our problems are the result of some complex, high tech glitch. We just want to make sure people can read the prescriptions – two out of three of these errors can be eliminated.[64]

7.57 The United States report *To Err is Human: Building a Safer Health System* recommended:

> a nationwide mandatory reporting system should be established that provides for the collection of standardised information by state governments about adverse events that result in death or serious harm. Reporting should

62 Submission No.55, p.29 (AHIA).

63 Australian Council for Safety and Quality in Health Care, *Safety First*, pp.1-9; The National Academies Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington D.C., National Academy Press, 2000.

64 U.S. President Bill Clinton, Office of the Press Secretary, The White House, 22 February 2000.

> initially be required of hospitals and eventually be required of other institutional and ambulatory care delivery settings.[65]

7.58 A comprehensive system of data collection on adverse events enables the health system to identify and learn from errors:

> Reporting is vital to holding health care systems accountable for delivering quality care, and educating the public about the safety of their health care system. It is critical to uncovering weaknesses, targeting widespread problems, analysing what works and what doesn't, and sharing it with others.[66]

7.59 The Committee highlights the urgency for the infection and medication error framework indicators to be completed noting that they are necessary to inform the development of national strategies to address these quality issues. The Committee believes that there should be mandatory reporting of both medication errors and hospital acquired infection rates and that these data should be made public.

7.60 There are a number of systems and methods in place at present to collect information about incidents and adverse events. These include the systematic audits of registers of death and selected complications associated with particular procedures or treatments and the Australian Incident Monitoring System (AIMS). AIMS is an incident reporting system operated by the Australian Patient Safety Foundation. It is a voluntary reporting system largely restricted to hospitals in South Australia and the Northern Territory. Data on adverse events are also collected by the Australian Council on Healthcare Standards as part of their surveys of facilities for accreditation purposes.[67] Evidence to the Committee indicated that these ad hoc attempts at data collection could be improved by implementing a system aimed at collecting comprehensive and consistent data across all hospitals nationally.[68]

7.61 The Expert Group argued that systems need to be put in place to support the efficient collection of incidents and adverse events – 'these systems need to be simple, usable, robust and must not add significant administrative burdens to those involved in their use'.[69]

7.62 Several submissions called for the establishment of a nationally consistent adverse incident reporting scheme.[70] The Expert Group also argued that there was a need for State and Territory Governments, health care organisations and other

---

65 The National Academies Institute of Medicine, *To Err is Human*, Executive Summary, p.9.

66 US President Bill Clinton, Office of the Press Secretary, The White House, 22 February 2000.

67 Expert Group report, p.11.

68 Submission No.41, p.36 (Queensland Government).

69 Expert Group report, p.11.

70 Submission No.63, p.42 (AHA, WHA, AAPTC); Submission No.55, p.29 (AHIA); Submission No.72, p.34 (CHF).

agencies involved in collecting data on incidents, adverse events and complaints to agree on common systems for efficient collection and reporting data on adverse events, with the capacity for national analysis of safety and quality trends.[71]

7.63 The Committee notes that the Australian Council for Safety and Quality in Health Care has set as one of its priorities the development of a national reporting system for errors that result in serious injury and death of patients in the health care system.[72] The Committee strongly supports the adoption of a uniform national approach to this problem as both necessary and long overdue.

7.64 The Committee believes that the national statutory authority could play an important role in overcoming the current ad hoc approach and in establishing a national system of data collection and reporting.

Recommendation 29: That a mandatory reporting system, especially for hospital acquired infection rates and medication errors, be developed as a matter of urgency.

Pilot projects

7.65 Submissions identified the need for pilot studies with system wide application to find solutions to the system failures which have been identified in the various studies of adverse events both in Australia and overseas.[73] In most studies of hospital systems, some form of system failure, for example, the absence of, or failure to use policy, protocol or plan; inadequate reporting; or inadequate training or supervision of staff is usually judged to be a contributing factor in up to 90 per cent of cases of adverse events.[74]

7.66 Dr Wilson noted that most quality problems in hospitals are not about individuals making mistakes but are due to system failures. He added:

> This is what happens when things do wrong in hospitals. The person in charge of theatre was not there that day; someone else was there who did not know the routine. The theatre team was new. The surgeon was not well or had been up all night. A whole series of events go wrong. It is not just about an individual misbehaving or behaving badly, or very rarely it is. It is mainly a system failure.[75]

7.67 Dr Wilson further stated that:

---

71 Expert Group report, p.12.

72 ACSQHC, *Press Release*, 18 February 2000.

73 Submission No.40, p.6 (CPMC).

74 QAHCS, p.471.

75 *Committee Hansard*, 21.3.00, pp.318-19 (Dr Wilson). See also Submission No.32, p.2 (Dr Masters).

> Implementing effective quality management that ensures real quality improvement, needs to be done slowly in a small number of facilities with carefully managed and monitored pilot projects. Such projects will require resources and will need to be evaluated to ensure that they are producing value for money.[76]

7.68 CPMC noted that clinician involvement in identifying and implementing solutions is crucial in any reduction in the frequency of adverse events.[77] The Committee notes that the Medical Colleges have indicated to the Department of Health and Aged Care that they are 'willing to take a leadership role in these activities'.[78]

7.69 The Committee believes that the problem of system failures in hospitals needs to be addressed and that pilot projects to investigate this problem should be undertaken by the new statutory authority. The Committee also believes that the connection between system failure in hospitals and cultural change needs to be addressed. The Australian Council for Safety and Quality in Health Care stated that there is a need for creating 'changes in the culture in which health professionals work from one of "judgement and blame" to one of "learning for quality improvement"'.[79] This cultural change will require more than just pilot projects, it will require national leadership to implement findings on a national scale.

Recommendation 30: That the new statutory authority to oversee quality programs initiate pilot projects in selected hospitals to investigate the problem of system failures in hospitals and that these projects have a high level of clinician involvement (see Recommendation 25).

Recommendation 31: That the issue of cultural change within the hospital system be addressed, particularly the capacity for improvements in information technology to drive change through greater transparency and the adoption of consistent protocols.

Financial incentives

7.70 Evidence suggested that there is a serious lack of financial incentives throughout the health system that will promote quality of care. CHPE stated that:

> The key issue is the lack of any reward under current payment arrangements for the achievement of high quality care…The full potential of financial levers is not explicitly recognised. In principle, a system committed to

76 Submission No.6, p.9 (Dr Wilson).

77 Submission No.40, p.6 (CPMC).

78 Submission No.40, p.6 (CPMC).

79 Australian Council for Safety and Quality in Health Care, *Safety First*, p.3.

> quality improvement would embody incentives to achieve this objective at all levels.[80]

7.71 Professor Richardson commented that 'when you change incentives and financial incentives you will actually change behaviour. That behaviour change, usually with a time lag, is followed by some sort of institutional change…there are any number of studies now from any number of countries – primarily, the United States – which illustrate that financial incentives do have a major effect'.[81]

7.72 Dr Wilson stated that:

> There are no drivers at all for quality management in health care. It is continually assumed that, if you have well-trained people, that is enough. It is important, but it is not nearly enough, not in today's world. So that is the next thing: drivers. And they probably have to be financial drivers because they are the most potent.[82]

7.73 A number of options were suggested to address the issue of the lack of financial incentives. In the area of private health insurance, AHIA suggested that the default payment should be linked with quality criteria, that is, hospitals should not automatically be entitled to benefits without meeting some degree of quality assurance, such as the implementation of a recognised quality improvement program.[83] The Australian Private Hospitals Association (APHA) argued that hospitals offering quality services should be rewarded by insurers through financial incentives, in the form of higher benefits.[84]

7.74 CHPE suggested that one option would be to reduce default payments (preferably to zero) for non-participating hospitals. The health insurance funds should be permitted to base their selection of preferred providers on explicit performance indicators of quality and be permitted to publicise what and why they have selected particular providers.[85]

7.75 With regard to public hospitals, Dr Wilson argued that financial drivers need to be applied to hospital boards and management, who should have prime responsibility for quality management and improvement programs. As noted above, he argued that at present there are no incentives for a hospital managers to undertake the steps necessary for 'quality management'. 'Quality management', as discussed previously, is a general term used to describe a range of hospital activity which aims

---

80 Submission No.46, pp.22-24 (CHPE). See also Submission No.53, p.5 (Professor Duggan).

81 *Committee Hansard*, 20.11.00, p.783 (Professor Richardson). See also *Committee Hansard*, 20.11.00, p.795 (Dr Braithwaite).

82 *Committee Hansard*, 21.03.00, p.311 (Dr Wilson).

83 Submission No.55, p.29 (AHIA).

84 Submission No.18, p.9 (APHA).

85 Submission No.46, p.24 (CHPE).

to produce a quality mature hospital. It includes activities such as risk management, quality assurance and credentialling of medical staff. Dr Wilson stated that the introduction of financial incentives available to hospital managers who implement a stated range of quality management activities that are verifiable within a certain timeframe, combined with a financial sanction for failing to achieve designated goals, would substantially improve quality and safety in hospitals.[86]

7.76 CHPE also suggested that the use of 'normative DRGs' and other penalties/rewards should be explored. With these, the cost weight per DRG would have a deterrent or reward loading which could reflect under or over used procedures; origin of the patient in an over or under serviced geographic location; the receipt of services from an accredited hospital; and some other quality related activity such as discharge planning and follow-up service.[87]

7.77 In relation to doctors, CHPE argued that accreditation may be linked to a differential fee. This could be extended so that a loading was added to fees when doctors indicated their compliance with broad evidence based guidelines. The extent of their commitment could, potentially, be monitored using routine administrative data.[88]

7.78 The Committee believes that the new statutory body should explore the use of financial levers to encourage improved quality of care in the hospital setting.

Recommendation 32: That the new statutory authority overseeing quality programs investigate the feasibility of introducing a range of financial incentives throughout the public hospital system to encourage the implementation of quality improvement programs (see Recommendation 25).

Accreditation processes

7.79 A number of submissions argued that there should be improved linkages and coordination between the range of current accreditation and quality improvement approaches, in order to minimise duplication and confusion for health service organisations regarding expected standards of care. In the joint submission of the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA) and the Australian Association of Paediatric Teaching Centres (AAPTC) it was noted that in addition to the Australian Council on Healthcare Standards there are now a number of other accreditation systems involved in the health care sector including those related to community health and aged residential care. A number of other professional accreditation systems also exist through specialists' colleges and health professional organisations.[89]

---

86 Submission No.6, pp.8-9 (Dr Wilson).

87 Submission No.46, p.24 (CHPE). See also *Committee Hansard,* 20.11.00, p.785 (Professor Richardson).

88 Submission No.46, p.24 (CHPE).

89 Submission No.63, pp.40-41 (AHA, WHA, AAPTC).

7.80 The Queensland Nurses' Union (QNU) raised the issue of how these separate processes interrelate and whether there is a need for an 'overarching framework' that will facilitate the involvement of all key stakeholders in activities relating to continuous improvement in health – 'we believe that better integration is required to facilitate consistency of approach with respect to these matters'.[90] The Australian College of Health Service Executives (ACHSE) expressed a similar view.[91]

7.81 ACHSE argued for the establishment of an accreditation authority for all health services. The authority would need to be independent of the funding authority and ensure that there was effective stakeholder and consumer involvement.[92] AHA, however, arguing against the creation of a national accreditation body stated that:

> I think accreditation is part of the overall process of managing risk and improving quality. I do not think it is the total answer to quality and safety so I do not necessarily think a national accrediting body could take responsibility for quality. However, I think an authority that has responsibility for safety and quality could certainly have a look at the plethora of accrediting bodies that are in place at the present time.[93]

7.82 AHA, WHA & AAPTC argued that the Commonwealth and State Governments should collaborate in the establishment of a national accreditation process for all types of health care facilities.[94]

7.83 Submissions also noted that accreditation currently focuses on quality control 'processes', that is, it has a strong input focus. The Australian Nursing Federation (ANF) argued that to strengthen its capacity to bring about significant reductions in the frequency of adverse events, accreditation criteria 'must be comprehensively linked to the achievement of desired health outcomes'.[95] AHA also stated that accreditation systems should move beyond the inputs, processes and simple indicators of the quality of products to an approach that is multidisciplinary in its focus to better reflect the nature of contemporary, best practice care delivery systems.[96]

7.84 Some submissions also argued that there was a need for more consistent national standards to underpin quality improvement and accreditation approaches. Professor Don Hindle of the School of Health Services Management at the University of NSW advocated the 'adoption of national standards for quality of care and outcome measurement'.[97] AHA, WHA & AAPTC stated that the proliferation of different

---

90 Submission No.16, p.18 (QNU).

91 Submission No.62, p.5 (ACHSE).

92 Submission No.62, p.5 (ACHSE).

93 *Committee Hansard*, 11.11.99, p.111 (AHA).

94 Submission No.63, p.41 (AHA, WHA, AAPTC).

95 Submission No.39, p.8 (ANF).

96 Submission No.63, p.41 (AHA).

97 Submission No.22, p.5 (Professor Hindle).

standards for the same type of facilities, and of different ways of measuring the same features in multiple settings is a major concern of the Associations.[98] The Expert Group noted that a first step should be to facilitate discussion and debate about the underlying quality standards that should be key elements of all quality improvement approaches.[99]

Recommendation 33: That the Australian Council for Safety and Quality in Health Care review the current accreditation systems currently in place with a view to recommending measures to reduce duplication in the accreditation processes.

Education and training in quality improvement

7.85 Submissions argued that the education and training available for health professionals and administrators at all levels in quality improvement needed to be improved. ACHSE argued that:

> greater emphasis and investment in education and training in the philosophy and techniques of quality and safety are required for managers and all health professionals. This will enable improved approaches to be established effectively and new accountabilities to be met.[100]

7.86 The Australian Association of Surgeons (AAS) argued that while formal quality improvement programs may decrease the frequency of adverse events educational activities are usually more cost effective.[101] The Doctors Reform Society (DRS) also argued that quality improvement programs should be an integral part of the on-going education of all medical practitioners.[102]

7.87 The Expert Group considered that there would be benefits from the development of core quality management aspects to be incorporated in all educational training provided to all health professionals, whether they are being trained for clinical or administrative roles. The Group also argued that there needs to be a national effort to improve the education and training of health providers in safety and quality matters and agreement on the curricula for continuous quality improvement for inclusion in all undergraduate, postgraduate and continuing education and training.[103]

7.88 The Committee notes that the Australian Council for Safety and Quality in Health Care has identified as a priority area the establishment of undergraduate and postgraduate programs to educate health professionals about safe practice and quality

98 Submission No.63, p.41 (AHA, WHA, AAPTC).

99 Expert Group report, p.14.

100 Submission No.62, p.4 (ACHSE).

101 Submission No.86, p.4 (AAS).

102 Submission No.20, p.19 (DRS). See also Submission No.60, p.30 (SA Government).

103 Expert Group report, p.17.

improvement.[104] The Committee supports this initiative noting the concerns expressed in evidence about the need for improvements in the education and training of health professionals in the areas of safety and quality.

Encouraging best clinical practice

7.89 Evidence to the inquiry called for the uptake of evidence-based health care and the further development and implementation of best practice guidelines.[105] 'Evidence-based health care' is an approach to health care based on a systematic review of scientific data. 'Best practice' in the health sector refers to the highest standards of performance in delivering safe, high quality care, as determined on the basis of available evidence and by comparison among health care providers.[106]

7.90 The National Health and Medical Research Council (NHMRC) stated that there has been an increasing move towards developing clinical best practice guidelines.[107] 'Clinical practice guidelines' are systematically developed statements to assist providers and users of health services to make decisions about appropriate health care for specific circumstances. The purpose of best practice guidelines is to improve the quality of health care, to reduce the use of unnecessary, ineffective services or harmful interventions and to ensure that care is cost effective. The NHMRC has been primarily responsible for the development and implementation of clinical practice guidelines to assist health care providers implement research into practice. There is also an increasing trend for other expert bodies and the learned Colleges and professional associations to develop clinical practice guidelines for endorsement by the NHMRC. Most States have also invested in clinical effectiveness units to promote evidence-based healthcare and to link research with local practice.[108]

7.91 NHMRC noted that with the development of evidence-based medicine, guidelines are becoming one of the critical links between the best available evidence and good clinical practice.[109] The guidelines are intended to be a distillation of current evidence and opinion on best practice. Clinical practice guidelines are sometimes referred to as clinical pathways, protocols and practice policies, although these differ from clinical practice guidelines in that they are often much more prescriptive and not always based on evidence.[110]

---

104 ACSQHC, *Press Release*, 18.2.00.

105 Submission No.45, p.31 (RACP, HIC, ACA); *Committee Hansard*, 21.3.00, pp.336-37 (Professor Hindle).

106 Expert Group report, p.47.

107 NHMRC, *A guide to the development, implementation and evaluation of clinical practice guidelines*, 1999, p.9.

108 Expert Group report, p.7; Rubin, G *et al*, 'Getting new evidence into medicine', *Medical Journal of Australia*, Vol.172, 21 February 2000, p.182.

109 NHMRC report, p.9.

110 NHMRC report, p.9.

7.92 Quality assurance and quality improvement activities have a complementary and reciprocal relationship with clinical practice guidelines. Quality assurance activities encourage the implementation of guidelines, and guidelines are a crucial component of quality assurance activities. Continuous clinical practice improvement aims to improve the quality of care by bringing together research on variation of cost, access, quality and standardised care. It requires a knowledge of processes and systems, human behaviour and an approach to continuous learning.[111]

7.93 During the inquiry witnesses discussed aspects of these approaches. For instance, RACP supported the development and implementation of clinical practice guidelines and evidence-based medicine. RACP stated that it is currently undertaking the Commonwealth-funded Clinical Support Systems Project (CSSP), an initiative which focuses on the measurement and improvement of clinical care through the implementation of clinical support systems. Such systems include clinical practice guidelines, clinical pathways, consumer pathways and information technology for clinical decision support and measurement of health outcomes. It is an approach that links clinical practice improvement directly to medical evidence and aims to improve the efficiency and quality of health care provision.[112]

7.94 Professor Hindle advocated the clinical pathways approach. A clinical pathway is a document which describes the usual way of providing multidisciplinary clinical care for a particular type of patient, and allows for annotation of deviations from the norm for the purpose of continuous evaluation and improvement. He agued that good clinical teams in Australia and overseas are increasingly using clinical pathways.[113] He argued that:

> Good clinicians want to work in teams. They want to specify how they will work together…so it is sensible to write down the protocol for what they will normally do. They are making these changes around Australia as we speak because they recognise that it will help them allocate their scarce resources–they won't waste resources on that patient when they are better spent on another of their patients. They will improve quality of care and outcomes by avoiding duplication of care or missing out on care and so on.[114]

7.95 Professor Hindle argued that evidence from around the world shows that clinical pathways improve quality of care and reduce costs because the team works better, thus avoiding omission, duplication and other errors. He suggested that the main barriers to the use of clinical pathways are that some clinicians are reluctant to

---

111 NHMRC report, p.39.

112 Submission No.45, pp.31-32 (RACP, HIC, ACA). See also *Committee Hansard*, 21.3.00, pp.378,380 (RACP).

113 Submission No.22, Additional Information, 12.4.00, pp.36, 40 (Professor Hindle).

114 *Committee Hansard*, 21.3.00, pp.336-7 (Professor Hindle).

work in a team, or are concerned to avoid anyone else being aware of, and consequently in a position to criticise, their clinical practice.[115]

7.96 The Expert Group argued that existing efforts to promote evidence-based practice through such groups as the learned Colleges and NHMRC should continue to be supported by all jurisdictions, Colleges and other relevant groups, and that this work should form part of an overall national action plan for safety and quality enhancement. The Expert Group considered that the focus on evidence-based care should also be underpinned by a commitment to continuous quality improvement in clinical practice. The Group also argued that national action should continue to be taken to research, develop and encourage implementation of evidence-based practice, including use of clinical practice guidelines and quality improvement tools that reduce unexplained variation and improve aspects of quality across the continuum of care.[116]

7.97 Some evidence indicated that the development of clinical practice guidelines by the Colleges has been relatively slow. Professor Richardson indicated that while a number of the Colleges are investigating evidence based medicine the pace of reform is 'leisurely' in relation to the importance of the issue.[117] The Menadue report into the NSW health system also commented on the slow development of clinical practice guidelines by most of the Colleges, with some notable exceptions.[118] The Committee is concerned at this development and encourages the learned Colleges to further facilitate the development of clinical practice guidelines.

7.98 NHMRC also stated that there needs to be greater attention given to implementation and evaluation of guidelines once they have been developed. NHMRC noted that many of those involved in producing guidelines have become frustrated by the lack of implementation. Further, health care professionals' acceptance of clinical practice guidelines has to some extent been marred by concern that the guidelines represent 'cookbook' medicine.[119] One study suggested that there were marked variations in the uptake of evidence-based methods among different practitioners in different fields of medicine – the fields that have a higher reliance on technology, such as neonatology, appear to adopt evidence-based practice styles more readily.[120]

---

115 Submission No.22, Additional Information, 12.4.00, pp.36,40 (Professor Hindle).

116 Expert Group report, p.8.

117 Submission No. 46, Additional Information, 15.3.00 (CHPE). See also *Committee Hansard*, 20.11.00, p.784 (Professor Richardson).

118 NSW Health Council, *A Better Health System for NSW*, (Chairman: Mr John Menadue), March 2000, p.69.

119 NHMRC report, p.12.

120 Rubin, G *et al*, 'Getting new evidence into medicine', *Medical Journal of Australia*, Vol.172, 21 February 2000, p.182. See also Phillips, P *et al*, 'Evidence for evidence-based medicine at the coalface', *Medical Journal of Australia*, Vol.172, 20 March 2000, pp.259-260.

7.99 The Committee notes the proposed establishment of the National Institute of Clinical Studies. As noted previously, the role of the Institute is to promote best clinical practice throughout the public and private health sectors and encourage behavioural change by the medical profession. The Committee notes that the Institute was due to begin operations in January 2000.[121] The Committee is disappointed at the delay in the establishment of the Institute given its potential importance in promoting best clinical practice.

7.100 The Committee notes that several witnesses stressed the importance of the Institute in addressing the issue of best practice medicine. Professor Donald Cameron representing the RACP stated that the Institute will be 'looking at outcomes – clinically significant outcomes, not the sort of thing that has happened in the past like some satisfaction surveys which usually ask if the doctor was polite and nice and so on'.[122] Professor Peter Phelan representing the CPMC stated that the Institute would assist in promoting best clinical practice:

> There are considerable variations in medical interventions across the community…they occur because there is not good evidence on which these interventions are based, so doctors use their own experience. We have not been able to provide them with information to allow them to make more informed judgements. I think the initiative to establish a national institute of clinical studies may well start to provide that sort of information to doctors which can make them more informed.[123]

7.101 The Committee supports the further development and implementation of evidence-based medicine and of clinical practice guidelines. The Committee believes that a firm commitment to evidence-based medicine will promote best practice and improve the quality of health care.

Recommendation 34: That initiatives by the National Health and Medical Research Council, the Colleges and other relevant groups to encourage the development and implementation of evidence-based practice, including the use of clinical practice guidelines, be supported.

Consumer participation in quality improvement

7.102 Evidence to the Committee from consumer organisations highlighted the need to improve consumer participation in the development of quality improvement programs and the health system generally. Mr McCallum representing the Consumers' Health Forum of Australia (CHF) stated that there was a need to:

> …strengthen individual consumers and communities to think more about the care they need, to make better choices about the care they access and to

121 Submission No.38, p.48 (DHAC).

122 *Committee Hansard*, 21.3.00, p.381 (Professor Cameron).

123 *Committee Hansard*, 23.3.00, p.500 (Professor Phelan).

> become partners with the health system. It worries me that we will craft solutions that will not involve the consumers and communities who might have solutions for us in this.[124]

7.103 The CHF outlined a number of requirements that they see as essential to any quality improvement program to reduce adverse events. CHF argued that consumers should:

- have access to their own medical records – 'medical records are still one of the most important sources of information for consumers trying to make sense of an adverse event';
- have access to effective information to help consumers understand their treatment options;
- have access to effective complaints mechanisms;
- be informed when a mistake has been made or an accident occurred as a result of the failure of the system, or of a medical practitioner; and
- participate in all levels of the health system.[125]

7.104 RACP, HIC & ACA also argued that to promote a high quality public hospital system there needs to be investment in better systems to promote 'consumer-oriented care'. This includes attention to best practice, clinical practice supports and protocols, the measurement and analysis of variations in practice and health outcomes measures.[126]

7.105 The Expert Group argued that national action should continue to be taken to research, develop and disseminate methods to enable better consumer participation in health care service delivery, planning, monitoring and evaluation at all levels, including strategies to improve the quality and accessibility of consumer health information.[127]

7.106 DHAC stated that the Commonwealth is working with consumer organisations, health service providers and State/Territory Governments to increase consumer participation in the planning, delivery and evaluation of health care. As noted previously, the Consumer Focus Collaboration aims to improve the accountability and responsiveness of the health care system to consumers.[128] The

---

124 *Committee Hansard*, 20.11.00, p.765 (CHF).

125 Submission No.72, p.34 (CHF).

126 Submission No.45, p.14 (RACP, HIC, ACA). See also Submission No.7, p.4-5 (Health Consumers' Council WA).

127 Expert Group report, p.7. See also Submission No.26, p.4 (Medical Consumers Association of NSW); Submission No.4, p.2 (Hunter Urban Network for Consumers of Healthcare).

128 Submission No.38, p.54 (DHAC).

Collaboration is overseeing some 14 projects funded through the Commonwealth. These projects include:

- Consumer and Provider Partnerships in Health project – the aim of the project is to document the most effective approaches available for teaching and learning the skills needed for effective communication between health care consumers and providers. The consultant undertaking the project will analyse the issue of education and training in health care to promote active consumer involvement in health system planning delivery and monitoring and evaluation.
- Project to support nurses to involve consumers in their own health care – the ANF and the Royal College of Nursing Australia have been funded for a project to develop strategies to support nurses in involving consumers in health care planning and delivery. A similar project involving the AMA and the CPMC is undertaking a project to work with medical practitioners to support their efforts to involve consumers in their health care.
- Structural and Cultural Marginalisation in Health Care project – the aim of the project is to identify ways that health services have involved or sought feedback from groups of consumers who have been excluded from existing processes due to structural or cultural barriers.
- Toolkit for consumer participation – the aim of the project is to provide a practical toolkit of approaches and strategies to assist service providers and consumers to achieve effective consumer participation in the planning, delivery and monitoring of health services.[129]

7.107 Many of these projects are close to finalisation but there is only one published report available to date on these projects. The results of individual projects are to be made available to the National Resource Centre for Consumer Participation. As noted previously, the Commonwealth has funded the National Resource Centre for three years. It is being established to assist health service providers to improve their strategies for involving consumers in the development of services and will act as a clearinghouse for information on methods and models of community participation in health care.[130]

7.108 At the State level, in NSW the Menadue report argued that action was needed in that State to improve consumer involvement in decisions about health care. The report argued that there needed to be increased consumer access to information. The report recommended that NSW Health establish a 24-hour Health Call Centre with full coverage across the State; and that a health care Internet site be established to provide

129 http://nrccph.latrobe.edu.au/aboutus.htm

130 Submission No.38, p.54 (DHAC).

information which supports the advice available through the Health Call Centre. The NSW Government subsequently accepted these recommendations.[131]

7.109 The Menadue report also called for expanded opportunities for local communities to participate in decisions about the type and location of health services. The report proposed that formal structures for ongoing community participation be established in each Area Health Service. In addition, the report argued that there should be greater involvement of consumer representatives in identifying health priorities at the State level through the establishment of a State-wide Consumer and Community Representative Forum to provide advice on planning, policy development and resource allocation at the State level.[132] The NSW Government announced that it will establish a Statewide consumer forum to provide input to decision-making on policy and resource allocation. [133]

Report cards

7.110 Some submissions argued that 'report cards' on hospitals and medical practitioners should be published so consumers can make informed choices concerning their treatment options. The Health Consumers' Council WA argued that hospital report cards 'would ensure greater knowledge of and confidence in our public hospital system. Data should be collected and analysed to support the report card concept'.[134] CHF also argued that consumers need more information on risks, benefits and options for treatment from their health care providers as a basis for decision making. CHF stated that reliable, independent information from sources other than the medical professional administering the treatment is also needed.[135]

7.111 The medical profession generally opposed the publication of league tables or report cards arguing that they are not reliable indicators of performance or best practice.[136] AMA argued that there are considerable difficulties in interpreting data based on report cards:

> …the more competent, senior experienced surgeons are likely to see the more difficult end of the spectrum and, amongst them, their death rates may be higher because, for instance, they may be operating, especially in a tertiary hospital, on patients that a surgeon at a peripheral hospital would not touch. That is really the problem about report cards on both hospitals and individual doctors.[137]

---

131 NSW Government, *Working as a Team – the Way Forward*, p.4.

132 Menadue report, pp.73-76.

133 NSW Government, *Working as a Team – the Way Forward*, p.4.

134 Submission No.7, p.4 (Health Consumers' Council WA).

135 Submission No.72, pp.29-30 (CHF).

136 Submission No.47, p.39 (AMA); Submission No.27, pp.4-7 (AMA -Victoria).

137 *Committee Hansard*, 11.11.99, p.94 (AMA).

7.112 AMA (Victoria) argued that current data collections and risk adjustment tools are poorly developed and inadequate for the publication of comparative performance indicators for hospitals and individual medical practitioners.[138]

7.113 The Committee questioned the AMA concerning the current situation where a GP refers patients to a specialist about which the patient as a consumer probably has little knowledge as to his or her medical competence and therefore is not in a good position to make an informed judgement concerning the surgeon. Dr Sandra Hacker, former Vice President of the AMA conceded that the current situation is 'not particularly' satisfactory.[139] Dr David Brand, former President of the AMA, added that 'I would agree that the public has a right to know, but it has a right to know about information where it can compare – if you are going to compare apples with apples you have got to be comparing apples with apples. That is something that is very difficult to do'.[140]

7.114 The Committee believes that consumers should have access to information on the relative performance of hospitals and the performance of individual providers so that they can make informed choices about their treatment options. The Committee is not convinced by the arguments advanced by the medical profession that because data are supposedly inadequate for the dissemination of reliable comparative performance indicators for hospitals and medical practitioners it therefore should not be made available. The Committee believes that this is more an argument for improving upon the current data than for not providing such information to consumers.

Conclusion

7.115 The Committee believes that there needs to be greater consumer involvement in the health system generally, including the provision of health information to consumers and consumer participation in health care service delivery and planning. The Committee commends the initiatives at the Commonwealth and State level to encourage consumer participation in the health system. The Committee further believes that measures that encourage consumer involvement in the health area need to be encouraged and expanded.

Recommendation 35: That strategies be developed to improve the provision of health information to consumers, improve the accountability of the health system to consumers by the release of information and comparable data and increase consumer involvement in the health system, including consumer participation in the development of quality improvement programs.

138 Submission No.27, p.7 (AMA -Victoria).

139 *Committee Hansard,* 11.11.99, p.95 (AMA).

140 *Committee Hansard,* 11.11.99, p.95 (AMA).

Performance measurement

7.116 Submissions argued that there needs to be greater priority given to the development of performance indicators and health outcome measures.[141] CHPE stated that:

> There is a need for the establishment of national performance indicators for public hospitals and associated services, including inpatient, outpatient and emergency department services. These performance indicators could be used for comparative purposes across institutions relating to efficiency, clinical outcomes and quality.[142]

7.117 DHAC indicated that data about quality of care and health outcomes are piecemeal at present – 'different parts of the hospital systems collect a great range of data…However the data is often haphazardly collected and there is little analysis of anything but information relating to financial requirements. The use of data to improve performance in the clinical area is at a very low level while data for system-wide analysis is unreliable and poorly articulated and collected'.[143]

7.118 The Expert Group argued that rigorous and reliable indicators for the measurement of safety and quality performance are required at all levels of the health system and that joint funding and support for national research and development of performance information and indicators for health care quality are critical to continued efforts in this area. The Expert Group argued for the development of a national framework for performance management and reporting for all health services.[144]

National health sector performance measures

7.119 In 1994 the National Health Ministers' Benchmarking Working Group was established to coordinate and report on the development of national health sector performance indicators and benchmarks. In August 1999 the Australian Health Ministers established the National Health Performance Committee (replacing the National Health Ministers' Benchmarking Working Group). The Committee, which has similar objectives to the previous Committee, aims to develop and maintain a national performance measurement framework for the health system, to support benchmarking for health system improvement and to provide information on national health system performance.

7.120 The new Committee will have a broader focus covering the whole of the health sector, including community health, general practice and public health. The membership of the Committee includes representation from each State and Territory

---

141 Submission No.45, p.14 (RACP, HIC, ACA); Submission No.63, p.42 (AHA, WHA, AAPTC).

142 Submission No.46, p.21 (CHPE).

143 Submission No.38, p.45 (DHAC).

144 Expert Group report, p.13.

and the Commonwealth together with representatives from other national bodies such as the NHMRC and the Australian Institute of Health and Welfare (AIHW).[145]

7.121 A number of other groups are working in the area of performance measurement and related activities. These include the Australian Council on Healthcare Standards, Australian Institute of Health and Welfare, individual health authorities, universities and other government authorities.

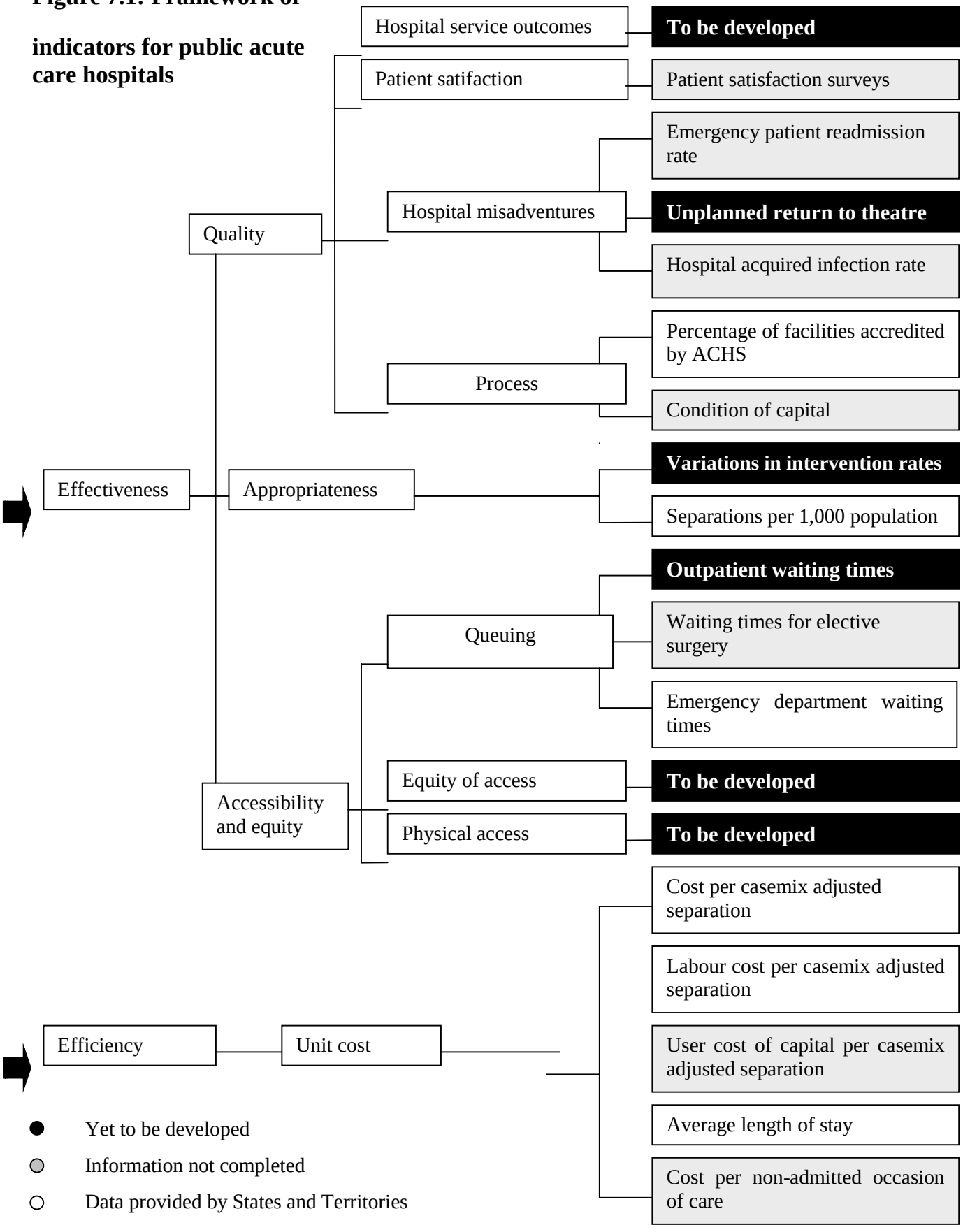
7.122 The terms 'performance indicators' and 'benchmarking' are often used interchangeably even though they deal with different but related concepts. A 'performance indicator' is a measure that quantifies the level of performance for a particular aspect of health service provision and allows comparison between service providers, modes of service provision or both. 'Benchmarking' can be defined as the continuous process of measuring products, services and practices against the best available in the relevant area. The process examines attributes of performance (indicators) in comparing individual units or organisations against standards (benchmarks) that are considered attainable and desirable. The process by which data are collected and collated can be defined as the process of performance measurement. The Benchmarking Working Group has essentially focussed on the development of performance indicators and the process of performance measurement. [146]

7.123 The Working Group's 1999 report provides details of a framework of performance indicators for public hospitals with an emphasis on those indicators of most relevance in gaining a 'holistic' view of the performance of the public hospital sector.

145 Submission No.38, p.44 (DHAC).

146 National Health Ministers' Benchmarking Working Group, *Third National Report on Health Sector Performance Indicators*, June 1999, pp.6, 72.

Figure 7.1: Framework of indicators for public acute care hospitals



Source: National Health Ministers' Benchmarking Working Group, *Third National Report on Health Sector Performance Indicators*, June 1999, p.7.

7.124 As indicated in the table while some performance indicators are provided by the States and Territories a significant number of indicators have yet to be developed or the information is incomplete. The report notes that comprehensive data that can fully investigate the two dimensions of 'effectiveness' and 'efficiency' are 'not yet available. Available data for reporting against the indicators…are, therefore, limited to a subset of the framework'.[147]

7.125 The Queensland Nurses Union (QNU), referring to the above table, stated that while the data give some indicators for public acute care hospitals they are far from complete:

> …when you look at the indicators you see that they state that hospital service outcomes are to be developed. Under quality outcomes and hospital misadventures, you see there is no development of anything for unplanned return to theatre. We are not assessing the number of patients who are discharged who need to be returned to theatre. In terms of appropriateness of health care, there is no assessment of variations in intervention rates. …If you look at queuing, there is some work being done on outpatient waiting times but it is not fully developed. If you look at accessibility and equity, you see that equity of access is still to be developed. Physical access is still to be developed. **A heck of a lot of indicators which would tell you whether the system is working are not even developed yet**.[148]

7.126 The Working Group's report noted that several barriers existed in further development of national benchmarking including the complexity of some of the measurement issues; the lack of coordination across jurisdictions; and the time required to establish and implement national data standards. The report argued that 'the establishment and implementation of national data standards, which are imperative for national benchmarking, will continue to be a slow and difficult process'.[149]

7.127 The Committee believes that a much more concerted effort should be made to develop performance indicators in the health sector, especially given that a national working group has been established since 1994 with the specific aim of developing national performance indicators for the health sector. The Committee believes that the slow progress to date in the development of national benchmarking points to the need for the establishment of an independent statutory body to drive reforms in the area of quality improvement. It is clear that the current system is too slow and that a new approach is needed.

---

147 Benchmarking report, p.27. See also National Health Performance Committee, *Fourth National Report on Health Sector Performance Indicators*, July 2000, pp.57-62.

148 *Committee Hansard*, 22.3.00, pp.438-39 (QNU).

149 Benchmarking report, p.66. See also National Health Performance Committee, *Fourth National Report*, p.2.

Performance measures – State level

7.128 In the States a range of activities have been initiated in developing and implementing performance measures. As noted earlier in the chapter, in NSW the Government has developed a performance measurement framework for Area Health Services that encompass indicators such as effectiveness, efficiency, safety and access.[150] The Menadue report also recommended that comparative data for all NSW hospitals, on factors such as admission rates, readmission rates, mortality rates and surgical intervention rates for the major planned surgical procedures, should be included on the NSW Health information website within 12 months.[151] The NSW Government subsequently announced that health data and information on treatments will be included on the NSW Health internet site.[152] In Victoria, the Government will require the Department of Human Services to publish a series of performance indicators by July 2001 to assess quality of care in public hospitals.[153]

Performance measures – AHCAs

7.129 The AHCAs also commits the Commonwealth and States to work together to develop and refine performance indicators and to publish information on performance against the indicators to demonstrate whether overall funding is contributing to better health outcomes. The objective in publishing this information is to enable the Commonwealth and the States to compare performance within the acute health sector in order to stimulate improvement in service performance and health outcomes; improve national and State acute health development; and facilitate best practice service delivery.[154]

7.130 A report on progress towards the development of performance indicators will be included in the first AHCA annual report due to be published in December 2000.[155]

Conclusion

7.131 The Committee believes that there needs to be a coordinated effort by the Commonwealth and States to develop a framework of indicators for the public hospital sector so that a comprehensive set of performance indicators is available across all States for comparative purposes.

7.132 The Committee notes that the National Health Performance Committee is working in this area but that progress has been relatively slow with several key indicators for public acute care hospitals yet to be developed. The Committee also

---

150 Submission No.79, p.23 (NSW Government).

151 Menadue report, p.72.

152 NSW Government, *Working as a Team – the Way Forward*, p.4.

153 Victorian Minister for Health, *Media Release*, 16 May 2000.

154 Submission No.38, pp.41-42 (DHAC).

155 Submission No.38, pp.42, 51 (DHAC).

notes that the States are also developing performance measures and that the implementation of the AHCAs also provides for reporting against a range of the performance indicators developed jointly by the Commonwealth and the States. As noted in this chapter, the first report is yet to be released some 2½ years after the Agreements commenced. The Committee believes that the delay in the release of data on comprehensive performance indicators, as provided for under the AHCAs, is unsatisfactory and their release should be a matter of high priority. The Committee also believes that there needs to be a high degree of co-ordination between the various bodies at the Commonwealth and State level in order to avoid duplication in the collection of data and in the development of performance indicators.

Recommendation 36: That the Commonwealth work with the States and Territories to develop a comprehensive set of national performance indicators in relation to quality issues for the public hospital sector, including the range of performance indicators as provided for under the current AHCAs, and that this information be released publicly as a matter of priority.

Recommendation 37: That the development of a comprehensive set of national performance indicators be the responsibility of the new statutory authority (see Recommendation 25).

Conclusions – strengthening the commitment to quality

7.133 Evidence received by the Committee suggests that while the quality of care in public hospitals is generally of a high standard, more attention needs to be given to quality improvement programs to reduce the frequency of adverse events and improve the overall quality of care.

7.134 Patient safety clearly must be an essential element of health care quality and accorded the highest priority, notwithstanding the fact that all healthcare interventions have some potential for risk. As noted previously, the Quality in Australian Health Care Study showed that 16.6 per cent of hospital admissions in 1992 were associated with an adverse event and that at least half of the adverse events were judged to be preventable. The extent of adverse events identified in this study and others clearly requires a concerted national effort to address safety and quality issues in the hospital setting.

7.135 While there have been numerous efforts at the Commonwealth, State and hospital level in relation to quality improvement in hospitals, evidence to the Committee indicated that much of the effort to date has been largely ad hoc and unsystematic. The Committee believes that a commitment to further quality improvement requires concerted national leadership by the Commonwealth and a firm commitment by the Commonwealth and the States and other key stakeholders to work together to improve the quality of health care services.

7.136 The Committee believes that the recent establishment of the Australian Council for Safety and Quality in Health Care has the potential to provide the necessary national focus on safety and quality issues and to promote a systematic

approach to these issues in the health care system. The Committee believes that the Council must be proactive in pursuing a reform agenda and be adequately resourced to address key areas of concern, and to provide essential national leadership and coordination.

7.137 The Committee has identified a number of key areas for reform. These areas include:

- the establishment of a national statutory authority with responsibility for overseeing the quality programs;
- the establishment of pilot projects to find solution to system failures identified in various studies of adverse events;
- establishment of a system of financial incentives throughout the health system to promote quality of care;
- improved linkages and coordination between the range of current accreditation and quality improvement approaches;
- improved education and training for health professionals and administrators in quality improvement;
- measures to encourage best clinical practice;
- greater consumer participation in quality improvement programs; and
- development of performance indicators and health outcome measures.

7.138 The Committee believes that a systematic and multifaceted approach to safety and quality issues and active national leadership together with the fostering of an effective partnership with State Governments and other key stakeholders will promote an environment where quality and safety issues are paramount, and that patients and the community generally can be assured that the quality of care received in public hospitals meets the highest standards.