Introducing Health System Change Strategies to Policy Makers: Some Australian Experiences

Brian T. Collopy, Director CQM Consultants and Clinical Advisor ACHS Clinical Indicator Program, Australia

ABSTRACT

In a world first, for accreditation programs, Clinical Indicators (clinical performance measures) were introduced into the Australian Council on Healthcare Standards (ACHS) accreditation process 21 years ago. The resulting national clinical database now receives data from over 740 health care organisations (HCOs) on 22 indicator sets, for different medical disciplines, containing almost 400 separate indicators. HCOs receive aggregate and peer comparative feedback and the types of action by HCOs in response to their results include further data reviews, policy/procedure changes, education programs, new appointments and equipment changes. Favourable data trends in patient care are evident and, with some indicators, cost avoidance can be demonstrated. Revision of the indicator sets is an essential task to ensure continued relevance to clinicians. The Federal Government response to a study in which patient care in Australian hospitals was, prematurely, judged to compare poorly with care in the USA (and later the UK) resulted in the establishment of The Australian Commission on Safety and Quality in Health Care which has now embarked upon a separate program of hospital-based outcome indicators, as have other health care providers. Advice is provided from the literature and personal experience on issues of presentation of material to health care policy makers.

Keywords: Accreditation, Clinical Indicators, Government Responses, Monitoring Change, Provider Reactions, Revision

INTRODUCTION: AUSTRALIA’S HEALTH SYSTEM

Australia, a large island continent with a population approaching 23 million, has a publicly funded universal health scheme operated by the Australian government authority, Medicare. It is nominally funded by an income tax surcharge set at 1.5%, which is shortly to move to 2% to cover a national disability support program. Residents are entitled to obtain free treatment in public hospitals and to subsidised treatment from medical practitioners, eligible nurse practitioners, midwives and allied health professionals who have been issued with a Medicare provider number. In addition approximately

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45% of the population currently take out private insurance, which entitles them to see a doctor of their choice and to obtain a bed in a private hospital when needed.

There are approximately 1300 hospitals in the country, of which just over 700 are public. Approximately 60% of procedures however are performed in the private facilities. There are approximately 85,000 beds and there are around 9 million separations from hospital annually, 40% of these being same-day acute cases. The majority of the beds are in larger hospitals in the more densely populated areas, with the largest hospitals having more than 1000 beds. However over 70% of the hospitals have fewer than 50 beds, being widely dispersed across a very large continent. The average length of stay for an “overnight” admission for acute care is 3 days in public hospitals and 2 days in a private facility (Australian Hospital Statistics 2011-12).

**HOSPITAL PERFORMANCE**

**Accreditation and Quality Assessment**

In 1974 a voluntary national hospital accreditation program was introduced, modelled on the US Joint Commission and the Canadian programs, by an organisation widely representative of health care peak bodies and Government, initially titled the Australian Council on Hospital Standards (ACHS), but subsequently called the Australian Council on Healthcare Standards (same acronym) as the program was extended to other health care facilities as well as hospitals. Accreditation can now be obtained through other organisations in this country but the ACHS remains the major organisation involved, and currently over 90% of Australian public and private hospitals are accredited (Australian Hospital Statistics, 2011-12). The acronym HCOs (Health Care Organisations) may be used from hereon as an alternative to hospitals for it encompasses other facilities such as Day Procedure Centres.

In the early 1980s the presence of a quality assurance process within a hospital became a requirement for ACHS accreditation. However at that time the clinicians’ view of the accreditation program was that it did not reflect patient outcomes and its concentration was on administrative processes. It was also evident that in some circumstances a hospital could be fully accredited and yet on-site surveys had failed to identify poor clinical outcomes, as there were no accessible documented measures of clinical care.

The purpose of a hospital is to treat compromised people i.e. patients, not clients. A client can make a decision to purchase or not purchase a service or item depending on price etc., but a compromised person has to “purchase” the service which should, hopefully, correct or reduce their compromised state. Compromised people can, for many disorders, be treated in primary care or in the specialist’s office, but other disorders may require multidisciplinary management in a facility which provides access to complex investigative and treatment pathways. The ACHS accreditation program, as such programs did, was ensuring that the environment, i.e. the processes and management in the facility, were appropriate. However, it had no system in place by which to determine the success, or otherwise, of the management of a compromised person.

**Clinical Indicators**

In 1985 the ACHS commenced discussions with the Medical Colleges, which conducted the majority of postgraduate vocational education, with the aim of having their involvement in the development of clinical performance measures. These were called “Clinical Indicators” (CIs), the term used by the Joint Commission in its “Agenda for Change” and it was a concept not dissimilar to the Maryland Hospital Association program of generic measures introduced in 1987 (Kazandjian et al., 1993).

An initial approach to the Federal Health Department for funding for the project resulted in an offer of a small development grant of $A 25,000. However when the written support of the Committee of Presidents of the Medical
G-NO-TECS: Generic Non-Technical Skills in Healthcare
www.igi-global.com/chapter/g-no-tecs/104071?camid=4v1a