Chapter 1

Quality of health care policies in Australia

This chapter reviews the policies and practices in place to measure and improve the quality and safety of health care in Australia. Overwhelmingly, there appears to be national consensus in making quality and safety a policy priority. This is marked by an improving culture of transparency and a move towards compulsory standards and hospital accreditation. This work needs to be evaluated and refined to ensure that quality improvement evolves from measurement to change management. While much of the attention has been on hospitals, quality in primary health care has received less consideration.

More challenging for Australia is a highly complex health system managed by two levels of government, and a mix of services delivered through the public and private sectors. Adding to the complexity is national inconsistencies in policy and performance measurement, although efforts are being made to improve harmonisation. Clearer government accountability and more explicitly defined roles between central and local authorities will help Australia overcome some of these impediments.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

1.1. Introduction

Achieving high-quality health care is increasingly attracting the attention of OECD countries. Health takes up a significant proportion of governments' budgets. The ageing population and accompanying chronic diseases, as well as technological developments, will likely make health care more expensive. This has prompted a greater focus on the quality and value of health services, and how they can be improved.

Australia has made good progress in embracing quality in its health system reforms. This chapter assesses the key policies and strategies used by Australia to drive improvements in the quality of its health system.

A framework for categorising policies affecting quality is illustrated in Table 1.1. This chapter sets the scene of the Australian health system, and focuses on the legislative framework and governance for quality of care, the quality assurance of health system inputs (such as health care professionals, hospitals and technologies), and policies for monitoring and standardising quality of care. It also considers the extent to which patients are involved in their own care and the policy-making process.

Table 1.1. A typology of health care policies that influence health care quality

Policy	Examples
Health system design	Accountability of actors, allocation of responsibilities, legislation
Health system inputs (professionals, organisations, technologies)	Professional licensing, accreditation of health care organisations, quality assurance of drugs and medical devices
Health system monitoring and standardisation of practice	Measurement of quality of care, national standards and guidelines, national audit studies and reports on performance
Improvement (national programmes, hospital programmes and incentives)	National programmes on quality and safety, pay for performance in hospital care, examples of improvement programmes within institutions

1.2. Design, costs and outcomes in the Australian health care system

A description of the Australian health care system is provided in Box 1.1.

Box 1.1. Overview of the Australian health system

The Australian health system is a complex mix of federal and state government funding and responsibility, interspersed with services delivered through the public and private sectors. Adding to its complexity is the nation's size, and the challenges of meeting the needs of people living in areas of extreme remoteness.

Australia has a universal health system funded through the Medicare scheme. It is mostly financed through taxation and entitles Australians to free care as public patients in public hospitals. It also entitles people to:

- free or subsidised treatment by health professionals such as doctors, specialists, optometrists and in specific circumstances dentists and other allied health practitioners;

- 75% of the Medicare Benefits Schedule (MBS) fee for services and procedures for private patients in a public or private hospital (not including hospital accommodation and items such as theatre fees and medicines); and

- some health care services in certain countries.

While public hospitals are jointly funded by the federal and state and territory governments, they are the responsibility of the states and territories as system managers. The Australian Government plays a role in policy making and monitoring with regards to public hospitals, but does not provide the services.

Primary health care is broadly the domain of the federal government, which pays medical practitioners for primary care services on a fee-for-service basis. Specialists and general practitioners (GPs) can choose to "bulk bill" patients, which means the consultation is fully covered by Medicare. However, many GPs choose not to bulk bill, and their patients face out-of-pocket costs. The states also play a role in primary health care, through the provision of community health services. This can include allied health services, chronic disease management, dental health services, drug and alcohol services and health promotion. Public health activities are shared by federal and state and territory governments.

The existence of two levels of government managing different domains of the health system has at times triggered tension between federal and state authorities over funding, and can cause confusion for patients and poor co-ordination of their care. Primary health organisations known as Primary Health Networks aim to help ease some of this fragmentation of services. Chapter 2 more comprehensively discusses primary health care.

The system's complexity extends to Australia's private hospitals, which are subject to a mix of federal and state regulations. The states are responsible for licensing private hospitals, while much of the federal government's legislation relates to private health insurance. Fund premium rises are approved by the federal health minister.

Private health insurance is voluntary, and can provide faster access to hospital services – such as elective surgery – that generally have longer waiting times in the public system. However, it is possible to be a private patient in a public hospital, and there is no change in waiting time in this instance. About 47% of Australia's population has this duplicate form of health insurance.

Box 1.1. Overview of the Australian health system *(cont.)*

Australian Government policy strongly incentivises people to take out private insurance, even though they have access to free public hospital care. Uninsured higher income earners must pay an extra 1% to 1.5% of their income in the form of a "Medicare Levy Surcharge". This surcharge begins for singles earning more than AUS 90 000 and families earning more than AUS 180 000 (at April 2015). An additional "Lifetime Health Cover" loading applies for people who do not take out cover after 1 July, following their 31st birthday.

Insurance must include appropriate hospital cover to avoid the Medicare Levy Surcharge, although insured people are still entitled to free treatment in public hospitals. The federal government subsidises private health insurance with rebates worth up to 37.09% of the cost of the insurance (at April 2015), dependent on age and income. Higher income earners receive either a reduced rebate or are ineligible for a rebate.

The federal government also subsidises some medication through the Pharmaceutical Benefits Scheme (PBS). Individuals contribute to the cost of their medication. This payment is lower for pensioners and the unemployed.

Health expenditure in Australia was 8.8% of GDP in 2012 (the latest year for which this information was reported), slightly lower than the OECD average of 8.9% in 2013. This does not include capital expenditure. Government financing accounted for 67.6% of expenditure, followed by 19.9% in out-of-pocket payments.

Australia has reduced the number of acute hospital beds from 4 per 1 000 population in 2000 to 3.8 in 2013, below the OECD average of 4.8. There has been a growth in the number of doctors, driven partly by an increase in medical graduates. The numbers rose from 2.5 practising doctors per 1 000 population in 2000, to 3.4 per 1 000 in 2013 – higher than the OECD average of 3.3. This reflects a deliberate policy to deal with workforce shortages, particularly in rural and remote areas. Australia has heavily relied on overseas-trained doctors to cope with this shortage. Chapter 4 discusses the challenges facing rural and remote Australia.

Source: Australian Government Private Health Insurance Ombudsman, *Medicare Levy Surcharge*, available at: www.privatehealth.gov.au/healthinsurance/incentivessurcharges/mls.htm (accessed 13 May 2015); Council of Australian Governments, *National Healthcare Agreement 2012*; OECD (2015), *Health at a Glance 2015;* Thomson, S., R. Osborn, D. Squires and M. Jun (2012), *International Profiles of Health Care Systems 2012*, The Commonwealth Fund.

Health status in Australia

Australians enjoy one of the best life expectancies in the world. In 2013, life expectancy at birth was 82.2, reflecting a growth of 11.4 years since 1970 (Figure 1.1). Australia is sixth highest in the OECD, and only narrowly trails the leader Japan's 83.4 years (OECD, 2015). Aboriginal and Torres Strait Islander people have considerably poorer health outcomes. The life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous people is 10.6 years for men and 9.5 years for women (ABS, 2013). Life expectancy disparities also exist when comparing

Australians from different socioeconomic backgrounds, and different regions. For example, the highest life expectancy in Australia is in metropolitan northern Sydney (84.6). It falls to 76.1 in rural central and north-west Queensland (National Health Performance Authority – NHPA).

Figure 1.1. Life expectancy at birth, 1970 and 2013 (or nearest year)
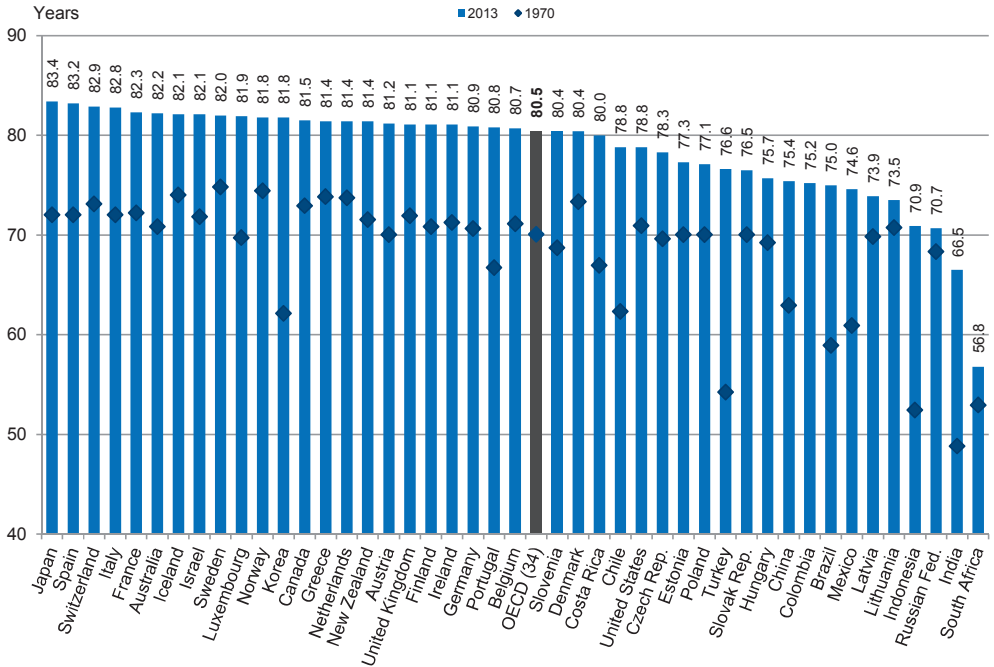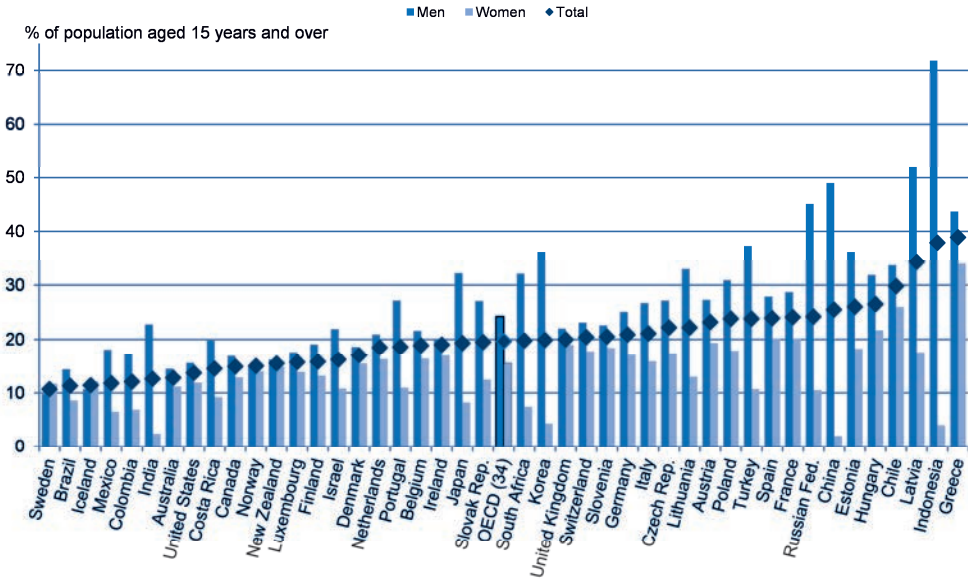

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Australia's health status compares favourably to that of its OECD peers. The ischemic heart disease mortality rate is well below the OECD average (98.2 per 100 000 population compared with 117.4) (OECD, 2015).

Australia has one of the lower rates of cancer mortality, with 197.7 deaths per 100 000 population, below the OECD average of 205.6. It also fares well in cerebrovascular disease mortality, transport accident mortality and infant mortality.

Through a range of public health initiatives, Australia has achieved one of the lowest smoking rates in the world. In 2013, 12.8% of Australians aged 15 years and over smoked on a daily basis, compared with an OECD average of 19.7% (Figure 1.2) (OECD, 2015).

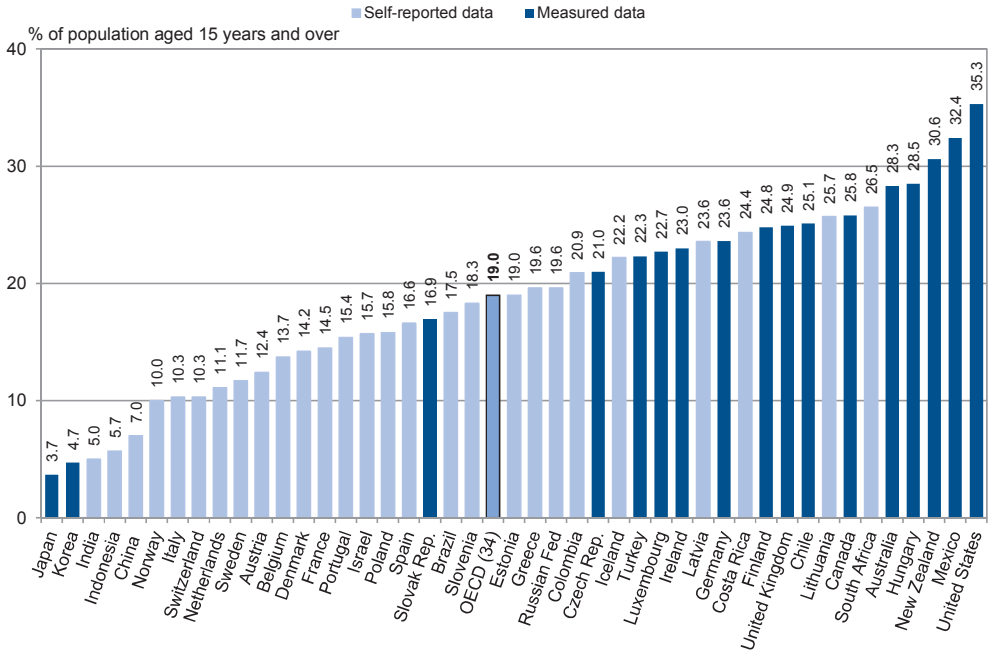**Figure 1.2. Daily smoking in adults, 2013 (or nearest year)**

Note: Countries are ranked in descending order of smoking rates for the whole population.

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Of greater concern for Australia is alcohol consumption. People aged 15 and over consume 9.9 litres per capita of alcohol per year, more than the OECD average of 8.8 litres (OECD, 2015). Obesity is also a significant public health issue in Australia (Figure 1.3). While adult obesity rates have been rising in every OECD country, Australia's rate is among the highest. More than one quarter (28.3%) of Australians aged 15 and over are obese. This is considerably higher than the OECD average of 19%. Only four OECD countries are more obese – the United States, Mexico, New Zealand and Hungary (OECD, 2015). The high rate of obesity is likely to add to the future prevalence of chronic disease, such as type 2 diabetes.

**Figure 1.3. Obesity among adults, 2013 (or nearest year)**

■ Self-reported data ■ Measured data

% of population aged 15 years and over

Japan	3.7
Korea	4.7
India	5.0
Indonesia	5.7
China	7.0
Norway	10.0
Italy	10.3
Switzerland	10.3
Netherlands	11.1
Sweden	11.7
Austria	12.4
Belgium	13.7
Denmark	14.2
France	14.5
Portugal	15.4
Israel	15.7
Poland	15.8
Spain	16.6
Slovak Rep.	16.9
Brazil	17.5
Slovenia	18.3
OECD (34)	19.0
Estonia	19.0
Greece	19.6
Russian Fed.	19.6
Colombia	20.9
Czech Rep.	21.0
Iceland	22.2
Turkey	22.3
Luxembourg	22.7
Ireland	23.0
Latvia	23.6
Germany	23.6
Costa Rica	24.4
Finland	24.8
United Kingdom	24.9
Chile	25.1
Lithuania	25.7
Canada	25.8
South Africa	26.5
Australia	28.3
Hungary	28.5
New Zealand	30.6
Mexico	32.4
United States	35.3

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Health spending in Australia

Health expenditure in Australia was 8.8% of GDP in 2012 (the latest year for which this information was reported), slightly lower than the OECD average of 8.9% in 2013. This does not include capital expenditure. Health expenditure per capita was USD PPP 3 866, compared with the OECD average of USD PPP 3 453 (OECD, 2015).

The annual average growth rate in per capita health expenditure in real terms was 2% between 2009 and 2013, compared with 0.6% on average across OECD countries (Figure 1.4). Government financing accounted for 67.6% of expenditure, followed by 19.9% in out-of-pocket payments (OECD, 2015).

Figure 1.4. Annual average growth rate in per capita health expenditure, real terms, 2005 to 2013 (or nearest year)

Annual average growth rate (%)
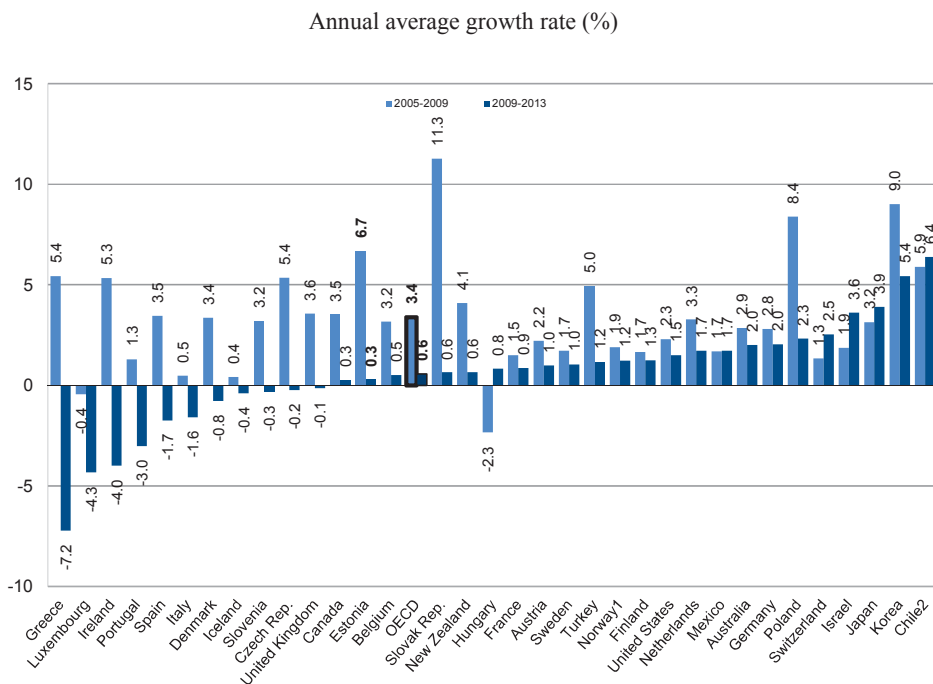
1. Mainland Norway GDP price index used as deflator.

2. CPI used as deflator.

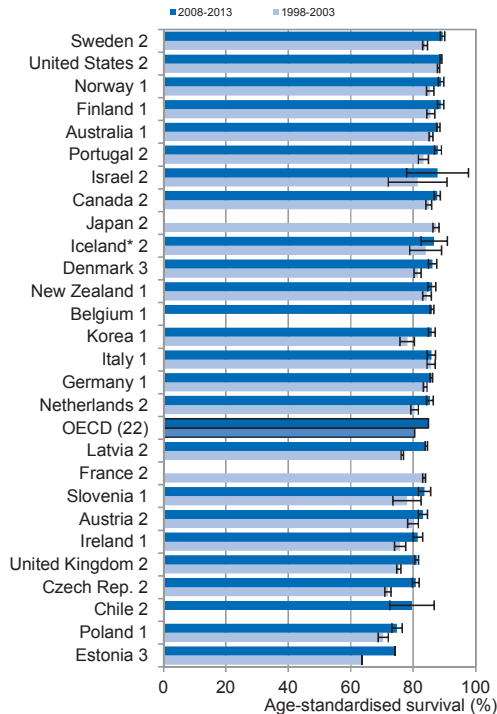*Source: OECD Health Statistics 2015*, www.oecd.org/els/health-systems/health-data.htm.

Internationally comparable indicators of the quality of health care paint a mixed picture

A range of indicators can be used to gauge how well a health system is performing. In this, Australia presents a mixed picture. Cancer survival can be a measure of how well a health system manages cancer patients, particularly with early detection and effective treatment. Australia's cervical cancer screening rate in women aged 20 to 69 declined from 61.1% in 2001 to 57.3% in 2013. This is below the OECD average of 61.6%, and suggests a need to focus more on health promotion efforts to encourage screening for early detection. Australia's cervical cancer five-year survival of 66.2% is about the same as the OECD average. Australia's mortality rate for cervical cancer is among the lowest across the OECD. The age-standardised

mortality rate per 100 000 women is 2%, compared with an OECD average of 3.5% (OECD, 2015).

Australia is one of the world leaders in breast cancer survival (Figure 1.5). Its five-year survival rate of 88% is only marginally lower than that of Sweden, the United States, Norway and Finland. However, the proportion of women aged 50 to 69 undertaking mammography screening has declined since 2003, from 56.7% to 55%. This is lower than the OECD average of 58.8%, and stands in contrast to countries such as Finland, Slovenia, Denmark and the United States, where the proportion exceeds 80%. The age-standardised rate of breast cancer mortality per 100 000 women is 24.8, about the same as the OECD average of 25.3 (OECD, 2015).

Figure 1.5. Breast cancer five-year relative survival, follow-up until 2003 and 2013 (or nearest years)

Note: 95% confidence intervals represented by H.

1. Period analysis. 2. Cohort analysis. * Three-period average.

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Australia has the third highest survival rate for colorectal cancer of 68.7%, compared with the OECD average of 62.2%. Its mortality rate (19%) is well below the OECD average of 24.2% (OECD, 2015).

Another indicator of the quality of acute care is deaths within 30 days after a patient is admitted to hospital for ischemic stroke. This can reflect the timeliness and effectiveness of medical interventions. Australia's age-sex standardised rate is 9.3 deaths per 100 hospital admissions of adults aged 45 and over, higher than the OECD average of 8.4 (OECD, 2015).

Australia has the OECD's lowest rate of deaths within 30 days following hospital admission for acute myocardial infarction (heart attack) (Figure 1.6). The age-sex standardised rate in Australia is 4.1 deaths per 100 admissions, compared with an OECD average of 8 (OECD, 2015).

Figure 1.6. Thirty-day mortality after admission to hospital for acute myocardial infarction based on admission data, 2003 to 2013 or (nearest years)
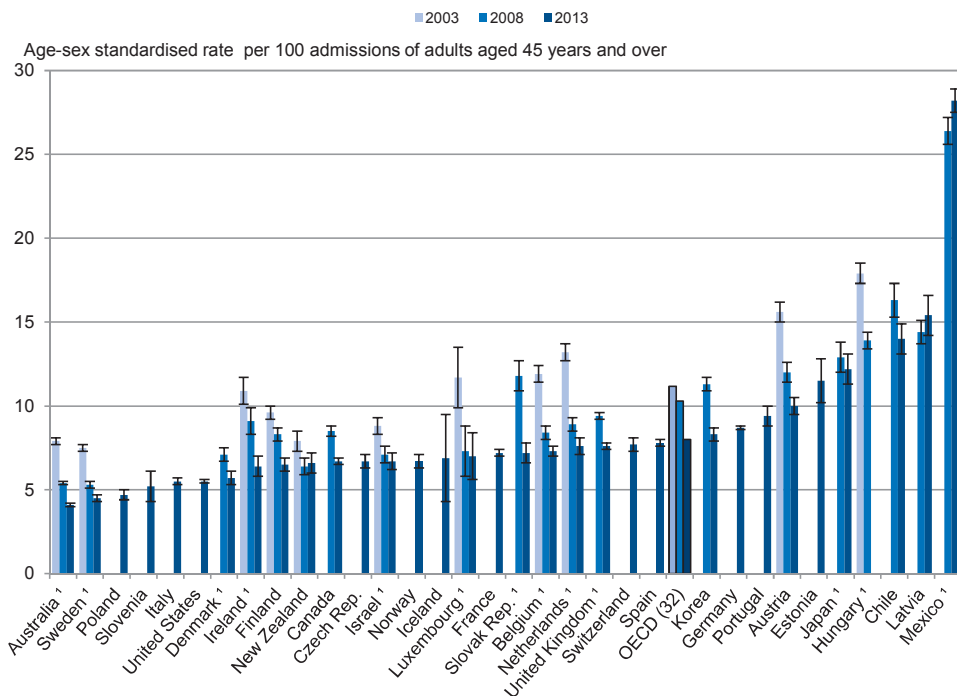
Note: 95% confidence intervals represented by H. Three-year average for Iceland and Luxembourg.

1. Admissions resulting in a transfer are included.

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Indicators of patient safety include obstetric trauma, surgical complications and post-operative sepsis. The complex nature of some procedures means these complications can never be fully prevented, however their risk can be reduced. Australia's complication rates appear high. The rate of post-operative pulmonary embolism in knee or hip surgeries in 2013 was 528.6 per 100 000 hospital discharges, compared with an OECD average of 329.4. The rate of deep vein thrombosis in knee or hip surgeries in 2013 was 1187.4 per 100 000 hospital discharges, compared with the OECD average of 506.1. The rate of post-operative sepsis in abdominal surgeries was 2 271.9 per 100 000 hospital discharges, compared with the OECD average of 1 818.6. Australia also appears to have a higher rate of foreign bodies retained during a procedure, of 8.6 per 100 000 hospital discharges compared with an OECD average of 5.7 (OECD, 2015). These figures are all based on hospital admissions when the surgery took place. Caution should be used when interpreting these figures, as they could be explained by more proactive reporting in Australia than in some other countries.

1.3. Governance for quality of health care in Australia

The National Healthcare Agreement sets out the roles and responsibilities of the federal and state and territory governments in the delivery of health care services. The Agreement's objective is to improve health outcomes for Australians, and the sustainability of the health system. It specifies that continued improvement in health service safety and quality is a shared responsibility between the federal and state and territory governments.

The shared commitment to achieving health care quality is reinforced by the Australian Safety and Quality Framework for Health Care, which was endorsed by federal and state and territory governments in 2010. The framework specifies that safe, high-quality health ought to be consumer-centred, driven by information and organised for safety.

Australia's health system has a complex governance model with multiple stakeholders and funders

The Australian health system features a complex split of federal and state and territory funding and responsibility, which can make it difficult for patients to navigate. However, it can broadly be characterised as one in which public hospitals are jointly funded by federal and state and territory governments, and are managed by the states. This arrangement is formalised through the National Healthcare Agreement (COAG, 2012) and the National Health Reform Agreement (COAG, 2011). The latter emphasises that the states are the hospital "system managers", while the federal government has "lead responsibility" for GP and primary health care. The agreements imply

that both levels of government are responsible for overseeing health care quality. As Figure 1.7 demonstrates, hospitals account for the largest proportion of health funding, followed by primary health care. The states and territories are responsible for providing public hospital services, and private organisations provide services in private hospitals. Meanwhile, as Chapter 2 discusses, the delivery of primary health care services is more complicated, with federal and state governments, as well as private providers largely in the form of GPs in private practice, all playing a role.

Figure 1.7. Australian health services funding and responsibility
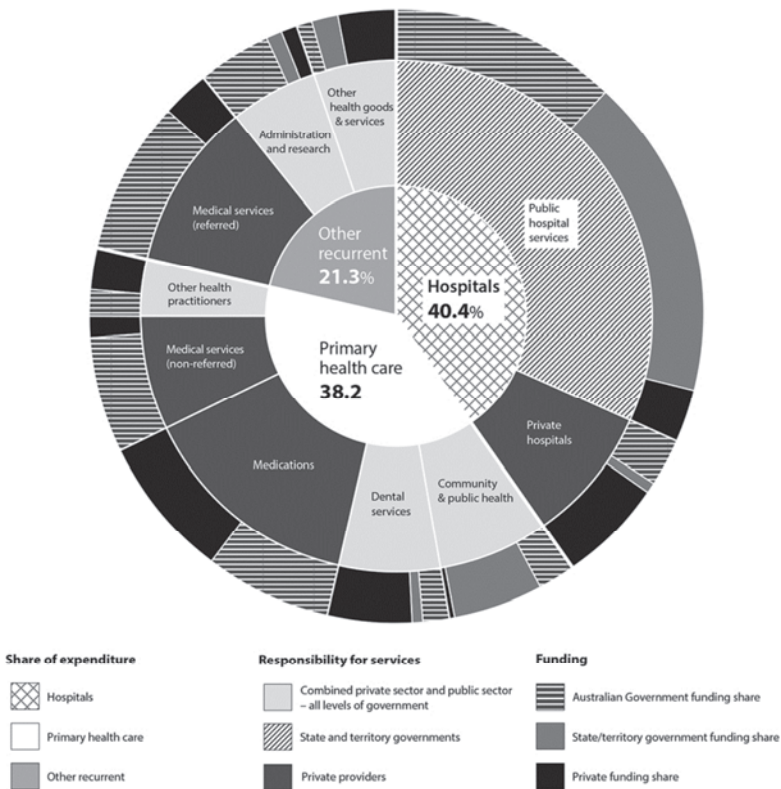
Note: The inner segments indicate the relative size of expenditure in each of the three main sectors of the health system ("hospitals", "primary health care" and "other recurrent"). The middle ring indicates the relative expenditure on each service in the sector (shown by the size of each segment) and who is responsible for delivering the service (shown by the colour code). The outer ring indicates the relative size of the funding (shown by the size of each segment) and the funding source for the difference services (shown by the colour code).

Source: Based on Australian Institute of Health and Welfare (2014), *Australia's Health*.

The structure of the system means at a federal level, the Department of Health has the main policy responsibilities of primary health care – particularly reimbursement for GPs – private health insurance, pharmaceuticals and blood and organ donation. The state and territory health departments have responsibility for the provision of a range of services including primary and community-based health services, public hospitals, public health services, emergency response, planning and delivery, ambulance services and food safety.

Adding to the system's complexity is the mix of public and private health services. For example, an individual with private health insurance can choose to be treated as a private patient in either a public or private hospital. Unlike public patients, this arrangement generally enables an individual to choose their own doctor and to fast-track their elective surgery in a private hospital, compared with a patient waiting for non-urgent surgery on a public hospital waiting list. Private health insurance also partially funds outpatient services provided by allied health professionals, such as dental treatment and physiotherapists – although there is often a gap fee. These are not covered by Medicare.

The system's complexity is amplified by a challenging and sometimes antagonistic relationship between federal and state and territory governments. This tension is particularly acute when political sensitivities arise over the federal government's contribution to hospital funding. The states argue federal hospital funding is insufficient. There are also frequent claims of cost-shifting. For example, the states argue that failures in the primary care system (a federal responsibility) lead to patients seeking care in public hospital emergency departments (a state and territory responsibility). This health system discord between the federal and state governments has, in the past, been characterised by protracted negotiations between the federal and state and territory governments over hospital funding.[1] Additionally, unclear lines of accountability threaten to undermine progress in areas where agreement already exists.

For patients, the consequences of a fragmented system include potential disruptions to continuity of care. Patients often need to navigate through a series of health services and providers in both the public and private sectors. The complexity is amplified when these services fall under the responsibility of different levels of government. This can be even more confusing for patients with multiple chronic health problems, or those in long-term care.

The lack of co-ordination and limited or delayed flow of information between primary health care providers and hospitals can be a source of frustration for health professionals in both sectors. It can also increase the

risk of adverse events and cause unnecessary hospital readmissions, compromising patient outcomes and raising costs.

Amid the shift towards national governance, there is scope for these functions to be strengthened

Several national bodies play a role in health care safety and quality. Principally, the Australian Commission on Safety and Quality in Health Care (ACSQHC) is a government agency that leads national improvements in safety and quality and is responsible for developing and maintaining national standards. It also administers the Australian Health Service Safety and Quality Accreditation Scheme and grants approval to accrediting agencies to provide accreditation for public and private hospitals and day procedure services against the National Safety and Quality Health Service (NSQHS) Standards. Two other federal government bodies whose functions intersect with quality to some degree have been established in recent years. The Independent Hospital Pricing Authority (IHPA) calculates an annual 'national efficient price' to help determine the level of federal funding for public hospitals. The National Health Performance Authority (NHPA) collects data on the performance of public and private hospitals and primary health care organisations, based on various measures and metrics. It publicly reports these findings through the MyHospitals and MyHealthyCommunities websites.

The National Prescribing Service (NPS) also carries some quality improvement functions and notably is co-ordinating Australia's Choosing Wisely initiative, which aims to reduce unnecessary tests, treatments and procedures.

There exist multiple bodies that report on health system performance. The NHPA, the Australian Institute of Health and Welfare (AIHW – the national custodian of data), the Australian Bureau of Statistics, the Productivity Commission and the Steering Committee for the Review of Government Service Provision all produce reports based on analysis of large amounts of data. This often represents a duplication of efforts, and potentially dilutes the impact of the information contained in these reports. A simpler approach could entail fewer and stronger central authorities, and the establishment of one main body whose key functions would include setting standards and monitoring performance.

The government should review the roles and responsibilities of existing national bodies centrally involved in the governance of health service quality and performance, with a view to identifying opportunities for role clarification and consolidation. In the 2014-15 budget, the federal government proposed – subject to consultation – to create a Health

Productivity and Performance Commission, by merging the ACSQHC, AIHW, IHPA, NHPA, the National Health Funding Body, and the National Health Funding Pool Administrator. The government should proceed with the proposal to consolidate these activities and functions, as this might present an opportunity to reduce duplication, and bring consistency and greater coherence to performance monitoring, reporting and improvement.

Health care quality is subject to a mix of federal and state legislation

The ACSQHC, the NHPA and the IHPA were all established under the National Health Reform Act 2011. The Act specifies the functions of the three bodies.

The Private Health Insurance Act 2007 is the principal legislation dealing with private health insurance in Australia. It sets out the provision of incentives to encourage people to have private health insurance, payments by the federal government to reduce premiums for those who comply with health insurance policies, and a lifetime health cover scheme under which premiums may rise for people who do not maintain private health insurance from an early age. The Act also requires private health insurance funds to make health insurance available to people in a non-discriminatory way and to meet other obligations. It also sets out enforcement mechanisms to monitor and ensure compliance with the Act and protect the interests of policy holders.

Additionally, the states and territories each have their own legislation governing the provision and quality of health services. Public hospitals and mental health services are governed by different laws in each state. Various state legislation and regulations also dictate the standards that private hospitals should meet as a condition of their licensing.

Despite agreed performance indicators, data collection continues to be inconsistent

Federal and state and territory governments have agreed to a set of national performance indicators, which have been updated several times. The public hospitals performance indicator framework (Figure 1.8) reflects the objectives of the National Healthcare Agreement. The performance framework for primary health care is discussed in Chapter 2. There also exist performance frameworks for maternity services and mental health management.

The performance framework for public hospitals encompasses equity, effectiveness and efficiency. The clinical outcomes of patients, however, do not figure strongly in the performance framework. Another limitation is the

actual reporting on these indicators has been slow. As figure 1.8 shows, in the most recent public report, few of the indicators were described as having the most recent data for all measures comparable and complete.

Figure 1.8. Public hospitals performance indicator framework
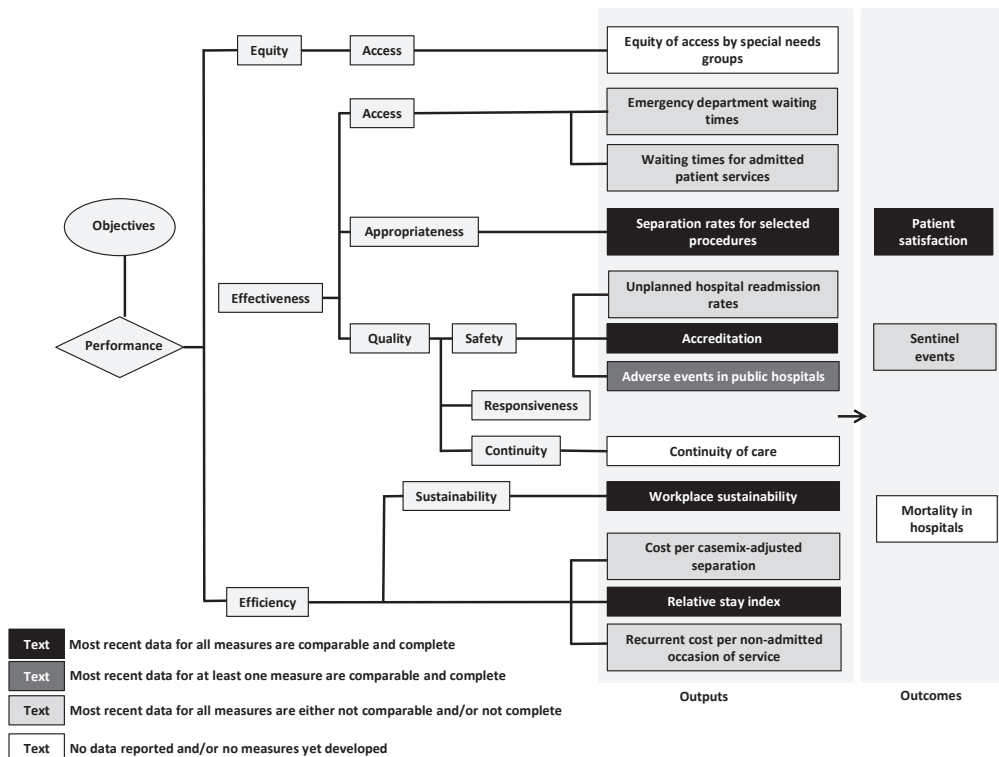
Source: Based on Steering Committee for the Review of Government Service Provision (2015), *Report on Government Services 2015*, Vol. E: Health, Productivity Commission, Canberra.

The quality components in the performance indicator framework are safety, responsiveness and continuity. According to the most recent report, however, no indicators have yet been developed to measure continuity of care. This should be considered a priority measure. Gaining an understanding of the extent to which patients experience care continuity is particularly important for the large number of patients with chronic disease, who often receive care from multiple health care services. For these patients, co-ordinated care can reduce the risk of medical errors due to lack of, or delayed, information exchange between health services about a patient's medical condition.

The harmonisation of national standards and indicators has been a necessary step to improving quality, and governments should persevere with this. There is also scope to enhance the performance indicators, so that the focus shifts more intently on measuring quality of care and patient outcomes. The indicators should also extend to private hospitals. Robust comparisons remain difficult, however, because of reporting discrepancies across the states and territories.

Private hospitals, too, report on various indicators to their boards, insurers and government. This inconsistency raises the risk of more heterogeneous data collection, increases the administrative burden, and makes states incomparable on some indicators.

Progress in the health outcomes of Aboriginal and Torres Strait Islander people, health system performance and the broader determinants of health are also subject to a performance framework that was developed under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). The framework encompasses data from more than 60 sources – including hospital morbidity, mortality, the Census, the National Aboriginal and Torres Strait Islander Health Survey, and the National Aboriginal and Torres Strait Islander Social Survey – in more than 60 indicators. Reporting against the framework is designed to promote accountability, inform policy and research, and foster informed debate. The AIHW produces a detailed report every two years (AHMAC, 2012).

The Council of Australian Governments (COAG) agreed to the development of National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care through the National Indigenous Reform Agreement in 2008. A set of 24 indicators that focus on chronic disease prevention and management and maternal and child health was approved by the AHMAC in 2011. Of these, 19 indicators have been implemented over a three-year period, with data on 11 indicators collected in 2011-12 and on an additional eight in 2012-13. Implementation of the remaining five indicators is being progressed.

The indicators are collected from primary health care organisations that receive funding from the Department of Health to provide services primarily to Aboriginal and Torres Strait Islander people. The indicators are used to help improve the delivery of primary health care for Aboriginal and Torres Strait Islander people, to improve health outcomes and to support progress towards the COAG Closing the Gap targets. They also provide a mechanism for monitoring progress and highlighting areas for improvement to support policy and planning at the national and state and territory levels. Performance against the indicators is improving over time and many individual organisations have used the indicators to inform their continuous

quality improvement processes. It has been noted that jurisdictions with health organisations that have a history of using continuous quality improvement processes, such as the Northern Territory and Queensland, perform better than those organisations that do not. As a result, the Australian Government is further implementing and expanding programmes to encourage continuous quality improvement.

The Australian Government provides funding to around 260 organisations to deliver primary health care, chronic disease prevention, child and maternal health, substance use, social and emotional wellbeing and other health services to Aboriginal and Torres Strait Islander people. These organisations contribute to the Online Services Report (OSR) data collection. The OSR collects information on these health services and their activities, the number of clients seen and contacts made, staffing levels and vacancies, service gaps and challenges. The OSR data collection provides information to support and enable effective programme management, facilitate policy and funding decisions, and reviews of demand and supply of services.

The capacity to capture more information about the experience and health outcomes of patients is hamstrung by data infrastructure

Internationally, there has been growing interest in measuring the continuity of care as patients move between primary care, hospital care, long-term care and social care. However, the capacity to capture a more detailed picture of patients' pathways of care is hamstrung by data infrastructure, and the ability to link patient records across datasets.

This has been the experience in Australia, where a major hindrance is limited capacity to link patient-level information. National hospital data lacks personal identifying information permitting data linkages. Most published health performance indicators do not involve the linkage of administrative databases, although there are pilot projects underway that may permit this in the future. Australian legislation also restricts the circumstances under which the two large national health administration databases – the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) – may be linked together (OECD, 2013).

Most OECD countries have invested considerable effort to be able to monitor patient pathways through the system, even if de-identified. Like many other OECD countries, Australia has a national number that uniquely identifies patients. Such a number can facilitate record linkage from multiple databases, providing accurate information through a less cumbersome process. Australia introduced the Individual Healthcare Identifier for patients and providers in 2010. Each individual is assigned a unique 16-digit number, which is used for the Personally Controlled Electronic Health

Record (PCEHR) system, health care provider clinical information systems, secure messaging and electronic referrals. However, the use of this number for data linkages has not been approved.

In an OECD questionnaire on the secondary use of health data, Australia was one of a minority of countries that did not have national data containing identifying information that could be used for record linkage for hospital inpatient data. Nor, as Table 1.2 shows, does it use national record linkage projects for regular health care quality monitoring (OECD, 2013).

Table 1.2. National record linkage projects are used for regular health care quality monitoring

	Hospital in-patient data	Primary care data	Cancer registry data	Prescription medicines data	Mortality data	Formal long-term care data	Patient experiences survey data	Mental hospital in-patient data	Population health survey data	Population census or registry data
Australia	No	No	No	No	Yes	No	No	No	No	No
Belgium	Yes	Yes	Yes	Yes	Yes	nr	Nr	No	No	nr
Canada	Yes	na	nr	na	nr	nr	Na	Nr	nr	nr
Denmark	Yes	Yes	Yes	Yes	Yes	na	No	Yes	No	Yes
France	nr	No	No	No	No	nr	No	Nr	No	No
Finland	Yes	na	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Germany	No	No	No	No	No	No	Na	Na	No	No
Israel	Yes	No	Yes	No	Yes	Yes	No	Yes	No	Yes
Japan	No	No	na	No	nr	nr	Nr	Nr	nr	nr
Korea	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No
Malta	Yes	No	Yes	na	Yes	No	Na	No	No	No
Norway	Yes	No	Yes	No	Yes	No	No	No	Yes	Yes
Poland	No	No	No	No	No	No	No	No	No	No
Portugal	No	Yes	nr	Yes	nr	nr	Nr	No	nr	nr
Singapore	Yes	na	Yes	No	Yes	Yes	No	No	Yes	No
Sweden	Yes	na	Yes	Yes	Yes	na	No	Yes	Yes	nr
Switzerland	No	na	na	na	No	No	Na	No	No	No
United Kingdom	Yes	No	Yes	No	Yes	No	No	No	No	No
United States	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Total Yes	12	4	11	7	12	4	1	5	4	4

Note: dk: don't know; na: not applicable; nr: no response.

Source: OECD Health Care Quality Indicator Questionnaire, Secondary Use of Health Data, 2011/12. OECD (2013), *Strengthening Health Information Infrastructure for Health Care Quality Governance: Good Practices, New Opportunities and Data Privacy Protection Challenges,* OECD Health Policy Studies, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264193505-en.

There appear to be moves to permit hospital data collected at the state level to be amalgamated nationally. The AIHW and the Population Health Research Network's Centre for Data Linkage are understood to be working together to build a national system enabling data at the state and national levels to be linked together for approved projects. But further complicating matters are discrepancies in the governance and legislation of different states (OECD, 2013).

As Table 1.3 demonstrates, there are many examples of countries using a national number that uniquely identifies patients. For example, Canada assigns a health card number that is used for all publicly-funded health care encounters. This is separate to a social insurance number assigned nationally

for tax and social security purposes. Other countries, such as Belgium, Denmark, Sweden and Israel, favour a number that is used more broadly, including for both health and taxation purposes.

Table 1.3. National number that uniquely identifies patients and the main uses of this number

	Name of the unique identifying number	Main uses of the identifying number
Belgium	INSZ NISS	INSZ NISS is a national person identifier (national number) used for various purposes, such as health care, social security, and tax.
Canada	Health Card Number	The provinces and territories assign a health card number that is a unique patient number for all publicly funded health care encounters. There is also a unique Social Insurance Number assigned nationally for tax and social security purposes that is not used for health care.
Denmark	CPR NR (Central Person Register Number)	Used for "everything" in relation to national and local governments including health care. Also banks and other business identifications etc.
Finland	Personal Identity Code	The personal identity code is used in practically all data collections in public services, such as health care, social welfare services, education, justice etc.
France	Numéro d'identification au répertoire (NIR)	Persons born in metropolitan France and overseas departments are registered on the national directory for the identification of natural persons (RNIPP) and are assigned a registration number (NIR). The NIR is used by medical authorities for the issuance of a "carte vitale". The NIR is also used for social security.
Italy	TS number	TS number contains both a health number and a tax file number and has nearly universal coverage of the population. It is managed through a publicly owned private company, SOGEI that could be considered as a trusted third party.
Israel	ID number	The ID number is used for tax, social security, education, health, licensing, banking and other identified activities.
Korea	Resident Registration Number	Resident Registration Number (RRN) is assigned to each individual upon his/her birth and contains various information including birth date, gender and location of birth. RRN is used in virtually all aspects of life, including economic activities, for personal identification in various documents and communications in Korea.
Malta	Identification Number ID No	ID No is a unique identification number used throughout the country for all purposes including electoral lists, taxation, social security, etc. It is based on the registration number at the Public Registry.
Norway	National Identification Number	The National Identification Number is used for tax, social security, health records, banking and other purposes.
Poland	PESEL	PESEL number is assigned to all citizens at birth; permanent residents; temporary residents with stays of 2 months or longer; applicants for an identity card; and other persons where regulations require it.
Portugal	Número de Utente do Serviço Nacional de Saúde	This number is used throughout the country for access to national health service care and benefits.
Singapore	National Registration Identity Card Number (NRIC)	NRIC is used for identification, government procedures, and some commercial transactions (e.g. the opening of a bank account).
Sweden	Personnummer (Personal Identity Number)	Personnummer is the main identifier used for all official purposes in Sweden (tax, social welfare, health care, living conditions, education and so on).
United Kingdom	NHS number Scotland also has the Community Health Index (CHI) number	Everyone registered with the National Health Service in England, Scotland and Wales is issued a unique NHS number. The NHS number is not used for tax/social security purposes. In Scotland, the CHI system was set up for administrative purposes to track patients registering with GPs.
United States	Social Security Number	The SSN is issued to US citizens, permanent residents, and temporary (working) residents and its main purpose is for taxation.

In Australia, an opportunity exists to follow the lead of other OECD countries and strengthen the data infrastructure to facilitate linkages across datasets, although this may be complicated by differing privacy legislation across states and territories. Such a move, however, would be a worthwhile investment, as it would help provide richer information on the quality of a patient's care, adverse events patients have experienced in the health system, and patients' clinical outcomes.

Additionally, improving the care co-ordination of patients has been held back by the protracted roll-out of an electronic health records system. By enabling health professionals to access information about a patient's health care in one place, electronic health has the capacity to make the patient pathway smoother, potentially reducing errors and improving continuity. This could also cut waste in the system, for example by reducing errors and duplication of services. Australia has long had a system requiring patients to "opt in", rather than a system in which patients are automatically enrolled and have the right to opt out. The opt-in system risks excluding those who would benefit from e-health, particularly older patients with chronic disease who may not have easy access to a computer but whose complex needs make it likely they will access health care across multiple providers. The low uptake of electronic health in Australia thus far is likely due to the opt-in system, and a lack of awareness of its existence and the benefits it brings.

It is encouraging that the federal government intends to trial an opt-out system, with its rebadged "My Health Record". The government has indicated the PCEHR will be redeveloped to improve its usability and clinical utility. The opt-out trial will inform future strategies to increase the uptake of electronic health. Like the present PCEHR, patients will retain control over what information is used in their individual record, and who can access it. It is likely that an opt-out system would improve e-health participation in Australia. This should be accompanied by a national campaign to raise awareness of e-health, and strong safeguards ensuring data privacy and security.

An example of a country Australia could follow is Denmark, which is one of the more advanced countries in health technology and has adopted a unique patient identification number to use in health care and other services. The country's electronic health system enables GPs to manage medication lists and generate electronic prescriptions and send them to pharmacies. To promote care co-ordination, after-hours services use the same computer systems as GPs. GPs are automatically notified when a patient is registered in a hospital emergency department, and receive reports electronically when their patients visit an after-hours service. Patients have access to their own electronic records and can interact via email with their doctors. Patients can

also electronically schedule appointments, renew prescriptions and access laboratory results. Notably, they can also view who has accessed their data (Protti and Johansen, 2010).

1.4. Assuring the quality of inputs to the Australian health care system

Australia has good quality assurance mechanisms in place, and these are further strengthened by the NSQHS standards mandated for all hospitals and day procedure services. More robust national data collection specifically on safety and quality and improved consistency in reporting across jurisdictions would improve the evaluation of policies.

Australia is advanced in professional certification and continuing professional development of health practitioners

To achieve consistency across the country, Australia has adopted a national system for regulating health practitioners in 14 professions. Previously, states regulated health professionals in an inconsistent manner, creating complications when they moved to other states. In a bid to overcome this complexity, Australia introduced the National Registration and Accreditation Scheme (NRAS) in 2010.

The regulation of health practitioners is governed by the Health Practitioner Regulation National Law Act 2009 (the National Law). This has been established by states and territories through a national "applied laws" model enacted in each state. The national scheme aims to protect the public by ensuring only suitably trained and qualified practitioners are registered. It also facilitates the assessment of overseas-trained health professionals. The 14 professions covered by the NRAS are: chiropractors, dentists, doctors, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.

The Australian Health Practitioner Regulation Agency (AHPRA) oversees the scheme and provides support for the 14 National Boards. This national approach aims to better protect public safety, make it easier for health professionals to move around the country with less red tape, and promote a more sustainable workforce. To be registered to practise, health professionals must meet the standards set by their relevant board. AHPRA keeps national registers of health practitioners, including any conditions associated with their registration.

The National Boards investigate complaints about practitioners and, under the National Law, set regulatory policy parameters for each

profession. This extends to responsibility for registering health practitioners who must meet mandatory standards in the English language, professional indemnity insurance, recency of practice, and criminal history. Another condition of registration is participation in a prescribed amount of annual continuing professional development (CPD). Notably, health professionals must renew their registration annually, and must declare on an annual basis that they have met these standards. AHPRA has a system of random audits to check practitioners' compliance.

Australia's move from a state-based to a national system, linked to annual CPD requirements, now makes it a leader in the OECD in the regulation of health professionals. It is also an example of what can be achieved when the federal and state and territory governments work collaboratively. Another innovation worthy of praise is an online register of practising and cancelled health practitioners. Employers and consumers can use it to check a health professional's registration status.

To maintain their registration, health professionals are expected to practise within the professional practice guidance documents (including registration standards, guidelines and codes) developed by the relevant Board. The guidance documents can vary among the Boards but include minimum standards that practitioners are expected to adhere to. These include guidance on advertising, mandatory notifications, professional conduct, sexual and professional boundaries, supervision and infection control. Professionals who breach any of the Boards' guidance documents can face disciplinary action if a complaint is lodged against them. More serious allegations can be referred to a tribunal. Consequences can vary between having conditions placed on registration, to temporarily or permanently losing registration. There is also scope for practitioners to face criminal charges if the allegations against them are of a criminal nature.

Credentialling is the process used to verify the qualifications and skills of health professionals, to gauge whether they can provide safe and high-quality care. A national standard for credentialling medical practitioners is being rolled out across Australia. Additionally, some states have their own policies for credentialling doctors in public hospitals. The focus of this work appears to be on doctors, but there is scope to extend it to other health professionals.

Individual medical colleges also play a role in training specialists and maintaining standards. For example, in addition to the CPD expectations of the National Boards, the Royal Australasian College of Surgeons has its own CPD requirements for its fellows. A certain proportion of fellows are randomly selected to verify their CPD data each year, to ensure supporting documentation matches the CPD data they provide to the College.

There are codes of conduct and professional guidance documents for the 14 health professions under the NRAS. Some Boards have scope of practice statements providing broad guidance to practitioners on how to practise safely and appropriately within their level of qualifications, taking into account their skills, knowledge and experience.

There are differing opinions, both within and between professional groups, about the definition of scope of practice, including understanding what is advanced practice and what is extended scope of practice. One view is that advanced scope of practice is taken to mean an increase in clinical skills, reasoning, knowledge and experience so the practitioner is an expert working within the scope of traditional practice. Extended scope is seen to include expertise beyond the currently recognised scope of practice. However, what specific skills are advanced and what could be regarded as extended is more difficult to define. There is also a terminology used, such as working to "top of licence", with the inference that this allows for the allocation of more routine tasks to lesser trained health care workers as part of the health care team.

In the present health care environment, there is an increasing focus on innovation and reform to gain efficiencies in health care delivery. There is also recognition that, with the need to enhance access to services in under-serviced communities, the roles and functions of different professional disciplines are increasingly being examined. This is a contentious area, with some stakeholders citing public safety as an issue when other professions try to increase or to formalise specific areas of practice for their discipline, such as the ability to prescribe medications. Governments, private health care providers, National Boards and professional associations all have a role in this area and it requires further exploration, co-ordinated action and the development of an evidence base.

As Chapter 3 discusses, the performance of clinical staff is also assessed as part of the new standards. The standards include provisions regarding the need to have a system to define and regularly review the scope of practice of the clinical workforce, and to ensure that the clinical workforce is working within its agreed scope of practice.

Regulation of pharmaceuticals and medical devices

Almost any product for which therapeutic claims are made must be entered on the Australian Register of Therapeutic Goods (ARTG) before it can be supplied in Australia. The ARTG is maintained by the Therapeutic Goods Administration (TGA), which is part of the Australian Government Department of Health, and is responsible for safeguarding and enhancing the

health of the Australian community through the effective and timely administration of the Therapeutic Goods Act 1989.

The TGA focuses on the quality, safety, efficacy and timely availability of therapeutic goods that are used in, or exported from, Australia. This involves authorising new medicines and devices for supply and for monitoring the performance of medicines (including prescription medicines, over-the-counter medicines and complementary medicines) and devices (including in vitro diagnostic medical devices) that are available on the Australian market. The TGA is also responsible for regulating blood, blood products and other emerging biological therapies.

The TGA maintains this system by applying scientific and clinical expertise to assessing the evidence of risks compared with the benefits of use of therapeutic goods. This involves assessing new therapeutic goods before they are released on the market by following a risk-based approach to regulation (i.e. a new cancer drug goes through more complex processes than a new vitamin C preparation). Ongoing monitoring of, and compliance in relation to, products already on the market is also part of the regulatory scheme. Products found to be non-compliant are subject to regulatory actions, which range from undertaking recalls or issuing safety alerts, updating prescribing guidance (product information) to removing the product from the market by cancelling the entry on the ARTG. The TGA also inspects and licenses manufacturing sites in Australia and assesses the standard of overseas manufacturing sites.

These activities are supported by structured communication and education programmes and partnership activities tailored to consumers, health professionals and industry. These activities include making publicly available online databases of products authorised for supply in Australia on the ARTG, which includes links to Product Information and Consumer Medicines Information, a recall database, searchable adverse event reports for medicines and medical devices, medicine shortages and information on prescribing medicines in pregnancy.

The TGA also offers programmes to facilitate access to unregistered products, and their import into Australia. These include the Special Access Scheme and Personal Import Scheme, which provide approval on an individual patient basis. There is also the Authorised Prescriber Scheme, which provides approval to patients of specially authorised prescribers.

At a state level, regulatory measures may include state-based poisons legislation, which can offer varying access controls to Scheduled medicines. Each state also has a level of medication governance achieved through drug and therapeutic committees or overarching therapeutic advisory groups. While these groups act independently, they interact and share information at

a national level through the Council of Australian Therapeutic Advisory Groups forum. Many states, through drug and therapeutic committees or therapeutic advisory groups, restrict medication access to specific indications or circumstances in an attempt to facilitate consistent, cost-effective and evidence-based prescribing practice. This is achieved in some states, including South Australia, Tasmania and Queensland, through a state-based formulary or approved medicines list.

Quality assurance of health care facilities is subject to national and state measures

As a means of driving improvement in safety and quality, all public and private hospitals and day procedure centres have to be accredited to the NSQHS standards. The standards are developed and maintained by the ACSQHC, which also approves agencies that can carry out the accreditation. These standards will be evaluated to determine what refinements are needed. They are discussed in more detail in Chapter 3.

Another key agency in quality improvement is the Australian Council on Healthcare Standards, a not-for-profit organisation. In addition to being authorised to accredit health services to the NSQHS standards, it has a history of promoting quality assurance through its long-running Clinical Indicator Program. It comprises 20 sets in areas such as anaesthesia, emergency medicine, paediatrics and radiology. Hundreds of public and private hospitals have voluntarily been involved in the programme, and receive reports comparing their performance with that of other hospitals. The aim is to improve quality through shared learning.

Policy work around quality is taking place against a backdrop of an improving culture of transparency, with the aim of encouraging reporting to maximise shared learning. For example, an ACSQHC report provides information on sentinel events covering all public hospitals and 99% of private hospital beds nationally (ACSQHC, 2011). However, the data are not stratified at a state or hospital level. The Steering Committee for the Review of Government Service Provision provides in its annual report data on sentinel events in public hospitals at a state level. The report, however, notes that the data are not comparable across jurisdictions. Consistencies in reporting would enable meaningful comparisons to be made across the states and provide a bigger pool of hospitals for benchmarking.

At a state level, hospital quality assurance differs around Australia. Most states and territories have clinical governance frameworks, and a range of policies and programmes to enhance safety, quality and performance.

Clinical audits can be a useful means of assuring quality

While there are requirements to conduct clinical audits included throughout the national standards, there are also different approaches adopted by the states. Western Australia, for example, has implemented a mandatory review of all deaths that occur in public hospitals and private health facilities that provide services for public patients. Queensland conducts an annual "Bedside Audit", where clinicians collect information on certain elements of care to gauge whether expected standards have been met. The state reports that this audit has led to improvements in practice in areas such as falls prevention, recognition and management of deteriorating patients, and medication safety.

At a national level, the Royal Australasian College of Surgeons makes it a requirement to participate in the Australian and New Zealand Audit of Surgical Mortality as part of the college's Continuing Professional Development programme. The college reports that surgeon participation increased from 60% in 2009 to 96% by the end of 2013. All public hospitals participate, while private hospital participation increased from 43% in 2009 to 89% in 2013. The aim is to achieve 100% participation by the end of 2015 (RACS, 2013).

The evidence suggests that clinical audits can influence quality improvement, but the way they are designed and carried out are important factors. A Cochrane Collaboration review measured the effect of audits and feedback mostly on doctors. Audits were used to influence doctors' performance in areas including the proper use of treatments, and the management of patients with chronic disease. The authors concluded that audit and feedback "generally leads to small but potentially important improvements in professional practice". Audit and feedback were most effective when health professionals were not performing well to start with, the person responsible for the audit was a supervisor or colleague, the feedback was provided more than once and given both verbally and in writing, and it included clear targets and an action plan (Ivers et al., 2012). To maximise possible benefits of clinical audits, they should be appropriately resourced, well designed and take into account the patient perspective.

1.5. Patient safety policies

The Australian Safety and Quality Framework for Health Care was endorsed by federal and state and territory governments in 2010 (Table 1.4). The framework describes a vision for safe and high-quality care, and how the vision can be achieved. It specifies three core principles for safe and

high-quality care: that care should be consumer-centred, driven by information and organised for safety. It documents 21 areas of action that all health system staff can take to improve the safety and quality of health care.

Table 1.4. Australian Safety and Quality Framework for Health Care:
Areas for action by people in the health system

Safe, high-quality health is always:		
Consumer-centred	Driven by information	Organised for safety
1. Develop methods and models to help patients get health services when they need them.	1. Use agreed guidelines to reduce inappropriate variation in the delivery of care.	1. Health staff take action for safety.
2. Increase health literacy.	2. Collect and analyse safety and quality data to improve care.	2. Health professionals take action for safety.
3. Partner with consumers, patients, families and carers to share decision-making about their care.	3. Learn from patients' and carers' experiences.	3. Managers and clinical leaders take action for safety.
4. Provide care that respects and is sensitive to different cultures.	4. Encourage and apply research that will improve safety and quality.	4. Governments take action for safety.
5. Involve consumers, patients and carers in planning for safety and quality.		5. Ensure funding models are designed to support safety and quality.
6. Improve continuity of care.		6. Support, implement and evaluate e-health.
7. Minimise risks at handover.		7. Design and operate facilities, equipment and work processes for safety.
8. Promote health care rights.		8. Take action to prevent or minimise harm from health care errors.
9. If something goes wrong, openly inform and support the patient.		

Source: Based on Australian Commission on Safety and Quality in Health Care (2010), *Australian Safety and Quality Framework for Health Care.*

At a state level, there are different approaches to monitoring and reporting patient safety incidents that occur in hospitals. For example, Western Australia introduced a Statewide Patient Safety Management System for reporting and analysing clinical incidents, including adverse events. Under this system, all deaths in the state's public hospitals and licensed private health care facilities providing services for public patients must be reviewed.

In South Australia, feedback from patients is regularly sought and entered into a Safety Learning System. Each year, the state publishes a Patient Safety Report, which is structured around the NSQHS standards. It includes information on policies promoting safety, sentinel events, maternal death or serious morbidity, hospital infections, and patient feedback.

Queensland formed the Health Patient Safety Board to monitor the performance of public hospitals, and to act when safety performance does

not meet expected standards. Indicators that may trigger action include "never events" (discussed later in this chapter), hospital-acquired third and fourth state pressure injuries, hospital-associated staphylococcus aureus bacteraemia, and deaths in low-mortality Diagnostic Related Groups. These indicators have "trigger points" signalling when health authorities should initiate action. Queensland Health also monitors 34 clinical indicators monthly, using a statistical technique called Variable Life Adjusted Display. This helps staff monitor extraordinary events, and compare their results to others in the state.

Alongside national sets of data standards and national health reform, the states have developed their own patient safety monitoring, and clinical incident management systems. The establishment of these systems is acknowledged and commended, and it is recognised that they rely on voluntary reporting and are principally designed to foster local review, risk management and learning. However, the lack of alignment and consistency represents a missed opportunity for a larger dataset that may, in the medium or long-run, foster shared learning at a national level. Adopting a common approach to reporting on patient safety incidents should be considered, so that knowledge can be shared and health professionals may learn from these incidents at a national level.

An example of how national harmonisation works well can be seen in Australia's approach to reducing hospital-associated infections. The federal and state governments agreed to reporting on staphylococcus aureus bacteraemia (such as MRSA), and this information is available on a national website called "MyHospitals", which comprises hospital-level data and measures hospital performance on a range of indicators across Australia.

To help curb the incidence of hospital-acquired infections, a National Hand Hygiene Initiative was implemented. Hospital compliance data are collected three times a year from public and private hospitals, and publicly reported annually on the "MyHospitals" website. Evidence suggests this initiative is helping to change the culture of hand hygiene, with hospital participation and compliance rates both rising. In August 2009, data from 182 hospitals showed an average compliance rate of 63.5%. In October 2014, data from 828 hospitals showed an average compliance rate of 81.9% (Hand Hygiene Australia, 2014). This strengthens the argument that national consistency in initiatives promoting quality, and greater transparency, can often stimulate positive change.

Efforts have been made to make medication safety a priority

As the population ages and with it, the prevalence of chronic disease rises, it is likely that more people will be taking multiple types of medication

to manage a number of conditions. The safe use of medicine is all the more important, to prevent interactions that may cause harm, and to reduce avoidable hospitalisations that are neither in the best interests of patients nor the health system.

A literature review on medication safety in Australia suggests medication-related hospital admissions remain stable at about 2% to 3% of all admissions. There were 9.3 million discharges from Australian hospitals in 2011-12, suggesting about 230 000 medication-related hospital admissions annually. With an average cost per discharge in 2011-12 of AUS 5 204, this suggests the annual cost of medication-related admissions is AUS 1.2 billion (Roughhead et al., 2013).

There appears to be a concerted national effort to make the safe use of medicines in hospitals a priority. Medication safety forms one of the NSQHS standards, as a condition of hospitals attaining accreditation. Health services are required to establish a governance framework for medication safety, assess the safety of their medication management systems and demonstrate a quality improvement approach to improving systems and rectifying any risks identified. This includes identifying high-risk medicines they use and ensuring they are stored, prescribed, dispensed and administered safely to minimise medication errors.

Australian federal and state and territory governments also agreed to implement a standard inpatient medication chart in all hospitals to reduce medication errors. ACSQHC conducts audits assessing compliance with the chart, and reports on this publicly. More than 240 public hospitals and 71 private hospitals participated in the 2012 audit of 13 880 patients' charts. While the audit demonstrated high levels of compliance with several aspects of the chart, there was poor compliance in areas such as complete patient identification, use of recommended abbreviations, documentation of indication, and practices regarding warfarin prescribing (ACSQHC, 2013b).

One innovation to improve hospital practice is the Medication Safety Self-Assessment for Australian Hospitals. It was originally developed by the Institute for Safe Medication Practices in the United States, and has been adapted by the New South Wales Therapeutic Advisory Group and the Clinical Excellence Commission for use in Australian hospitals. Hospitals enter data on a web-based programme to assess their medication practices, compare themselves to similar hospitals and identify opportunities for improvement (Clinical Excellence Commission). The tool is now being used in hospitals nationally.

Outside of the acute hospital setting, there are efforts to improve medication safety practices in community pharmacies. More than 90% of pharmacies are accredited in the Pharmacy Guild of Australia's optional

quality assurance programme. The pharmacies are audited every two years, and compliance is monitored with random assessments.

Medication safety is a core component of the Quality Use of Medicines objective of Australia's National Medicines Policy. The federal Department of Health funds two independent, not-for-profit organisations to work to improve Quality Use of Medicines, including medication safety.

The National Prescribing Service (NPS MedicineWise) provides education and support for health care professionals and consumers in Quality Use of Medicines in Australia, and consults with academic experts to produce online learning resources and decision support tools. A number of these education programmes are aimed at improving medication safety and reducing medication errors. NPS MedicineWise also produces resources to enable consumers to keep a comprehensive record of all their medicines and to assist with the accuracy of medication histories taken on admission to hospital.

The National Return and Disposal of Unwanted Medicines programme provides a system for people to safely dispose of unwanted and out-of-date medicines through collection bins placed in community pharmacies throughout Australia. It is a partnership between government, pharmacies, wholesalers and consumers. In 2013-14, more than 700 tonnes of medicines were collected.

The low rate of health literacy in Australia should be improved as a priority

Health literacy refers to an individual's capacity and skills to access and understand information that helps them attain and maintain good health, and that informs decisions they make about their health care. Good health literacy can empower patients to play a lead role in making decisions affecting their health care. Poor health literacy, however, can place patient safety at risk. This is particularly pertinent when it comes to understanding instructions patients are given by their doctor, such as complying with instructions for medication use. It is also important in understanding what behaviours, such as tobacco and alcohol consumption, can increase the risk of disease. Education is a social determinant that can influence people's health outcomes. Therefore, strategies to improve health literacy need to take an intersectoral approach that goes beyond the health sector to include education and social services.

The most recent national survey in Australia indicates that in 2006, only 41% of Australian adults were assessed as having adequate or better health literacy skills (ABS, 2009). This demonstrates that health literacy in Australia

should be considered a priority for improvement. It is all the more vital for groups such as Aboriginal and Torres Strait Islander people, who typically have poorer outcomes in both health and education. It is also critical for vulnerable refugee communities in Australia, and migrant groups who may have difficulty speaking English. The evidence indicates that social disadvantage is associated with both poorer health literacy and health outcomes. Health professionals need to be provided with training and support to effectively communicate complex information to patients. This is fundamental to promoting patient-centred care, self-management of chronic disease, and to enable patients to be active participants in decision making affecting their health care. Improving health literacy can help prevent disease, reduce adverse events, and reduce hospitalisations. Not only is this better for population health, it can also reduce health system costs by minimising safety incidents, thus reducing the need for subsequent health services.

Health literacy is among the areas of action in the Australian Safety and Quality Framework for Health Care. Work undertaken by the ACSQHC indicates that while there has been much health literacy activity occurring, there has been little national co-ordination, and limited opportunity for organisations to learn from one another (ACSQHC, 2013a). It is also unclear the extent to which these programmes are being evaluated.

It is encouraging that Australia adopted a national approach to health literacy in 2014. The *National Statement on Health Literacy: Taking Action to Improve Safety and Quality* recognises the importance of addressing health literacy in a co-ordinated way across health, education and other sectors (Figure 1.9).

The ACSQHC intends to use the National Statement to raise awareness and foster a climate of national action and collaboration on health literacy. In addition, the ACSQHC will promote and provide resources for health care organisations to address health literacy at a local level. This will include emphasising linkages between health literacy and the NSQHS standards.

The National Statement could be accompanied by requirements to improve health literacy that apply in all the states and territories. For example, health services could be required to ensure that all health professionals have been trained in communicating complex information to patients. Community pharmacies also have an important role to play in communicating information about the safe use of medicines to consumers. There could be scope within the Quality Care Pharmacy Program to raise awareness of health literacy among pharmacies, and assess the extent to which pharmacies are providing accessible information about the safe use of medications.

Figure 1.9. A co-ordinated approach to health literacy

1. **Embedding health literacy into systems**
   This involves developing and implementing systems and policies at an organisational and societal level that support action to address health literacy. These systems could include altering funding mechanisms to encourage awareness and action on health literacy, implementing policies that prioritise health literacy in program planning, and designing healthcare organisations in a way that makes it easier for people to find their way.

2. **Ensuring effective communication**
   This involves providing print, electronic or other communication that is appropriate for the needs of consumers. It also involves supporting effective partnerships, communication and interpersonal relationships between consumers, healthcare providers, managers, administrative staff and others.

3. **Integrating health literacy into education**
   This involves educating consumers and healthcare providers and could include population health programs, health promotion and education strategies, school health education, and social marketing campaigns as well as formal education and training of healthcare providers.

Source: Australian Commission on Safety and Quality in Health Care (2014), *National Statement on Health Literacy: Taking Action to Improve Safety and Quality*.

It would be timely to conduct another national health literacy survey, as the most recent survey is almost ten years old. It would also be useful to measure health literacy in specific population groups, to determine the need and to help guide evidence-based approaches to improving health literacy among the most vulnerable populations.

1.6. Clinical care standards and guidelines

The ACSQHC has commenced developing a Clinical Care Standards programme for a number of common health conditions and interventions for which known practice variation exists despite consensus on appropriate protocols. This aims to maximise the appropriateness of care and reduce unwarranted variations – that is the overuse, underuse and misuse of various treatments. The standards are accompanied by indicators as a quality improvement tool. Standards have so far been developed for antimicrobial resistance, stroke care and acute coronary syndromes. Standards for other conditions are under development.

The National Health and Medical Research Council (NHMRC), the federal government body responsible for clinical guidelines, publishes annual audit reports on Australian clinical guidelines. The most recent report notes that clinical practice guidelines represent a significant financial and

intellectual investment for government and the health sector. At any given time there are between 500 and 600 guidelines in circulation in Australia, covering a wide range of clinical topics and settings, and of varying quality and currency. However, the report concludes there are "ongoing serious and systemic problems in the way guidelines are funded and developed in Australia" (NHMRC, 2014).

Among the observations in the report, which is based on 1 046 clinical practice guidelines published between 2005 and 2013, is the fact that rates of declarations of conflicts of interest remain low – although this improved from 2% of guidelines in 2005 to 27% in 2013. Governments funded 22% of the guidelines in the report, but 60% of the guidelines contained no acknowledgement of funding, making it impossible to gauge how their development was funded. Only 11% of those funded and developed by government were published with documented evidence of a full systematic literature review, suggesting governments are funding guidelines where the evidence base has not necessarily been established.

The report also demonstrates that the patient perspective seems to be under-used in the development of clinical guidelines. Of all 1 046 guidelines published between 2005 and 2013, only 14% documented consumer involvement, 46% did not document consumer involvement, and 40% did not allow determination to be made on the information provided (NHMRC, 2014).

The existence of hundreds of clinical guidelines produced by numerous organisations seems to be causing confusion, while the extent to which they are useful is unclear. It is unknown the extent to which clinical guidelines are contributing to quality improvements in the health system, or better population health outcomes. The NHMRC notes that it is unable to identify the specific impact of clinical guidelines in the delivery of health care. This is worthy of some investigation. So, too, is the extent to which health services are using clinical guidelines to promote best practice in treating patients and to minimise unwarranted variations in care.

Problems with clinical guidelines have also been identified in work by the ACSQHC. As part of its consultation process about patient safety issues in primary care, the ACSQHC identified a range of competing guidelines and standards. Feedback obtained through this consultation process indicated that these guidelines have often been developed "by different agencies for different purposes using different evidence specification, collection and evaluation processes" (ACSQHC, 2011). This can lead to a situation where there are conflicting recommendations given for the same condition.

A more co-ordinated and evidence-based approach to developing clinical guidelines would help to alleviate some of this confusion, and

minimise the risk to safety. In Australia, the NHMRC has a legislated role in the approval of guidelines meeting its guideline development standards. Guidelines granted NHMRC approval are recognised as representing best practice and the NHMRC publishes requirements for organisations to receive this approval. These requirements include systematic identification of the evidence, full disclosure of conflicts, and the inclusion of the perspective of the consumer specifically affected by the guideline.

While the NHMRC approval carries more credibility, it is not mandatory for developers of guidelines to obtain it and, as the NHMRC's own research demonstrates, poor practice in guideline development persists. There could be an opportunity for the NHMRC to play a greater role in enforcing standards of clinical guidelines, including a mandatory disclosure of conflicts and inclusion of the patient perspective.

It would also be useful to produce more guidelines that are not only disease-specific, but take in broader clinical pathways and multiple morbidities. This is in recognition of the fact that an ageing population will be associated with increased complexity and multiple chronic health conditions.

It is encouraging that the ACSQHC, NHMRC and the federal Department of Health have been working together to develop a national approach for future clinical guideline development, in recognition of the need to streamline the process. The new approach will:

1. Establish an agreed list of priorities for clinical guideline development by the ACSQHC based on agreed criteria that incorporate clinical need and practicality.

2. Refine the process of NHMRC consideration of externally developed clinical guidelines to enable a rapid and efficient approval.

3. Provide appropriate and clear guidance for guideline developers that ensures development of guidelines that are high quality, relevant and implementable.

While the majority of guidelines will be developed by relevant professional groups, they will be able to seek NHMRC approval through a streamlined process.

A more co-ordinated national approach to developing clinical guidelines should emphasise transparency as a key principle, with full disclosure of conflicts and the methodology of the guideline's development. The NHMRC report notes that there are guidelines being developed for use in specific jurisdictions that have the potential to be adapted for national use. Strategies

to harmonise guidelines produced by states, when they have national relevance, should also be considered to minimise the risk of confusion and conflicting guidelines.

1.7. Managing health system improvement

Australia has made steady progress in placing quality and safety high on the policy agenda, and linking this to performance monitoring. The extent of national health system improvement can be monitored on two websites run by the NHPA. The MyHospitals website provides public and private hospital-level data, with the focus on a range of access indicators such as emergency department waiting times and waiting times for various types of surgery. However, quality of care information is sparse. Currently, the only safety and quality data reported relates to staphylococcus aureus bloodstream infections and hand hygiene. Much more could be included, such as the results of patient experience surveys, standardised mortality rates, outcomes of common procedures and interventions, and the results of hospital accreditation.

Hospital performance is also reported by the AIHW and the Steering Committee for the Review of Government Service Provision. Additionally, the jurisdictions produce their own reports, but there are disparities. For instance, in New South Wales, reporting of surgical site infection rates for hip and knee surgery is mandatory for public hospitals. In Victoria, hospitals and community health services are required to publish annual quality of care reports that include safety and quality indicators for infection control, medication errors, patient experience and consumer participation in decision making. Queensland publishes regular online public hospitals performance, which includes patient experience results. The annual reports in the Western Australian and Tasmanian health departments include information on unplanned readmission rates, and Western Australia also includes a section on patient evaluation of health services. South Australia publishes an annual patient safety report and an annual report on measuring consumer experience. In the Australian Capital Territory, quarterly reports include data on unplanned readmissions, unplanned returns to operating theatre and hospital-acquired infections. The Northern Territory Health Department's annual report has a chapter on clinical governance including information on complaints, hand hygiene, staphylococcus aureus bacteraemia and unplanned readmission rates (SCRGSP, 2015). As previously highlighted, the inconsistencies across jurisdictions make comparisons between the states and territories difficult.

At a primary health care level, the NHPA publishes comparative information about primary health organisations known as Medicare Locals

(replaced by Primary Health Networks in July 2015) on the MyHealthyCommunities website. Much of the information relates to health service activity and access rather than quality. But unlike MyHospitals, the website does include information about patient experience through measures such as how often GPs listen and show respect.

The extent to which the public is aware of these websites is unclear, so it is hard to gauge their utility. Efforts to promote the existence of these resources should be made at a national level, and also through local health services.

There are few examples in Australia of hospital funding that drives improvements in safety and quality

Australian health service funding is mainly based on activity or outputs. This is in the form of fee-for-service in primary care, and activity-based funding for public hospitals. Quality and safety are not specifically taken into account in Australian national hospital financing, although paying hospitals a standard price for services can encourage technical efficiency. The ACSQHC and the IHPA have been exploring potential options to incorporate safety and quality into pricing of public hospital services. Australia is already providing non-financial incentives to hospitals to lift quality by publicly reporting on their performance. Incorporating quality considerations into pricing could be another performance incentive for consideration.

Incorporating safety and quality into pricing has already been introduced in some states, as described in Box 1.2.

The funding mechanisms of these states and others should be evaluated to assess what impact they have had on improving quality. This work could help inform policy regarding hospital pricing at a federal level. If the state reviews demonstrate there is merit in linking quality to hospital funding, there is potential for this to be applied in a nationally consistent manner.

Should Australia decide to go down this path at a national level, vigilance should be exercised to minimise the risk of data manipulation and fraudulent reporting to gain financial bonuses. The provision of financial incentives to improve hospital performance should be accompanied by regular audits to ensure that data are reported accurately.

Box 1.2. Factoring quality into hospital funding

Queensland authorities withhold payments for six "never events". These include:

- procedures on the wrong patient or body part resulting in death or major permanent loss of function,

- retained material after surgery requiring further surgical intervention,

- haemolytic blood transfusion reactions resulting from blood incompatibility,

- infants discharged to the wrong family,

- intravascular gas embolism resulting in death or neurological damage,

- entrapment in bedrails or other bed accessories resulting in death or major permanent loss of function.

Queensland Health has also defined two adverse events, for which there is a reduced payment based on estimates of the additional hospital costs of patients who acquire these conditions. Hospital-acquired bloodstream infections attract penalties of AUS 10 000, while stage 3 and 4 pressure injuries have penalties of AUS 30 000 and AUS 50 000 respectively.

Queensland Health also offers quality improvement payments in four areas:

1. achieving national elective surgery targets within the clinically recommended time,

2. meeting the target for the percentage of patients admitted as an emergency for the repair of fractured neck or femur to be taken to theatre within 48 hours of admission,

3. achieving national emergency access targets requiring 77% of all emergency department patients to have a length of stay of four hours or less, and 90% of all emergency department ambulance patients to be off stretchers within 30 minutes,

4. Improved access and quality of stroke care.

Western Australia uses a Performance-based Premium Payment Program to promote quality in hospitals. In 2013-14, incentive payments were paid directly to clinicians for best practice in the areas of fragility hip fracture treatment, stroke unit care, and acute myocardial infarction treatment. Eligible hospitals received AUS 200 for each patient who received "best practice".

In Tasmania, general practitioners contracted to provide medical services at rural hospitals receive payment to participate in safety and quality activities.

1.8. Strengthening the role and perspective of the patient

While other stakeholders are often more influential in shaping the policy-making process, there is universal acknowledgement that quality health care places the patient at the centre. This encompasses involving

patients in decisions affecting their care and treatment, and improving health literacy so they may understand information affecting their health. Ideally, it should extend to empowering patients so they play a role in the policy-making process. The NSQHS standards include requirements to involve consumers in governance processes as well as their care.

The experience of patients is among the indicators in the National Healthcare Agreement for both hospitals and primary care. The Australian Bureau of Statistics collects population-level information about patient experience, but this survey does not permit comparisons between health services.

At a hospital level, the states and territories collect information about patient experience. However, the survey methodology differs between jurisdictions, making direct comparisons difficult. For example, in New South Wales, the Adult Admitted Patient Survey is a paper survey mailed to more than 6 000 patients each month. The survey can also be completed online, and in non-English languages, through an interpreter phone service. Victoria's method is via email, if the patient has provided an email address, and a postal mail-out for other patients with the option of responding online. Queensland, South Australia and Western Australia conduct the survey by computer-assisted telephone interviews. The ACT does a mail-out survey (SCRGSP, 2015).

There is also wide variation in the survey response rate. In Victoria, the response rate was 21.6% for adult emergency department attendees and 37.7% for adult admitted patients, while Western Australia achieved response rates higher than 90% for adult admitted, emergency and long-stay patients (SCRGSP, 2015).

It is welcome that the ACSQHC has worked with the states, territories and private hospital sector to establish a set of core, common patient experience questions for Australian hospitals and day procedure services. When implemented, this should be mandatory for all hospitals, including private hospitals, to allow for hospital-level comparisons on the MyHospitals website. This is an important step to quality improvement because, as Box 1.3 demonstrates, measuring patient experience can have a positive impact on quality.

Box 1.3. Hospital improvements after measuring patient experience

- In the Australian Capital Territory, improvements include medication safety, clinical handovers, promoting patient-centred care, staff communication, admission and discharge process/continuity of care, reviewing IT systems for appointments, reviewing waiting times, infrastructure, planning and design of new service areas and a volunteer programme within aged care wards to enhance meal and nutrition experience.

- In Victoria, improvements include managing complaints, and patient discharge and follow-up processes.

- In Western Australia, improvements include reducing waiting times, access, appropriate storage for care plans, recording and cross-referencing food for allergens, communication and information sharing between staff and patients.

- In South Australia, improvements include routine dissemination of findings to appropriate levels of clinical governance in services, where action can be taken. Statewide issues such as mixed gender accommodation in health services were addressed through policy change.

- In the Northern Territory, Aboriginal liaison officers now have a dedicated room to meet with clients, there has been increased patient knowledge on health care rights, and improvements in the variety of available meals.

- In Tasmania, improvements include discharge practices, staff communication and the quality of information provided to patients.

Source: Australian Commission on Safety and Quality in Health Care (2012), *Review of Patient Experience and Satisfaction Surveys Conducted Within Public and Private Hospitals in Australia*.

Less is known about how health services perform with regards to cultural competence. An ACSQHC review of how patient experience is measured suggests surveys are not well catered to people with little or no English. Translated versions are generally not available. It cites the Northern Territory and Victoria as examples of jurisdictions that have made efforts to ease language barriers. The Northern Territory incorporates meaningful pictures and symbols into surveys. In Victoria, patient experience surveys are available in 16 languages other than English (ACSQHC, 2012). These two examples could form the basis for developing a nationally consistent and inclusive approach to measuring patient experience.

Protecting patients' rights

The Australian Charter of Healthcare Rights was developed by the ACSQHC, and endorsed by federal and state and territory governments in 2008. Its three guiding principles are:

1. Everyone has the right to access health care.

2. The Australian Government commits to international human rights agreements recognising everyone's right to the highest possible standard of physical and mental health.

3. Australia is a society of different cultures and the Charter respects these differences.

The Charter has been widely endorsed by stakeholders, and is promoted in public and private hospitals. The NSQHS standards include a requirement for organisations to have a patient Charter of Rights consistent with the national Charter.

The National Health Reform Agreement requires all the states to have a Public Patients' Hospital Charter accessible to everyone, including people from non-English speaking backgrounds and people with disabilities. The Charter must be promoted and made publicly available wherever public hospital services are provided. It has to set out the process by which people can make complaints to the hospital, and highlight that complaints may be referred to an independent body. It must also include a statement of a patient's right to be treated as either public or private patients in public hospitals – regardless of their health insurance status.

The Agreement also makes it mandatory for each state to maintain an independent health complaints body, with powers to investigate, conciliate, and adjudicate on complaints. These state health commissioners are independent from the previously discussed National Boards, which discipline health professionals for misconduct. To add the consumer perspective, all the Boards are required to include community representation. There is also scope for patients to seek compensation for medical malpractice through various state medical indemnity bodies.

Individuals who are unsatisfied with an experience they have had with a private health insurance fund can direct their complaints to the Private Health Insurance Ombudsman. This role was subsumed into the Office of the Commonwealth Ombudsman in July 2015.

Australian patient groups

There are numerous groups representing the interests of patients. The main consumer health groups are the Consumers Health Forum and the Australian Consumers' Association. They are actively involved in the policy-making process and provide regular public commentary on government policy.

In the state of Victoria, for example, the Health Issues Centre is an organisation that seeks to involve consumers in government committees and working groups, to encourage consumer participation in policy making. Most jurisdictions have similar organisations.

While not a patient group, the Clinical Excellence Commission in New South Wales works with health services on a "patient-based care challenge" to increase consumer engagement in governance and individual care. Its Partnering with Patients programme supports partnership with patients and family to improve safety and quality.

At a hospital level, the role of the patient is factored into the NSQHS standards. Hospitals need to show evidence of "partnering with consumers" as a condition of accreditation. Criteria to meet this standard include consumer partnership in service planning, designing care and improving the patient experience, and in service measurement and evaluation. Suggested outputs listed include consumer membership in key committees and/or boards, and the establishment of a "critical friends group" or consumer advisory group that provides advice to the hospital.

This is a good initiative, but could go further. An example is the Netherlands, where every hospital is obliged to have a "client council" made up of people such as former and current patients and their relatives. They aim to strengthen patient involvement by advising hospital management on issues affecting patients and quality of care. Mechanisms similar to this exist in many Australian jurisdictions. For example, health services in Victoria are required by legislation to have health consumer advisory committees.

All health services in every jurisdiction should be required to have "client councils" or something similar, to ensure that patient involvement is not merely symbolic, but a genuine consideration in hospital governance. This role should extend to other health and social services, such as long-term care, mental health services, and disability services.

Australia has several disease-based patient groups, with varying influence in the policy-making process. To survive, they rely on various funding sources, including pharmaceutical companies. With government funding limited, this reliance on commercial financing is unavoidable for

smaller organisations. Their members do not have the capacity to fund them. It is a delicate balance, as patients rely on these groups for their voice to be heard. These groups should aspire to be independent, regardless of their source of funding.

Medicines Australia, the peak body for the pharmaceutical industry, makes specific reference to engagement with consumer health groups in its Code of Conduct. The guidelines were developed with collaboration from the Consumers Health Forum of Australia and other health consumer groups. Pharmaceutical companies must consider these principles when entering into relationships with health consumer organisations. The Code emphasises relationships with consumer health organisations should ensure independence is maintained, and be open and transparent. Under the Code, no drug company may request that it be the sole funder of a consumer organisation, or any of its major programmes. A company must not seek to influence the text of health consumer organisation material in a manner favourable to its own commercial interests. Each pharmaceutical company must supply Medicines Australia with a list of consumer organisations with which it has relationships. The information must include financial support and significant non-financial support, and the monetary and/or non-monetary value (Medicines Australia, 2014).

Medicines Australia publishes this information on its website, in the form of Health Consumer Organisation Support Reports. A brief report is provided for each pharmaceutical company comprising the name of the consumer organisation, the description and purpose of the support, and the monetary or non-financial nature of the support. This transparency is welcome and is important in helping consumers make informed decisions.

1.9. Conclusions

Australian federal and state and territory governments have demonstrated an interest in promoting the safety and quality agenda in health care. This is specifically referred to in legislation and national agreements, and is promoted through the mandatory accreditation of health services.

The commitment to quality and safety extends to health professionals and stakeholders, who seem to have widely welcomed the introduction of the NSQHS standards for hospital accreditation. The next step is to evaluate these standards and refine them. While progress on improving quality and safety in hospitals is more advanced, it has been given less consideration in primary health care. This needs attention, as a vast number of patients have their first encounter with the health system in primary care.

The complexity of Australia's health system continues to pose considerable challenges. The division between federal and state responsibilities has the potential to disrupt continuity of care. It may also raise questions about accountability when there are breakdowns in quality of care. This can be exacerbated in cases where patients are using services that are split between the public and private sectors. National inconsistency on a range of measures, including the way in which states collect data and manage performance, is also an impediment to quality improvement.

More clearly defined responsibilities, and improved harmonisation on performance management, will ease some of these complexities and promote quality.

Note

1. A particularly striking example of this can be seen in the Australian Government's first budget in 2014. When state and territory governments requested a special meeting to discuss health and education funding cuts in the budget, the then Prime Minister is reported as having replied that the people of Australia expected "grown-up, adult governments in the states just as they now have a grown-up adult government in Canberra" (Grattan, 2014).

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