The safety and quality of health care: from Council to Commission

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Time to capitalise on past achievements and become more effective

Australians are fortunate in many ways with their health care system. It is affordable and accessible to all; it is peopled by professionals of skill and dedication; and anybody who falls ill can reasonably expect a high standard of care. And yet, all is not well. The results of care and patients' experiences of the health care system are too often less than ideal. Access to care, while universal, is too often delayed: the public hospitals are repeatedly in fiscal deficit and stretched for resources; there are worrying shortages and maldistribution of the health workforce; and, most importantly, the care that we give is not always as safe as it should be.

The safety of health care became a national issue in Australia with the publication in 1995 of the Quality in Australian Health Care Study (QAHCS).[1] Sixteen per cent of people admitted to hospital were found to suffer an adverse event, although that figure was revised down to about 10% when the data were analysed in a manner which allowed comparison with other countries.[2] These comparisons showed our quality and safety performance was not unique; other countries, such as New Zealand,[3] the United Kingdom,[4] Canada[5] and Denmark,[6] had comparable incidences for adverse events in hospital care.

Following the release of the QAHCS, a Taskforce on Quality in Australian Health Care was promptly established. It made 56 recommendations, many of which were not implemented.[7] In 1998, a second national body, the National Expert Advisory Group on Safety and Quality in Australian Health Care was set up and recommended 10 national actions.[8] Then, in 2002, Australian Health Ministers established the Australian Council for Safety and Quality in Health Care, which has recently completed its 5-year tour of duty.

Where are we, then, 10 or more years on from QAHCS? A lot has been accomplished by the Council, a fact acknowledged by the review of the national arrangements for safety and quality of health care (the Paterson Review) conducted last year.[9] Much work has been undertaken by safety and quality bodies in jurisdictions, and there is a wider awareness and understanding of safety and quality issues among health professionals and managers. But it is hard to escape the conclusion that improvements have been patchy, fragmented and, in many cases, transient — with excellent and instructive projects failing to be sustained and incorporated into lasting system improvements. It seems we are still some way from the fundamental reform of health care that will ensure that care is "safe, effective, patient-centered, timely, efficient and equitable".[10]

The Paterson Review noted several limitations to the effectiveness of the Council, the most important of which were felt to be:

- inadequate links between Council, jurisdictions and other key stakeholders;
- a narrow focus on safety in the acute sector; and
- its large size and unwieldy internal arrangements.[9]

Proposed initial set of indicators of the safety and quality of care, based on available data of acceptable quality*

- Sentinel events
- Fractures resulting from in-hospital falls
- Asthma mortality
- Ambulance response time
- Cardiac arrest survival
- Mortality after coronary angioplasty
- Mortality after cardiac surgery
- Stroke after carotid endarterectomy
- Pressure ulcer point prevalence
- Accreditation status
- Aboriginal and Torres Strait Islander infant mortality
- Suicide rate
- Postoperative surgical-site infection rate
- Intensive care unit survival
- Mortality after trauma
- Renal transplant rejection rate
- Five-year survival for priority cancers, such as breast and colorectal cancer
- Interval cancer rate following mammography
- Central intravenous line-associated bacteraemia

* Proposed by the Advisory Group on Assessing the Safety and Quality of Health Care in Australia. The group comprises R Smallwood (Chair), J Bartlett, J McNeil, S Redman, J Youngman and D Casey. ◆

The review group considered that more effective relationships could have been developed to ensure:

- implementation;
- performance measurement and reporting; and
- coordinated dissemination of information.

In effect, the Council's ability to bring about change was not fully realised, given its lack of an effector arm and its fairly narrow focus.

So a fourth national body has now come into being, the Australian Commission on Safety and Quality in Health Care.[9] It is recommended that the Commission have:

- a broader focus on safety and quality, both in and beyond the acute hospital sector;
- a governance structure and membership that is less unwieldy and that ties it more closely to state and territory governments;
- clearly defined functions to include public reporting; and
- responsibility for developing a National Strategic Framework for Improving the Safety and Quality of Health Care as one of its first tasks.

The Commission is expected to make things happen in a way that its predecessor could not.

If the Commission is to know whether things are indeed happening, it will need data of high quality. These will also be needed for the proposed National Report on the State of Safety and Quality due in June 2007. And there's the rub. Epidemiologically sound data which might be used for benchmarking nationally or internationally, or to show trends over time, are not easy to come by.

Last year, the Council commissioned a small advisory group to examine what data might be readily available somewhere in the health system of sufficient quality and importance to make up an initial national dataset. The group proposed that an indicator included in the dataset needs to be:

- strongly and obviously related to quality of care;
- measurable in a systematic, accurate and reproducible manner;
- adjustable for factors outside a provider's control;
- available from routine data sources or, at reasonable cost, from targeted data collections; and, finally
- able to be benchmarked to judge performance.

To get the best return on investment in the collection of quality indicators, it was recommended that priority should be given to areas where high costs are incurred, where the outcome is of major significance, where the consequences of poor care have major implications for survival or quality of life and the cost of subsequent care, and where remedial action is practical.

With these factors in mind, an initial set of 19 indicators was identified (Box), based on data that are available in one or more jurisdictions. In virtually every case, further work will be needed to assure a quality of data that will allow benchmarking across the nation or with health services overseas. The report from the advisory group entitled *Towards a sustainable framework for measuring the quality of health care* (as yet unpublished) has been forwarded to the new Commission, where it might serve as a useful starting point for developing the mooted National Report.

The advisory group did consider the questions of whether QAHCS could usefully be repeated, perhaps now and in the future. However, while acknowledging the immense importance of the initial study, it was felt that the major difficulty of achieving consistent and reproducible definitions of "adverse event" and "preventable adverse event" would seriously hinder accurate comparisons of any new study with those of the past.

The new Commission has a Herculean task ahead of it. As the US Institute of Medicine has asserted, health care requires fundamental reform.[10] The Commission has been given a solid basis for action by the Council, but it will take vision, skill, resources and, above all, persistence to achieve the changes we are all hoping for.

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