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Reducing Regulation in the Health Portfolio

29 June 2015

1. Background

The Victorian Healthcare Association (VHA) is the peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

The VHA welcomes the opportunity to contribute to "Reducing Regulation in the Health Portfolio". The VHA agrees to this submission being treated as a public document and being cited in any reports that may result from this consultation process.

2. Understanding the Regulatory Burden

Three key aspects of regulation exist in the health portfolio – accreditation of health services against safety and quality standards, reporting against funded activities, and regulation through credentialing of health professionals. Mandatory regulation for health services is a time-consuming, but necessary process required to ensure quality improvement and safety within health services.

The VHA recognises that rigorous regulation is critical to ensure the safety and quality of our public healthcare system. However overlapping standards are placing an unnecessary burden on many health services. In particular, we draw your attention to the financial burden this can impose, especially for organisations with limited administrative capacity.

Any mandated regulatory processes must be evidence-based and address safety, quality and effectiveness of health services. The VHA supports accreditation with clear quality and safety benefits to consumers, and believes that multiple accreditation should be avoided where it does not improve service quality, safety, or health outcomes. We believe the current approach to regulation lacks a strategic oversight, is poorly coordinated and is often duplicative. The current approach should be modified in order to properly reflect the truly important goals of such regulation, being to improve quality and safety, and to ensure patient care is appropriate.

Significant operating inefficiencies for health services are created through costs incurred in fulfilling the requirements for accreditation and regulatory reporting. These costs are difficult to quantify, and are therefore not visible across the sector. Costs borne by health services include those related to:

- staffing specific business units dealing with accreditation processes;
- clinical time lost through education of clinical staff and preparation of clinical areas; and
- the cost of individual health services developing their unique systems and processes to manage their accreditation processes.

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These costs are further magnified in smaller health service settings, such as rural and regional health services, where the administrative burden is imposed upon smaller numbers of staff, in some cases requiring dedicated business units to address the requirements of accreditation and regulation.

2a. Regulation Through Accreditation

Different accreditation standards apply across the health service spectrum. Many of Victoria's health services provide healthcare across the care continuum, including aged care, hospital care and community care, therefore they must submit to accreditation against multiple, often overlapping, standards. These are outlined in the appendices (attached).

For example, a large metropolitan public health service in Victoria may be expected to comply with all of the following at a bare minimum:

- the National Safety and Quality Health Service (NSQHS) standards;
- the National Standards for Mental Health Services;
- the Commonwealth Residential Aged Care Standards;
- the Community Care Common Standards;
- Commonwealth Diagnostic Imaging Accreditation Scheme; and
- National Pathology Accreditation.

A community health service must also be accredited to:

- the NSQHS standards, and depending on the services delivered,
- the National Standards for Mental Health Services;
- the Commonwealth Community Care Common standards (encompassing Home and Community Care (HACC) and the National Respite for Carers Program (NRCP)), and
- the Diagnostic Imaging Accreditation Scheme.

An excellent example of the duplication between different mandatory accreditation procedures is available on pages 31 and 32 of the *Accreditation Workbook for Mental Health Services*[1].

These lists, whilst lengthy, do not take into account voluntary accreditation procedures that a number of health services undertake. These are coordinated by both Commonwealth funded and independent bodies. Although these bear further financial costs, health services consider these additional accreditation measures to be a means of ensuring good governance procedures, demonstrating quality of care to consumers and demonstrating compliance with relevant legislation to health service boards. Relevant legislation varies between different jurisdictions. In Victoria relevant legislation includes, but is not limited to, the *Health Services Act 1988* (Vic), *Public Administration Act 2004* (Vic), *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic), and the *Corporations Act 2001* (Cth).

Voluntary accreditation procedures include accreditation against EQUiP standards, and standards related to specific service provision, such as the National Standard Assessment Program (Improving Quality in Palliative Care).

[1] Available from http://www.safetyandquality.gov.au/wp-content/uploads/2014/03/Accreditation-Workbook-for-Mental-Health-Services-March-2014.pdf

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A number of health organisations are also required to comply with government mandated accreditation processes regulated by multiple government departments. These departments include, but are not limited to, the Commonwealth Department of Health, Commonwealth Department of Social Services, and the state Department of Health and Human Services.

Whilst the focus of each set of accreditation standards differs, it is not uncommon for a number of standards within each accreditation program to duplicate those contained within another. In particular, accreditation standards such as corporate policy, governance and management processes are often repeated with each program. However, although information collected may be similar, there are significant inconsistencies in the method of information collection and level of detail required by each accrediting body. Differences exist between accreditation reporting in rating scales, regulatory tools, definitions, and evidence required to demonstrate compliance with standards. This is of particular concern when areas are repeatedly accredited against a number of similar standards associated with different accreditation bodies, resulting in duplication of work to ensure administrative and reporting compliance with those required by each different agency.

Additionally, independent of funding sources, the cross-over between departments responsible for regulation creates additional barriers for health services. Notably, aged care services are largely regulated by the Commonwealth Department of Social Services, yet many of these services in Victoria are provided by the public hospital and health sector. Consequently the requirements for accreditation for each service lack consistency in regards to language, even though the overarching principles and service assessments are generally quite similar.

The overlap of accreditation standards and the inconsistencies of regulatory requirements create inefficiencies for Victorian health services, especially services providing care across sectors such as acute, residential, community and mental health care.

2b. Regulation Through Reporting

Health services are required to complete mandatory reporting processes related to funding activities. Reporting requirements vary according to the source, reason and evaluation processes for the funded program. Generally, reports are required on activity levels in regards to service delivery, achievement of service targets, and acquittal of funding. Different funding streams determine the level of reporting required, as well as the reporting style and type, with varying expectations across programs.

In addition to the variation between reporting requirements, levels of support for reporting are reported to vary between jurisdictions, with support from Victorian Government liaison staff reported to be more accessible than support from Commonwealth staff. Additionally, the reporting requirements are often inversely related to funding provided, with smaller levels of project funding subject to more onerous reporting compared to larger amounts of funding. Health services may receive small Commonwealth grants, but must then submit multiple, detailed project reports disproportionate to the level of funding.

The absence of a strategic approach to regulation also has resulted in many differences in regulation processes and reporting for health services. Consequently, reporting is currently burdensome, and often considered to be meaningless due to lack of transparency regarding reporting outcomes in comparison to other health services.

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2c. Regulation Through Credentialing

Profession specific regulation exists for healthcare staff through the medical colleges and national registration systems. Health practitioner registration, with some exempted groups, is nationally regulated through the Australian Health Practitioners Regulation Agency (AHPRA).

In addition to national registration, clinicians are credentialed by their employer to verify academic and post-graduate qualifications, and to undertake police checks and working with children checks. This is consistent with the national "Standard for credentialing and defining the scope of clinical practice, July 2004", which was originally developed by the former Australian Council for Safety and Quality in Health Care, prior to the introduction of AHPRA. These credentialing procedures are undertaken by each employer, and state specific policies provide guidance for health services in relation to credentialing. In Victoria, the relevant document is "*Credentialing and defining the scope of clinical practice in Victorian health services – 2011 update*"[2].

There is a time investment in the number of staff required to undertake these tasks, which can impact on clinical service delivery. Across the health sector, especially when clinicians are employed by multiple health services, any inefficiencies of the credentialing process are felt through the duplication of such processes by multiple organisations. While it remains crucial for employers to be certain that they have conducted sufficient checks and balances to ensure competency and suitability for employment for all employees, where national regulation already exists there is an opportunity to reduce duplication.

Case Study

For each medical practitioner at each health service, police checks are undertaken, qualifications are reviewed to ensure authenticity and relevance to role, and professional indemnity insurance and specialist college membership are confirmed as relevant. Some of these processes are repeated as required, such as when further qualifications are attained or on reappointment, but others such as police checks are only completed on initial recruitment. Annual staffing reviews must confirm professional registration with AHPRA and professional indemnity insurance coverage.

This process may be repeated at each health service where a medical practitioner is employed, leading to duplication and inefficiencies across the broader sector.

In Victoria, third-party credentialing is one method of reducing inefficiencies. Health services are able to make arrangements that accept credentialing performed by a third-party, such as a primary employer, if the Victorian credentialing policy framework is observed. This arrangement can reduce duplication of the credentialing process.

[2] Available from: http://docs2.health.vic.gov.au/docs/doc/F75634AE22D42207CA25790D001A379F/$FILE/credentialling-and-defining-scope-of-clinical-practice-2011-update.pdf

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3. Reducing the Regulatory Burden

What is fit-for-purpose regulatory intervention that minimises burden to the health industry while ensuring appropriate protection from harm for health consumers and the public in general?

The "Reducing Regulation in the Health Portfolio" policy background paper asks a series of questions designed to shape the discussion on topic. The relevant questions are addressed in this section, and aim to raise the concerns of the VHA, as well as provide constructive recommendations on reducing the regulatory burden.

Of greatest concern to the VHA is the lack of consistency in regulatory approaches across all of healthcare, in particular the regulation that is necessary to continue operation. The VHA urges the Commonwealth to develop an overarching approach to regulation, taking into account a number of considerations.

Recommendation:

1. The Government should support the development of a framework to establish national oversight measures for regulation and accreditation procedures relevant to the health care sector. This should ensure that a unified, strategic approach is designed and embedded to support improvements in healthcare quality and service, as well as improving health outcomes.

3a. Regulation Through Accreditation

The accreditation process for health services currently adopts a "one-size-fits-all" approach, with no regard to the size of individual health services, or their administrative capacity. This is particularly burdensome where health services are undergoing multiple accreditation activities. Many accreditation bodies overlap in the items they regulate, however the way in which they review the material for accreditation differs, placing the onus on the health service to comply with multiple accreditation standards, often assessing the same area of service delivery.

The VHA urges action to explore opportunities for streamlining accreditation to reduce duplication. This could lead to a hierarchy of accreditation, where organisations are first accredited against a core set of standards, and then specific service standards, avoiding multiple assessments in areas such as corporate policy, governance or management processes. Furthermore, accreditation requirements should be reflective of the size and relative risk of a health service.

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Case Study

A major regional health service providing residential aged care services must be accredited against:

- NSQHS Standards
- Commonwealth Residential Aged Care Standards
- Community Care Common Standards
- Diagnostic Imaging Accreditation Scheme
- National Pathology Accreditation Advisory Council
- National Standards for Mental Health Services

It may also choose to seek accreditation against:

- EQUiPNational
- National Standard Assessment Program (Improving Quality in Palliative Care)

Each of these accreditation processes has differing timeframes, but there is significant overlap with regards to standards covering corporate governance, clinical governance and consumer engagement (further detail in Appendix B).

A suggested approach to reduce the burden of multiple accreditation for all health services is to introduce a hierarchy of accreditation. This would see organisations first accredited against a core set of standards, such as corporate governance, clinical governance, consumer engagement, and then against standards dealing with specific services, such as residential aged care or mental health services. This would remove multiple assessments of areas such as corporate policy, avoid duplication and provide consistency in approaches to accreditation for health services.

Recommendation:

2. The Government should move towards a unified, streamlined, hierarchical accreditation process for health services which meets the objectives of ensuring quality and safety benefits to users, and avoids overlap and duplication in the accreditation process.

3b. Regulation Through Reporting

The burden of regulation is exacerbated by the involvement of multiple agencies and departments in the oversight of health service regulatory reporting, and the disproportionate reporting requirements in relation to amount of funding provided.

The VHA recommends this could be addressed with work towards a streamlined approach with strategic oversight for reporting to be coordinated by one department. Where reporting is mandatory and related to several government departments, the Commonwealth and States should work together to ensure that the required workload for health services to meet regulatory obligations is not excessive and does not result in duplication. The Commonwealth Government could provide leadership in moving towards a unified, strategic approach which supports improvements in quality and service, consistent with the Abbott Government's commitment to reduce unnecessary red tape. Streamlining of regulatory reporting processes could be achieved through the creation of document proformas, for example, which collate the relevant information with consistent layouts and structure in regards to

reporting requirements. Furthermore, information which is unlikely to change such as organisational information should be able to be accessed in a pre-filled manner, to reduce duplication. A streamlined approach should also ensure that reporting requirements accurately reflect the level of funding provided.

Recommendation:

3. The Government should move towards developing consistent reporting frameworks for reports required for Government purposes. Reports should be user-friendly, avoid duplication, strive to provide structural consistency for the report writer, and the burden of reporting should be reflective of the level of funding provided.

3c. Regulation Through Credentialing

In order to reduce the burden on health services when credentialing employed health professionals, the VHA suggests that service efficiencies may be gained if information associated with the credentialing process that is required elsewhere be made available to health services. This would allow them to independently access the information from a centralised point without the need to request it from individual health practitioners. For example, this approach could include measures such as:

- geographic collaboration between health services at a State or regional level,
- support for effective implementation of third-party credentialing processes, and/or
- broader engagement with AHPRA and the relevant profession specific board where applicable, with respect to processes undertaken and information they hold which may be of assistance to health services during their credentialing process.

Within regions, there is an opportunity for health services to collaborate and work together to ensure consistency and to promote best-practice processes for credentialing activities. Additionally, individual health services could be better supported to streamline their own processes and to ensure they are working within existing policies and frameworks, and utilising efficient approaches such as third party credentialing.

Additionally, there are a number of processes relating to police checks, confirmation of professional indemnity insurance, verification of qualifications and assurances of continued professional development already undertaken by national bodies such as AHPRA which could contribute to providing assurances to health services regarding staff credentialing. The VHA has made contact with the Medical Board of Australia to highlight this issue with a view to exploring effective solutions for the health sector. However, funding and legislative constraints currently limit the opportunities for reform in this area.

There is an opportunity to explore measures that would allow employers to maintain oversight of employee recruitment and clinical competency, whilst improving process efficiencies.

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Recommendation:

4. The Government should support health services to collaborate to implement best practice processes for the credentialing of employees, including full use of existing programs and policies. This would benefit health services by reducing their administrative burden and avoiding duplication especially when health professionals practice at more than one health service.

Further Information

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Appendix A
Accreditation and the Hospital Sector

Victorian hospitals are compulsorily accredited against the ten overarching National Safety and Quality Health Service (NSQHS) standards introduced in 2013, which are overseen by the Australian Commission on Safety and Quality in Health Care. Without successful accreditation, a hospital may lose its licence to operate. This accreditation process occurs every three years, however must also include mid-cycle reviews by the organisation.

Additionally many hospitals continue to be involved in the accreditation process through EQUiPNational, which is coordinated by the Australian Council on Healthcare Standards. These standards focus on non-clinical systems, and continuous quality improvement. Although not mandatory, the EQUiP process is subscribed to by 88 public health sector organisations in Victoria[3], including hospitals and Medicare Locals.

Hospitals providing residential aged care services, particularly those in rural and regional areas, must also comply with Commonwealth Residential Aged Care Standards, which are overseen by the Department of Social Services. Compliance with these standards is required to continue to receive Commonwealth Government subsidies. The Residential Aged Care Standards consist of four standards, which include 44 expected outcomes. The overarching standards are detailed in Appendix B.

Specific hospital-based services such as diagnostic imaging and pathology must undergo accreditation against the standards developed by the Diagnostic Imaging Accreditation Scheme and the National Pathology Accreditation Advisory Council.

Hospital services which provide General Practitioner services can choose to be accredited by GP peers against the Royal Australian College of General Practitioners Standards for general practice. In the case that mental health services are part of the hospital's delivered services, accreditation must occur against the National Standards for Mental Health Services (NSMHS). These ten standards ensure ongoing quality of mental health service provision, appropriate to the consumer, carer, community and other service providers.

Palliative care services are accredited voluntarily against the National Standards for Palliative Care Provision, which is coordinated by Palliative Care Australia. Thirteen standards exist against which quality palliative care is assessed (see Appendix B).

Finally, if a hospital provides community care services, these services are currently accredited against the Community Care Common Standards. However, the VHA is cognisant that this program will soon be transitioned to the Commonwealth Home Support Program, which will presumably impact the regulation processes and requirement.

[3] Source: http://www.achs.org.au/achs-members/member-organisations-list/

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Accreditation and the Community Health Sector

The community health sector provides a vast range of services to consumers in community-based settings. These services are subject to regulation as stringent as that of the hospital sector, and include interfaces between a number of government departments, as well as non-government bodies. Specifically these include accreditation activities for mental health services, general practice services, home care services, dental services.

Specific services delivered by Community Health services, such as diagnostic imaging and pathology must undergo accreditation against the standards developed by the Diagnostic Imaging Accreditation Scheme and the National Pathology Accreditation Advisory Council.

Community Health services which provide General Practitioner services can choose to be accredited by GP peers against the Royal Australian College of General Practitioners Standards for general practice.

Many Community Health services deliver mental health services which must be accredited against the National Standards for Mental Health Services (NSMHS). These ten standards ensure ongoing quality of mental health service provision, appropriate to the consumer, carer, community and other service providers.

Palliative care services are accredited voluntarily against the National Standards for Palliative Care Provision, which is coordinated by Palliative Care Australia. Thirteen standards exist against which quality palliative care is assessed (see Appendix B).

Finally, if a Community Health services delivers community care services, these services are currently accredited against the Community Care Common Standards. However, the VHA is cognisant that this program will soon be transitioned to the Commonwealth Home Support Program, which will presumably impact the regulation processes and requirement.

Along with mandatory accreditation, many Community Health Services choose to participate in a number of voluntary accreditation processes. Whilst these are not specifically linked to regulation *per se,* that community health services are choosing to spend their limited funds on these programs illustrates the perceived value. VHA consultation demonstrates that community health services see value in the public messages associated with voluntary accreditation processes, and that such processes act as assurances to Boards that the organisations are fulfilling their legislative and governance responsibilities.

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Appendix B

Examples of duplication between selected mandatory accreditation procedures:

	National Safety and Quality Healthcare Standards (NSQHS)[4]	National Standards for Mental Health Services (NSMHS)[5]	Community Common Care Standards (CCCS)[6]	Commonwealth Residential Aged Care Standards (CRACS)[7]
Services covered	Hospitals, Public Dental Services	Mental Health Services	Home and Community Care, National Respite for Carers Program	Public Residential Aged Care
Health services impacted	Hospitals, Community Health, Public Dental Services, Day Procedure	Hospitals, Community Health	Hospitals, Community Health, Multi-Purpose Services	Hospitals, Public Residential Aged Care
Desk top audit	Yes	Yes	Yes	Yes
Interviews on site	Yes	Yes	Yes	Yes
On site audit	Yes	Yes	Yes	Yes
Accreditation timeline	3 yearly plus mid-cycle reviews	3 yearly plus mid-cycle reviews	3 yearly plus mid-cycle reviews	3 yearly plus annual unannounced visits
Relevant standards in each accreditation process				
Corporate governance	1. Governance for safety and quality in health service organisations	1. Rights and responsibilities 8. Governance, leadership and management	1. Effective management	1. Management systems, staffing and organizational development 2. Health and personal care 3. Care recipient lifestyle 4. Physical environment and safe systems

[4] For further detail see: http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf
[5] For further detail see: http://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf
[6] For further detail see: https://www.dss.gov.au/sites/default/files/documents/09_2014/community_care_standard_guidelines2.pdf
[7] For further detail see: https://www.aacqa.gov.au/copy_of_BROCAH0011AccreditationStandardsfactsheetEnglishv14.1.pdf

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	NSQHS	NSMHS	CCCS	CRACS
Clinical governance	1. Governance for safety and quality in health service organisations 3. Preventing and controlling healthcare associated infections 4. Medication safety 5. Patient identification and procedure matching 6. Clinical handover 8. Preventing and managing pressure injuries 9. Recognising and responding to clinical deterioration in acute health care 10. Preventing falls and harm from falls	2. Safety 8. Governance, leadership and management 9. Integration 10. Delivery of care	1. Effective management 2. Appropriate access and service delivery	2. Health and personal care 3. Care recipient lifestyle 4. Physical environment and safe systems
Consumer focus	2. Partnering with consumers	1. Rights and responsibilities 3. Consumer and carer participation 4. Diversity responsiveness 6. Consumers 7. Carers 9. Integration	2. Appropriate access and service delivery 3. Service user rights and responsibilities	2. Health and personal care 3. Care recipient lifestyle 4. Physical environment and safe systems
Mandatory if receive funding	Yes	Yes	Yes	Yes

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Mandatory accreditation processes required for each type of health service:

Sector	Accreditation Standards
Hospitals	• Governance for Safety and Quality in Health Service Organisations • Partnering with Consumers • Preventing and Controlling Healthcare Associated Infections • Medication Safety • Patient Identification and Procedure Matching • Clinical Handover • Blood and Blood Products • Preventing and Managing Pressure Injuries • Recognising and Responding to Clinical Deterioration in Acute Health Care • Preventing Falls and Harm from Falls
Day Procedure Centres	As above
Public Dental Services	• Governance for Safety and Quality in Health Service Organisations • Partnering with Consumers • Preventing and Controlling Healthcare Associated Infections • Medication Safety • Patient Identification and Procedure Matching • Clinical Handover
Commonwealth Residential Aged Care Standards	• Management Systems • Health and Personal Care • Resident Lifestyle • Physical Environment
National Standards for Mental Health Services	• Rights and Responsibilities • Safety • Consumer and Carer Participation • Diversity Responsiveness • Promotion and Prevention • Consumers • Carers • Governance, Leadership and Management • Integration • Delivery of Care
Community Care Common Standards (HACC, NRCP) *likely to change with*	• Effective Management • Appropriate Access and Service Delivery

shift to CHSP	• Service User Rights and Responsibilities
Department of Human Services Standard (any services funded under the Disability Act 2006, and/or Children, Youth and Families Act 2005)	• Empowerment • Access and Engagement • Wellbeing • Participation
Diagnostic Imaging Accreditation Scheme	• Organisational Standards • Pre-procedure Standards • Procedures Standards • Post-procedures standards
National Pathology Accreditation Advisory Council	

Voluntary accreditation processes undertaken for each type of health service

Sector	**Accreditation Standards**
National Standard Assessment Program (Improving Quality in Palliative Care)	• Care Planning • Holistic Care • Ongoing Assessment • Coordinated Care • Carer Support • Needs of the Dying Patients • Service Provision • Bereavement Care • Community Capacity • Access • Research and Quality Improvement • Workforce • Self-care
EQUiP National (Hospitals, Day Procedure, Dental)	• Service Delivery • Provision of Care • Workforce Planning and Management • Information Management • Corporate Systems and Safety