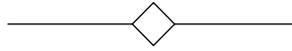


BEST PRACTICE



Best practice in the health sector

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Adapted from the Opening Address delivered at the 1996 Best Practice in the Health Sector conference.

Abstract

The Commonwealth Government is increasing its emphasis on public health and quality of care, which will require a capacity to measure health outcomes and develop strategies for continuous improvement. The reforms being considered by the Council of Australian Governments (COAG) are designed to improve the quality of health services by allowing the Commonwealth to concentrate on broader strategic analysis and performance measures. The health industry will need to take a pivotal role in improving service delivery through collaboration with industry leaders and aiming for best practice.

Introduction

The Australian health sector is facing a very dynamic period of change. New government policies within a very tough budgetary environment mean a fresh perspective on health provision within this country. Best practice and its emphasis on quality is essential as we approach the turn of the century.

This article provides an up-to-date view of the broader changes also coming about through the process initiated by the Council of Australian Governments (COAG), which will be the context for many of the transformations seen in the health sector in the coming years. I have also outlined some of the activities in

the Department of Health and Family Services which will support the initiatives foreshadowed by COAG and place the department in a new role. Finally, I share my vision of the Commonwealth's role as a promoter of best practice for quality in the future.

Broader reforms and quality

Achieving quality health care

In the past few years there has been a change in emphasis by governments in their approach to the funding and provision of health services. Rather than only considering inputs – how many dollars and how much activity occurs – governments are looking more to outputs and outcomes from health services. Casemix funding and funder/purchaser/provider splits are perhaps the best known examples of this change of emphasis.

The Commonwealth Government remains fully committed to Medicare and its primary objectives of access and affordability. It is looking now, however, to move beyond health financing to increase the focus on public health and quality of care.

At first sight, an increased focus on quality might seem inconsistent with the budgetary imperative. There is reason, however, to believe that a system which follows people rather than programs and providers, and which emphasises best practice in public health care treatment and use of pharmaceuticals, will indeed allow better management of the health budget. That said, there will inevitably be some trade-offs between quality and cost – the challenge is to make that trade-off in an informed, optimal fashion.

Two things are required if the focus is to shift successfully. Firstly, there needs to be measurement, not only of the level of activity but also the impact of that activity in terms of quality and health outcomes, because without valid measures we will never know whether we are pursuing the right course or making changes that contribute to quality of care. Secondly, those measures should inform the adoption of best practice, to guide in developing strategies for continuous improvement and to indicate areas of weakness.

Why best practice?

The Commonwealth Government is supporting the adoption of best practice for quality in the health sector so that service providers can focus on achieving improved health outcomes for their patients. Models and tools are being provided

to assist health services to take a managed approach to providing quality care and service improvement.

In the health sector, best practice provides a powerful mechanism to deal strategically with the reforms and budget constraints present for health managers and clinicians. It provides a set of principles that focus on outcomes and meeting consumer needs. It recognises the value of leadership and the contribution of staff, and emphasises the need to look externally towards the world's best practice for inspiration and guidance.

The Commonwealth intends to work in partnership with the States and industry representatives to focus upon quality of care and improved health outcomes. The partnership approach will allow a joint commitment to the development of best practice and quality improvement strategies, identification of tools and benchmarks in the health sector, and a shared understanding of the outcome indicators to be used to measure success and identify areas for further improvement.

COAG

Commonwealth–State relations and the reform direction being pursued by COAG is *not* simply about roles and responsibilities, nor is it about the Commonwealth shirking its responsibility for health or blithely handing programs over to the States.

The primary focus of the COAG reforms is to overcome well-recognised problems inherent in current arrangements including, in particular, their complexity, poor coordination and lack of focus on the people who use the health system.

The problem of rigid program boundaries is not new. There have been previous attempts to address the problem, for example, through the Home and Community Care Program which was intended to improve the balance between residential and non-residential care. But there remain serious concerns that program boundaries are causing inappropriate and poor quality care and considerable inefficiency, including cost-shifting between governments.

The COAG reforms come down to two straightforward principles:

- a focus on people rather than programs, and on providing high quality, cost-effective care designed to meet people's needs
- a clearer delineation of the roles of each level of government.

An enormous gulf can exist between principles and implementation, but I am confident that there is now a willingness and commitment from all parties to make the transition.

The model that COAG has agreed to develop means shared responsibilities but distinct roles for the Commonwealth and the States. These are as follows.

- Both levels of government will jointly set objectives, priorities and strategic directions for all health and related community services with defined performance standards and agreed outcomes.
- The Commonwealth will take a leadership role, particularly for the nation's public health standards and for medical research, and for ensuring a nationally consistent information and payment system.
- The States will be primarily responsible for managing and coordinating the provision of services from the bilateral joint funds and for maintaining direct relationships with most providers.

The model involves developing over time comprehensive bilateral agreements within a multilaterally agreed framework. Funds across all health and related community services will be pooled for each State to achieve agreed outcomes and standards, with financial risks shared.

Key issues to be addressed include the nationally consistent information and payment system and the measurement of outcomes and standards.

Level of activity and the impact of that activity needs to be measured in terms of quality and health outcomes. For the proposed COAG reforms to be effective, information and payment systems have to be focused around patients rather than providers. The Commonwealth and States are currently trialling coordinated care provision for people with long-term health care needs, investigating alternative care management, service coordination and payment systems. Work is also commencing on initial steps towards this long-term reform in the areas of aged care, public health and a number of specific health-related programs that might be integrated with the Medicare Agreements on hospitals.

The important thing to note is that the COAG reforms are not solely driven by financial considerations – the changes are primarily designed to improve services, both in a clinical sense and in the sense of providing the services that meet the needs of consumers, reflecting the commitment to quality that underlies the agreement.

Commonwealth activities and priorities in line with COAG

The COAG reforms will have a major impact on the Commonwealth Department of Health and Family Services. It will need to shift away from service delivery to broader strategic analysis and performance measurements. It will need to balance emphasis on health financing with the skills, information and networking necessary to ‘add value’ in the areas of health outcomes and quality of care. The department is looking to become a world-class national health authority.

The Commonwealth has been working for some time on the development of performance and outcome indicators in the health sector. This work will now have greater significance in the context of the COAG reforms. Under the new arrangements, the Commonwealth’s leadership role in health extends to utilising the performance and outcomes measures to identify, develop and promote the adoption of best practice approaches to achieving quality care.

The Commonwealth is strongly committed to working in partnership with the States as well as with the broader health industry to develop models and demonstration projects. These models will show how different parts of the health sector can adopt best practice approaches to organisational and clinical practice in a real and practical sense.

Essentially, we want to establish jointly with the industry performance indicators and health outcomes measures that can inform the development of models and guidelines for best practice quality of care.

Quality of care and health outcomes

Measuring performance has taken on new levels of importance, both for the Commonwealth and for providers, particularly those operating in a casemix or funder/purchaser/provider environment. You may question whether this is developing yet another area for duplication across levels of government – my answer would have to be no.

While we are working to develop national consistency in data collection requirements and performance indicators of health outcomes and quality of care, this work is being done with the States and the industry to develop, trial and implement national performance indicators which are valid and reliable at the local, regional and State levels. We do not want to generate information and data collection activities that are not relevant at the provider level, as this is the level where improvement strategies are most likely to be relevant.

For example, some commonly used indicators, such as rate of unplanned return to an operating room, have limitations as hospital-wide quality of care indicators. Rather than the rate of unplanned return to operating room being used as a national indicator, it would appear to have more practical use for surgeons at the local level who may wish to use it to review and improve their individual practice.

The 'unplanned readmission rate' also appears to have limitations as a hospital-wide indicator and it would be more valuable to examine it against specific medical conditions and surgical interventions, so that it is more meaningful. Rates vary considerably across illnesses/surgery types and high or low rates may easily become hidden in aggregated data.

In the long term, it is the States and providers that will use the greater flexibility in Commonwealth–State funding arrangements to offer a range of better services to consumers, with the Commonwealth concentrating on the outcomes to be achieved. I expect that we will be moving to a system where States and providers can draw out more detailed measures of performance relevant to their management responsibilities, while the Commonwealth can report from the same system on the bigger picture of performance in terms of population health outcomes, quality of care and access to service.

Clinical best practice

Another dimension of quality is clinical best practice supported by evidence-based guidelines, more commonly known as evidence-based medicine.

An essential component of developing a best practice approach to care is having the evidence of the effects of care. However, evidence-based practice is not just about collecting and analysing all the data on the effectiveness of a particular intervention. Information must be available and readily usable within a framework that supports quality directly.

Other issues that have an influence on effectiveness need to be identified and incorporated, such as resource and access issues, the characteristics of particular subgroups of patients and the views of particular practitioners. The work done by health organisations on customer focus, the needs of patients and patient education contribute significantly to achieving evidence-based results.

Best clinical practice can be supported by an improved understanding of the resource demands, patient needs and clinical experience collectively held by the health service. Clinical practice guidelines are not 'cook-book medicine' – they are guidelines that have been systematically developed by practitioners to help decide appropriate health care for specific clinical circumstances. They can

inform practitioners, patients and resource managers about the range of treatment options and their relative effectiveness. The aim should be to improve practice so as to improve patient health outcomes.

The National Health and Medical Research Council (NHMRC) has embarked on a demonstration program to introduce the Australian health community to the process of developing and implementing evidence-based clinical practice guidelines. The NHMRC is encouraging widespread participation by the professions in the development and use of evidence-based guidelines, including the establishment of a set of procedures which bodies outside of the NHMRC can follow if they wish to seek endorsement of guidelines they themselves develop.

A key challenge for the department is to make far more use of the world-class expertise in the NHMRC network to support improvements in public health and disease treatment.

The health industry and best practice

Ultimately it will not be governments that determine the success of the COAG reforms. That role will fall upon service providers, and the leaders and innovators in the health industry.

It is important for the broader health industry to adopt and own responsibility for best practice.

The role of government is to set the broad directions for public health improvement and health outcomes that the community seeks and can afford. Government can also assist service providers to achieve improved outcomes by facilitating the identification and development of best practice approaches, clinical protocols and guidelines, and by the collection of nationally consistent data. Governments must also develop new financial mechanisms which promote rather than hinder best care for individuals.

But leadership should not be left solely to government.

Leadership is the first key principle of best practice. In many respects best practice can be described as the search for leadership and direction – the identification of the best by an individual or a corporation, and the systematic determination to replicate, adapt and improve on it. It is important that the industry builds a culture which focuses on performance and acknowledges the best with shared pride.

Collaboration and cooperation

The challenge is to create opportunities for others to learn and develop from the experience of the leaders in the health industry, and from leaders in other fields dealing with similar challenges.

Barriers to cooperation within and between health organisations must be overcome. While this is possible using aggregated data and broad clinical and practice guidelines and protocols, the experience of best practice organisations is that detailed benchmarking and collaboration with industry leaders on processes and outcomes leads to breakthrough levels of change.

Collaboration in a competitive environment might sound contradictory but it is essential if we are to encourage the spread of best practice approaches to health. A number of organisations have already established fruitful and enduring partnerships – not necessarily with direct competitors, but with those organisations with a commitment to share and profit by the lessons that can be gained from establishing partnerships.

However, a clear message coming from organisations participating in benchmarking and collaborative partnerships is that there is not yet a sufficient critical mass of organisations involved in best practice. Finding suitable benchmarking partners is difficult and there is a significant resource pressure on organisations identified as industry leaders as others seek their assistance.

Until there is sufficient expertise in the health industry, and wide acceptance of benchmarking and collaborative partnerships, progress on implementing best practice will be constrained. A further barrier is the traditional divide between the public and private sectors and between the health industry and other service industries.

Mainstream quality management approaches are now broadly accepted, if not widely practised, in the health sector. The efforts made by organisations such as the Australian Quality Council to incorporate the health sector into the quality movement and encourage health services to apply for quality awards will add considerable drive to the introduction of best practice for quality care.

As the department restructures and changes its focus, it will take an active part in promoting collaboration and cooperation across the whole health sector. For this to occur, it needs to build up its capacity to 'add value' and be a world-class organisation in its own right.

Commonwealth support for best practice

The Commonwealth Government considers that it can play a strategic role in assisting the health industry to identify and adopt best practice for quality. The development work on best practice and quality measures being done by the department includes:

- the demonstration projects of the Best Practice in the Health Sector Program, designed to give practical examples of how organisations have gone about developing and implementing best practice in a range of health settings
- the development of an Integrated Quality Management Model in acute hospitals, with the aim of generating a model structure for integrating quality management programs
- the benchmarking report on the health sector, which seeks to provide nationally consistent benchmarks for the health sector and the information necessary to pursue quality, access and appropriateness of care issues
- activities associated with the department's collaborative change program involving major public hospitals, which is investigating and developing models for best practice approaches to the management of waiting times for elective surgery
- the identification and trialling of quality of care and outcome indicators which will provide nationally consistent performance measures to assess outcomes and quality of care in Australian hospitals.

The message emerging from these activities is that the hospitals and other health services that are leaders in their field have not become so by chance. They have achieved that status by adopting well-developed and strategic management processes, by having a culture and practice based on quality and having the structures in place to support the pursuit of quality.

Conclusion

Organisations that have adopted a best practice approach to change have drawn information and inspiration from a number of sources – in particular, the convergence between best practice, quality management and benchmarking.

The key principles of quality management – leadership, policy and planning, information and analysis, people, customer focus, process and service, and organisational performance – are now well accepted and proven in their application to a broad part of the health industry.

Benchmarking – the search for best industry practice aimed at achieving superior performance – is also being increasingly accepted by health organisations looking beyond their own walls and beyond the health industry for ideas and innovation.

Above all, the convergence of best practice and quality management approaches to change supports the proposition that there is a role for all – clinicians, support staff, managers, consumers and governments.

It is hoped that we will see an increasing and enduring development of networks and links within the health sector, in particular, among small and medium-sized organisations. There are many examples of organisations adopting best practice through partnerships with similar organisations or with the assistance of larger partners. The cost and complexity involved in adopting best practice is a barrier – but one that many organisations have demonstrated can be overcome by selective and strategic partnerships with other organisations seeking solutions to particular organisational or clinical issues.

The future of best practice lies with the health industry in its broadest sense. In the end it is the industry that will evaluate and judge the merits of a quality approach to health care, deciding whether this approach offers the way towards achieving improved outcomes for patients and quality patient care.