Cost Analysis of

Safety and Quality Accreditation

in the Australian Health System

Prepared by Glenn Appleyard and John Ramsay & Associates for the Australian Commission for Safety and Quality in Health Care

17 January 2008
# Table of contents

Executive summary............................................................................................................. 3

Introduction ......................................................................................................................... 5

Section 1 - Scope of analysis............................................................................................. 8

Section 2 - Methodology employed............................................................................... 10

Section 3 - Consultation process.................................................................................... 13

Section 4 - Conclusions from survey interviews and case studies.......................... 15
   Results by health institution, category of institution .................................................. 15
      General Practitioner Services ................................................................................. 15
      Hospital Services...................................................................................................... 18
      Physiotherapists....................................................................................................... 21
      Optometrists.............................................................................................................. 23
   Case studies ................................................................................................................... 25
      Radiologists ............................................................................................................. 26
      Other stakeholders................................................................................................. 30
      Benchmarking efforts ............................................................................................. 30

Section 5 – Key findings.................................................................................................. 33

Appendices ........................................................................................................................ 35

Appendix A  Extract from Request for Tender – Statement of Requirement A1
Appendix B  Business Cost Calculator: Business Cost Categories A6
Appendix C  List of interviews A9
Appendix D  Summary of interviews with GPs A11
Appendix E  Summary of interviews with hospitals - ACHS A29
Appendix F  Summary of interviews with hospitals – ISO 9001 A56
Appendix G  Summary of interviews with physiotherapy practices A65
Appendix H  Summary of interviews with optometry practices A77
Appendix I  Case studies A75
Appendix J  Tables extracted from the relevant ABS publication; 8685.0 Private Medical Practices 2001-02 A95
Appendix K  References A98
Executive summary

The consultants were commissioned to undertake a cost analysis of safety and quality accreditation in Australia in order to establish an indicative baseline cost associated with participating in the accreditation process. This is an important first step in gauging the level of resources and effort currently committed towards this activity. It was not intended that the survey should be a full cost benefit analysis. Such an analysis will only be possible when the nature and extent of any proposed reforms have been fully articulated and possible options documented. Nonetheless, it is expected that the information in this report will form a useful basis for further work.

Considerable effort was made through a series of structured interviews across a range of health care providers to establish quantitative data to enable an analysis to be undertaken. However, it is evident that separate, identifiable data is not collected purely in relation to the costs of health service accreditation.

The structured interviews with individual sites plus discussions with a range of other key stakeholder groups have provided a considerable amount of qualitative data concerning the processes associated with accreditation. While much of this information related to cost and time imposts, nearly all of the participants also volunteered evidence regarding the benefits associated with the processes. While we recognise that the terms of reference did not seek an evaluation of the benefits as well as the costs, nonetheless, it is significant that in describing the hidden costs, many interviewees saw fit to balance these comments against the perceived benefits.

While the specific findings for each category of health care provider differ there are a number of common themes. Among them are:

- a strong sentiment that the activity required to achieve accreditation is essentially perceived as part of core business in the hospital and GP sector and that many of the costs required for compliance with the standards would be incurred as part of quality or good practice;

- in many instances, accreditation is inseparable from sound risk management and quality management procedures;

- the overlap of accreditation processes with quality management and continuous improvement means that it would be difficult to separately identify the costs; some may argue that to do so would run counter to efforts to embed accreditation processes with everyday operations;

- the smaller the organisation the more burdensome the task of preparation and compliance for accreditation, and the more likely that accreditation will be seen as a process diverting resources from income producing or service delivery activities;
• accreditation is more likely to be undertaken if there is a direct financial incentive for doing so.

Many organisations, while supportive of accreditation, were frustrated at the extent of overlap and duplication between accreditation, regulatory and contractual requirements, for example, having to meet State licensing requirements, accreditation requirements and requirements established as part of contractual arrangements with health insurers and consider that this involves additional cost.

A note of caution must be added. The range of health care providers surveyed had all undergone accreditation and have agreed to participate in the survey for this analysis. For that reason, the survey group was more predisposed towards the concepts of accreditation and generally were more open to recognising the intangible benefits that are expected to flow from the accreditation process.
Introduction

Objectives of the study

The Australian Commission on Safety and Quality in Health Care (ACSQHC) [the “Commission”] engaged Glenn Appleyard, public finance consultant who worked in collaboration with John Ramsay and Associates Pty Ltd, health consultants, to undertake a cost analysis of safety and quality accreditation in Australia in order to establish an indicative baseline cost associated with participating in the accreditation process.

Terms of reference

The terms of reference for the study were set out as a Statement of Requirement in part B of the Request for Tender document issued by the ACSQHC in August 2007. The relevant extract from the Statement of Requirement is included in Appendix A.

The Statement of Requirement stated that:

“…the baseline cost will be developed from the following perspectives:

- Hospital services;
- Primary care services; and
- General Practitioner (GP) services within the public and private sector.

In determining the indicative baseline cost for participating in the accreditation process, the following cost categories should be used as a guide:

**Hospital services** may be categorised according to:

- Large (i.e. 400+ beds);
- Medium (i.e. 100-400 beds); and
- Small (i.e. < 100 beds) hospital services from a metropolitan, out of metropolitan and rural perspective within public and private sector;

**Primary Care services** may be categorised according to:

- Metropolitan;
- Out of Metropolitan; and
- Rural.

within the public and private sector.

**GP services** may be categorised according to:

- Solo practice (1 GP);
- Group practices (2 – 10 GPs); and
• Corporate practices (> 10 GPs).
from a metropolitan, out of metropolitan and rural perspective.”

Structure of the report

This report commences with a section describing the scope of the analysis undertaken. It refers to original range of institutions nominated, and the extent of coverage in accordance with the terms of reference. It refers to the areas where coverage was expanded in relation to GPs and hospitals, and in regard to the types of primary care providers engaged for consultation.

Section 2 describes the methodology employed for the analysis. It refers to the initial development of a detailed questionnaire survey in the expectation that detailed cost data on accreditation might be held by some organisations and would be capable of extraction form their financial reporting systems. The intention to use the cost categories defined by the Business Cost Calculator, a costing tool developed by the Office of Best Practice Regulation (OBPR) unit of the Productivity Commission is documented (Productivity Commission 2008, see Appendix B). The process by which the survey instrument was refined through consultation with key stakeholders is described. Benchmarking efforts to validate the information received are also discussed.

Section 3 provides details of the consultation process itself. While maintaining contact with the ACQSHC, on-going consultations were held with some standard setting organisations, accreditation agencies, major industry groups, and other parties with an interest in the accreditation process. The Section also summarises the process of gathering data and the structured interview held to gain the information required from the survey participants.

Section 4 presents the summaries of the information collected, and the conclusions reached regarding the data. It draws together both the empirical findings and the anecdotal evidence relating to the costs of accreditation, in all of the sectors researched. It also contains a number of case studies aimed at highlighting the impact of accreditation on a typical primary care provider.

The final Section presents the key findings from our study. It describes the extent to which cost attribution has been possible, refers to what has been achieved to date and what might prove to be of practical value in the future, and concludes with some observations that it is hoped might be of assistance to the Commission in its future work program.

A series of appendices provide relevant background information to the study.

Acknowledgements and disclaimer

The assistance provided by the staff of the Commission is greatly appreciated. In addition, during the consultation process, many organisations and individuals gave freely of their
time and expertise to respond to questions and requests for data. We are particularly grateful to them for their helpful suggestions and support.

The conclusions reached in this report are attributable to the consultants only, and are not to be taken in any way as representing the views of the Australian Commission on Safety and Quality in Health Care or the organisations involved in the gathering of the data and information.

The report has adopted the approach to language used in the Commission’s Report on Initial Stakeholder Consultations: The review of national safety and quality accreditation standards that “...there is a range of terminology used to apply to processes that can broadly be described as accreditation, certification or surveying against standards. This report uses the terminology that is most common in the health sector, but recognises that other terminology is also used. The use of terminology in the report does not imply support for any particular approach.” (Australian Commission on Safety and Quality in Health Care 2007 p. 21).

The report is based on information available as at 17 January 2008.
Section 1 - Scope of analysis

Original range of institutions – coverage

The cost of accreditation could be broadly interpreted to include the costs of:

- developing standards used for accreditation by standard setting bodies
- assessment of performance against the standards by accrediting bodies
- participation in accreditation programs by health services

The study focuses on the costs of participation in accreditation programs by health services.

Once commissioned, one of the initial tasks was to establish a group of organisations suitably representative of the types of institutions described as being within the scope of the study. The Commission assisted in the identification of organisations prepared to assist in the collection of data. The Commission provided contact details for:

- 10 GP practices, 7 of which participated in interviews with 6 providing information for use in the study
- 10 public hospitals and one private hospital, all of which participated in interviews

The following health services were identified through national organisations and participated in interviews:

- 3 private hospitals
- 3 physiotherapy practices
- 4 optometry practices
- 2 primary health services

The list of organisations was designed to provide sufficient coverage across both the public and private sectors, where applicable, and a cross-section of units by scale and geographic location. Location was designed to cover a range of States as well as urban, regional and rural sites. This issue was important in relation to general practitioners (GPs) and hospitals given the different characteristics associated with operations of different sizes and at diverse sites. For primary care providers, where more frequently solo practitioners or smaller practices were involved, geographic factors were less of a focus.

Expanded coverage of GPs

Given the significance of General Practices within the health care system and the period for which accreditation has been in operation, efforts were made to maintain the number of practices included in the survey as some original nominees chose not to participate.
Expanded coverage of hospitals

Similarly, the number of hospitals was expanded in terms of the number of individual sites as well as corporate organisations that represented large groups of hospitals of various sizes and locations.

Broadened range of primary care services

While the number and types of primary care providers was not specified in the indicative cost categories, approaches were made to a number of national organisations as well as individual businesses. Primary care providers included in the survey were physiotherapists and optometrists. There were also discussions held with the national peak body for psychologists as these professional groups had established voluntary accreditation programs.

Included in the appendices to this report is a schedule listing those organisations that participated in the study. It illustrates the geographical coverage achieved as well as the range and size of agencies involved. The report and summaries of interviews do not attribute data and comments to the organisations interviewed. Accordingly, the list of participants refers to some organisations by name, whilst others at their request are identified by description only.
Section 2 - Methodology employed

Original intentions - detailed questionnaire

Because of the different nature of the health care involved, it was initially intended to establish a detailed survey questionnaire for each type of provider; that is, separate survey instruments for the General Practices, hospitals, and other providers to be covered. In order to provide a context within which responses could be given, the initial drafts of the survey instruments were framed around the Standards used by each accreditation agency. These have been developed by the accrediting body in conjunction with the relevant professional body. Based on this framework, it was expected that a considerable degree of disaggregated information might be capable of collection for each particular area covered by the various Standards. An approach of this kind would have proved practical had the various health units developed costing systems capable of identifying the costs of accreditation as they occurred, as either direct or indirect cost inputs.

Cost categories based on BCC template

Had this detailed information been available, a further refinement contemplated was to segment this information using the cost categories identified by the Business Cost Calculator developed by the Office of Best Practice Regulation (Office of Best Practice Regulation, see Appendix B). The Business Cost Calculator is designed to provide a standardised process for policy development considerations, including estimating the existing compliance cost on businesses of regulatory measures. It is intended to cost first-round effects only and to give a verifiable indication of the size of the compliance burden. This basis of cost attribution would have been useful to the Commission, as part of any future Regulatory Impact Statement that might be required in relation to the further development of accreditation. However, the lack of detailed costing information prevented application of these elements. Nonetheless, the cost categories may provide a useful starting point for any future detailed costing exercise.

Process of engagement, feedback and modifications to survey/interview instrument to match accrediting bodies’ and standard setters’ expectations.

Having developed the draft survey instrument, we thought it prudent to submit it to both the standard setting bodies and the accreditation agencies to gauge their reaction to the applicability of the survey format and level of detail sought. The response led us to make significant alterations to the survey in terms of the content and the manner in which to engage the survey participants. It became evident that the extensive reference to the standards themselves was not necessary given the degree of familiarity with them, and that highly disaggregated cost information was unlikely to be available. The length of the survey was reduced and the cost categories derived from the Business Cost Calculator were deleted.
It was also deemed preferable that rather than requiring the respondents to complete the survey questionnaire unaided, the information should be gathered through structured interviews with each respondent.

**Curtailment of detailed cost information**

The reduction in the level of detailed cost information capable of being produced from the survey has caused a change in the overall nature of the study. Rather than being an empirical analysis of the overall level of cost of accreditation and the components that contribute to it, the study draws from the interviews with the individual sites and the corporate participants their impressions and observations regarding the manner in which accreditation impacts on their businesses. While some broad elements of the cost of accreditation have been established, definitive data as to the cost impact cannot be obtained at this stage. In some areas of health services, this is because accreditation is a relatively recent development. In other areas, although accreditation has been in place for many years, in the absence of a specific costing system capable of identifying those elements of cost related to accreditation, reliable and relevant data cannot be obtained.

The data available precluded any comparison of accreditation costs between different parts of the health sector. However, any attempt to compare accreditation costs is likely to be problematic and probably invalid, due to the different standards, processes and approaches involved.

**Costs of participating in accreditation programs and compliance with standards**

It is evident that accreditation involves a range of costs. Some of those costs are clearly only attributable to accreditation. Other costs may relate to activities which are partly done for accreditation and partly for another purpose eg general quality activities, risk management, regulatory requirements, business operations or best practice. Sometimes accreditation may require additional documentation about activities.

The study attempted to identify as accurately as possible the costs which directly or indirectly relate to accreditation. Where only a proportion of a cost relates to accreditation, the study was designed to attempt to quantify that proportion.

Costs relating to accreditation can be broadly divided into two groups:

- Costs of participating in accreditation programs, including payment of fees to an accrediting body, documentation in preparation for survey, arrangements for survey including planning, staff time to accompany the survey team, actioning survey recommendations etc.
- Standards costs – costs associated with complying with the relevant standards for the accreditation process

The second group of costs is more complex to identify as attribution of costs between accreditation, ordinary business activity, best practice, regulatory requirements, continuous improvement etc is not straightforward.

**Attempts at benchmarking**

As well as the responses from the survey interviews, it is useful to contextualise the overall level of expenditure in relation to accreditation. It has proven difficult to access data of a comparable timeframe and quality. However, wherever possible efforts have been made to benchmark the cost estimates.
Section 3 - Consultation process

Engagement with ACSQHC throughout project

During the course of the project we have consulted closely with the staff of the Commission. Discussions were held regarding the range and scope of health services to be consulted and initial contact regarding their willingness to participate in the survey was made by Commission staff. This approach helped to maximise the number and quality of responses to our structured interviews. Staff of the Commission also provided helpful feedback during the drafting of the report.

Key stakeholders

In order to ensure that the survey instruments used were as relevant as possible, early consultations were held with some key accreditation agencies and standard setting bodies, including the Australian Council on Health Care Standards (ACHS), the Royal Australian College of General Practitioners (RACGP), QIP/AGPAL and the Quality Improvement Council (QIC). Similar, but separate survey instruments were framed for each group of health care providers based closely on the standards used for accreditation. The feedback provided enabled us to refine the structured interviews to ensure that they were both pertinent to the issues involved and could elicit a response within a relatively brief period of time.

These key stakeholders also gave us important contextual and general information regarding the accreditation cycle and the relationship between clients, their self-assessment processes and the work of the surveyors. They were also prepared to provide some insights into previous efforts to quantify the costs associated with accreditation.

Expanded group of stakeholders:

As well as the in-depth discussions with the key accreditation and health bodies in the general practice and hospitals sectors, interviews were also conducted with a range of other health care provider peak groups, such as the Optometrists Association Australia (OAA), the Australian Physiotherapy Association (APA), the Australian Psychological Society (APS), and the Royal Australian and New Zealand College of Radiologists (RANZCR).

Other interested stakeholders that contributed to the project included the Professional Services Review (PSR) and the Aged Care Standards and Accreditation Agency (ACSAA) and the Department of Health and Ageing (DoHA). A list of those groups and organisations that were consulted during the course of the project is attached as Appendix C.
Structured interviews; responses to questions and other key feedback

Following the refinement of the survey questionnaire as described earlier, structured interviews were conducted during November and December 2007 to elicit responses from the practices, hospitals and other health care providers prepared to participate. As well as the specific questions raised, the participants were given an opportunity to make any other general comments regarding the accreditation process.

Case studies

The study also undertook two case studies of primary care services accredited against QIC Health and Community Services Core Standards. QIC suggested that a case study approach would more effectively engage with services using its core standards. The primary care services were interviewed in person about their experience with accreditation against the QIC core standards and the costs involved.
Section 4 - Conclusions from survey interviews and case studies

Results by service type

General Practitioner Services

GP practices can volunteer to be accredited against the RACGP Standards for General Practices and once accredited can access the incentive payments through the Practice Incentives Program (PIP).

Survey interviews were conducted with six general practices and these are summarised in Appendix D. The participating practices included in both rural and non-rural locations and ranged in size from a sole GP to a group practice of 9 FTE GPs. Most had gone through several accreditation cycles. None of the practices had attempted to track accreditation costs separately, and generally, few had attempted to estimate the costs associated with accreditation.

A common response was that the preparation and on-going maintenance costs associated with accreditation were considered to be part of core business. The boundaries between quality management, risk management, compliance with standards or regulatory requirements, as opposed to accreditation per se, were extremely blurred and generally described as part of good business practice and continuous improvement.

Accreditation costs

According to a major accreditation provider, 90% of GP practices are accredited (AGPAL). The following fees were obtained from one of the two GP assessment bodies, QIP/AGPAL on 16 January 2008 (QIP/AGPAL 2008):

<table>
<thead>
<tr>
<th>Service description</th>
<th>Fee item</th>
<th>Time period</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGPAL</td>
<td>GP practices</td>
<td>Registration Accreditation 1st cycle Accreditation 2nd cycle Accreditation 3rd cycle</td>
<td>Per FTE $1,380.00 + GST Per FTE $1,880.00 + GST Per FTE $1,345.00 + GST Per FTE $1,815.00 + GST Per FTE $1,260.00 + GST Per FTE $1,760.00 + GST</td>
</tr>
<tr>
<td>GPA Accreditation Plus</td>
<td>GP practices</td>
<td>No fee information available</td>
<td>3 years</td>
</tr>
</tbody>
</table>

One practice estimated that preparation involved at least 200 person hours and based on a labour rate averaging $30 per hour, this suggested a preparation cost of around $6,000. It
was reported that the survey process mostly involved the practice manager and nursing staff, with the majority being the practice manager’s time. The accreditation survey itself was estimated to take around 4 hours.

Several practices referred to one-off costs related to modifications or re-configurations to surgeries, but all concluded that the access to PIP benefits substantially outweighed the costs. In addition, there was an overall sense that accreditation brought with it intangible benefits. The following statements best summarise the sentiments of the respondents;

“Accreditation gives the patient peace of mind because they know that you are conducting the practice to a high standard. We have a sign on the door that this is an accredited practice and think the message got through to patients.”

“We get minimal benefits from accreditation. It’s nice to know that we are accredited from a patient perspective but we’ve always maintained high standards and I’m sure there is a proportion of the patient base that really appreciates that the practice is accredited. However, we’ve always been in the situation of having more patients than we know what to do with, so there is no marketing advantage in terms of being accredited. The one factor where you could say there is an invisible advantage is that by being accredited and having an enforced discipline about standards, the chances of being sued or potential litigation are probably reduced.”

Some general views of RACGP officers reported at the time of the RANZCR post implementation review report (Royal Australian and New Zealand College of Radiologists 2005) were as follows:

“RACGP officers believe the non-economic benefits to general practice of accreditation include:

- Peer review assessment of practice procedure
- Standards provide a safety net for practitioners
- Accreditation provides general practice with professional recognition

Information systems play a part in the accreditation process, transferring data to the Health Insurance Commission (HIC) and providing a record of recall rates. However, these aspects are only a small part of the process, with the standards addressing access, continuity and coordination of care as well as diagnosis and management of specific health problems.

The RACGP officers stressed that accreditation was a part of an overall practice improvement process that included education and quality assurance programs.”

Some references were made to the overly bureaucratic nature of the accreditation process. The general consensus was that the first round of accreditation had proved to be particularly onerous, principally in relation to the documentation and preparing the manuals required, whereas subsequent rounds of the accreditation cycle had proved to be less time consuming.
The initiative by one of the accreditation providers to develop an electronic assessment tool is likely to address these concerns, and should reduce time and costs of preparation.

A recurring theme in relation to sole practitioner surgeries was that the preparation of documented manuals and self assessment activities fell almost entirely to the GP, given relatively few resources by way of support staff, and that the processes represented time out from what would otherwise be fee generating time.

An observation from one surgery concerned the duplication of accreditation where medical students from three different universities were on rotation to the practice. Although the AGPAL processes generally met the conditions required, nonetheless, further accreditation documentation was involved. Practices ordinarily require specific accreditation to participate in education and training programs. Any overlap between practice and education and training accreditation processes has not been explored as part of this cost study or the broader accreditation review undertaken by the Commission but is an issue for some primary care and GP services.

An observation was made in discussions during the study that accreditation is not well promoted to the community as an important factor on which to base the choice of a practice, and as a result, the benefits of accreditation are less than they might otherwise be. The benefit to the practice was frequently in the pre-accreditation process and the self assessment. The standards are viewed by the RACGP, as custodian of the profession’s standards, as normative – not minimal or best practice, but what is considered to be normal good practice. This represents an important medico/legal context in that, if an organisation did not meet the RACGP standards, it may be perceived as beneath the professionally accepted standard.

In April 2003, the Productivity Commission released a research report on General Practice Administrative and Compliance Costs (Productivity Commission 2003). In its findings, that report gave considerable prominence to the costs of accreditation as they related to access to the PIP. While the report attaches caveats to the estimates made and the data used, in our view, it remains the best resourced and most accurate estimate that has been made of accreditation costs impacting on a health care provider sector.

The report concluded that, based on the 4,829 practices involved, total annual accreditation costs were $48.7 million, comprising $19.3 million of non-labour costs [nearly $4,000 per practice] and $29.4 million of labour costs. These labour costs were made up of GP costs of $5.8 million [$1,200 per practice], nurse costs of $7.2 million [$1,500 per practice], practice manager costs of $5.6 million [$1,171 per practice] and receptionist costs of $10.7 million [$2,216 per practice].

This estimate of the cost of accreditation was the second highest impost on GP practice costs recorded, exceeded only by vocational registration associated with Medicare access, where the total cost was estimated to be $74.2 million. As the number of practices undertaking accreditation has increased since then, we would expect that the overall cost estimate has also grown proportionately. However, while the overall cost may have increased, the costs within individual practices may have decreased over time as there are efficiencies from
participation in second and subsequent accreditation, and the development of on line and electronic support tools for accreditation will no doubt generate efficiencies.

**Hospital Services**

Hospitals participating in organisation wide accreditation generally use the ACHS EQuIP standards or ISO 9001 quality management systems requirements. ACHS accredits health services against the EQuIP standards, while a number of providers certify against ISO 9001.

Government policy may require public hospitals to participate in accreditation programs. Private hospitals may be required to be accredited under licensing legislation or under contracts with health funds. Private hospitals must satisfy the Private Sector Quality Criteria, to access second tier default benefits under private health insurance arrangements. Compliance with the criteria can be demonstrated through accreditation by an industry approved and accredited accreditation agency.

Within this sector, it was possible not only to conduct interviews with a range of sites varying in terms of size and location, but also with senior personnel from a number of major corporate organisations in the private sector responsible for the operation of multiple hospital facilities. A summary of interviews in relation to hospitals accredited by ACHS is at Appendix E and those undergoing certification against ISO 9001 quality management systems requirements is at Appendix F.

**ACHS fees**

A list of health services and organisations accredited by ACHS is available on the ACHS website www.achs.org.au. ACHS accredits 73% of public hospitals and 80% of private hospitals.

ACHS fees are determined through a mutually agreed assessment (between ACHS and the member organisation) based on the size, complexity and geographic spread. Interviewees provided information in relation to fees paid to ACHS which are determined through a mutually agreed assessment (between ACHS and the member organisation) based on the size, complexity and geographic spread. Interviewees provided examples of fees they paid to ACHS which ranged between $8,000 to approximately $15,000 for hospitals varying from a small rural to a medium metropolitan hospital. These figures were provided by interview participants, who did not necessarily specify what the fees covered. They have not been verified with the assessing body and therefore should not be interpreted as comparable. Respondents were also able to identify separate costs for training, delaying scheduled surveys and other services provided by ACHS.

**ISO 9001 Health service certification**

A number of certifying bodies are licensed to certify against ISO 9001 Quality Management Systems, and each has their own fee structure. The number of health services that are
assessed against these standards is unknown. Interviewees provided examples of the fees they paid to ISO assessing bodies which varied between $6,000 to $30,000 for small to medium sized hospitals. These figures were provided by interview participants, who did not necessarily specify what the fees covered. They have not been verified with the certifying body. Accordingly the figures should not be interpreted as comparable or representative of fees charged by certifying bodies assessing against ISO standards.

Comments from interviewees

There were strong similarities in many comments about accreditation/certification from hospitals, whether public or private or using ACHS EQuIP or ISO 9001. Accordingly, this section summarises the overall feedback with more detailed information available in Appendices B and C.

For the corporate organisations, the common theme was that accreditation was largely a by-product of existing quality management programs and efforts towards continuous improvement. A significant proportion of departmental budgets included elements of quality care that were ultimately reflected in the accreditation outcome. Elements included:

- Participation in quality groups;
- Components of strategic planning;
- Documentation of policies;
- Incident reviews;
- Medication chart audits.

While the large corporate entities had not undertaken specific costing exercises in relation to accreditation, they were well aware of the proportion of the budget devoted to quality management, and that it was increasing in importance. Frequently costs associated with accreditation would emerge in the form of additional capital works required to comply with standards assessed as part of accreditation requirements, fire safety being a regularly quoted example.

Accreditation processes provided the large corporate entities with the capacity to undertake internal benchmarking on a range of activities including corporate governance, clinical governance, patient satisfaction and standard of care. This aided the targeting of areas for improvement. For example, where possible some organisations align their internal KPIs and clinical indicators with those in the standards used for accreditation. Performance is then tracked against the indicators, as well as in terms of the percentage of recommendations made in the surveys that have been addressed.

The point was made that there was a significant degree of duplication of data requirements, particularly in relation to private health fund insurers. While seeking similar types of information, there were nuances in terms of different clinical indicators for specific issues, and variations in patient satisfaction ratings. Although efforts could be made to manipulate the same dataset, the different requirements for licensing authorities, health funds and accreditation did not necessarily interface. At times, this duplication is increased because of State variations where State regulatory requirements do not align with those used by the
accrediting body. For example, efforts to develop national medication indicators by one organisation that operates in several States were frustrated by State differences.

Many of the issues that emerged from the structured interviews with the ten separate hospitals have a resonance with the finding from the discussions with the general practices, albeit on a different scale. Empirical cost data has not been assembled, although elements of it are recorded as part of risk management and quality management budgets. In some responses, it was inferred that the notion of isolating costs purely for accreditation ran counter to efforts to inculcate the culture of quality activities within ordinary business and procedures.

A quality assurance program can provide early warning signs of issues that need to be factored into budgetary processes. For example, where costs arise in relation to additional capital works requirements, the necessary works are sometimes fast tracked in order to comply with recommendations.

For smaller or more specialised organisations, it appears that the standards required may be somewhat less relevant and some of the actions required are purely for accreditation rather than necessarily being part of quality management. Nonetheless, a common sentiment was that while it is generally considered that the cost of accreditation may seem high if measured solely in financial terms, there are both tangible and intangible benefits. There are some tangible benefits which may, in part, offset the costs; for example, more streamlined and efficient operational systems. In addition, there are considerable intangible benefits including:

- an increased focus on quality and safety including an improved understanding of continuous improvement and systems evaluation
- a good framework within which to assess performance and to carry out a gap analysis for improvement
- a means of benchmarking performance against recognised leaders
- operational improvements which are not costed in terms of benefit but are accepted to result in improved outcomes for consumers eg avoidance of surgery, reduced recovery time, etc
- review by independent surveyors giving rise to various recommendations leading to improved performance
- increased consumer confidence/satisfaction that can lead to increased demand for services
- better outcomes for and communication with consumers which tend to lessen the number/severity of complaints registered and the cost associated with responding to them
- increased consumer/patient satisfaction by showing the organisation’s commitment to safety and quality
- assistance with governance structures and recruitment – many staff prefer to work with an agency that has been accredited.
- there is a measure of morale involved, particularly for smaller communities to know that the standards have been met and for the staff to know that they are doing a good job.
Duplication of accreditation type processes was evident in many of the structured interviews. Among the processes mentioned were:

- NATA accreditation of pathology services;
- Professional medical college accreditation for education and training in specialty areas;
- Accreditation for education and training for undergraduate and postgraduate students;
- State based standards and quality management assessment such as the Clinical Governance and Clinical Excellence Commission in NSW;
- OH&S and Workcover assessments, and food safety audits.

**Physiotherapists**

The peak industry body, the Australian Physiotherapy Association (APA) has developed accreditation standards and offered a practice accreditation program for some years. Accreditation is voluntary and there are no financial incentives for participation.

Discussions held with the APA about their standards revealed that empirical information on the costs of accreditation was not available. However, the APA reported that the findings from a review conducted in 2004 included evidence that the absence of a favourable cost/benefit outcome was one of the reason cited for the decline of the system of accreditation in place at that time.

QIP is now the sole provider of accreditation services against the Australian Physiotherapy Association Standards for Physiotherapy Practices. QIP advised that approximately 10% of physiotherapy practices voluntarily participate in accreditation.

**Fees**

The practices reported that the previous fee was $250 - $300 + GST in a survey year (every three – four years), with a $100 maintenance fee in the intervening years.

The following fees were obtained from the QIP/AGPAL website (QIP/AGPAL 2008) on 16 January 2008:

<table>
<thead>
<tr>
<th>Cycle</th>
<th>Surveyor Team</th>
<th>Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>ANY</td>
<td>ANY</td>
<td>$500.00 + GST</td>
</tr>
<tr>
<td>Accreditation 1st</td>
<td>PEER SURVEYOR</td>
<td>PER FTE</td>
<td>$990.00 + GST</td>
</tr>
</tbody>
</table>

Anecdotal feedback from accredited practices was that there were substantial costs including direct staffing costs that needed to be attributed to the process, direct costs for fees, as well as general upgrade costs that may be required. The costs were considered to be significant enough to cause providers to think carefully before embarking on the process. It was noted also that most physiotherapy practices did not have practice managers, and therefore there
was less opportunity to delegate some of the work required to prepare for accreditation, as occurs in some general practices). The 2004 review contained feedback that accreditation had taken substantial time away from clinical service. Further, when auditing was undertaken by a colleague it was sometimes perceived as a threat, adding to the negative perception of accreditation in some circumstances.

The interviews highlighted the difficulty in identifying costs which are largely integrated into core business rather than tacked on. The APA representatives noted that:

“The stronger the culture of quality a practice builds, the more difficult it is to quantify the cost of accreditation because it is embedded within the culture. If a practice doesn’t have that culture, there is a lot of work required to prepare for accreditation. Those practices are more likely to be able to quantify their costs but they are not practices to emulate.”

The APA is conducting a further benchmarking study in the first half of 2008. In terms of future work, the APA did indicate a willingness to work with the Commission to track accreditation costs in physiotherapy practices commencing accreditation, to determine what costs were part of ordinary business practice and which were specifically required for accreditation.

The issue of the need for incentives for extension of accreditation to the sector was also raised.

Survey interviews were conducted with three physiotherapy providers ranging from a solo practice to a large corporate business operating from a number of sites. None of these practices had developed formal costings of accreditation but were able to provide valuable insights into some of the main cost drivers. One practice estimated that the physical preparation of the documentation for an application to be accredited involved the practice manager for about 4 hours, while the principal’s involvement for document preparation also totalled about 4 hours. Other peripheral costs incurred partly to meet accreditation requirements included CPR certification for staff and OH&S assessments, development of new signage, and purchase of fireproof containers.

One respondent noted that while accreditation provided support by way of a management tool, there were no tangible benefits in the form of direct income or referrer advantage. GPs did not differentiate between accredited and unaccredited physiotherapy practices, nor was there any incentive element for Medicare or private health fund rebates. Another respondent argued along similar lines:

“The main cost is time getting the documentation ready. The process is good for you to keep up to date and make sure you have appropriate procedures – with 2 physios and 2 receptionists, you have to make sure they do courses, staff reviews and appraisals – all the things that you might let slip get picked up for accreditation eg staff contracts, emergency procedures, staff communication.
All these little things add to the cost of running a practice. The thing that makes money is seeing patients and anything that takes me away from that is expensive. So the processes involved in accreditation are good in keeping management skills a bit more advanced but they don’t help you treat patients better.”

In response to the question as to what investment would have been made in this area, had the practice not undergone accreditation, one practitioner estimated that roughly 90 per cent of expenditure would have been required in terms of meeting the standards, with around 5 to 10 per cent attributable to the decision to seek accreditation.

A detailed summary of the responses to the survey interviews is attached as Appendix G.

**Optometrists**

The Optometrists Association Australia (OAA) has developed standards for accreditation of optometrical practices. QIP offers practice accreditation against the OAA standards. Accreditation is voluntary and there are no financial incentives for participation such as the PIP program for GPs.

The OAA described its participation in the development of the standards with QIP, including the extensive consultation process conducted with its members. The standards development process involved an extensive literature search, consultation with other professions and people with expertise in the field, and analysis of other professions’ practice standards. The objective behind the development of the standards was to improve the manner in which its members operated their practices. The standards are despatched to the OAA members in the hope that even if practices choose not to participate in accreditation, they will use the standards to improve performance. OAA advised that it did not have any general information regarding the costs of accreditation to its members other than the fees charged.

Around 150 practices undergo accreditation out of 3000 practices throughout Australia. Generally speaking, there is no financial incentive for practices to undergo accreditation. However, the OAA advised that many accredited optometry practices are in Queensland possibly due to the actual or planned operation of a preferred provider scheme for accredited practices in which private health insurance funds direct patients to selected practices.

The OAA believes that unless there is a tangible incentive or financial reward such as the PIP program for GPs, most practices are not interested in accreditation. A practitioner with a number of practices indicated that he might get one practice accredited and then apply the outcomes to all the practices. This issue is pertinent to the current fee structure. The OAA also noted that it is difficult to encourage practices to undergo accreditation for the second time, as the perception is that the standards are unchanged and there is therefore little value in repeating the exercise.
QIP fees

QIP is now the sole provider of accreditation services against the Optometrists Association of Australia Practice Standards. QIP advised that approximately 10% of optometry practices voluntarily participate in accreditation.

The following fees were obtained from the QIP/AGPAL website (QIP/AGPAL 2008) on 16 January 2008:

<table>
<thead>
<tr>
<th>Cycle</th>
<th>Surveyor Team</th>
<th>Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>ANY</td>
<td>ANY</td>
<td>$500.00 + GST</td>
</tr>
<tr>
<td>Accreditation 1st</td>
<td>PEER SURVEYOR</td>
<td>PER FTE</td>
<td>$900.00 + GST</td>
</tr>
</tbody>
</table>

The responses from the 3 optometrists participating in the survey reflected several of the observations made by other primary care providers. The task of documentation was singled out as being onerous, but that much of the rest of the preparatory work required for accreditation was generally expected as part of good business practice. Most notably, the conclusion was that the first cycle was the most expensive and that unaccredited practices were unlikely to hold documentation on policies and procedures.

As regards the lack of cost information, one respondent volunteered:

“A lot of optometrists do accreditation because they think it will improve services and more holistic reasons and as a result they are less likely to quantify costs. Part of the reason for the lack of cost information is that accreditation is a progressive process – the main cost is staff time in documenting and reviewing processes and procedures. A lot of activity is not new - just formalising things so the cost is difficult to quantify. There is no infrastructure available to cost time such as there is in a legal practice.”

So far as the perceived benefits are concerned, the following extract from the responses reflects the position:

“A lot of practitioners tend to underestimate the benefits of accreditation because they focus on the cost whereas there are benefits in retention of staff, improving staff efficiency through good policies and procedures and standards and accreditation mean that you have good risk management in place so that the exposure to poor patient outcomes is significantly reduced. People often fail to quantify those benefits. Patient complaints are time consuming etc so good processes reduce the number and time involved.”

Further observations were made drawing parallels between the introduction of Continuing Professional Development (CPD) programs, and accreditation. The inference made was that accreditation was not yet accepted as part of the landscape of operating in the profession whereas CPD, after initial reticence, is now an integral part of the industry. The specific comment was:
“There is a lack of awareness of what the accreditation process confers on the practice eg risk management benefits and hidden financial benefits.

There is a perception in the profession that accredited practices hold themselves out as better and use it as a marketing tool. Some practices don’t want others to market on this basis as they see it as conferring an advantage even though they could access the advantage if they wished. There is an illogical loop that can go on and can be reinforced amongst practitioners in a political sense within the profession. We are trying to overcome and change those perceptions and create a positive perception of accreditation because we believe its an important step in raising standards in the profession. A few years ago, in relation to CPD, no-one kept records and now there is a move across the professions for a requirement for CPD and monitoring.

The resistance was similar to accreditation now – people should be left to their own devices. CPD is well recognised and most comply to reasonable degrees now. People should do CPD and if they don’t then they know they should. We are not at that point yet with accreditation. Assistance from government and the wider industry would be very valuable in setting those expectations and benchmarks.”

A detailed summary of the responses to the survey interviews is attached as Appendix H.

Case studies – primary care services

The case studies with two primary care services accredited against QIC Health and Community Services Core Standards involved more in depth discussions. Both services found that the benefits of the accreditation process outweighed the costs, although the costs were not separately tracked. The services were both part of larger health services, and there are commonalities between their views of accreditation and the opinions expressed by hospital services. The case studies are contained in Appendix I.

Fees

The costs of participating in the Quality Improvement Council program vary between providers licensed to accredit against the QIC standards. Providers commonly structure their fees according to the type of service being offered and the size, configuration and circumstances of the organisation. One QIC licensed provider states that the cost for undertaking the process ranges from approximately $1,500 - $30,000 depending on the size, complexity and particular needs of the organisation (Quality Management Services 2008) Another QIC licensed provider specifies annual fees for organisations of different sizes, commencing from an organisation of 1 – 5 FTEs at a cost of $4,311.00 up to an organisation of 76 – 100 FTEs at a cost of $20 026.00. The provider also offers a range of packages with different pricing (Institute for Healthy Communities Australia 2008).

Similarly to the other interviews conducted, the case studies were not able to identify detailed accreditation costs. One organisation indicated that its fees to be assessed against the QIC standards were $5,000. One organisation had initially attempted to quantify the
number of staff hours required to prepare for accreditation, but had not persisted due to the difficulty of the task. Both organisations acknowledged that there were a range of indirect costs of accreditation, including opportunity costs.

Both organisations highlighted a commitment to quality improvement and how this is reflected in the organisations’ approaches to accreditation. Organisation one commented that there is a tension between the imperative to gain accreditation for funding purposes and the philosophy of quality improvement. That organisation perceived that accreditation had assisted the organisation in recruiting staff.

Organisation one acknowledged the lack of evidence about the benefits of accreditation to client outcomes.

Organisation two commented that there is not enough information about the investment a service must make to achieve accreditation, and not enough organisational recognition of the additional resources required. This organisation considered that accreditation had been instrumental in the organisation’s investment in quality. The interviewee believed that without accreditation the organisation would not have reached the same standard of performance and that accreditation had built capacity in the service.

Both organisations considered that the benefits of accreditation outweighed the costs, although they were unable to quantify either the costs or the benefits.

**Relevant comments from other stakeholders**

As well as the categories of health care provider and their peak bodies, we also had discussions with a range of stakeholders involved in the accreditation processes. They included the National Association of Testing Authorities, [NATA], the Aged Care Standards and Accreditation Agency [ACSAA], the Australia Psychological Society [APS], and the Royal Australian and New Zealand College of Radiologists (RANZCR).

**Radiologists**

RANZCR has been developing a Quality and Accreditation Program for medical imaging practices in Australia since 1997 (Royal Australia and New Zealand College of Radiologists 2008). RANZCR states that “the ultimate aim of the program is the development of minimum standards of accreditation for all modalities of medical imaging….“  (2008). A voluntary accreditation scheme, jointly administered by RANZCR and the National Association of Testing Authorities (NATA) commenced in May 2004. The development and evolution of this accreditation process has given RANZCR a valuable insight into the associated costs.

The Quality Use of Diagostic Imaging Program (QUDI Program) which is managed by the RANZCR on behalf of the Commonwealth Department of Health and Ageing, undertook a post implementation review of accreditation of radiology practices in September 2005, very shortly after the voluntary accreditation scheme commenced (Royal Australia and New
Zealand College of Radiologists 2005). RANZCR has advised that since the review was conducted there has been significant review and development activity to further refine the accreditation scheme; this activity has addressed a number of the issues identified in the QUDI report and therefore the report does not reflect the current operations of the accreditation program.

Although the review is somewhat outdated, it is one of the only studies of accreditation costs, and has been included as an example of a historical study, subject to RANZCR’s qualifications above.

Historical information

The study contained an extensive discussion of the cost of accreditation as it related to this particular program. It also included a literature review of costs of accreditation in both the USA and Europe, but concluded from that review that:

“Data on costs for implementation of accreditation is absent in the literature apart from application and facility assessment costs.”

The main conclusions regarding the costs of implementation, based on a limited survey conducted by the project consultant, were as follows:

“Stage 3 preparation costs

Total Stage 3 preparation per site costs range from $71,111 for a single site public hospital to $166,610 for a multiple site private practice. Based on the comprehensive practice example given, RANZCR/NATA fees amounted to between 6 % and 15 % of the total Stage 3 preparation costs.

Average annual costs

Costs of monitoring the accreditation program range from $25,546 per annum for public hospitals to $27,559 for private practice.

10 Year Costs

Total costs on a 10 year basis range from $301,023 for a single site public hospital to $414,636 for a multiple site private practice. Annual NATA membership fees amount to between 16 % and 22 % of the total 10 year costs.

The independent practices indicated 40 % of a practice manager’s time and 20 % of an assistant’s time was required to prepare for accreditation (0.6 FTE).

All practices estimated on going monitoring of the program to be 10 % to 20 % of a Chief Radiographers time each site. Other resources required were limited to workshop and assessor training. Costs of attending assessor training involved replacement staff cost and some travel expenses.
NATA annual membership costs were considered to be excessive by all private practices.

Collection of accreditation costs per modality is not available in private practice, however may be possible in public hospitals."

The peak body also highlighted the dangers of duplication of processes given the number of bodies to whom its members are accountable.

RANZCR advised that the RANZCR/NATA program has evolved since its introduction. They highlighted the progress that had occurred since the review, including changes to the site assessment team arrangements and the standards documentation package. These revisions address issues raised in the QUDI report.

RANZCR considers that the views above are no longer likely to be representative. RANZCR suggested that it would be necessary to interview more recently accredited sites to get a more current and educated view of how sites are coping with the cost of accreditation under the Program. Unfortunately time precluded further discussions.

More recent developments

The RANZCR website contains information about the current costs of the RANZCR/NATA accreditation program (RANZCR 2008). An extract from the website including more definitive examples of direct accreditation costs by type of practice is set out below:

“RANZCR/NATA Accreditation Program - Site Examples of Costs

- The current hourly rate for the NATA staff officer is $202.
- A document review would only be required once per any group practice if the quality manual is applicable to all sites.
- If a site is part of Corporate Accreditation (i.e. part of a group practice with a uniformed quality management system applied across all sites) ongoing annual fees are reduced.
- After the initial assessment visit, all costs associated with future routine reassessments, to be conducted once every three years, will be covered by the ongoing annual fees.

Example of costs (inclusive of GST) as at December 2007

1. Small regional site offering plain film X-rays and CT. All reporting is performed off-site. One radiographer assessor will be required together with one NATA staff officer.

Application Fees: $2070 (NATA component)
Accreditation requirements package: $77
Document review of quality manual (3 hrs): $606
Pre & post assessment activities (~10 hrs)*: $2020
On-site (6-8 hrs): $1616

$6609#

2. * This is a rough approximation of hours and costs will vary depending on the hours required to service the applicant.
   # The site will incur additional expenses for assessor travel and accommodation. The extent of these will depend on whether the site is located at a distance from a capital city or the assessors are from interstate.

3. On-going annual fees (based on 1 assessor unit): $3305
   Note: After the initial assessment visit, all costs associated with future routine reassessments, to be conducted once every three years, will be covered by the on-going annual fees.

4. Large centralised site offering plain film X-rays, CT, mammography, interventional, ultrasound, BMD, MRI, nuclear medicine. There are separate fees for College quality assurance activities (i.e MQAP and MRI Image Review). 4-6 assessors required dependent on shared experience between them (1-2 radiologists to ensure all reporting aspects for each modality are covered) together with one NATA staff officer over three days.

Application Fees: $2070 (NATA component)
$220 (College component)

Accreditation requirements package: $77
Document review of quality manual (3 hrs): $606
Pre & post assessment activities (~15 hrs)*: $3030
On-site (20 hrs): $4040

$10043#

5. * This is a rough approximation of hours and costs will vary depending on the hours required to service the applicant.
   # The site will incur additional expenses for assessor travel and accommodation. The extent of these will depend on whether the site is located at a distance from a capital city or the assessors are from interstate.

6. On-going annual fees (based on 4 assessor units): $8780
   Note: After the initial assessment visit, all costs associated with future routine reassessments, to be conducted once every three years, will be covered by the on-going annual fees.

The RANZCR is planning a project to collect data on the cost of accreditation, as the first sites to participate in the RANCR/NATA program are starting to be reaccredited. RANZCR considers that this work is likely to elicit more accurate information about accreditation costs and perceptions of costs.
Other stakeholders

Among the observations made were comments that it was important not to view the act of becoming accredited in isolation. Benefits could include opportunities for increased work from the accredited status, and possible reductions in professional indemnity insurance because the organisation is accredited by a recognised accreditation body. Emphasis was placed on the need to consider the hidden costs of not being involved in an accreditation program, as how organisations approach accreditation through their own value systems and culture is important. If organisations see being accredited as a way of marketing, gaining competitive advantage, they are more likely to see it as a cost set against generated revenues.

The observation was made by the ACSAA that the effective test was whether an organisation endeavouring to operate a quality facility would undertake the elements required to achieve the accreditation standards, regardless of whether accreditation existed or not. In that sense, the real ‘cost’ of accreditation is the actual assessment itself. The other costs are simply the costs related to the conduct of a business within a quality framework. From the perspective of shareholders and owners of a business, achieving accreditation has a value in terms of public confidence. However, not unexpectedly, the fact that some accreditation arrangements form part of a regulatory environment and are thereby forced on providers lead them to perceive accreditation as a cost. For consumers, there is a value in evidence of proven performance.

The importance of avoiding multiple, confusing and potentially duplicative areas of accreditation was regularly highlighted. The point was made that if accreditation is to extend to providers such as allied health, it would need to be a clear and transparent process with minimal duplication. Mutual recognition of current processes should be pursued to reduce duplication and avoid settling for the minimum standard.

One national organisation advised that their basis of accreditation was voluntary but that an incentive to participate had been established because of the credits gained towards Continuing Professional Development. Thus as well as benefits derived for service delivery, there may be professional development benefits, although the take-up rate is low.

The study did not explore the costs of accreditation of pathology laboratories, although useful discussions were held with the National Association of Testing Authorities (NATA) about accreditation costs. We note that NATA fees are available from the NATA website (NATA 2008).

Benchmarking

Because of the lack of quantitative data, it is not possible to extrapolate from the survey an estimate of the national cost impact of accreditation. However, it is useful to provide some overall industry financial information to add context to the relative importance of accreditation costs. The information that follows, is included on that basis, but is meant to be indicative only.
Based on the annual reports of the major accreditation providers, it is possible to estimate the total amounts paid by way of accreditation fees. Having regard to the proportions of the health care providers using these accreditation agencies, efforts have been made to extrapolate the total amounts paid by way of fees.

Total fees payable in 2006-07 to one of the major accreditation agencies were in excess of $4 million (QIP/AGPAL 2007). The average accreditation cycle runs for 3 years suggesting that accreditation fees for practices currently undergoing accreditation total in excess of $12 million, given the level of coverage claimed by this accreditor.

An alternative assessment of fees could be based on the number of practices and the average fee per practice. The ABS survey of Private Medical Practices conducted in 2001-02 (Australian Bureau of Statistics 2003), provided details of the structure of general practices throughout Australia. At the time of the survey, there were 9,600 general practices operating from 12,091 locations. Of these, 8,046 were classified as operating in metropolitan areas, 1,406 in rural areas, while around 150 were classified as operating in remote regions.

In terms of practice size, 6,579 or 68.5 % were single practitioner operations, 2,429 or 25.3 % were practices with 2-5 practitioners, 492 or 5.1 % were practices with between 6-10 practitioners, with the balance of around 100 practices, or less than 1 %, consisting of more than 10 practitioners. Based on the number of locations and average fee per location, and the extent to which accreditation is undertaken, this suggests costs of the order of $13 million over the three yearly cycle.

So far as broader costs and revenues are concerned, the ABS survey recorded that total income was $4.4 billion, of which $170 million was by way of payments under the PIP, only a part of which would relate to a practice’s accreditation status.

Some of the major expense categories were labour costs totalling $1.8 billion, insurance premiums totalling $98 million, and rent of premises totalling $281 million.

Appendix J provides tables extracted from the relevant ABS publication; 8685.0 Private Medical Practices 2001-02, which are included to place the level of cost of accreditation into perspective.

**ACHS**

Established in 1974 as an independent, not for profit organisation, the ACHS currently has more than 1050 participating health care organisations and accredits 73 % of public hospitals and 80 % of private hospitals, excluding day facilities, in Australia, accounting for more than 87 % of total available beds. Its accreditation program includes acute care, community health services, nursing services, ambulance services, divisions of general practice, corporate offices and member organisations. They also undertake in-depth assessments based on the National Standards for Mental Health Services. ACHS conduct approximately 400 on site assessments each year.
The ACHS accreditation process known as the ‘Evaluation and Quality Improvement Program’ (EQuIP) is a four-year program including two onsite surveys and support to participating sites for self assessment in the other two years. The fee is spread evenly over the four years.

Based on the information published in its annual accounts, the comparable amount in respect to member fees which are essentially health service accreditation program revenues (see page 17 above) under the ACHS program in 2006-07 would appear to be of the order of $7 million. However, the ACHS fees encompass all costs inclusive of surveys, support, documentation, electronic tools, standards development and review, support for research, as compared to some other programs.

While accreditation fee costs for general practices are generally well known and documented, for other health sectors, fee information is not as readily available. A number of organisations do not publish their fees, presumably for competition reasons. A wider range of accrediting bodies participate in the market and the levels of participation are more variable. A number of organisations are small, and are not required to publish annual reports so information about gross fee income is not readily accessible. Therefore, information comparable to that provided above in relation to general practices has not been documented.
Section 5 – Key findings

Level of cost attribution

Based on the interviews with each group of healthcare providers, it is evident that, to date, little empirical information had been collected regarding the costs of accreditation. This is not surprising, given that it appears that very few organisations, other than perhaps major hospital groups, have developed sophisticated financial systems capable of recording such costs, nor is there a recognised set of definitions and cost codes by which to identify accreditation costs. There has also been no imperative or incentive to keep track of such costs.

While it is possible to establish the immediate direct costs such as the accreditation fees paid to the accrediting body, further estimates of the cost of accreditation would appear to be premature at this stage.

What we could establish, and what we couldn’t

We have established that while there is general support for the principle of accreditation, small allied health practices appear reluctant to embed it within established business practices unless there is a direct financial incentive to do so. Most hospitals and larger health services interviewed generally accepted the need for some external review of service quality.

A note of caution must be added. The range of health care providers surveyed had all undergone accreditation and have agreed to participate in the survey for this analysis. For that reason, the survey group was more predisposed towards the concepts of accreditation and generally were more open to recognising the intangible benefits that are expected to flow from the accreditation process. In fact, several interviewees expressed a degree of frustration with the process itself and the direct cost, but understood that the overall gains were likely to flow from the preparatory stages, the self assessment, and the discipline provided by the documentation of manuals covering policies and procedures.

We did not aim to survey non accredited bodies as they were unlikely to have information on accreditation costs. Presumably, their decision not to pursue accreditation is based, at least in part, on their perception that the costs, both direct and indirect, outweigh the benefits that would accrue from the process. This was the case in the one unaccredited physiotherapist practice that was interviewed.

Our work confirmed the difficulty in separating the costs of complying with accreditation standards from compliance for other purposes, such as good business practice. Some organisations were inclined to attribute the entire cost of their quality management/improvement system to accreditation, whilst others were much more
selective in their cost attribution. It will be important to control for these variances in any more comprehensive study of accreditation costs.

Comments as to statistical validity

Constraints as regards the length of time set aside for this study, its scope and the level of information available have meant that the cost analysis of accreditation undertaken is at best indicative, rather than a definitive survey capable of achieving a level of statistical significance. For example, assuming collectable data were available that conformed to standard definitions and costings, to be statistically significant at the 95% confidence level, a survey of the 9,600 General Practices throughout Australia would need to cover at least 96 practices. For that reason, where referenced, estimates of order of magnitude and cost impacts should be regarded as indicative of the overall position.

Information required for Regulatory Impact Statements

In the event that regulatory impact analysis of any proposed accreditation reforms is required, it is likely that the information contained in this report would be relevant to that analysis, given that it addresses both the costs and perceived benefits of accreditation. If however, it was considered desirable to undertake further specific cost studies, several organisations and sites about to participate in an accreditation program for the first time indicated their willingness to assist in such a project, subject to satisfactory resourcing arrangements.
Appendices

Appendix A  Extract from Statement of Requirement
Appendix B  Business Cost Calculator: Business Cost Categories
Appendix C  List of interviews
Appendix D  Summary of interviews with GPs
Appendix E  Summary of interviews with hospitals - ACHS
Appendix F  Summary of interviews with hospitals – ISO 9001
Appendix G  Summary of interviews with physiotherapy practices
Appendix H  Summary of interviews with optometry practices
Appendix I  Case studies
Appendix J  Tables extracted from the relevant ABS publication; 8685.0 Private Medical Practices 2001-02
Appendix K  References