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Shared decision making in Australia in 2017

Partizipative Entscheidungsfindung in Australien im Jahr 2017

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ABSTRACT

Shared decision making (SDM) is now firmly established within national clinical standards for accrediting hospitals, day procedure services, public dental services and medical education in Australia, with plans to align general practice, aged care and disability service. Implementation of these standards and training of health professionals is a key challenge for the Australian health sector at this time. Consumer involvement in health research, policy and clinical service governance has also increased, with a major focus on encouraging patients to ask questions during their clinical care. Tools to support shared decision making are increasingly used but there is a need for more systemic approaches to their development, cultural adaptation and implementation. Sustainable solutions to ensure tools are kept up-to-date with the best available evidence will be important for the future.

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ZUSAMMENFASSUNG

Partizipative Entscheidungsfindung (PEF) ist in Australien mittlerweile fest in den nationalen klinischen Standards für die Akkreditierung von Krankenhäusern, Tageskliniken und öffentlichen Zahnarztpraxen sowie in der medizinischen Ausbildung verankert; und es bestehen Pläne, diese auf allgemeinmedizinische Praxen, Alten- und Behinderteneinrichtungen auszuweiten. Die Implementierung dieser Standards und die entsprechende Ausbildung von Gesundheitsfachkräften stellen für den australischen Gesundheitssektor derzeit eine der wichtigsten Herausforderungen dar. Die Einbindung der Konsumenten in Gesundheitsforschung, Gesundheitspolitik und Steuerung der klinischen Leistungserbringung hat ebenfalls zugenommen, wobei der Schwerpunkt darauf liegt, Patienten zu ermutigen, im Rahmen ihrer medizinischen Versorgung Fragen zu stellen. Immer häufiger werden Instrumente zur Unterstützung partizipativer Entscheidungsfindung genutzt, ihre Entwicklung, ihre kulturelle Adaptation und Implementierung erfordern jedoch stärker systemisch ausgerichtete Ansätze. Für die Zukunft wird es nötig sein, nachhaltige Lösungen zu entwickeln, um zu gewährleisten, dass diese Entscheidungshilfen auf der Grundlage der besten verfügbaren Evidenz ständig aktualisiert werden.

Introduction to Australia, its health system and a health snapshot

Australia currently has a population of approximately 24.2 million people [1]. Australians enjoy one of the highest life

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expectancies in the world with males born between 2012 and 2014 expecting to live until 80.3 years and for females, until 84.4 years [2]. Coronary heart disease remains the leading cause of death, accounting for 13% all deaths in 2013. Cancer is the leading cause of disease-burden followed by cardiovascular disease, mental and substance abuse disorders, musculoskeletal disease and injury. However, 63% of Australian adults (11.2 million people) were overweight or obese in 2014-15 with 5 million of these being obese. Aboriginal and Torres Strait Islander peoples in Australia continue to have lower life expectancy and much higher rates of diabetes, kidney disease, heart disease and injury. Over half of Australians have very poor or marginal health literacy, meaning they have inadequate skills to meaningfully engage in health care and shared decision making (SDM), and this has been linked to worse chronic disease outcomes [3]. Australia spends about 9.4% of Gross Domestic Product (GDP) on health, in line with the average health expenditure of 9.3% for OECD countries [2].

Healthcare costs in Australia are funded by a mix of government, private health insurance and consumer out-of pocket expenses. The *Australian Government's Medicare system* provides a safety net to ensure access to essential healthcare. General Practitioners (GPs) and other members of the primary health care team (community nurses, pharmacists, allied health, dentists etc.) are usually the first point of contact with over 80% of all Australians seeing a GP at least once per year. Most medical and some allied health services are funded by a fee-for-service system called the *Medicare Benefits Schedule (MBS)*. Most essential medication is subsidised by the Pharmaceutical Benefits Scheme (PBS). These systems are administered by the national Australian Government, whilst hospital care is administered by the seven State and Territory governments. These different jurisdictions have relevance to the complexity of SDM implementation in policy and practice.

Australian policy developments in shared decision making

Since our 2011 manuscript, the interest in SDM in Australia has increased and this is evident from the incorporation into policy, or discussion about, SDM by a number of national and state organisations. For example, the *Australian Commission on Safety and Quality in Health Care (ACSQHC)*, who lead and coordinate national improvements in safety and quality in health care, hosted national symposiums about SDM in 2013 and 2014 to which representatives from stakeholder health organisations were invited. In conjunction with the ACSQHC and the *National Health and Medical Research Council (NHMRC)*, SDM researchers also hosted Australia's inaugural symposium on SDM Research, with a view to encouraging collaboration and raising awareness of SDM among Australian clinicians and health organisations. An 'awareness-raising' article resulting from this was published in the centenary issue of the Medical Journal of Australia [4].

The ACSQHC have also extended their earlier work [5] by developing several programs in SDM, Health Literacy and Partnering with Consumers. In 2017 they plan to release the second version of the *Australian 'National Safety and Quality Health Services Standards'* and by 2019, all health services will be assessed against these standards for accreditation [6]. The evolution of "*Standard Two: Partnering with Consumers*" in the 2012 version to the new version in 2017 is shown in Table 1 and demonstrates a clear shift towards patients being more actively involved in their own care if that is their preference.

The draft version of the new standards go further to explicitly mandate that "health services have processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about the current and future care". These standards apply for accreditation of all public and private hospitals, day procedure services and public dental services in Australia. There has also been a change to begin aligning general practice, aged care and disability service accreditation with this same framework and process. The *Royal Australian College of General Practitioners (RACGP)* states that patients have the right to make informed decisions about their health and that "the clinical team must demonstrate how they provide information to their patients about the purpose, importance, benefits and possible costs of proposed investigations, referrals or treatments." ACSQHC has also established an Expert Advisory Committee to provide oversight and advice on the development of safety and quality strategies, tools and resources for primary care. The committee includes representation from audiology, podiatry, nursing, dentistry, psychology, consumers, pharmacy, optometry and general practice. This process of wider consultation will occur from mid-2017.

Box 1: Key components of the Australian Charter of Healthcare Rights

Access: I have the right to health care
Safety: I have a right to receive safe and high quality care
Respect: I have a right to be shown respect, dignity and consideration
Communication: I have a right to be informed about services, treatment, options and costs in a clear and open way
Participation: I have a right to be included in decisions and choices about my care
Privacy: I have a right to privacy and confidentiality of my personal information
Comment: I have a right to comment on my care and to have my concerns addressed

Further documentation of the right of patients to be informed and involved in their healthcare is supported by the requirement for all health organisations in Australia to have an easily accessible version of the "Australian Charter of Healthcare Rights". This Charter comprises seven core components (See Box 1).

The ACSQHC has also commissioned the *Australian Atlas of Healthcare Variation* [7] which has highlighted variation in antimicrobial prescribing, diagnostic and surgical interventions, psychotropic and mental health treatment, opioid prescription and interventions for chronic disease. The ACSQHC has explicitly identified SDM as a strategy to address unwarranted clinical variation. The Australian specialist colleges have also participated in the Choosing Wisely international movement but as yet there is no explicit inclusion of SDM as a strategy for reducing over-diagnosis and over-treatment.

Patient and public involvement in SDM policy and research

Consumer involvement in policy

The peak body for consumer representation in Australia remains the *Consumers Health Forum*, which has national and state branches. Members of these not-for-profit organisations are actively engaged in policy, advocacy, health service planning and research where possible and these organisations run a range of training programs for their members.

There has been growing interest in citizen's juries as another mechanism for engaging consumers in health decision-making and policy [8]. For example, in the state of Victoria, a jury of 78 Australians met daily for six-weeks to explore evidence and question experts to come up with 20 action points to address the growing problem of obesity in our community.[1] Some of the requests they put forward were for better health ratings on food labels,

[1] https://www.vichealth.vic.gov.au/programs-and-projects/victorias-citizens-jury-on-obesity.