Making (public) hospitals work

Professor Stephen Duckett
Adjunct Professor
ACERH/University of Queensland

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ACERH
AUSTRALIAN CENTRE FOR ECONOMIC RESEARCH ON HEALTH

THE UNIVERSITY OF WESTERN AUSTRALIA

THE AUSTRALIAN NATIONAL UNIVERSITY

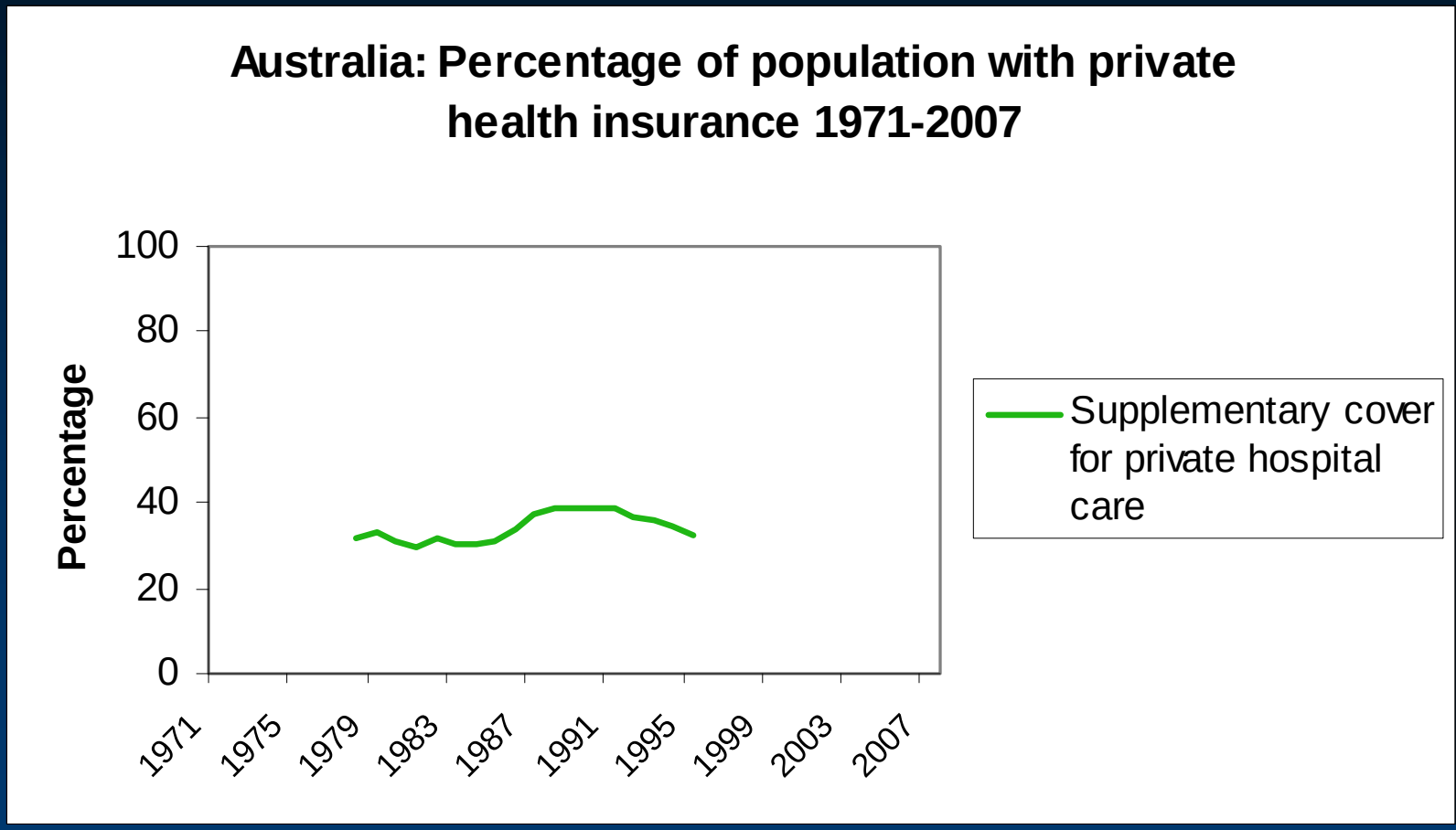
THE UNIVERSITY OF QUEENSLAND AUSTRALIA

The issues

- Declining Commonwealth support
  - Commonwealth share and PHI
- Measuring, rewarding and reporting hospital performance

The obsession with health insurance in the last decade – what happened to balance?

- +$3b for private health insurance rebate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Supplementary cover for private hospital care

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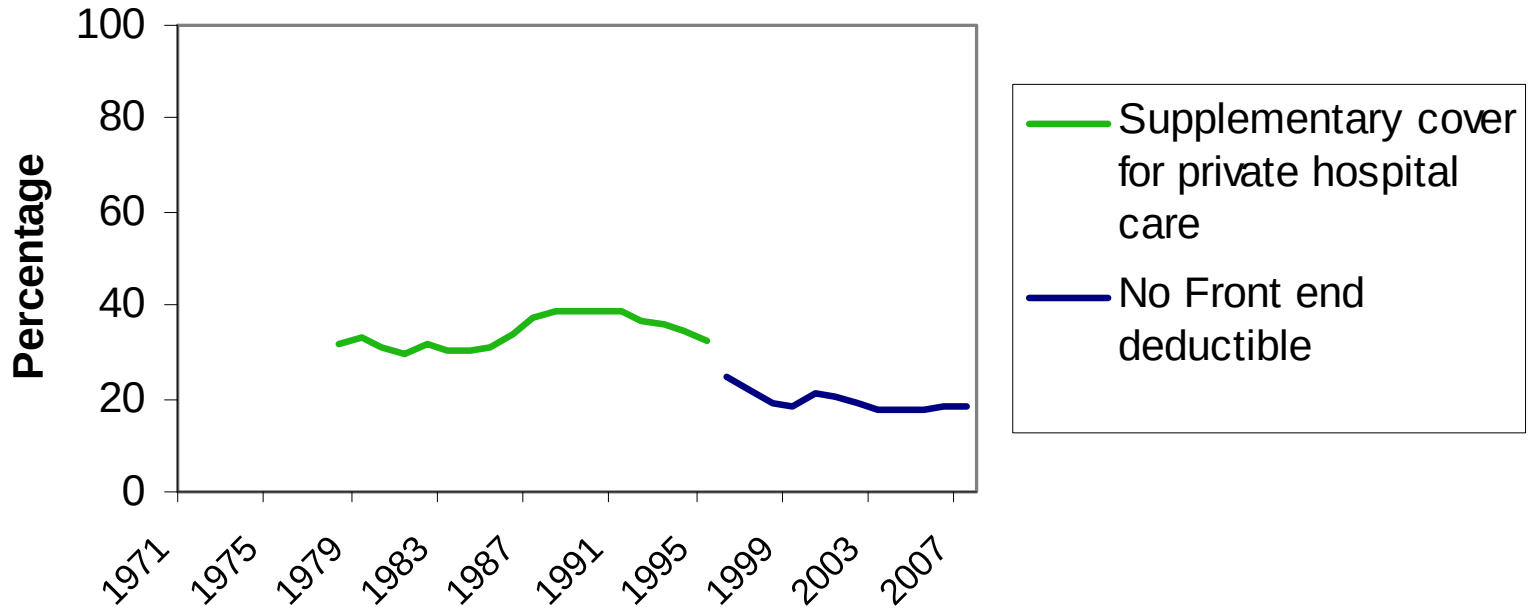

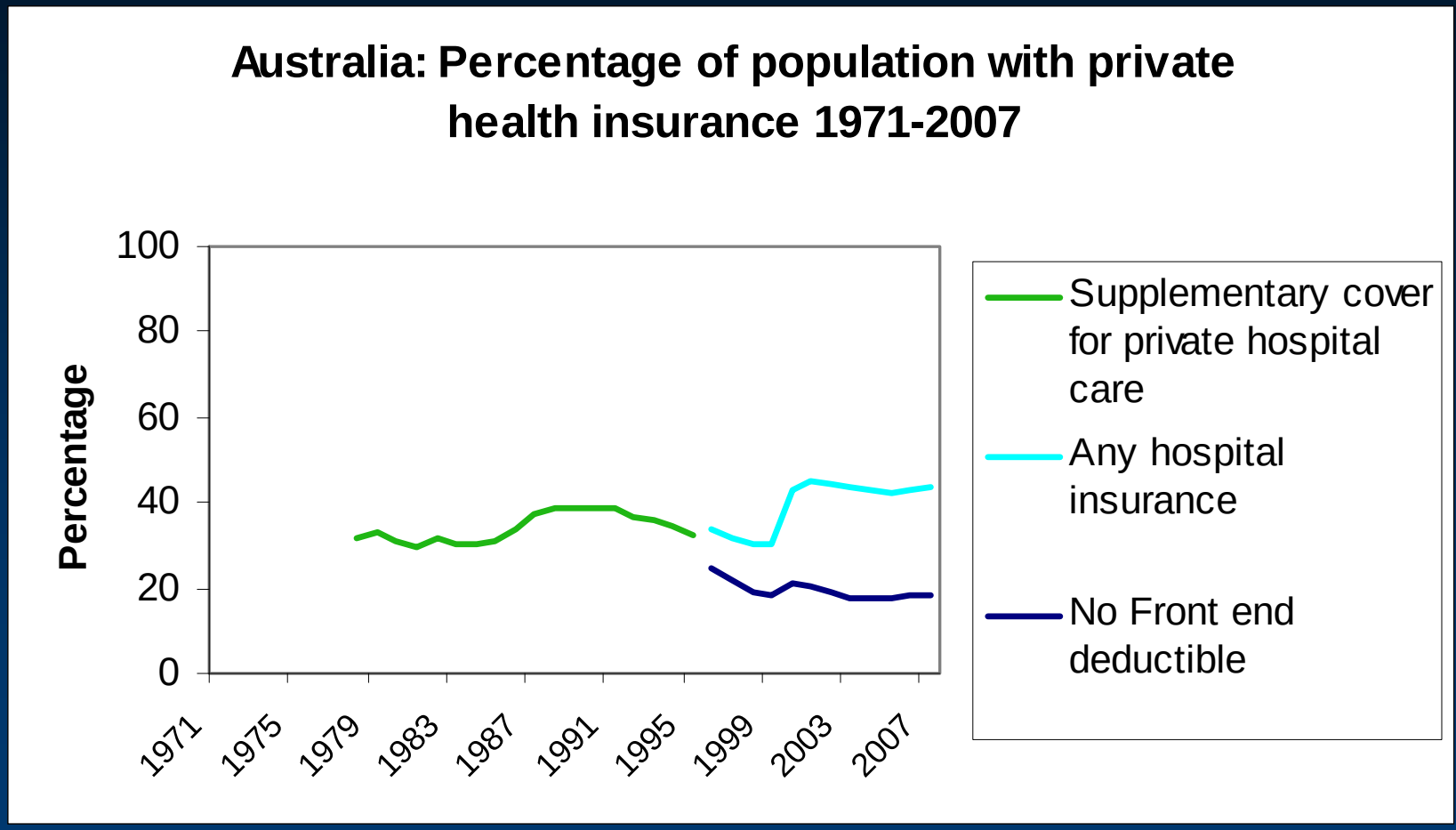
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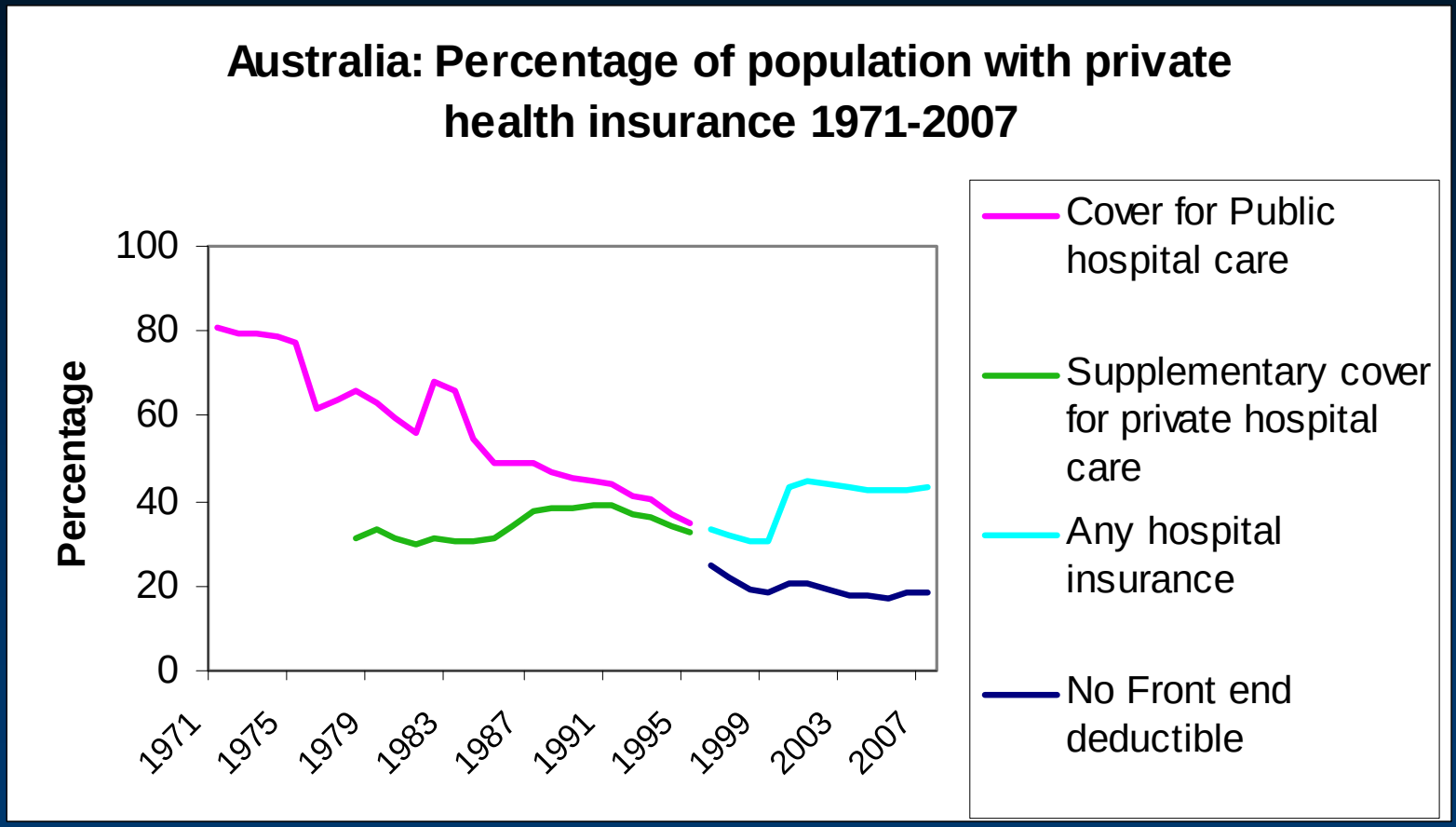
No Front end deductible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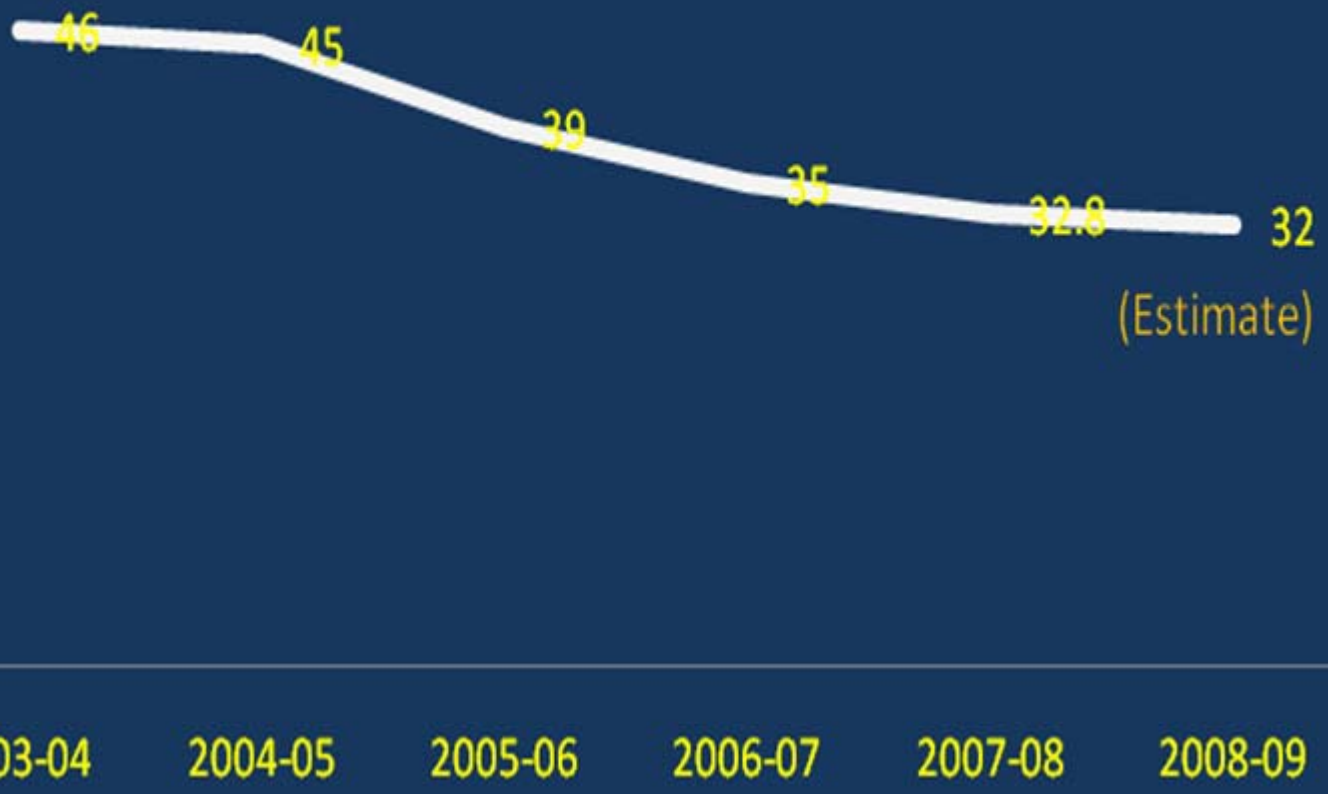
The obsession with health insurance in the last decade – what happened to balance?

- +$3b for private health insurance rebate
- -$1 for 2003-2008 AHCA

ACERH

Commonwealth share of Queensland public hospital expenditure



The declining Commonwealth Share: the eye story

- Cosmetic surgery vs cataract surgery
  - Tax, with no PHI
- Cataract surgery for 70 year old in private day procedure centre (charges around $3800 for surgery and centre) vs public hospital ($2600)
- Commonwealth support for former is 78% higher than latter.

Measuring performance

- Waiting lists/times
- Quality

Issues in waiting time bench marking

- Consumer information
- Systematic priority setting
- Whole of episode waiting

Information for consumers

- What timeliness data are reported?
  - Cross sectional survey data of experience of those waiting (i.e. not yet admitted) vs
  - Analysis of experience of those admitted to hospital from waiting list: completed wait time distribution
- Doctor level data?
- Level of specificity and presentation

State approaches to waiting list reporting

State	Reporting Approach
NSW	Search engine, By doctor, Completed waits
Victoria	Search engine, By hospital, Completed waits
Queensland	PDF Report, By hospital, Time on list
ACT	Search engine, By doctor, Completed waits
National	Excel Report, By state and sentinel procedure and specialty, completed waits (not category)

Refine your search

These are the waiting times for **Total hip replacement** for the location, hospital and doctor you have chosen. The first waiting time column shows the time within which fifty percent (50%) of people waiting were admitted to hospital. The overwhelming majority of people, ninety percent (90%), were admitted by the time shown in the second waiting time column.

For SEMI-URGENT waiting times (usually admitted within 90 days) click here
or for URGENT waiting times (usually admitted within 30 days) click here

Doctor	Hospital	Non-Urgent Waiting Times	
		50% Admitted Within	90% Admitted Within
Dr Rami M Sorial	Mount Druitt Hospital	4 weeks	14 months
Dr Christine E Castle	Mona Vale & District Hospital	5 weeks	2 months
Dr Simon P Coffey	Mount Druitt Hospital	6 weeks	19 months
Dr Mark W Horsley	RPAH Rheumatology & Orthopaedics Instit	7 weeks	3 months
Dr Paul D Stalley	RPAH Rheumatology & Orthopaedics Instit	8 weeks	4 months
Dr Ian L Meakin	Bankstown/Lidcombe HS - Hosp. units	3 months	5 months
Dr Robert P Sew Hoy	Manly District Hospital	3 months	3 months
Dr Anthony K Leong	Wollongong Hospital	3 months	9 months
Dr John S Fox	Westmead (all units)	3 months	6 months
Dr Peter R Holman	RPAH Rheumatology & Orthopaedics Instit	3 months	4 months
Dr Dimitri G Papadimitriou	Ryde Hospital	3 months	4 months
Dr Allan J Pollack	St. Vincent's Public Hospital	3 months	4 months
Dr Rami M Sorial	Penrith DHS - Nepean Hospital	3 months	16 months
Dr Jorgen M Hellman	Maitland Hospital	3 months	5 months

Your hospitals

AN OVERVIEW OF PUBLIC HOSPITAL ACTIVITY

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Time to treatment for patients admitted for surgery, October 2005 to September 2006

Hospitals	Time to treatment for Total hip replacement	
(click on hospital to see contact information)	Category 2	Category 3
Sunshine Hospital	4 weeks	*
Latrobe Regional Hospital	8 weeks	18 weeks
Williamstown Hospital	8 weeks	15 weeks
Western Hospital	10 weeks	11 weeks
Bendigo Health Care Group (Bendigo Hospital)	11 weeks	10 weeks
Maroondah Hospital	11 weeks	53 weeks
Sandringham Hospital	11 weeks	4 weeks
Goulburn Valley Health	12 weeks	*
Ballarat Health Services (Ballarat Base Hospital)	12 weeks	44 weeks
Northern Hospital	15 weeks	*
Box Hill Hospital	15 weeks	*
St Vincent's Hospital	19 weeks	*
Monash Medical Centre	20 weeks	49 weeks
Dandenong Hospital	23 weeks	60 weeks
Alfred Hospital	24 weeks	*

Developing more systematic priority setting tools

- Categorisation into 1, 2, 3 developed in 1980s
- Targets incorporated partly by definition, partly as political tradeoff

Elective surgery categorisation definitions

Category 1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
Category 2	Admission within 90 days desirable for a condition causing some pain, dysfunction, or disability but which is not likely to deteriorate quickly or become an emergency.
Category 3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

Developing more systematic priority setting tools

- Categorisation into 1, 2, 3 developed in 1980s
- Targets incorporated partly by definition, partly as political tradeoff
- 'Inter-rater reliability' perceived to be weak
- Although broadly reflect expectations and clinical reality (some exceptions)

Stretch target?

- Do we need categorisation (or improved priority setting) if everybody is seen in, say, 90 days?
  - Can have targets for both median and 90th percentile (or for 10, 50 and 90 percentiles) to deal with within-specialty priority setting
- Additional queues add management complexity
- Need to move to whole of episode waiting measurement
  - Requires record linkage

Safety vs quality (SJD version)

- Safety is about preventing (incidence and prevalence) of unintended consequences
- Quality is about trying to improve the intended consequences

- Some overlap in strategies


SL
Scan

Paediatric Tonsillectomy and/or Adenoidectomy Readmissions VLAD: Hospital A, July 2003-April 2007

Why do we want reporting and benchmarking?

- Consumer (or referrer) choice
  - Evidence not strong
- Stimulate improvement
- Public accountability

The paradigm transition problem

- Old paradigm:
  - System inerrancy
  - A few bad eggs
  - Name, blame, shame
- New paradigm
  - System problems
  - Embrace error
  - System learning

Misclassification in adverse event labelling & decisions

		Gold Standard	
		Adverse event not actually present	Adverse event actually present
Other Identification Method	Adverse event described as present	Type I error (false positive)	✓
	Adverse event described as not present	✓	Type II error (false negative)

Misclassification in adverse event labelling & decisions

		Gold Standard	
		Adverse event not actually present	Adverse event actually present
Other Identification Method	Adverse event described as present	Should minimise in old paradigm	✓
	Adverse event described as not present	✓	Should minimise in new paradigm

Hospital performance — surgical clinical indicator table

Legend

- ✓ *hospital v peer satisfactory*
- ★ *hospital v State favourable*
- ● *hospital v State unfavourable*
- *indicator not applicable*

Peer group	Hospital	Fractured Neck of Femur In-hospital Mortality	Fractured Neck of Femur Complications of Surgery	Laparoscopic Cholecystectomy Complications of Surgery	Colorectal Carcinoma Complications of Surgery (Whole Admission)	Hip Replacement (Primary) Complications of Surgery	Hip Replacement (Primary) Readmissions within 60 days	Hip Replacement Long stay	Knee Replacement (Primary) Complications of Surgery	Knee Replacement (Primary) Readmissions within 60 days	Knee Replacement Long stay	Prostatectomy Complications of Surgery	Paediatric Tonsillectomy and Adenoidectomy Readmission	Paediatric Tonsillectomy and Adenoidectomy Long stay
Principal referral and specialised	Mater Childrens Public												●	✓
	The Prince Charles			✓		✓	✓	✓	✓	✓	✓			
	Royal Childrens												●	✓
	Princess Alexandra	✓	★	✓	✓	✓	✓	●	✓	✓	✓	★		
	Nambour General	✓	✓	✓	✓	✓	✓	★	✓	✓	✓	✓	✓	✓
	Gold Coast	★	✓	●	✓	✓	✓	✓	✓	✓	●	✓	★	●
	Townsville	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Royal Brisbane and Womens	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Cairns Base	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mater Adults Public	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Ipswich	✓	✓	●	✓	✓	✓	✓	✓	✓	✓	✓	●	✓
	Redcliffe	●	✓	✓	✓	✓	✓	★	✓	✓	✓	✓		
	Queen Elizabeth II Jubilee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Redland			✓										
	Logan	★	✓	✓	✓	✓	✓	✓	✓	✓	✓			

Measuring clinical outcomes

Over the past few decades there has been an increased focus on public reporting of outcomes of care in hospitals. Public reporting of outcomes is still controversial, partly because of the inherent statistical variability of outcome data. Research in the United States*, for example, has shown that hospital performance in one year is no predictor of performance in the following year – so past performance is not a good basis for consumer choice. The perspective adopted here is that public reporting of quality of care is about demonstrating to Queenslanders that Queensland Health is open and transparent about identifying, and acting on, potential issues. That is, we are emphasising a 'continuous improvement' approach to quality of care. The focus of our reporting is thus on action: that when a potential issue has been identified, action is taken to examine the issue and redress any problem.

Variable Life Adjusted Display (VLAD)

To explain further, where variation in ou
identified, hospitals investigate aspects r
validity of data, the patient case mix, wh
are adequate, was the process of care app
professional practice. This investigation
by a multi-disciplinary team who provid
is overseen by the hospital District Mana
Executive Officer.

Management action plans are submitted
and reviewed by the governance units at
State level depending on the likelihood t
performance is due to chance.

The indicators being monitored at presen
into four categories:

- Medical
- Surgical
- Mental health
- Obstetrics and gynaecology

These indicators are comparable with nat
international definitions, and have been

days

- knee replacement long stay

Fractured neck of femur in-hospital mortality

This indicator measures the number of patients who have died in hospital following an admission for fractured neck of femur. Fractured neck of femur is a condition that commonly affects the elderly population, and requires hospital admission.

- *Redcliffe Hospital*

The primary cause of this flag was poor documentation in patient medical charts which led to a classification error. This coupled with the complexity of patient cases means there will be ongoing monitoring of the mortality rate.

Status: Ongoing investigation

Laparoscopic cholecystectomy complications of surgery

This indicator measures the number of patients who have complications arising out of laparoscopic surgery to remove their gallbladder.

- *Ipswich Hospital*

A process of care issue was identified as a primary cause of this flag. An audit of all cases was carried out and ongoing monitoring will take place.

Status: Ongoing investigation

management issue. The Ear Nose and Throat Clinical Nurse Consultant (CNC) was on extended leave during the latter part of 2006 which may have impacted on the level of advice and education being provided to both parents and patients. The Clinical Nurse Consultant has incorporated an age specific education into the CNC Succession Plan in order to provide appropriate descriptions and education to all of the patient population.

Status: Closed.

- *Ipswich Hospital*

The hospital considers the current practices to be appropriate and prudent and would prefer junior staff to err on the side of caution with readmissions. Individual examination by the VMO prior to readmission is the only way to increase supervision of junior staff and this is not cost effective compared with the costs of the readmission. Parents of patients are provided with verbal and written instructions on discharge.

Status: Ongoing investigation

- *Mater Children's Public Hospital*

Data, patient case-mix and process of care were 3 areas identified as contributing to this flag. As a result, Mater Children's Public Hospital has implemented a clinical care pathway. Data reviewed was found to contain coding errors. These errors have been fixed and the data has been resubmitted.

The Commonwealth ESWL approach

- Specific end of chapter and T codes
- In Queensland in 2006/07:
  - 6463 episodes had those codes (6% of all elective surgery admissions)
  - Of those, 3451 arose during admission (54%), remainder present on admission
  - In contrast, 5292 cases had other new diagnoses ('adverse events') which arose during admission. (In all about 8.1% of cases had new diagnosis)
  - Commonwealth method picks up about 40% of new diagnoses ('adverse events') missing in-hospital falls, hospital acquired pneumonia

So my advice?

- A critical issue about making (public) hospitals work is to fund them properly, the Commonwealth and states both have a role here
- We need to be more transparent about the performance of the hospital system, but designing measures is tricky

- Stephen_duckett@health.qld.gov.au