GRATTAN Institute

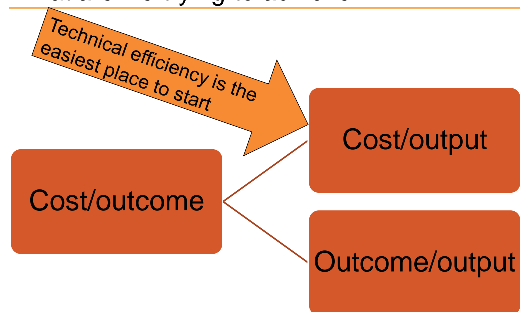
Improving efficiency in hospital care

Stephen Duckett
@stephenjduckett

Presentation to
Tasmanian Economic Forum
October 2015

What are we trying to achieve?

GRATTAN Institute

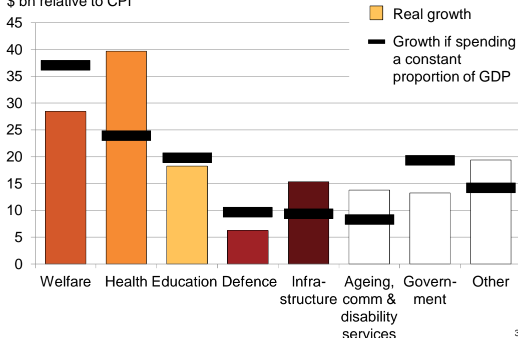


2

Health expenditure is the fastest growing segment of government expenditure

GRATTAN Institute

Change in Australian governments' expenditure 2003-2013
$ bn relative to CPI

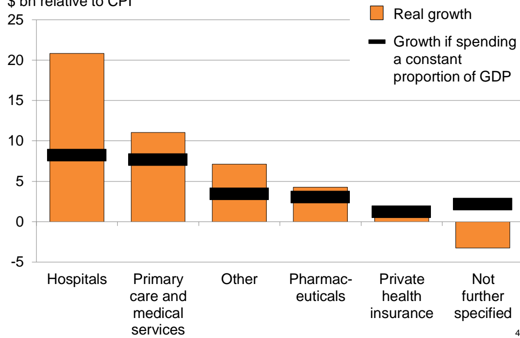


3

Hospitals are the fastest growing segment of health expenditure

GRATTAN Institute

Change in Australian governments' health expenditure 2003-2013
$ bn relative to CPI

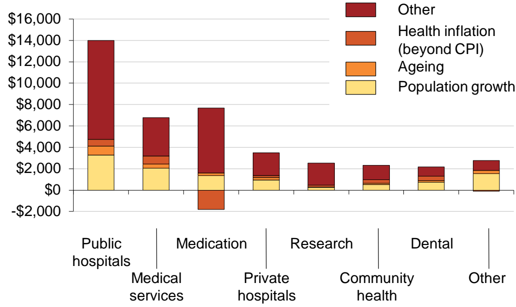


4

Most of the spending increases is a result of more services per person of a given age

GRATTAN Institute

Change in Australian governments' health expenditure 2004-2011
2011$ m



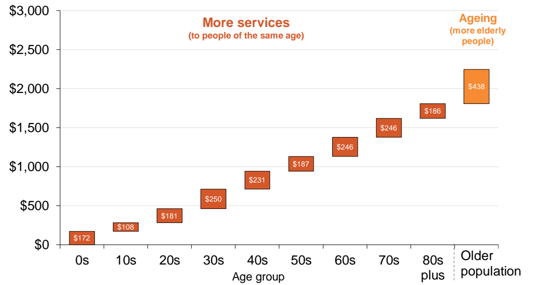
Sources: AIHW; ABS; DOHA

5

Growth in spending is evenly balanced across ages

GRATTAN Institute

Why are we spending more per person?
Contribution to increase in per-person costs, 1989 to 2010

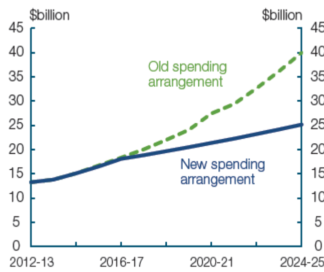


Note: Less reliance ought to be placed on figures for 80+, as sample sizes are small and data categories change across surveys
Source: ABS Fiscal Incidence Studies (various years); ABS Cat. 3101.0 Table 59; Grattan analysis

6

Projected Commonwealth government grants for public hospitals to states have been cut substantially (sort of)

GRATTAN Institute



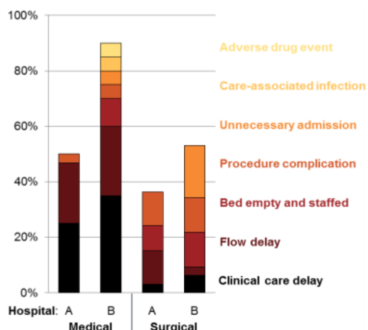
Source: 2014-15 Budget Overview p7
http://budget.gov.au/2014-15/content/overview/download/Budget_Overview.pdf

7

GRATTAN Institute

Grattan Health Program on hospital waste

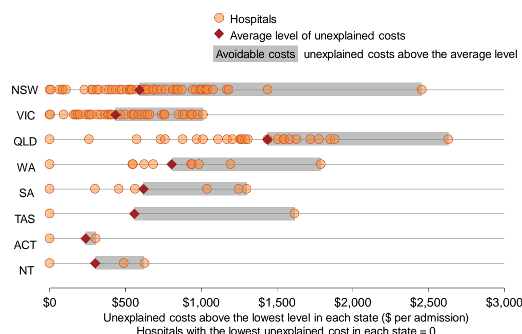
Waste abounds in hospitals: proportion of beds with identified waste at audit



Note: Only one type of waste was recorded for each bed.

Resar, R. K., et al. (2011) *Hospital inpatient waste identification tool*, Institute for Healthcare Improvement

There is significant within-state variation in public hospital costs (2010-11 data)



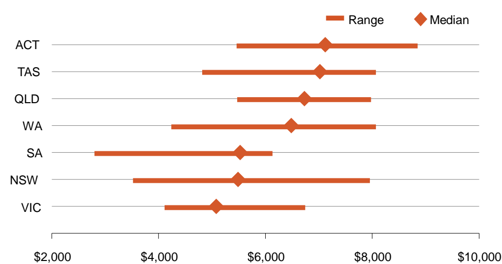
Note: Some small hospitals (total admissions < 4,000 p.a.) not shown

Avoidable costs add up to $1 billion a year

Avoidable cost by state, 2010-11
$ million

There is huge variation in the cost of treatments, e.g. gall bladder removal …

Cost of laproscopic colecystectomy (gall bladder removal), unadjusted, 2010-11

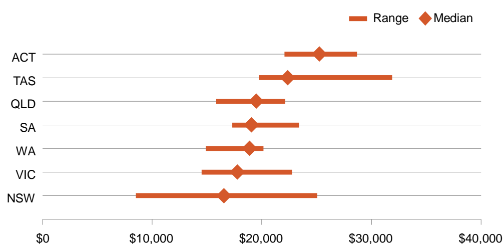


Note: H08B, the less complicated DRG category for the procedure

… and hip replacements

GRATTAN Institute

Cost of hip replacement, unadjusted, 2010-11



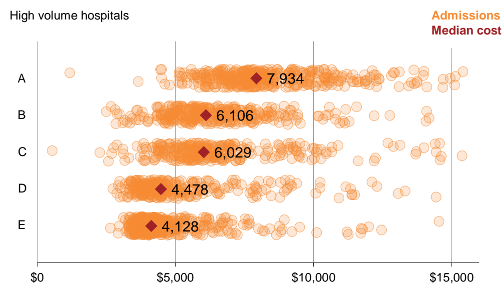
Note: I03B, the less complicated DRG category for the procedure

13

Costs aren't driven by scale

GRATTAN Institute

Cost of gall bladder removal, unadjusted, five high-volume hospitals, 2010-11



Note: H08B, the less complicated DRG category for the procedure

14

There are three steps to remove avoidable costs, starting with setting the right price

GRATTAN Institute

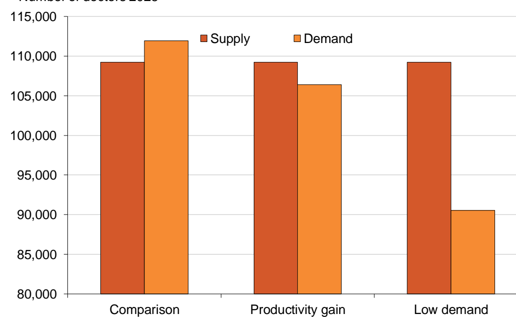
What costs are funded?

What standard should hospitals reach?	Arbitrary	Pay for costs caused by patient factors	Don't pay for avoidable costs	Pay for care that works: Adjust for adverse events / Adjust for readmissions	Pay for care that works: Pay for pathways / Adjust for outcomes
Their own pervious standard	**What care *does* cost**				More research & better data needed
Average cost		Current system	**Grattan proposal**		
Below-average cost					**What care *should* cost**

15

Medical workforce supply and demand – three scenarios

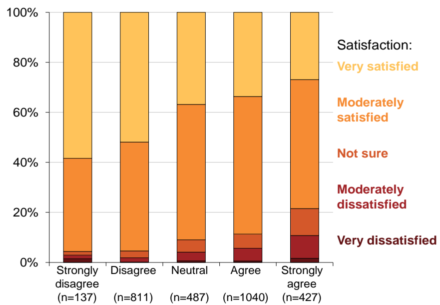
GRATTAN Institute



16

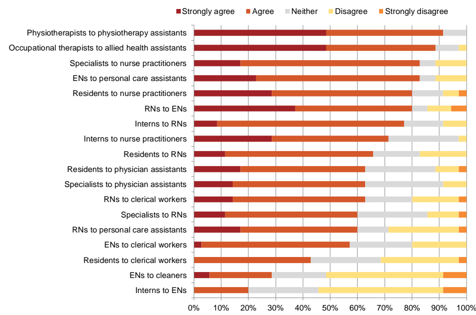
Job satisfaction improved with more complex roles

Hospital specialists' overall job satisfaction by responses to the statement "I often undertake tasks that could be done by somebody less qualified than me"

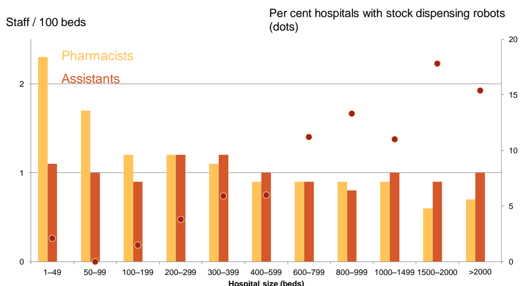


There was very strong agreement with a wide range of substitution options

Respondents were asked to what extent they agreed that the following shifts of workload would reduce the cost without reducing quality and safety



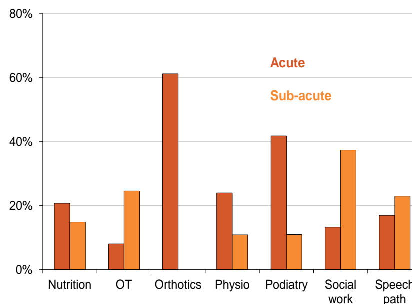
Pharmacy staff mix and automation, European hospitals, 2010



Frontini, R., Miharija-Gala, T. and Sykora, J. (2012) 'EAHP survey 2010 on hospital pharmacy in Europe: Part 1. General frame and staffing', *European Journal of Hospital Pharmacy: Science and Practice*, 19(4), p 385-387 (and Part 2)

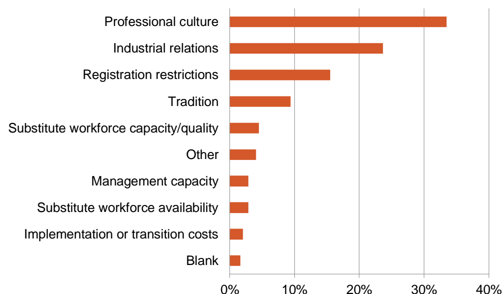
Substitution opportunities reported in Victoria

Percentage of time that allied health practitioners spend completing assistant-attributable tasks.



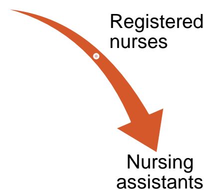
Professional culture and industrial relations were seen as the biggest barriers to substitution across all fields …

Different barriers as a proportion of all responses (top barrier)



7
21

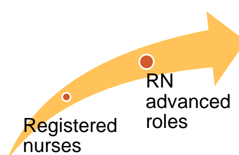
Opportunity 1: Nursing assistants



- Identify roles currently performed by registered nurses that can be performed by nursing assistants
- Nurse assistants are away of recruiting from a different pool (non-school leavers, returning to workforce)

22

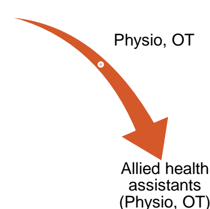
Opportunity 2: Specialist roles for nurses

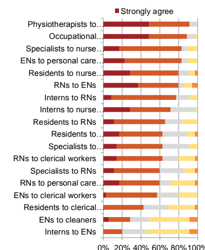


- International and Australian evidence show that nurses can do low-risk, high-volume procedures well and safely
- We propose specialist nurse endoscopy and nurse sedationist roles
- Nurse endoscopists would only provide less-complex endoscopies (no biopsies or other interventions)
- Nurse sedationists would only work in low-risk age groups and cases

23

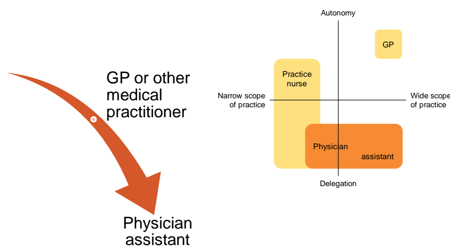
Opportunity 3: Allied health assistants





24

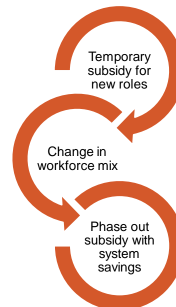
Opportunity 4: Physician assistants



25

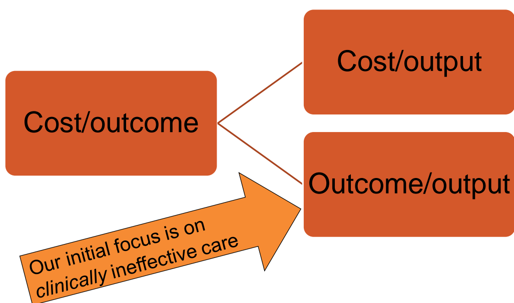
Transition grants to facilitate change

1. Hospitals sign up to
   - embed new roles in their workforce
   - agree to a target ratio of existing and new (not simply adding)
2. Hospitals get a time-limited grant to fund a proportion of the cost of introducing new workforce. It tapers over time.
3. At mid-point, hospitals must prove they are halfway to meeting the final staffing ratio. The second half of the grant is conditional upon demonstrating progress.
4. The transition grant finishes at end of workforce introduction period, by which time new workforce roles embedded.
5. Savings will be passed back to the system by a fall in the cost of care (and prices).



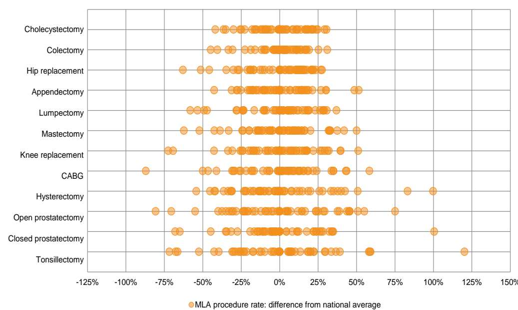
26

What are we trying to achieve?



27

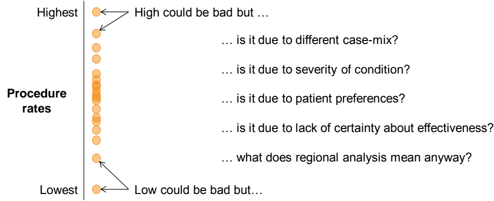
Most variation analyses look at geographic variation and find large disparities …



Source: Grattan Institute

28

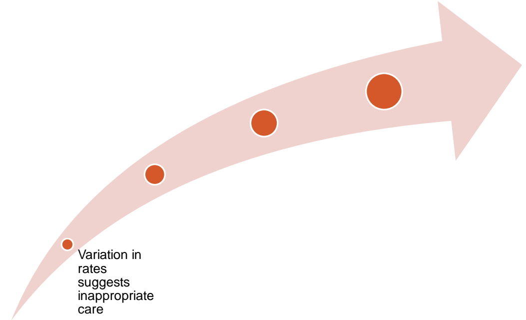
… but that doesn't tell you much



There's little clarity about when variation is legitimate
That's made it difficult to develop effective policy

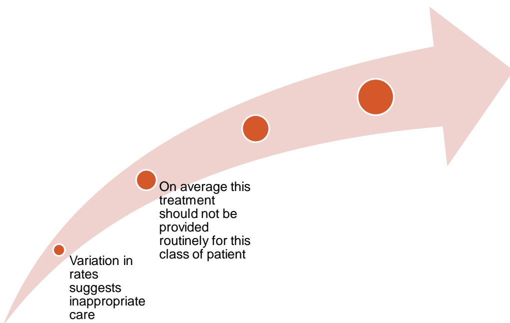
29

Increasing certainty that variation can identify inappropriate care



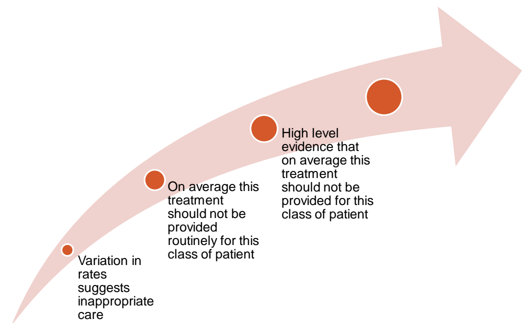
30

Increasing certainty that variation can identify inappropriate care



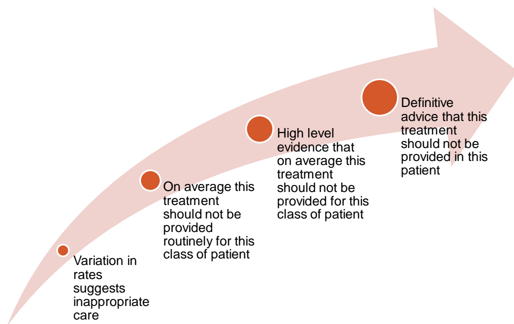
31

Increasing certainty that variation can identify inappropriate care



32

Increasing certainty that variation can identify inappropriate care



33

We analyse 5 'do-not-dos' and 3 'do-not-do routinely' treatments from NICE, MSAC and Prasad

Do-not-dos:

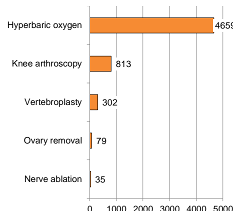
- Vertebroplasty for osteoporotic vertebral fractures
- Arthroscopic lavage or debridement for OA of the knee
- Laparoscopic uterine nerve ablation for chronic pelvic pain
- Removing healthy ovaries during a hysterectomy
- HBOT for a range of conditions (inc. osteomyelitis, cancer, and non-diabetic wounds and ulcers)

Do-not-do routinely:

- Fundoplication for gastro-intestinal reflux
- Episiotomy for spontaneous vaginal births
- Amniotomy to augment a normal delivery

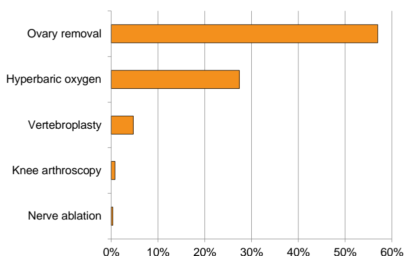
Patients with 'legitimating' diagnoses are excluded

Do-not-do procedures, Australia, 2010-11



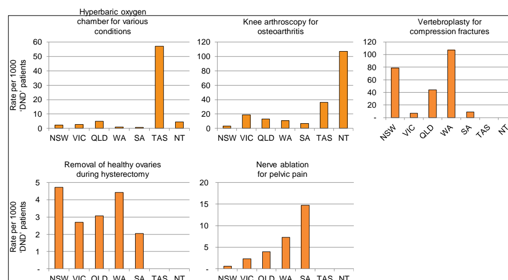
34

A large proportion of relevant patients have do-not-dos



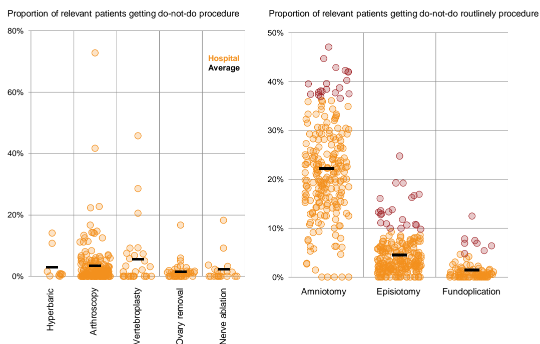
35

Rates of do-not-dos vary across states



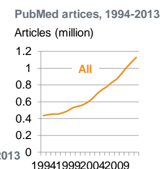
36

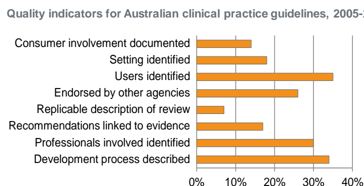
There are outliers with troubling patterns of care

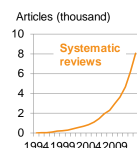


Information gap 1: What not to do

- There is a huge volume of evidence
- Guidance focuses on what to do, is of variable quality, is inconsistent & hard to use
- 50+ organisations work on disinvestment and their approaches are largely uncoordinated and inconsistent



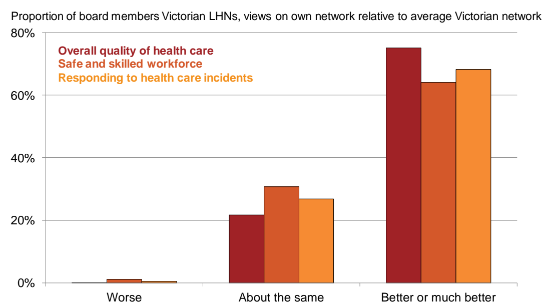




Source: National Health and Medical Research Council

Information gap 2: Who's doing what

Proportion of board members Victorian LHNs, views on own network relative to average Victorian network



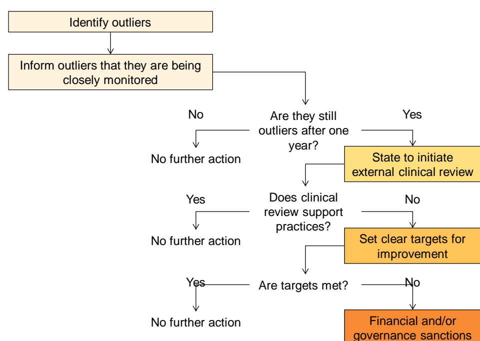
Notes: n = 233, 70% response rate, 96% of networks included
Source: Bismark et al (2013)

Recommendation 2: ACSQHC report to all providers & funders

Hospital Name – 2010-11	Multiples of national rate	DND/Rs	Relevant patient group
Do-not-dos			
HBOT DNDs	- -	- -	- -
Removal of healthy ovaries	13.0	8	183
Vertebroplasty for CFs	0.0	0	31
Knee arthroscopy for OA	0.5	2	95
Nerve ablation for pelvic pain	0.6	1	75
Do-not-do routinely			
Fundoplication for GORD	0.6	3	366
Episiotomy	2.9	211	1507
Amniotomy	0.4	26	1912

- - not in comparator group
Over benchmark
Less than 10% under benchmark

Accountability gap
Recommendation 3: clinical reviews with consequences

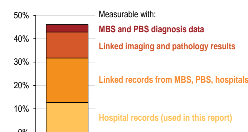


41

Recommendation 4:
Improve variation measurement

- Find more do-not-dos elsewhere (e.g. Cochrane) and add more do-not-do routinely treatments
- Link patient separations to
    - analyse treatments that should not be given first-line
    - adjust for readmissions
    - allow better adjustments for morbidity

Many more NICE do-not-dos can be measured with data we already collect



- Link to PBS and MBS data to acute data to allow measurement of more do-not-dos (e.g. primary care do-not-dos, polypharmacy, patients not getting routine first-line drug therapies)
- Pilot morbidity database for GP care in a few PHNs – collect data as part of MBS billing

42

Some of our choices

- How much 'benefit of doubt' to give?
    - o Is a 'Do Not Do' a 'Never Do'?
- Who should initiate investigation for potentially inappropriate care?
- Is it OK for private hospital to be the focus (vs surgeon)
- When should private insurers be able to deny payment?
    - o When ACSQHC makes a determination?
    - o When clinical review makes a determination?
    - o When hospital fails to respond to external review?

43

What hospitals might do:

Table the Grattan report for discussion with the relevant clinical governance group:

- Are any of the DNDs or DNDRs are an issue in the hospital?
- There are other issues we didn't look at which are prominent in the public debate (e.g. diagnostic test use). Are they relevant?

- How robust are your clinical governance processes?
- Is appropriateness of care being systematically monitored?
- What are the accountability mechanisms for clinical choices?

- NB: I don't think there are big savings for hospitals here
- NB: I do think this will be an increasing clinical governance issue

44

What Tasmania could do:

GRATTAN Institute

- Initiate clinical reviews where appropriate for both the Do Not Dos and the Do Not Do Routinelys
- Ask ACSQHC to develop a guideline program about clinically ineffective care
- Ask ACSQHC to use link other data sets to investigate other DNDs which can't be identified with the Hospital Morbidity data set
- Maybe start looking at *cost*-ineffective care?

45

Some suggestions

GRATTAN Institute

- Drive (technical) efficiency through
  - benchmarking ←
  - tight(er) pricing *(change range)*
  - workforce reform *(change mean)*
- Drive allocative efficiency through
  - benchmarking ←
  - P4P/nP4nP
  - accountability for ineffective care

stephen.duckett@grattan.edu.au

46