Questionable care: what to do about things which shouldn't be done

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Outline

- The variation continuum
- Care which is *prima facie* questionable
- A strategy

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

... but that doesn't tell you much

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Highest</th>
<th>Lowest</th>
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<tbody>
<tr>
<td>Cholecystectomy</td>
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<td>Colectomy</td>
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<td>Hip replacement</td>
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<td>Laparotomy</td>
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<td>Mastectomy</td>
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<td>Knee replacement</td>
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<td>CABG</td>
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<td>Open prostatectomy</td>
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<td>Closed prostatectomy</td>
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<td>Tonsillectomy</td>
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<tr>
<td>Appendectomy</td>
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<tr>
<td>Hysterectomy</td>
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Source: Grattan Institute

There's little clarity about when variation is legitimate
That's made it difficult to develop effective policy
Increasing certainty that variation can identify inappropriate care

Definitive advice that this treatment should not be provided in this patient.

High level evidence that on average this treatment should not be provided for this class of patient.

On average this treatment should not be provided routinely for this class of patient.

Variation in rates suggests inappropriate care.

Definitive advice that this treatment should not be provided in this patient.
We combine variation and clinical effectiveness to identify troubling patterns of care

- Unit of analysis is hospitals (not patient geography)
- Compare hospitals that do the procedure and treat the diagnostic group (not all hospitals)
- Compare procedure rates among patients with relevant diagnosis (not all admissions)

Hospital propensity (likelihood of procedure)

<table>
<thead>
<tr>
<th>Highest</th>
<th>Average</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Medium</td>
<td>Low</td>
</tr>
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</table>

Confidence that ineffective care can be identified in data

- Low
- High

Likely to be inappropriate

- Average
- 1
- 2
- 3
- 4
- 5

Procedures w/o diagnosis codes

- Do - do
- Do - not do

Procedures w. diagnosis codes

- Do - do
- Do - not do
- Do - not do routinely

We analyse 5 ‘do-not-do’ and 3 ‘do-not-do routinely’ treatments from NICE, MSAC and Prasad

Do - not-do:

- 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
- HBO for a range of conditions (inc. osteomyelitis, cancer, and diabetic wounds and ulcers)

Do - not-do routinely:

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

Patients with 'legitimating' diagnoses are excluded

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

- Ovary removal
- Hyperbaric oxygen
- Vertebroplasty
- Knee arthroscopy
- Nerve ablation

It's not a public or private sector problem, it's both

- Public
- Private
- Aust.
Rates of do-not-dos vary across states

In almost all states, do-not-do treatments are concentrated in a minority of hospitals

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

Quality indicators for Australian clinical practice guidelines, 2005-2013

Articles (thousand)

Articles (million)

PubMed articles, 1994-2013

• Consumer involvement documented
• Setting identified
• Users identified
• Endorsed by other agencies
• Replicable description of review
• Recommendations linked to evidence
• Professionals involved identified
• Development process described

Source: National Health and Medical Research Council
Recommendation 1:
HPPC provides up-to-date, accessible do-not-do guidance

Options for HPPC role in identification of do-not-do treatments

- Initial role
  - Coordinate
  - Evaluate
  - Initiate

- Bottom-up
- Top-down

- Coordinate
  - Collate and publish disinvestment findings and research plans of other organisations
  - Promote best practices in identification of disinvestment opportunities
  - Propose priorities for evaluation
- Evaluate
  - Evaluate disinvestment identification done by other organisations, publishing only the findings that the HPPC supports
- Initiate
  - Execute / commission research to identify disinvestment, with topics chosen by the HPPC

Recommendation 2:
HPPC report to all providers & funders

Information gap 2:
Who's doing what

Proportion of health care same or better than comparator network

- Overall quality of health care: safer and skilled workforce
- Responding to health care incidents

Notes: n = 223.75; response rate: 67.5%; 21 networks included
Source: Bisma et al (2013)

Accountability gap
Recommendation 3: clinical reviews with consequences

- Identify outliers
  - Warn outliers that they are being closely monitored

- Are they still outliers after one year?
  - Yes: State to initiate external clinical review
  - No: Set clear targets for improvement

- Does clinical review support practices?
  - Yes: No further action
  - No: Set clear targets for improvement

- Are targets met?
  - Yes: Financial and/or governance sanctions
  - No: No further action

Hospital Name – 2010-11

<table>
<thead>
<tr>
<th>Do-not-do</th>
<th>Multiples of national rate</th>
<th>DND/Pa</th>
<th>Relevant patient group</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBOT DNDs</td>
<td>10.0</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Removal of healthy ovaries</td>
<td>1.0</td>
<td>291</td>
<td>150</td>
</tr>
<tr>
<td>Epistomy</td>
<td>2.4</td>
<td>25</td>
<td>300</td>
</tr>
</tbody>
</table>

- Not in comparator group
- Less than 5% under benchmark
- Over benchmark

<table>
<thead>
<tr>
<th>Do-not-do routinely</th>
<th>Multiples of national rate</th>
<th>DND/Pa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundoplication for GORD</td>
<td>0.6</td>
<td>35</td>
</tr>
</tbody>
</table>

- Less than 5% under benchmark

Notes: n = 223.75; response rate: 67.5%; 21 networks included
Source: Bisma et al (2013)
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
- 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

Some of our choices

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

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