GRATTAN Institute

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

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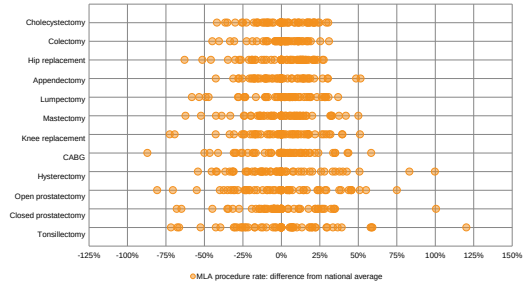
Private Healthcare Australia Conference 2015
March 2015

Outline

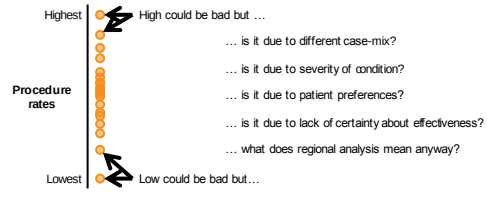
- The variation continuum
- Care which is *prima facie* questionable
- A strategy

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



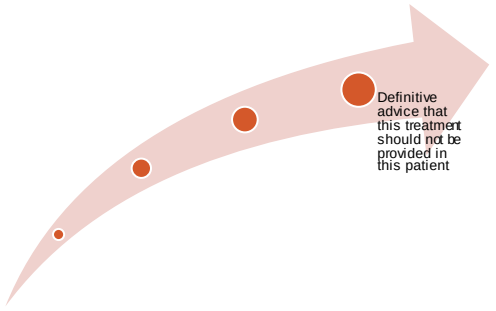
Source: Grattan Institute

… 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

Increasing certainty that variation can identify inappropriate care



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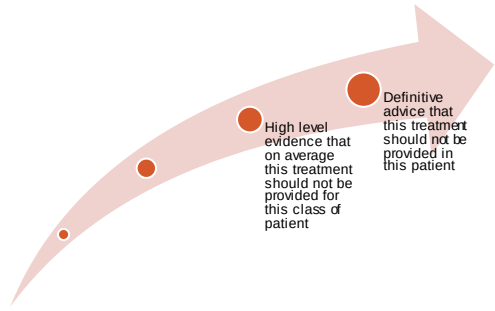

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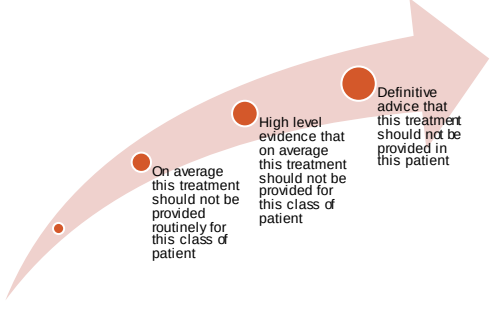

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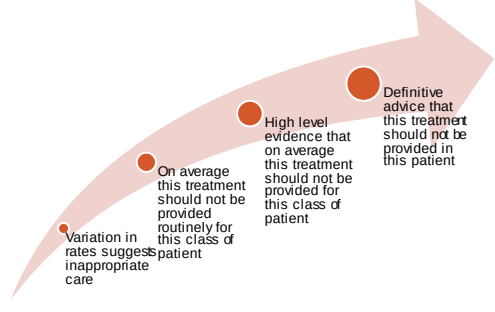

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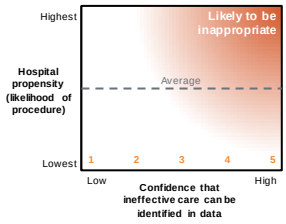
We combine variation and clinical effectiveness to identify troubling patterns of care



1 Procedures w/o diagnosis codes
2 Procedures w. diagnosis codes
3 Do-not-do routinely (some patients)
4 Do-not-do (some patients)
5 Do-not-do (all patients)

- **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)

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

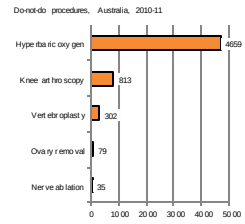
Do-not-dos:

- 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 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



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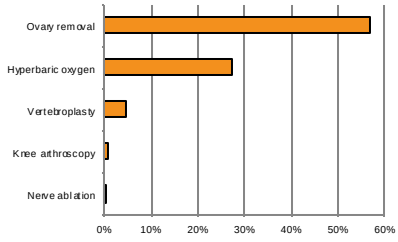
A large proportion of relevant patients have do-not-dos



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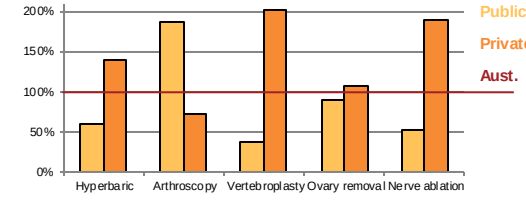
It's not a public or private sector problem, it's both



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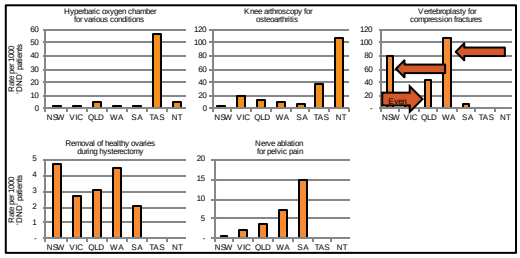
Rates of do-not-dos vary across states



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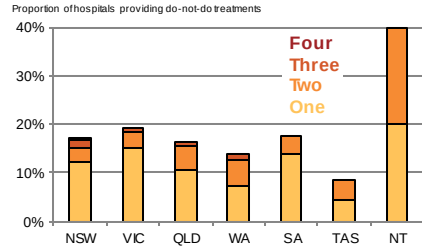
In almost all states, do-not-do treatments are concentrated in a minority of hospitals



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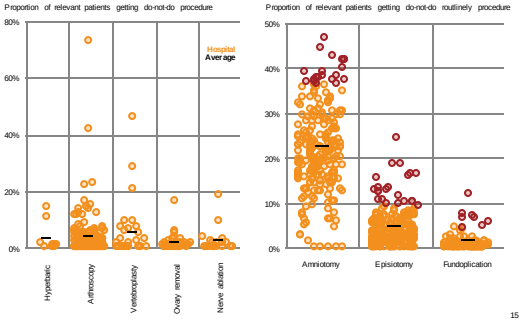
There are outliers with troubling patterns of care



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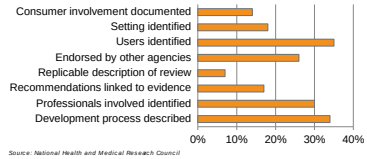
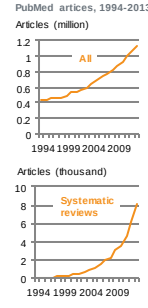
Information gap 1: What not to do

- 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





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Recommendation 1: HPPC provides up-to-date, accessible do-not-do guidance

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

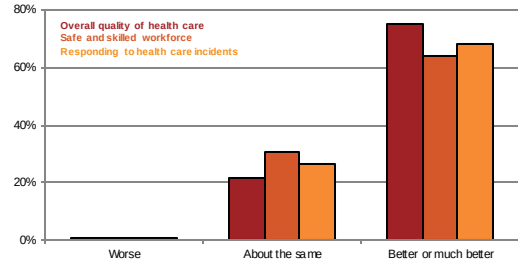
Initial role

Bottom-up ⟷ Top-down

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

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)

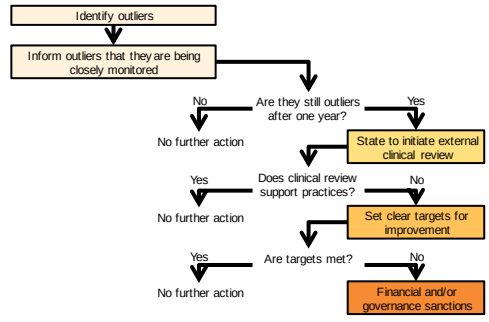
Recommendation 2: HPPC report to all providers & funders

Hospital Name – 2010-11

Do-not-dos	Multiples of national rate	DND/Rs	Relevant patient group
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



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

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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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