CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITALS 2017-2018

The framework describes some principles for rewarding quality and a desire to not fund perceived poor quality. A number of alternatives are described. Please find below some brief comments regarding the Sentinel or “never” Events and the Preventable Hospital Acquired Conditions.

The premise of wanting to design a funding model which directs healthcare towards better quality and minimizes poor quality or harm is strongly supported. How best to do this, without significant harmful unintended consequences, and without invoking Goodhart’s Law, is the significant question. (Goodhart’s Law was originally described for financial systems but interpreted for healthcare is when something becomes a target it no longer remains a good measure. In other words distortions in the system occur to satisfy the target without having the beneficial effects intended).

Sentinal Events are mercifully rare and the actual saving from not funding the episode of care associated with the event (estimated at $5mill) while saving the money is very unlikely to change the frequency of the events. The events are likely tied up in some human and system factors for which there is already a significant financial penalty to healthcare staff and institutions in the form of insurance premiums and litigation, the actual value of which would be far greater than $5mill. Despite this they continue.

More interesting are the discussions surrounding the “Preventable Hospital Acquired Conditions”. These are far more common and worth a much more significant quantum of money. The first issue is around the definition of “preventable”. There is, even in the best institutions, a background of complications that occur despite the most meticulous technique and attention to detail. Complete elimination of these events, such as post operative haemorrhage, anastomotic dehiscence and return to ICU is impossible. I’m sure this has been debated at length by the expert panel and that there will be numerous submissions addressing this issue.

What is more important is rapid patient rescue from these events which will involve return to theatre and sometimes return to ICU and/or transfusion. There is significant evidence now that the discriminating factor between high performing and poorly performing institutions undertaking complex surgery is not the incidence of complications but the ability of the institution to recognise and rescue patients from these events (al least when measured by perioperative mortality). Imposing financial penalties on institutions for invoking processes of patient rescue risk the unintended consequence of much greater patient harm including death (interestingly for which there is no suggested penalty). While this is of course not the intention of the proposal it could be the outcome. While I don’t believe that any institution would deliberately allow patient harm because of possible financial penalty these influences can be very subversive and somewhat imperceptible. There would exist some subtle pressure to tough things out on the ward and to delay reintervention or return to ICU until there was absolutely no alternative with the potential for significant harm.

There is a growing trend for rapid recovery (or so called enhanced recovery after surgery-ERAS) following significant procedures. This has overall patient and institution benefit (less morbidity, shorter recovery times and decreased length of stay) but comes at the risk of slightly higher return to ICU rates and hospital readmission rates. The issue of penalty for these events could encourage a return to significant conservatism to keep patients in ICU longer and delay discharge to minimize risk of return.

In a similar vein there are significant trends to increase day surgery rates for procedures such as laparoscopic cholecystectomy and there will be an unexpected and small readmission rate because of this (this is in the third category and not under consideration at present). Literature evidence from very large healthcare studies suggests that the major defect in healthcare is omissions of aspects of care that should have been delivered. (McGlynn et al,

New England Journal of Medecine, 2003 and Runciman et al, MJA, 2012). Strategies to address quality improvement in healthcare would be best directed at reducing the omissions and ensuring that patients receive the appropriate care far more reliably than they do at present. I don't believe that imposing financial penalties will achieve that. The risk of significant unintended consequences is too great and will not likely give rise to significant improvements but rather a series of workarounds, with both data and the way care is delivered.

The question is then how to promote quality using the mechanism of financial levers without the unintended consequences. Exploring a reward system would most likely be the safest and least likely to do harm. It was noted in the discussion paper of the UK example of only paying the full amount for fractured neck of femur to those institutions that demonstrated adherence to a bundle of best practice process measures. I think this is where the best application of the financial lever can be applied. It is possible to design "bundles of care" for many of the episodes of care undertaken in the acute sector and other sectors of the system. Demonstrated application of best practice bundles could be mandated to receive the full funding component as per the UK example. It should not be based on a single process measure for any condition because Goodhart's Law then comes into play. Thus rewarding the positive rather than penalizing the negative seems the better and safer option.

This principle could also be extended to reward to routine application of quality improvement programmes and involvement in clinical standardization and minimization of inappropriate variation. This together with a demonstration of delivery of appropriate care is my recommendation for further exploration.

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