



Special Commission of Inquiry into Healthcare Funding

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Submission to The Special Commission of Inquiry into Healthcare Funding [NSW] addressing ToR "D".

Submitted by Professor Adam Elshaug

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 - Professor of Health Policy, Melbourne School of Population and Global Health, University of Melbourne
 - Professor of Health Policy, Melbourne Medical School, University of Melbourne
- Member (2023-): Expert Advisory Committee, Unleashing the Potential of our Health Workforce: Scope of Practice Review, Commonwealth Department of Health and Aged Care
- Member (2022-): Strengthening Medicare Taskforce, Commonwealth Department of Health and Aged Care
- Member (2022-): Research Partnership Advisory Group [translational research priorities 2022-24], Victorian Government Department of Health
- Member (2022-): Victorian Perioperative Learning Health Network Advisory Group, Safer Care Victoria
- Member (2021-): Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC), Commonwealth Department of Health and Aged Care
- Honorary Professor (2020-): Menzies Centre for Health Policy and Economics, Sydney School of Public Health, The University of Sydney
- Member (2019-): Expert Advisory Committee for Evidence-based Interventions (Academy of Medical Royal Colleges, NHS Clinical Commissioners (NHSCC), the National Institute for Health and Care Excellence (NICE), NHS England and Improvement)
- Health Economics and Policy Advisor (2014-): Cancer Australia

Previously:

- 2017-2022 Member, Board of Directors: New South Wales (NSW) Bureau of Health Information (BHI)
- 2020-2022 Member: Health Expert Working Group, Australian Broadband Advisory Council (ABAC); Reporting to Australian Commonwealth Government
- 2014-2020 Member: Medicare Benefits Schedule Review Task Force (MBSRTF), Australian Government Department of Health
 - Member (ex-officio): Principles and Rules Sub-Committee (of MBSRTF)
- 2014-2018 Member: Atlas of Healthcare Variation Advisory Group, Australian Commission on Safety and Quality in Health Care (ACSQHC)
- 2013-2020 A/Prof (2013-16), Prof (2016-20), Menzies Centre for Health Policy, University of Sydney
 - Co-Director, 2016-2020

Dear Mr Richard Beasley SC and Members of the Special Commission Secretariat,

I am a researcher and policy advisor who works closely with healthcare payers across 15 jurisdictions nationally and internationally to design and implement reforms to reduce waste and optimise health care safety and value, including the design and evaluation of alternative care and payment models. This includes as lead of a large program of low-value care research and reform. From this experience, combined with insights garnered from the committee and advisory roles listed above, I would welcome any opportunity to engage with The Special Commission on topics spanning the Terms of Reference.

In this submission I will focus on an extensive program work developed in partnership with the NSW Ministry of Health focused on measuring the prevalence, trends, costs and harms associated with low-value health care, defined as the use of a healthcare intervention where evidence suggests it confers no or very little benefit on patients, or risk of harm exceeds likely benefit, or, more broadly, the added costs of the intervention do not provide proportional added benefits.

This submission specifically addresses Term of Reference “D”: *Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;*

However, the ramifications of the work spill-over to multiple parallel Terms of Reference. I will keep it brief and provide necessary references should you wish to delve further. Also, I would be happy to engage further on any elements of the work.

Submission (1) peer reviewed publication: *‘Low-value care in Australian public hospitals: prevalence and trends over time’*

Open Access URL: <https://qualitysafety.bmj.com/content/28/3/205>

Objective: To examine 27 low-value procedures, as defined by international recommendations, in New South Wales public hospitals.

Design: Analysis of admitted patient data for financial years 2010–2011 to 2016–2017.

Main outcome measures: Number and proportion of episodes identified as low value by two definitions (narrower and broader), associated costs and bed-days, and variation between hospitals in financial year 2016–2017; trends in numbers of low-value episodes from 2010–2011 to 2016–2017.

Results: For 27 procedures in 2016–2017, we identified 5079 (narrower definition) to 8855 (broader definition) episodes involving low-value care (11.00%–19.18% of all 46 169 episodes involving these services). These episodes were associated with total inpatient costs of \$A49.9 million (narrower) to \$A99.3 million (broader), which was 7.4% (narrower) to 14.7% (broader) of the total \$A674.6 million costs for all episodes involving these procedures in 2016–2017, and involved 14 348 (narrower) to 29 705 (broader) bed-days. Half the procedures accounted for less than 2% of all low-value episodes identified; three of these had no low-value episodes in 2016–2017. The proportion of low-value care varied widely between hospitals.

Submission (2) peer reviewed publication: *‘Measuring Hospital-Acquired Complications Associated With Low-Value Care’*

Open Access URL: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2725081>

Key Points

Question: Do patients who are admitted to the hospital for a low-value procedure (ie, those that would not be expected to require admission) develop hospital-acquired complications?

Findings: In this cohort study and descriptive analysis of 9330 episodes of low-value use of 7 procedures (ranging from 56 low-value spinal fusions to 3963 low-value knee arthroscopies), depending on the procedure, between 0.2% and 15.0% of patients receiving these low-value procedures developed at least 1 of 16 hospital-acquired complications, the most common being health care–associated infection.

Meaning: Use of these 7 low-value procedures is harming patients, consuming additional hospital resources, and potentially delaying care for other patients for whom the services would be appropriate.

Abstract

Importance: Studies of low-value care have focused on the prevalence of low-value care interventions but have rarely quantified downstream consequences of these interventions for patients or the health care system.

Objective: To measure immediate in-hospital harm associated with 7 low-value procedures.

Design, Setting, and Participants: A cohort study with a descriptive analysis using hospital admission data from 225 public hospitals in New South Wales, Australia, was conducted from July 1, 2014, to June 30, 2017. All 9330 episodes involving 1 of 7 low-value procedures were evaluated, including endoscopy for dyspepsia in people younger than 55 years (3689 episodes); knee arthroscopy for osteoarthritis or meniscal tears (3963 episodes); colonoscopy for constipation in people younger than 50 years (665 episodes); endovascular repair of abdominal aortic aneurysm in asymptomatic, high-risk patients (508 episodes); carotid endarterectomy in asymptomatic, high-risk patients (273

episodes); renal artery angioplasty (176 episodes); and spinal fusion for uncomplicated low back pain (56 episodes). Sixteen hospital-acquired complications (HACs) were used as a measure of harm associated with low-value care.

Main Outcomes and Measures: For each low-value procedure, the percentage associated with any HAC and the difference in mean length of stay for patients receiving low-value care with and without HACs were calculated.

Results: Across the 225 hospitals and 9330 episodes of low-value care, rates of HACs were low for low-value endoscopy (4 [0.1%] episodes; 95% CI, 0.02%-0.2%), knee arthroscopy (18 [0.5%] episodes; 95% CI, 0.2%-0.7%), and colonoscopy (2 [0.3%] episodes; 95% CI, 0.0%-0.9%) but higher for low-value spinal fusion (4 [7.1%] episodes; 95% CI, 2.2%-11.5%), endovascular repair of abdominal aortic aneurysm (76 [15.0%] episodes; 95% CI, 11.1%-19.7%), carotid endarterectomy (21 [7.7%] episodes; 95% CI, 5.2%-10.1%), and renal artery angioplasty (15 [8.5%] episodes; 95% CI, 5.8%-11.5%). For most procedures, the most common HAC was health care–associated infection, which accounted for 83 (26.3%) (95% CI, 21.8%-31.5%) of all HACs observed. The highest rate of health care–associated infection was 8.4% (95% CI, 5.2%-11.4%) for renal artery angioplasty. For all 7 low-value procedures, median length of stay for patients with an HAC was 2 times or more the median length of stay for patients without a complication. For example, median length of stay was 1 (interquartile range [IQR], 1-1) day for knee arthroscopy with no HACs but increased to 10.5 (IQR, 1.0-21.3) days for patients with an HAC.

Conclusions and Relevance: These findings suggest that use of these 7 procedures in patients who probably should not receive them is harming some of those patients, consuming additional hospital resources, and potentially delaying care for other patients for whom the services would be appropriate. Although only some immediate consequences of just 7 low-value services were examined, harm related to all low-value procedures was noted, including high rates of harm for certain higher-risk procedures. The full burden of low-value care for patients and the health system is yet to be quantified.

Additional papers on this topic can be found at: <https://pubmed.ncbi.nlm.nih.gov/?term=elshaug+a&sort=date>

Thank you for accepting this submission.

Sincerely,



Professor Adam Elshaug

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