“**M**aking **A**naesthetic, **P**erioperative and **S**urgical care **S**ustainable”

A submission to the Panel, WA Government Sustainable Health Review (SHR) 2017-2018

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Disclaimer:

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- Department of Anaesthesia and Pain Medicine, Fiona Stanley & Fremantle Hospital Group.
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Introduction:

We are currently the largest Anaesthetic department in Australia with a membership of 249 staff spread across 190 FTE that actively manage all aspects of our patients' surgical and perioperative journey. We also provide substantial services to emergency presentations and resuscitation of critically ill in-patients. We would like the Sustainable Health Review (SHR) panel to benefit from our holistic expertise in the field of anaesthetic, perioperative and surgical care – hence we have actively engaged our surgical colleagues in providing input into this submission. We also engaged actively with Pain Management specialist colleagues – they are providing the SHR with a separate submission.

Key themes and recommendations:

As a department and a craft group, we share your vision to develop a more sustainable, patient-centered health system in WA. Our collated feedback from craft groups involved in providing care to our patients found key themes as follows:

- *The mix of services needs to be addressed:* The current mix of services needs to be reviewed and tailored to deliver care in the most appropriate setting and maximize health outcomes. The government usually focusses on the gaps in service provision, but in terms of efficiency and sustainability it is equally important to focus on the problems that stem from service replication. Care closer to the home is important but a balance needs to be struck when generating a care resource that amounts to financially unsustainable costs for the tax payer.

- *Reducing costs in the long term while maintaining quality will need upfront investment:* We need to adopt pro-active approaches to reduce costs in the long term. An example of such an approach in the peri-operative setting is the utilisation of Enhanced Recovery After Surgery (ERAS) programmes[1]. ERAS guidelines[2] are a well-utilized, well-researched and proven approach to dealing with elective surgery patients that reduces hospital stay, reduces cost and improves patient outcomes. Setting up such a program at a health service level requires clinical leadership, multi-disciplinary stakeholder engagement and employment of ancillary staff to drive pathway compliance and audit. Prehabilitation to improve perioperative outcomes is another example of a strategy that delivers good outcomes with investment upfront. Such investments yield ongoing dividends and the financial returns from this approach has been well documented in the NHS, Canadian and Scandinavian settings. If we wait for the current clinical system to fail before an investment is made, it is far too late for a vast proportion of patients - as well as the tax payer who expects return on investment.

- *Reducing variation in practice is a key driver to make the current system lean and efficient:* Significant work is being undertaken on this front by different organizations including the Royal Australian College of Surgeons (RACS). There is good evidence from a review commissioned by RACS[3] utilizing Medicare data that while procedures such as hernia repair can be performed as day-case surgeries very effectively, there is marked practice variation in the private setting. We suspect the same is true within the public sector. We suggest that these concepts need to be explored widely across different sectors (including different specialties and hospitals) as such initiatives not only reduce cost, they help greatly in identifying patients that

[1] *Sturm L and Cameron AL. Fast-track surgery and enhanced recovery after surgery (ERAS) programs. ASERNIP-S Report No. 74. Adelaide, South Australia: ASERNIP-S, March 2009.*

[2] Please visit http://erassociety.org.loopiadns.com/guidelines/list-of-guidelines/

[3] *RACS Choosing Wisely – Same Day Inguinal Hernia Repair presentation (manuscript of project is currently pending peer-reviewed publication).*

require extra-care as soon as they deviate from specified care pathways. Hence appropriate interventions can be initiated early while these costs generators can be identified more clearly as variations within models like "activity based funding". These initiatives also identify practitioners who may not be making the most sustainable choices and their delivery on investment can be more clearly addressed.

- *The concept of "value" varies within context which needs to be addressed when "trade-offs" are suggested:* There is substantial evidence to confirm the idea that "value" in defined differently by the patient, clinicians and managers. There needs to be mechanisms to ensure that value behind every initiative is defined and any trade-offs highlighted. Choosing Wisely Australia is such an initiative that challenges the way we think about healthcare, questioning the notion 'more is always better'. Even within the clinical setting, the complexity of tests, treatments, and procedures available to modern medicine present a tangible challenge - since not all add value. Some are rendered redundant as others take their place. Such challenges need to be recognized and addressed since unnecessary practices are a diversion away from effective care. Unnecessary practices often lead to more frequent and invasive investigations that can expose the consumer to undue risk of harm, emotional stress, or financial cost. Such decisions extend beyond the realm of informed consent by the patient – they extend into physician recommendations, government subsidies to care and community / tax-payer values.

- *Data utility in the form of registries is a proven effective strategy from a patient-centered, financial and clinical governance view point in the Australian setting:* We are delighted that the panel would focus on digital innovation, the use of new technology and data to support improved performance and care delivery – systemic change needs to be informed by good quality data and information. That is why registries are important. Using a conservative methodology, a study[4] to evaluate the economic impact of five Australian clinical quality registries showed that Australian clinical quality registries have delivered significant value for money, when correctly implemented and sufficiently mature. This particular study was conducted by the Australian commission on safety and quality in health care (ACSQH) and engaged Monash University as well as Health Outcomes Australia. Each of the five clinical quality registries included in the study had an influence on clinical practice and improved the value of healthcare delivery at relatively low cost. Substantial benefits were measured, including greater survival for patients, improvements in quality of life after treatment and reduced costs of treatment. In a budget poor system, the facets of financial feasibility and sustainability reign prime around any new initiative. The above study showed benefit to cost ratios ranged from 2:1 to 7:1 – meaning that for every dollar spent, the return on that investment ranged from $2 to as much as $7. The study also suggested that the return on investment would range around $4 per dollar invested if broader coverage at a national level were achieved by all five clinical quality registries. However, the study noted that not every clinical quality registry will be cost-effective. Problems such as low coverage, inadequate reporting and inadequate collection of information about patient outcomes will limit the effect of clinical quality registries, and their value to the health system. Any future ventures into the area of setting up registries or employing other data tools is a high gain venture – but it requires planning and investment at the outset in order for it to deliver ongoing financial benefit in a sustainable manner.

- *Goals of care for our consumers should to be defined robustly in a proactive and informed manner:* A key focus for our craft group is to align our clinical management at all times with well outlined goals of care for each patient (especially those near the end of life). Such initiatives need to be supported as they present a valuable opportunity to establish a shared

[4] *The Australian Commission on Safety and Quality in Health Care. Economic evaluation of clinical quality registries: Final report. Sydney: ACSQHC; 2016.*

mental model with the consumer in terms of care delivery and establishing what is independently valuable for each patient. In the US setting for example, out of the $1627 billion spent on health care in 2011, approximately 13% (or $205 billion) was devoted to care of individuals in their last one year of life. [5] The key to avoiding such disparity in costs is to outline goals on care in a proactive manner and avoid unnecessary interventions including operative interventions.

- *Vast enthusiasm exists within the perioperative care community for initiatives that streamline care delivery and improve efficiency – they need appropriate supports i.e. executive, resources and expertise:* We welcome your initiative to leverage existing investments in primary, secondary and tertiary healthcare as well as new initiatives to improve pathways and transition. What is lacking at times is provision of resources to enable clinicians to play an active role as a change agent. We understand the budget stretched climate that faces us currently– but access to pre-existing resources such as executive support, business input and IT can also prove to be anecdotally difficult. Any formalized frameworks to ensure that this support is provided readily will be well utilized by the clinicians who are engaged in driving system improvement at the frontline.

- *Duplication extends beyond care delivery services into the managerial and governance structures:* There is a very real opportunity within the state of WA and especially within the Metro area to drive partnerships across sectors to reduce duplication. The duplication extends beyond the physical infrastructure – it is tangible within current management structures. A review of the recent co-director model adopted at a health service level is needed. In the words of a colleague about meeting project approval deadlines: "*We now have to meet deadlines which are half as short, since we have to follow a process of approval at a local health service level before the same can occur at a department of health level. It is twice the bureaucracy and half the time spent on our projects for the same outcome!*". While divestment of responsibilities downwards (to specific health services and further to specific departments) has its own merits, replicating the bureaucratic structure at each level has added to the previously 'clunky' process. We need decision making ability paired with accountability within leaner governance structures if our public health system aims to move forward efficiently. We also need data fed 'down' the hierarchy rather than in a one way 'upwards' direction to arm staff at all levels with the right information when implementing sustainable change.

- *We should encourage pathways that de-emphasize the "sick role" unless physiologically warranted and should investigate better patient flow structures from the private sector*: One avenue driving improvements in safety and quality for patients is tying patient outcomes with patient engagement. We are aware of similar approaches having worked well in the past when patients are recovering from elective surgery where patients almost "competed" with each other to achieve targets of recovery on their daily recovery plan. This involved designing and implementing high quality patient pathways and investing infrastructure (e.g. nursing staff) to drive these pathways forward. It also involves a critical review of processes that impose the 'sick' role on any patient the moment they enter a hospital e.g. being transferred in a bed, lying helpless in a gown - even when they are presenting for an elective day case. Examples of how patients can be kept out of the "sick role head space" need to be explored to allow for quicker and flexible check in/check out systems – especially for day case surgery. There are examples of patient pathways that have been implemented by individuals in a private health care setting that can be borrowed when designing recovery pathways in our public hospital setting. These pathways should be eminently replicable to a large extent because the clinicians involved are often working across both sectors.

[5] *Aldridge MD, Kelley AS. Epidemiology of serious illness and high utilization of health care. Available at:* *http://www.nap.edu/read/18748/chapter/14*.

- *More streamlined connections between GPs, surgical, pre-operative clinics and multi-disciplinary teams needed so that information is not lost or replicated:* Value and financial sustainability go hand in hand with technical efficiencies. We need to ensure that robust mechanisms are implemented to ensure that tests are not duplicated, patients get reviewed in a timely manner and hospital care is "built upon" what is being provided in the primary health setting. Supporting streamlined referral services, shared information technology infrastructure and better communication (e.g. Telehealth) is where significant time can be saved while value at macro level gained. This is especially important for patients that are accessing health care from rural and remote areas – service models need to be investigated to reduce overall burden of access for such patients while reducing the bill for the tax payer.

- *Resources such as time and wages need to be allocated to non-clinical tasks invested within key people to improve the system as a whole*: At the level of professional colleges, we are acutely aware of the key enablers of new efficiencies and change. These are reflected in our non-clinical roles - including, research, teaching and training. We need these roles supported unconditionally. More avenues need to be opened where target clinicians can achieve formal training in leadership development, performance monitoring, business process management and quality improvement. This suite of skills has become increasingly important in a financially stretched system and needs to be taught formally for best return on investment. According to one of our Anaesthesia colleagues: *"Sustainability can only become a reality when time and wages are put into education and research. Mandatory healthcare education should include principles of sustainable healthcare to change the current culture of workforce and management".*

- *The priorities for this review's mandate can be clarified further:* We welcome the Sustainable Health Review and its focus on maintaining essential services and staff - while creating value and improving the efficiency of our health system. We found this mandate unclear in terms of its priorities. Where does your priority lie in terms of sustainability? Will the system's inefficiencies be addressed for the sake of sustainable health care delivery and if required will services that go against the review's recommendations be restructured or revoked? We note this with interest as respect for this review's mandate of sustainability is essential. It is eventually the staff on the front lines and patients that face the ill effects of previously unsustainable decisions.

- *The health care consumer's responsibility needs to be clarified when pursuing sustainable health delivery goals in a "patient centred" model:* We strongly agree with the panel that ensuring robust consumer and carer input and engagement is an essential part of the process. But we would also like to stress that such consumer and carer engagement needs to be harnessed on well-defined terms of engagement. If expertise to drive clinical care is truly considered to lie on both sides of the stethoscope (i.e. with a treating clinician as well as the patient), then why is the responsibility and accountability to implement a caring partnership not shared equally? Utilising patient satisfaction and PROMs (patient reported outcome measures) to drive our aims of safety, quality and service provision goals is a key strategy that needs support from the government sector. Meanwhile, a substantial part of our time is utilized in educating and trying to engage consumers who are firmly disengaged, disenchanted and divorced from their own outcomes. This stems from a perceived lack of financial or other repercussions combined with an overall reluctance to consider change. Who is accountable for such behaviour? If you wish to find proof, a quick preview of the Vascular Surgery pre-admission clinic lists would be a prudent example – the prevalent rates of smoking and lack

of utilisation of QUIT smoking advice diligently issued by treating staff will paint a realistic view of consumer engagement issues for our panel. The lack of accountability on behalf of particular patient sub-populations is something the panel should investigate when exploring the theme of patient centred care to tie clinical outcomes to patient drivers. Investment in 'health prevention' initiatives such as smoking cessation, 'sugar tax' etc may need to be legislated or incentivized to deal with certain sub-populations. Education and appealing to one's good nature alone are NOT yielding the results that were predicted initially.

- *Major healthcare sustainability initiatives should be driven by 'patient focussed' expertise rather the 'voter centred' policy – Hence key accountability measures need to be pre-defined:* It would not surprise us if your panel found engagement a difficult task. When engaging the stakeholders to feed into this submission, one of the clearest themes to emerge was the disenchantment of front line staff with government and department of health initiatives because of past experience. We were asked repeatedly – "*why should stake holders (such as clinicians) continue to engage when repeated reviews and their recommendations continue to get ignored in the light of election promises?"* Previous reviews into our health care service provision have utilized substantial time and resources. If one was to take the outcomes of the *Reid Report* to inform our discussions, both the panel and the government need to justify why major recommendations of this particular report were discarded despite substantial investment of tax payer dollars in conducting the review. The staff have witnessed recommendations (much like what the SHR intends to provide) rejected or stalled repeatedly in favour of political gain and election promises. While the policy climate utilizes a short-term cycle within short governmental terms aided by a rapid media cycle, those delivering your frontline services face the results of poor policy decisions for years to come. We have seen major recommendation for a reform of health services by the *Reid Report* within Perth Metro area successfully legislated against (e.g. Royal Perth Hospital Bill[6]) by members of the state parliament. It was suggested widely from the stakeholders that a much more clearer and stricter delineation between government and the department of health roles needs to be considered. Divorcing sustainable health care goals from election promises needs to be considered strongly if long term gains are to be made and recommendations of informed panels are going to be followed. As one of our surgical colleagues pointed out: "*You can't have sustainability without accountability. Who are we to hold accountable when projects that rely on a 5 to 10year time frame are rejected by an incoming government for short term electoral gains?"* While clinicians continue to engage with processes such as the SHR, a number of staff who engaged with our submission wanted it clarified at an early stage (perhaps through the SHR interim report) what the threshold for action by any government or department is expected to be at the time of implementing informed recommendations by your panel.

Conclusion:

We are happy to be consulted further if our expertise can inform your approach to sustainable care within the anaesthetic, surgical and perioperative care settings. These areas have traditionally seen a marked proportion of hospital expenditure allocated. It is perhaps within the same setting that some of the most significant gains can be achieved.

We wish you well with the review.

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[6] *Royal Perth Hospital Protection Bill 2013 – accessible at* http://www.parliament.wa.gov.au/Parliament/Bills.nsf/9C8F60B29578F45148257B6C00208631/$File/Bill009-1.pdf