Private Healthcare Australia
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Press Release

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NO MORE EXCUSES

Private Healthcare Australia (PHA) strongly supports moves by private health insurers to ensure patients receive better quality care by minimising preventable hospital errors.

PHA CEO Dr Michael Armitage said health costs are rising, the population is ageing and there is an increasing demand for the best available health services.

"Keeping health costs under control requires people to tackle unnecessary expenditure arising from preventable readmissions caused by hospital errors", Dr Armitage said.

"The Australian healthcare system has faced this challenge for decades, and too little has so far been done to address these preventable mistakes despite the increased pain and suffering caused to patients, and the significant cost added to the system.

"The argument for 'no change in healthcare' overlooks the fact that many of Australia's hospitals, including several large hospitals, have already agreed that the Medibank list of quality and safety initiatives leads to better care, and have entered into contracts on this basis.

"And", Dr. Armitage asked, "why wouldn't they do so, given that it will help to minimise preventable mistakes that cause patients to be readmitted unnecessarily to hospital? These mistakes can lead to prolonged inactivity, delayed return to work, further medical procedures and increased cost, in addition to the emotional strain for the patient."

While some hospital providers have their heads in the sand, others are proactively working to prevent errors. Recently, the CEO of the St John of God Health Care group, Dr. Michael Stanford, wrote in the journal of Catholic Health Australia:

> *"CHA and the broader sector would be wise to work with funders on establishing agreed quality measures, publishing our results openly, and we should be prepared to get paid less (or not at all) for poor quality, and more for demonstrably exemplary quality."*

"It is disappointing that not all hospital providers are willing to engage in a serious discussion about the quality of care they provide. It is not enough for hospitals and doctors to merely pay lip service to improving quality of care. Without concerted action to address preventable hospitalisations, nothing will change and patients will continue to face unnecessary costs and poorer outcomes.

"We must act now. Ideally, everyone should be willing to partner in this process, but sadly some parties instead want to play politics with the sustainability of the healthcare system and patient outcomes.

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"It would be better for all concerned to work collaboratively to incentivise the quality and consistency of health care rather than defending the indefensible by insisting on charging patients for preventable errors.

Taking preventive action now will improve care for patients, reduce the need for readmissions, and ensure health insurance premiums remain affordable."

Dr Armitage welcomed Health Minister Sussan Ley's decision to expedite the release of a Government list of preventable hospital events.

"The Minister's decision to bring forward the release of the Government's own list will hopefully demonstrate that hospitals cannot simply ignore concerns about quality of care and waste in the system."

Dr Armitage said recent statements about charging out of pocket costs when a hospital did not have a contract with a private health insurer were surprising. Many hospitals operate without agreements with health insurers and choose not to charge additional costs to patients.

"The fact that a hospital feels compelled to charge additional costs to some patients raises questions about the prices being charged by these hospitals," Dr Armitage said.

"Patients would be entitled to ask why other hospitals in similar circumstances, without a contract, do not charge. Patients would be entitled to ask for comparisons of costs between hospitals to see how much more their treatment actually cost and ask why."

See attachment: Clinical examples from the Australian Council of Healthcare Standards and their implications for patients (next page)

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Results from 2013 ACHS Australasian Clinical Indicator Report - 316 private and 415 public hospitals

Indicator	Results	Implications
Antibiotic prophylaxis in elective and emergency caesarean section	The proportion of women receiving an appropriate prophylactic antibiotic at the time of either an elective or emergency caesarean section has increased from 64.0% in 2008 (when the CI was first collected) to 92.5% in 2013 (Obstetrics CI 5.1).	7.5% of women have a caesarean section do not receive appropriate antibiotics to prevent infection.
Venous thromboembolism prophylaxis	The utilisation of evidence-based guidelines for thromboprophylaxis in high-risk medical patients was reported by 12 HCOs in 2013, with a high rate of 90% (Hospital-Wide CI 8.1).	10% of high risk medical patients do not receive medication to avoid DVT.
CI 7.1 Hysterectomy – appropriate thromboprophylaxis, patients >40 years (H)	The annual rate was 93.5 per 100 patients.	6.5% of hysterectomy patients do not receive medication to stop DVTs
CI 8.1 High-risk medical patients admitted who receive VTE prophylaxis (H)	In 2013, there were 3,901 patients reported from 12 HCOs. The annual rate was 90.2 per 100 patients. The potential gains totalled 260 more high-risk medical patients who received VTE prophylaxis. There were three outlier records from three HCOs whose combined excess was 127 fewer high-risk medical patients who received VTE prophylaxis. The outlier HCO rate was 73.9 per 100 patients.	260 patients did not receive appropriate medication to avoid DVT in the ICU unit. While the nation rate was 90.2%, one hospital had a rate of only 74%.
Inpatient falls in patients 65 years or older	The proportion of inpatients aged 65 years or older that fall has increased slightly since 2008, from 0.46% to 0.54%. In 2013, there were 12,434,424 bed days reported from 385 HCOs. The annual rate was 0.38 per 100 bed days. The potential gains totalled 17,710 fewer inpatient falls, corresponding to a reduction by approximately one-third. There were 166 outlier records from 109 HCOs whose combined excess was 7,411 more inpatient falls. The outlier HCO rate was 0.66 per 100 bed days.	1 in 200 patients over age 65 who are admitted to hospital suffer a fall while in hospital The worst hospitals have 1.5 times the average rate for falls. If all hospitals had the same rate as the best hospitals, then 17,710 fewer patients would fall in hospital.
CI 3.1 Laparoscopic gynaecological surgery – injury to a major viscus with repair	In 2013, there were 11,111 patients reported from 46 HCOs. The annual rate was 0.75 per 100 patients. There was no significant trend in the fitted rate. The potential gains totalled 26 fewer patients receiving an injury to a major viscus during a laparoscopic gynaecological operative procedure, corresponding to a reduction by approximately one-quarter.	If all hospitals reflected best practice, there would have been 26 fewer women who received injuries to major organs during laparoscopic surgery.
CI 6.1 Significant adverse blood transfusion events	In 2013, there were 78,329 transfusions reported from 146 HCOs. The annual rate was 0.19 per 100 transfusions. In 2013, the potential gains totalled 58 fewer significant adverse blood transfusion events, corresponding to a reduction by approximately one-third.	About a third of blood transfusion reactions could have been avoided if all hospitals followed best practice.