ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

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LET'S OPERATE WITH RESPECT

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2 November 2016

Commissioner Stephen King
Commissioner, Introducing Competition and Informed User Choice into Human Services
Productivity Commission
530/12 Collins St
Melbourne VIC 3001

Dear Commissioner King

Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform: Public Hospital Services

Thank you for providing the Royal Australasian College of Surgeons (RACS) with the opportunity to engage with the Productivity Commission's Human Services Roundtable: Public Hospital Services on Friday 21 October 2016.

RACS is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and international medical graduates across Australia and New Zealand. The College also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. As part of our commitment to standards and professionalism RACS strives to take informed and principled positions on issues associated with the delivery of health services.

RACS would be pleased to continue to engage with the Commission regarding the reform of Australia's public hospitals. In relation to the publication of performance outcomes data, RACS advises that it supports the public release of performance outcomes data to consumers at the team, institutional, state and national level, but does not support the public release of such data at an individual level.

Using data to inform surgical best practice
As part of RACS commitment to continuing education and ongoing analysis of performance outcomes data for our Fellowship, the College maintains a division dedicated to Research, Audit and Academic Surgery. As an education and membership body, RACS focus is on analysing and providing information for use by our Fellowship to improve the quality of medical care and to build public trust and confidence in healthcare delivery

From 2009, RACS has managed the Australian and New Zealand Audit of Surgical Mortality. The audit program is part of quality assurance activity aimed at the ongoing improvement of surgical care. Clinical reviews are conducted by surgeons who practice in the same specialty but who practice at a different hospital. Following release of the sixth national audit report in November 2015 it was noted that participation in the audit had increased from 60% to 97% of surgeons and that the numbers of adverse events was the lowest yet recorded - (http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm/#).

In 2016, in partnership with Medibank, RACS began publishing de-identified surgical variance reports on common procedures within a number of surgical specialties. The reports are robust and provide context for potential variation. The reports provide clinicians with an opportunity to reflect on their own practice and consider reasons for differences in practice when compared to aggregate data from other specialists. By highlighting variation in practice the RACS and Medibank hope to assist clinicians to reflect on their own practice and make improvements to clinical outcomes and patient care where necessary: (http://www.surgeons.org/policies-

publications/publications/surgical-variance-reports/).

Using data to inform public reports on surgical outcomes and performance
RACS supports the publication of performance outcomes information to the public that are valid, reliable and transparent at a team, institutional and national level. RACS supports the release of appropriate public reports that establish trust, ensuring providers and patients can be confident that reports accurately reflect health care. RACS position on Public Reports on Surgical Outcomes and Performance is publically accessible: (http://www.surgeons.org/media/24786132/2015-12-02_pos_fes-pst-056_public_reports_on_surgical_outcomes_and_performance.pdf).

RACS does not support the release of reports on individual surgeon performance or the concept of league tables; however, RACS does accept that outliers be reliably identified and managed. Medical interventions in public hospitals are provided by teams rather than individual specialists, the outcomes of which rely on the effective functioning of those teams. Collecting and releasing outcomes at the team and institution level offers an opportunity to assess and benchmark performance, contributing to ongoing quality improvement.

Serious failures in healthcare are often related to systemic issues rather than individual competence. The recent release of the Duckett Review on 14 October in Victoria (https://grattan.edu.au/news/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria/) highlights both that complications are rarely the result of individual incompetence or malice and that hospitals need strong processes to minimise the risk and consequences of human error. Collecting data about team and hospital performance may be more likely to identify these systemic issues than collecting individual practitioner outcomes.

RACS is aware of the work being done in the United Kingdom regarding public reporting of outcomes of individual practitioners. Anecdotally it has been suggested that clinicians within the NHS may take steps to avoid negative mortality statistics, including refusing to operate on high-risk patients or keeping their caseload low. While unable to confirm these comments, RACS acknowledges the danger of creating perverse incentives through publication of individual clinician outcomes that could create an environment where clinicians are less likely to support their peers and teams, focusing instead on the manner in which their individual results may be reflected.

In 2016, the Health Quality and Safety Commission New Zealand published a position paper on the transparency of information related to health care interventions (http://www.hqsc.govt.nz/publications-and-resources/publication/2463/) discouraging the public reporting of individual clinician data on the basis that it is unlikely to be statistically sound and that it may be counterproductive, undermining the teamwork the health system hopes to encourage. The paper is extremely well referenced and provides an excellent resource to further investigate some of these issues.

RACS appreciates the opportunity to comment on the preliminary findings report. We hope the above information is useful and we look forward to seeing how the consultation progresses. If you would like to discuss further please contact me via the attached details.

Yours sincerely

A/Prof David Hillis
Chief Executive Officer