

Caring about carepaths in Queensland and Bulgaria: a commentary

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I found the paper by Pearson and Macintosh (2001) to be exciting and disturbing. It is an achievement when several clinical disciplines work together to make major changes in their daily work. It is disturbing that, when they have made so much progress, there should be talk about undoing it all – or at least some of it.

Pathways are a good idea

Any team that has taken carepaths seriously will have considered quality and outcomes as well as cost, and worried about equity and priority. Team members will have taken account of world-wide evidence as well as local peculiarities, and will have created the basis for valid comparisons of clinical practice. In short, they will have addressed just about everything that matters in health. They will have done it at a point in the health care system where sensible trade-offs can and should be made.

One of the attractive features of carepaths for me is that they are an integrating idea. We have talked about integration and co-ordination, and co-operation and seamless care for longer than I can remember. Yet most of the innovations that are discussed in sacred ways at expensive conferences actually do more to fragment than to unite the health care sector.

Examples are legion. DRGs say nothing about quality and encourage cost-shifting to the community. Privatisation breaks down teamwork within the public sector. Men's health and rural health aim to integrate on one plane but they cause discontinuities elsewhere. Quality assurance and casemix units, that are established as temporary measures in tin sheds in the car park, do their best to redefine good clinical practice as anything left when the tin sheds are full. In other words, elements of good clinical practice (like the comparison of outcomes and maintenance of clinical classification systems) become separate 'administrative' rather than integral parts of 'clinical' work, even though they were originally the invention of the clinical professions.

The assumption of simplicity

One of the great strengths of carepaths is also a potential weakness. Their logic is simple and strong, and we consequently tend to assume that change will be easily accomplished without the need for vigorous and thoughtful planning on the part of purchasers and care providers alike. By purchasers, I mean state health authorities and private insurers in the Australian context. There are differences among purchasers, but they are not important in the context of this short paper.

Perhaps the assumption of simplicity is why so little effort has been made to establish pathways in many parts of the world. \$50 million in research funding was needed in order to establish DRG-based funding in Australia, but far less has been made available to support carepaths. The logic might have been that carepaths are easy and obviously sensible, whereas DRG-based funding is so technically difficult and less than obviously a good thing.

Purchaser interference

There are other, more plausible reasons for the unbalanced investments. One is that many of the major initiatives for change tend to originate with the purchasers of health care, and pathways may be too close to clinical practice for non-clinicians to feel comfortable about having a view.

It is common for purchasers to say they have not pushed the use of clinical pathways because that would mean 'interfering in clinical practice'. This is illogical on two grounds. First, a purchaser can demand the use of pathways without dictating their content. Second, all purchasers interfere in clinical practice all of the time (and this will always be the case, unless they decide to pay for everything without question). The issue is not whether purchasers should interfere, but rather whether they will choose to interfere intelligently.

The fear of transparency

Another constraint to active support for pathways is that they make the rationing decisions more easily recognised. If the purchaser and the care provider agree to describe a product as 'Stroke with CCs' it is hard for anyone to claim there is under-funding or risk to quality of care. The product is so crudely defined that almost any price can be claimed to be reasonable. Thus there are many circumstances in which the last thing a payer wants to do is make the rationing and its consequences open to scientific analysis. This is one reason why I have consistently encouraged care providers to bring their pathways to the price negotiation table; and when the purchaser says \$2000 is enough, to slap down the relevant pathway and ask "OK, which of the care elements would you like to be removed, and can I quote you?"

Mind you, I have also encouraged purchasers only to purchase care that is specified in a pathway. So, can the same argument attract both sides? I suspect neither side will benefit from discussing the trade-off between cost and quality over copies of a pathway if we continue to live in a world that does not recognise mutual dependence and responsibility. The fact is that many purchasers of health care have the dominant goal of containing the immediate costs (although they say otherwise). It is equally the case that the dominant goal of at least a few care providers is to retain the right to be paid without having to explain why there is no clinical management process worth having. They are reluctant to admit that there are too many care providers who lack common beliefs across clinical professions, that there are inadequate ways of dealing with the dangerous idiosyncrasies of autocratic doctors, too many constraints to innovative thinking by nurses, and so on.

Some purchasers are taking the lead

There is a better way, and it is evidenced by changes taking place around the world. An example is the nationwide change to pathway-based care in Bulgaria. The government's health insurance agency, which funds the large majority of care, had been planning for two years to introduce DRG-based funding for all hospitals along Australian lines. This presented many problems because clinical coding was poor, product costing was hardly known, a DRG variant would need to be selected and adjusted to suit Bulgarian conditions, expensive software would be needed, and so on.

In January this year, they took a bold decision to change direction. 30 high-volume case types would be identified for a start. The list would be extended later. Expert committees would design illustrative clinical pathways and present them for comment to all hospitals. The edited pathways would then be costed as the basis for pricing, and all hospitals would be required to use the illustrative pathways (with local modifications as appropriate, and subject to audit by the insurance agency) as a condition of contract. Auditing would then be directed primarily at checking the extent to which the pathways were actually being used in production management.

The new scheme was implemented five months later, on 1 July. It is too early to be sure, but initial experiences suggest there have been immediate benefits in terms of improved clinical practice – and consequent gains in quality of care and efficiency. Care provider reactions were initially negative: all the standard complaints were aired. However, not a single hospital chose to avoid pathways by turning down the offer of a government contract. Many claimed they accepted pathways against their better judgement and in the face of government threats. The sensible clinical teams kept quiet, because it was obvious to them that they were seeing the rare phenomenon of a purchaser acting intelligently.

Why not Queensland Health?

It follows that I sympathise with the clinical teams at Cairns Base Hospital. They have had some degree of support from their main purchaser, Queensland Health, but they believe they would have benefited from more of it. They might have preferred to deal with the National Health Insurance Fund of Bulgaria, but would not have enjoyed the prices.

In fact, Queensland Health has been more positive about pathways than most purchasers. As I understand it, one of the reasons for disruption of the work at Cairns is because Queensland Health wants to establish a statewide framework for clinical pathways and related systems. Irritating delays are a common risk for innovators. It may also be that part of the difficulty relates to the common event of trying to maintain work that began with one-off funding.

This said, I can understand why many well-meaning and generally competent purchasers are reluctant to become involved in the promotion of pathways and related ideas. They have experienced too much frustration in the past over what they perceive to be bloody-mindedness on the part of some clinicians, and especially of visiting medical officers and a few other senior doctors.

I noted that the Bulgarian care providers initially presented all the standard negative views. I was referring to my own top-ten list of comments about pathways that has stood the test in the thirty or so countries in which I have worked in the last decade or so. In short, doctors say that pathways mean 'cookbook medicine'. They constrain research and development of new methods of care. They are expensive and time-consuming to design. They are only useful in hospitals (and only for elective surgery). They increase the risk that clinicians will be sued. They frighten and confuse patients and their families. They increase the amount of clinical documentation. They are only practical if there are specialised support staff to design and maintain them. They are merely a cost-cutting tool. I forget the tenth, but know for sure that it is equally invalid. There are many sources of refutation in the literature.

Incompatible world views

How can some highly intelligent, dedicated and well-meaning doctors say these things? The answer is that the 'system' made them this way, and especially that part which is directed at maintaining medical culture. The same may be said of other professions, but they generally have less power to make or to veto change.

I have been frustrated in the past at doctors' objections to pathways, and have only recently become adequately aware of the broader context in which their objections originate. The breakthrough for me was the realisation that, if a doctor accepts carepaths, he or she is likely to be the most imaginative and persistent of all. It was my ignorance of the cultural complexity and its ramifications that caused me to be less effective than I should have been. Pathways are only simple and obvious if you believe health care is practised in a value-free and objective world.

If there is a lesson from the Cairns experience, it is the same message that applies to most changes in health care: health professionals, clinicians and others, need to find a way of recognising the patently obvious and then acting accordingly. Part of the obvious is that health professionals have different cultures, and consequently have what the systems thinkers like to call different *weltanschauungen* or world views. For example, Checkland and Scholes (1990) argue that, when doctors, nurses, and health economists look at (say) clinical pathways, what they see largely depends on who they are. As a consequence, you need to define the *weltanschauungen* of yourself and the other parties (and understand and respect the differences) before there is any chance you will move towards seeing the same thing.

Good clinical teams go through this process in one way or another, and other groups of health professionals need to be given a little support. Where this does not happen, we continue the tribal warfare. While passing the blame across the artificial divide between purchaser and provider is often fun, it delivers no health gains.

Reference

- Pearson B and Macintosh DJ 2001, 'Caring about carepaths', *Australian Health Review*, vol 24 no 4.
- Checkland PM & Scholes J 1990, *Soft systems methodology in action*, John Wiley and Sons, Chichester.