Bad doctors deserve to be exposed

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We have the right to know a lot more about deaths in our hospitals.

Wouldn't it be great if hospitals, surgeons, government and economic reformers resolved to cut heart surgery mortality rates by 40 per cent in the next three years. Well, it can be done. All we need is some guts — like politicians have shown with economic reform generally — and some high-quality information.

Public information about the quality of health care is critical to driving improvements. That's why the publication in *The Age* this week of information about hospital accidents is at least a promising step forward.

Alas, it was in a format that prevented identification. We were told this was to protect patients' privacy. To use the immortal words of Lord Wellington, if you believe that, you'll believe anything. The reason there was a lack of specific information was to protect everyone other than the patients — and particularly to protect bad doctors and bad hospitals.

Something similar happened in New York state more than a decade ago, but the outcome was quite different. *Newsday* got hold of information from a major study of heart bypass surgery within the state. The information identified patients and surgeons.

There was a fearful outcry from surgeons — one presumes the worst surgeons were the most keen to protect their patients' privacy. They feared that a hospital and surgeon "league ladder" would see a massive swing of patient demand away from the worst hospitals and surgeons towards the best. Heaven forbid.

But system administrators held the line and insisted on maintaining the data — and publishing it — in a form that would identify hospitals and patients.

The recently released Victorian hospital data is useless in this regard. Not only can we not identify the particular incidents, but even if we could we wouldn't know what they showed, because we have nothing to compare current performance with.

In the New York study each medical episode was carefully "risk rated" — that is, the system predicted a likely mortality rate before an operation. So a surgeon losing 5 per cent of her patients might look bad on their raw score, but not if they were specialising in high-risk operations with a predicted mortality rate of 10 per cent. Risk rating was also carefully audited, so there was minimal incentive to turn the riskier cases away to protect mortality ratings.

The results were remarkable.

It turned out that the dramatic consumer reaction to the publication of clinical data — what the economists might have hoped and the worse surgeons and hospitals feared — never materialised. In the absence of more vigorous consumer education, consumers continued to rely on their local networks to choose health care providers.

The second lesson from the New York episode is that even if consumer choice cannot be induced to play the role economists assign it in driving improvements, information is a remarkably benign commodity. Although in this case the information did little to change the demand for services, it revolutionised their supply.

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The information the program generated drove reforms within hospitals in myriad ways. The data demonstrated the benefits of specialisation. "Low-volume" surgeons had much higher mortality rates than "high-volume" ones. In the first three years of the program 27 low-volume surgeons stopped performing bypass surgery. Their risk-adjusted mortality rates were nearly 12 per cent, compared with a state average of 3 per cent.

The data was also used to identify new areas of specialisation as some surgeons and hospitals found they excelled at some procedures and lagged in others. The upshot of all such changes was a 41 per cent decline in risk-adjusted post-operative mortality in the state over the first three years of the program, although some of this is attributable to other factors such as general improvements in technique.

The Age's revelations from freedom of information documents have helped Victoria take the first step towards reform. Sadly, we're also intent on taking a step backward. The State Government says it does not want to create a "league table" of hospitals. As Keynes once said: "Worldly wisdom teaches that it is better for the reputation to fail conventionally than to succeed unconventionally."

The great virtue of economic reform was that (at least at its outset) it was unconventional — and history has shown it was an unconventional success.

At a time of widespread reform fatigue, what better way for reformers to get back on the front foot than with an agenda that emphasises what economic reform is supposed to be about — tangibly improving our lives?

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