

Laying down the law on healthcare-associated infections

In response to growing concern about avoidable complications that patients acquire in hospital, particularly healthcare-associated infections (HAIs), the US Congress has enacted legislation that from October 1 will provide hospitals with financial incentives to improve patient care. From that date, Medicare payments to hospitals for the extra care that patients require after contracting certain "hospital-acquired conditions" will be withheld. These conditions include catheter-associated urinary-tract infections, vascular-catheter-associated bloodstream infections, and certain types of surgical site infection, plus others unrelated to infection. The initiative raises the question of whether it is possible to control HAIs effectively via the mechanisms of legislation and government-mandated targets?

The Centers for Medicare and Medicaid Services, which oversees these government health-payment schemes, decided against including *Staphylococcus aureus* septicaemia, *Clostridium difficile* associated disease, and Legionnaires' disease among the HAIs for which payment would be withheld after representations from organisations such as the Infectious Diseases Society of America. Indeed, the likely impact of the legislation is difficult to estimate because at the national level, and even within many individual states, accurate data on the scale of the problem are not available because surveillance of HAIs is not mandatory.

When governments face pressure from the public and medical community to respond to the threat of HAIs, it seems obvious that they should require compulsory collection of surveillance data. Yet even within the UK, a country where HAIs probably create more headlines than anywhere else, it was only in the present decade that mandatory surveillance of meticillin-resistant *S aureus* (MRSA) bacteraemia, *C difficile* infection, and glycopeptide-resistant enterococcal bacteraemia was introduced. The USA is catching up: about half of all states now require hospitals to report HAIs, and by the beginning of 2008 only four state legislatures had not considered mandatory HAI reporting. During 2007, Illinois, New Jersey, and Pennsylvania became the first states to set compulsory infection-control requirements for healthcare facilities.

Based on data available from mandatory reporting, the UK government set National Health Service (NHS)

hospitals in England and Wales the target of reducing MRSA bloodstream infections by 50% between 2004 and 2008. Figures released in July show that annual MRSA bloodstream infections had fallen from 7700 (2003–04) to 4438 (2007–08), a reduction of around 42%. The government argues that its success against achieving the 50% target should be judged from quarterly figures for April–June, 2008 (data to be released shortly). Critics contend that this is moving the goalposts from the original target of a "year on year" reduction by March, 2008. Others have argued that targeting a reduction in MRSA infections takes no account of local priorities, and is neither cost effective nor fair when the much larger number of patients with other types of HAIs are taken into account. And the argument has also been advanced that chance variability makes it impossible to judge whether individual hospital trusts are meeting their requirement for MRSA reduction. Interestingly, NHS hospitals will be allowed to set targets for reducing *C difficile* infection that are "locally appropriate".

In the US context, among the unintended consequences of withholding payment for care related to HAIs might be unnecessary screening tests at the time of admission and over-prescription of antibiotics, which would only worsen the problem of antibiotic-resistant HAIs. Hospitals might also be less inclined to admit patients at increased risk of one of the proscribed HAIs or to carry out risky procedures.

For mandatory reporting of HAIs to be useful there need to be uniform surveillance procedures at local, national, and—ideally—international levels. Results for each hospital should be freely available, set in the context of the type of patients the hospital treats. Otherwise, we can see no argument against mandatory HAI surveillance. Initiative to control HAIs based on cost incentives might only work when patients have the choice of institutions with low infection rates.

Actionable solutions to the problem of HAIs will be the focus of a conference entitled "Healthcare-associated infections—moving beyond headlines to clinical solutions" that *The Lancet Infectious Diseases* is organising in London on December 11–12. For more details of the meeting, follow the link to the conference website on this page. ■ [The Lancet Infectious Diseases](#)



For *The Lancet Infectious Diseases* conference on healthcare-associated infections see <http://www.hai.thelancetconferences.com>