Dear Productivity Commission

I am a freelance health journalist who moderates Crikey's health blog Croakey (http://blogs.crikey.com.au/croakey/) and I also coordinate the Crikey Health and Medical Panel (more info attached) – a group of more than 150 health and medical experts who are interested in supporting and stimulating debate around health issues.

Below is a somewhat informal submission to your inquiry, arising out of discussions at Croakey. I hope it is of interest/use; please do not hesitate to contact me if you would like more information.

Some thoughts about hospitals and the Productivity Commission (http://blogs.crikey.com.au/croakey/2009/07/08/some-thoughts-about-hospitals-and-the-productivity-commission/)
July 8, 2009 – 2:55 pm, by Croakey

As mentioned previously at Croakey, the Productivity Commission is studying the relative performance of public and private hospitals with a draft report scheduled for release in September and a final report due to go to the Government in November.

As part of the study, the Commission has been requested to consider:

* comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals
* the rate of hospital-acquired infections by type, reported by public and private hospitals
* rates of fully-informed financial consent by privately-insured patients, out-of-pocket expenses for patients who do not give such consent, and best-practice examples where fully-informed financial consent is provided for every procedure
* other relevant performance indicators, including the ability of such indicators to inform comparisons of hospital performance and efficiency.

The Commission recently released this issues paper to guide submissions, which are due by 27 July.

It strikes me that the terms of reference are overly narrow, and that it would be far more useful if the Commission was also able to consider some broader issues.

Here are some other issues the Commission might like to consider (or at least to suggest are included in any future such inquiries):

• The inequity of our current system is one of the biggest challenges facing health policy makers – the fact that those who are most likely to have worse health are also least likely to have access to appropriate services. What is the relative contribution of private and public hospitals to reducing the inequities in health and health care?

• As a country we have identified eight national health priorities, including mental health, obesity and cancer. What is the relative contribution of private and public hospitals to achieving improvements in these priority areas?

• Closing the Gap in Indigenous health and disadvantage is another national priority. You could argue, perhaps, that hospital services will have only a minimal impact, relative to all

the other forces affecting health. Even so, there's no doubt that hospitals could do a lot more to provide appropriate, accessible care to Aboriginal and Torres Strait Islander people. What is the relative contribution of public and private hospitals to Closing the Gap?

• Given the widespread concerns about the increasing health spending – with even the editor of the Medical Journal of Australia wondering whether Medicare is sustainable – surely we should be asking much tougher questions than simply how much hospitals spend on particular procedures. Like – what proportion of procedures and treatments in public and private hospitals are backed by reliable evidence? And how do the systems compare when it comes to providing procedures and treatments that are unnecessary, ineffective or potentially even harmful?

• Given the importance of improving the linkages between evidence and practice, perhaps the Commission could also compare how well private and public hospitals do in establishing systems and structures to drive evidence-based care.

• With so much talk about the need to reorient the health system towards primary care, perhaps we should also be asking much tougher questions about what hospitals are doing to support and integrate better with primary care. Are private hospitals more or less likely to link in with primary care?

• Given that our health system has historically done a very poor job of incorporating the values and priorities of the community into how funds are spent or services are provided, perhaps the Commission could also measure how well the two sectors perform in this area. Are public hospitals more or less likely to engage their communities?

• Caring for patients is not the only role of public hospitals. Traditionally, teaching and research have also been an important part of their beat. What is the relative contribution of public and private hospitals to teaching and research?

• With the increasing focus on prevention and health promotion, there is an argument for expecting that health services generally should have a role in public health advocacy, whether at the local community level or more broadly. What is the relative contribution of public and private hospitals to public health advocacy?

I could go on, but it would be nice to hear from some Croakey readers. I will compile a Croakey submission to go to the Commission; if you'd like to contribute, drop me a line.

***

Feedback from CHAMP members

http://blogs.crikey.com.au/croakey/2009/07/13/some-more-questions-about-hospital-performance/

July 13, 2009

Croakey has previously argued that the Productivity Commission inquiry into public and private hospital performance has overly narrow terms of reference.

Below you can read some more suggestions for the Commission from several Croakey contributors, but first have a look at how much further the debate on hospital performance has advanced in some other countries.

In the UK, patients contemplating heart surgery can go to this website, for example, to examine the relative performance of hospitals.

In the US, this article from USA Today links to sites allowing patients to compare death rates for heart attack, heart failure and pneumonia for more than 4,400 hospitals.

Meanwhile back to the Productivity Commission:

Gordon Gregory from the National Rural Health Alliance would also like to see the inquiry consider:

• What is the relative role of public and private hospitals in ensuring that the 'mainstream' health system provides culturally safe and appropriate care to Aboriginal and Torres Strait Islander people? (ie what is their relative record on employing Aboriginal liaison offfcers; Aboriginal Health Workers; and in providing supported employment for Aboriginal nurses and interns?)

• Where private hospitals exist in regional areas, are they more or less part of the de facto primary care system than public ones? [hospitals doing primary care isn't a good idea but needs must where there are no primary care providers. Are, for example, Catholic hospitals doing more or less of this than the public ones?]

• If one accepts the notion of a rural medical deficit (ie the extent to which rural and remote folks miss out on using Medicare), what is the extent of the rural and remote hospital deficit? (This is not so much a matter of public/private as metropolitan/rural and remote, but there may be some angles for the Commission to consider)

***

Associate Professor Merrilyn Walton, Director of Patient Safety at the University of Sydney:

The first two terms of reference for the Productivity Commission's current inquiry have merit but I agree with Melissa Sweet that they are indeed narrow.

Terms of Reference 1: Comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals

Variation of costs is not the only issue for patients, variation in the provision of health care is also a significant issue for patients. A significant amount of variation is caused by differences in practice between providers of health care rather than differences between groups of patients. Research shows substantial levels of inappropriate care including under and over treatment.

Terms of Reference 2: The rate of hospital-acquired infections by type, reported by public and private hospitals

We do need to publish infection rates but the bigger issue is to minimise the transmission of infection in all health care environments. World expert on system failure James Reason says that breaches of infection control are routine in health care and equate to an intentional violation. We need to change the culture in health care as well as collect data.

***

Patrick Bolton, a senior public hospital manager, would like the Commission to consider these two points:

1. Turning the Commission's question around a bit: Which bits of the healthcare system are best provided publicly, and which privately?

Whilst the evidence is not strong, my understanding is that not for profit hospitals (I use this term because much of the data come from North America and therein lies a comparison issue) deliver better outcomes than for profit ones. Outcome is of course only half of the efficiency story(!)

The interim report of the NHHRC seemed to accept that the private sector might be a better funder/purchaser of health, with not much analysis of the alternatives at that level or evidence that I recall, but there is an important question there.

I would like to see the role of the private sector in health capital management further discussed: This is a separate set of skills from health service provision. In my experience it is not generally well developed in the public health sector and might be better provided privately.

One advantage of such an approach is that it changes the incentives around flogging equipment until it breaks as often happens under public sector priority setting, because the cost is sunk and so the incentive is to drive the private provider to provide good capital.

2. I refer you to "The Science of Health Care Reform" RH Brook JAMA 301(23)2486-7 which I found through the Hospital Alliance for Research Collaboration newsletter.

This is a short and stimulating review of the reason for the gap between health expenditure and outcome, which has to be a concern of anyone with an interest in efficiency.

Essentially it attributes the gap to poor quality (ie doing things wrong) and poorly targeted interventions (doing the wrong thing). If this is correct then (a) one might expect the private sector to be more distorted than the public sector by incentives to provide inappropriately targeted services, but (b) the dichotomy between public and private might be looking at the wrong questions entirely.

Perhaps the question should really be how do we ensure that we do the right things right in any setting?

Certainly Brook says that high level policy approaches, which must include the public-private balance, are too crude to address the problem that he has identified.
***

A health policy expert who did not want to be identified offers the following comment to the Commission:

Private hospitals tend to have a much lower level of quality improvement activity, such as audits of series of procedures (eg looking at rates of deep surgical infections, or deaths

within 7 days of an anaesthetic), or data driven improvement projects. It would be interesting to compare participation in quality activities.

****

Professor, Chris Baggoley, CEO, Australian Commission on Safety and Quality in Healthcare adds:

What I can say is that we have found the private sector very willing to take on and implement the safety and quality initiatives from our work that Ministers have endorsed, across the full range of these initiatives, including the Australian Charter of Healthcare Rights.

***

Michele Kosky, Health Consumers Council WA:

We would be very interested in seeing a comparison of the accurate reporting of adverse incidents in public and private hospitals, the overt commitment to patient safety in public and private hospitals, the involvement of patients and their families in the reduction of unintended medical harm in public and private hospitals, and the adoption of the open disclusure standard in public and private hospitals.

***

Emeritus Professor Kerry Goulston, University of Sydney:

I like and agree with Croakey's points. I strongly agree that the Commission's terms of reference are too narrow.

Whilst nearly half of elective and day surgery is done in private hospitals, there are not many private Emergency Departments. And relatively little training of healthcare workers occurs in the private sector There are some notable exceptions - Carina and Epworth in Melbourne, and Greenslopes in Brisbane.

We really need more medical students in private hospitals - patients accept them and it exposes students to private hospital medicine.

**

Robert Wells, Director Menzies Centre for Health Policy, Director Australian Primary Health Care Research Institute, ANU

Broadly speaking, there can be three possible findings from the inquiry:

1. no appreciable difference between private & public;
2. private generally performs better against the areas of inquiry; or
3. public performs better.

If the answer is 1, then we probably can just muddle along as we are
If the answer is 2, then should we privatise all hospitals?
If the answer is 3, then why would we continue to subsidise the private sector via PHI

measures?

Therefore the really pertinent question is: what do the study's creators intend for it to find? (bearing in mind the maxim that one never sets up an inquiry without first knowing what the answer will be).

Melissa Sweet

Freelance journalist and health writer
&
Adjunct Senior Lecturer
School of Public Health
University of Sydney