Submission to the Productivity Commission Study into the performance of public and private hospital systems

South Australian Government

Overview

South Australia strongly supports the Productivity Commission's (the Commission) study into the performance of public and private hospital systems and recognises the importance of continuing national efforts to improve hospital performance across Australia. Studies such as this can provide invaluable information to help drive reform to deliver improved efficiencies and service improvements.

Policy questions around hospital performance and the relative performance differences between private and public hospitals have been around for some time and economists have been grappling with these issues for many years. Any work the Commission can do to progress this understanding will be invaluable.

The Commission's Issues Paper contains cautionary comments about the inherent difficulties in comparing performance, particularly in relation to data issues, and these are noted.

Whilst the terms of reference require comparison of performance between public and private hospitals, the ability to deliver robust comparable data is clearly questionable. This raises further concerns that any answer developed by the Commission will be used to address a range of policy questions beyond the scope of the data to support.

It will be critical that the Commission details the issues with the data and provides appropriate cautions about the use of any comparative analysis to ensure results are not used inappropriately.

This is a serious risk and if, at the end of the day, the data is not suitably robust it would be preferable to have an outcome which provides a clear way forward for the improvement of data collections to enable robust performance analysis in the future. It may also be possible to deliver more specific answers to the question of performance in some very discrete areas.

The provision of clear direction by the Commission in regard to necessary data collection improvements for the purpose of comparative analysis will be valuable to all stakeholders. It is anticipated that the work on consistent methodology, for the purpose of activity based funding being undertaken as part of the Council of Australian Governments (COAG) reform process, will deliver significant improvements in the capacity to undertake more robust cost comparisons in future.

South Australia, through the COAG reform process, is committed to the national reform directions for health and notes in particular the commitment to developing nationally consistent classifications and data collections for

hospital care including admitted, sub-acute, emergency, outpatient and hospital auspiced community health services.

This submission focuses on the comparison of public and private hospital performance, primarily on the contextual issues in regard to comparability and a range of specific data concerns that will need to be addressed by the Commission in their approach to the analysis and the framing of their draft report. Comment is also made about Informed Financial Consent. This submission does not address the Medicare Surcharge issue raised in the Issues Paper.

Discussion

Private and Public Hospitals – fundamental differences

Private and public hospitals operate under very different frameworks with different financing and workforce structures.

Public hospitals have an obligation to provide all Australians who present to them with free public hospital care and access to services based on clinical need. Public hospital access also needs to be provided across the State to ensure reasonable access to hospital care by residents. This means providing the full range of specialist inpatient, outpatient, emergency and diagnostic services at all times. For South Australia, it also means operating minimum volume hospitals in country areas. Due to size and location, such country hospitals are often relatively expensive to operate, but their importance to communities cannot be underestimated. Almost 50 per cent of South Australia's country hospitals (n=35) are treated as minimum volume hospitals in its case mix funding model and receive $16 million in subsidy under the Rural Access Grant, with the State providing an additional $115 million for their minimum budget.

This compares to private hospitals that can choose where, how and what they offer. This fundamental paradigm divides private and public hospitals and results in very different profiles of use and patient type with consequential impacts on performance.

Furthermore, the funding frameworks, incentives and workforce structures result in very different environments with very different base structures. For example, public hospitals employ primarily salaried medical staff, undertake the majority of medical training and have limited (and generally fixed) access to benefits from private health insurers. Private hospitals have primarily fee for service staff, undertake limited medical training and have major contractual relations with private insurers. Private hospitals are also generally smaller and specifically focused where as public hospitals are generalist and usually larger in size, particularly in metropolitan South Australia. These factors create fundamentally different environments that impact on not only how and what services are provided, but the cost of those services and the drivers available to influence performance.

Analysis of the effectiveness and efficiency of hospitals must be undertaken within the context of these fundamental differences, including:

- Provision of the majority of emergency procedures in public hospitals skews data relating to outcomes, throughput and efficiencies.
- Procedures that are high-risk or more complex are often referred to the public system or transferred from the private to public, once again skewing this data. In South Australia, approximately 1 300 admissions in 2007/08 were received from private hospitals. Whilst this may only represent less than 0.5 per cent of public hospital admissions, the flow-on cost impacts of such transfers are still worthy of note.
- Differences in pre and post admission service pathways, including rehabilitation which may impact on inpatient length of stay. For example, private hospitals specialising in major surgery usually discharge post surgery to specialist rehabilitation services, while in public hospitals rehabilitation is provided in house.
- Demographic characteristics of patients in public and private hospitals will affect outcomes. South Australia's data appears to indicate that public hospitals tend to have older patients than private hospitals with longer bed days and it is reasonable to assume higher levels of complications.

Comparative efficiency
Comparing costs across the private and public sectors will be challenging.

The Issues Paper recognises the main areas where costs have to be adjusted (medical, pharmaceutical and capital), but how much precision can be achieved with these adjustments is an issue, particularly for medical costs where charge data (not cost data) for medical services largely provided by independent medical specialists (not employees of the private hospitals) needs to be used to develop a private hospital comparison that is reasonable to public services. There is a need for significant debate on the use of mixed sources (For example, cost versus charging data versus revenue based data) to determine comparative costs.

The Issues Paper does not mention that there should also be adjustments made in the public hospitals for medical costs for private patients as the rights of private practice income is not included in the National Hospital Cost Data Collection (NHCDC).

Private hospitals have missed several rounds of the NHCDC so they do not have the same discipline around their costing data and processes as the public sector.

The cost measures proposed for average cost per separation for clinically similar procedures and average cost per casemix adjusted separation are sensible. However, as per the comments above, the quality of the costing data in the NHCDC must be questioned, particularly for private hospitals.

Comparison of costs by cost bucket is supported as it gives the opportunity to exclude certain cost buckets where the quality is questionable. Cost bucket data should at least be used in the verification of costs between and across the sectors.

Whilst the NHCDC removes the training and education costs associated with undergraduate and graduate training it does not remove the indirect costs that result from the provision of this training and education. In the public sector this has flow on cost implications including supervision time, increased theatre time and extra testing that may result from trainees learning on the job, impact on other staff time to assist (including theatre nurses) with trainees' education, and on the total volume of work undertaken.

Whilst it is difficult to quantify these flow on impacts in South Australian metropolitan public hospitals, teaching costs represented over five per cent of the total costs in those hospitals. South Australian casemix funding rules applied in public hospitals allocates 25 per cent of senior medical officer time for supervising junior staff, which clearly impacts on services. Teaching is a major role public hospitals perform and it is important that this function and its impact on public hospital performance is adequately accounted for in the Commission's study.

Major public hospitals are typically large and diverse. Private hospitals in South Australia are typically small and focused on specific specialities (and with limited training responsibilities). This enables them to provide focused clinics. The mechanics of operating larger more diverse services with high levels of trainees results in a very different environment in public hospitals. Public hospitals also manage the majority of emergency services, which also impacts on theatre and elective surgery cases. As an example, in a sample of four metropolitan hospitals in 2007/08, over 800 surgery cancellations were made due to more urgent emergency cases, being almost four per cent of the elective surgery admissions.

An additional factor impacting here is the employment structure for doctors. Medical services in private hospitals are provided on a fee for service basis rather than by the hospital. One result is that it is in the doctors' best interests to ensure as many theatre cases as possible are done in each set of booked theatre time.

These environmental differences require careful consideration in considering any analysis of data.

South Australia would like to see opportunities for jurisdictions to have some input into the verification of costing data.

Ideally data should be able to be disaggregated down to the lowest possible level to either take or add in controls to address differences with the data and ensure comparability. At the national level there is no patient level cost data available. Given the differences in private and public costing structures and data availability this is a major concern. The NHCDC provides this capacity for most metropolitan hospitals, but not for country or private hospitals for which only cost modelled data is submitted.

It is noted that the NHCDC for the public sector includes emergency department costs associated with individuals who are subsequently admitted. This would need to be removed to ensure comparability with the private sector.

Due to differences across private and public hospitals, outpatients data should also be removed. It is also noted that renal dialysis may not be treated similarly in all cases. For example, in South Australia an off-site satellite clinic is not included in the NHCDC data.

Clinically similar procedures

The clinically similar procedures list (the name of this is misleading as a number of the Diagnosis Related Groups are medical) were originally chosen by Australian Institute of Health and Welfare to compare average length of stay with variations considered to result from differences in performance of hospitals rather than differences in patients.

The Issues Paper notes that the basis of selection included that they were frequently observed in both public and private hospitals, represent a high percentage of health expenditure, are clinically diverse and generally without complications or co-morbidities. Whilst on the surface it would appear that these may provide a reasonable basis for comparison of costs, it is noted that there are far less medical patients in private hospitals. How representative the costs will be, therefore, especially if they are disaggregated to jurisdictions, is questionable. Also a comparison based on cases without significant complications and co-morbidities will only be a partial comparison as these difficult cases are largely dealt with in large public hospitals. It may also be wise to limit average cost per casemix separation to acute patients only.

In general, the number of measures proposed (around 15) is quite small and may not provide the complete picture of the relative efficiency of both sectors. Much will hinge on the validity of the costing data.

Quality

SA Health does not agree with the proposed use of Australian Council on Healthcare Standards data (Clinical Indicator Program [CIP]) for infection rates and adverse events. The voluntary nature of the data provision, the small sample sizes, partial provision of data and the consequent lack of data verification bring into question the representative nature of the data and its ability to be used for comparison purposes.

The preference would be for SA Health to be able to submit its own verified data for public hospitals, particularly for the infection control indicators.
SA Health does not collect quality data for private hospitals and is not able to advise on an alternative data source or comment on private hospital site collections.

As part of the CIP project, the targeted surgical site indicator is under development. It is not collected centrally at this stage, but is being

progressed. At the service level data collections are ad hoc. SA Health is also concerned about the robustness of the data in regard to central line infections and is aware of issues with this indicator across South Australian public hospitals.

The National Health Information Standards and Statistics Committee is moving to using morbidity data that will still have some data quality issues in terms of how comprehensive and accurate the coding is, but at least it will provide wide coverage of patients and hospitals.

South Australia has been collecting data on Condition Onset since 1 July 2008, which indicates whether or not a person acquired an infection/condition as a result of a hospital stay or brought that condition in with them.

SA Health believes that falls and adverse events arising from medication related errors should be looked at as a quality issue, given the significant contribution these two areas make in regard to the level of harm experienced.

From a quality perspective there should also be some consideration of workforce as it is an important indication of quality. Issues such as credentialing and scope of practice are two examples that SA Health is beginning to collect as part of its own safety and quality performance measurements.

Patient Satisfaction
The inconsistency in the questions asked by jurisdictions in patient satisfaction surveys is an issue in the absence of any national data.
SA Health is not able to provide advice regarding private hospital patient satisfaction surveys.

The potential for differences in the focus of surveys, as well as inter-jurisdictional differences in public hospital surveys, may mean there is limited value in the use of these surveys for comparative purposes.

Multivariate analysis
The Issues Paper does not provide detail on the variables that will be included in the multivariate analysis, so it is difficult to provide specific comment until a more detailed methodology can be provided. In principle, the use of multivariate analysis seems reasonable. The critical factor will be ensuring that the variables used for analysis are variables that are comparable between public and private.

Waiting time is not seen as a comparable factor, as there is relatively no waiting time in private hospitals for elective surgery (or if there is, the construction of waiting lists is undertaken using different administrative mechanisms) and most private hospitals do not provide emergency services. The use of waiting time as an access measure would only be relevant in comparing public hospitals.

Patient categories such as rehabilitation, mental health, prisoners, long stay older patients and any residential aged care or respite patients would also have to be removed due to the differences in public and private provision to these patient groups.

Assuming appropriate and comparative data can be identified and accessed, any analysis finding differences would need to go to the next level of investigation to provide useful information in understanding what was behind those differences.

Informed Financial Consent

South Australia has in place Rights of Private Practice agreements that require salaried doctors to bill only to the level of the full Medicare Benefits Schedule (MBS) fee. This means that their privately insured patients incur no out of pocket expenses, as their private insurance would cover the gap between the MBS benefit paid and the full scheduled fee.

Visiting Medical Officers (VMOs) in South Australia are able to sign up under South Australia's Rights of Private Practice Agreement and those that do so must agree to only charge the MBS rate.

Not all VMOs are signed up to these arrangements. Those who do not sign are therefore free to charge as they wish. In these cases there is no data on the charging practices of the VMOs concerned, however, given South Australia's rights of private arrangements it is thought the out of pocket expenses for patients, particularly in metropolitan hospitals, would be relatively low due to the fee for service arrangements for medical services in country areas. It is anticipated that there is a greater likelihood for out of pocket expenses to be experienced by private patients in country public hospitals. Most country public hospitals provide the opportunity for private medical practitioners to see their patients after hours at clinics at the hospital. These clinics provide information on these fees although it is noted that from time to time SA Health does receive complaints about these out of pocket expenses in country areas. However, these tend to be about issues of equity rather than about a lack of prior information regarding any charges.

South Australia also only charges the listed default rate for private patient accommodation, so there would be no out of pocket costs for insured patients.

Conclusion

Whilst South Australia is very supportive of the proposed work by the Commission there are clearly major concerns about the ability to undertake the analysis with sufficient robustness. If it is not possible to develop sufficiently robust and comparable data in the timeframes proposed, it would be preferable for the Commission to deliver partial performance analysis (assuming some specific areas can be done confidently) together with some clear directions forward on how the public and private sectors can improve data collections to enable comparison in the future.

The work occurring under COAG for the Activity Based Funding is noted and may provide a potential vehicle to help deliver data improvements for the purpose of cost comparison.

South Australia would like to extend an offer to participate in further discussions regarding the data development as the Commission progresses its work.