MONASH University

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Productivity Commission
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Dear David,

It was good to meet with you, Greg Murtough, Ilias Mastoris and Philip Harslett on 3rd July as we could not make the original round table discussions earlier that week. The following summarises our thoughts regarding this inquiry, and forms our submission at this stage of the process.

We had a number of points and concerns which we raised on the day, and this document summarises those we feel most important, as well as some subsequent information.

On p III of your June 2009 Issues Paper you note the Governments commitment to move towards a nationally consistent approach to activity based funding and performance reporting. We would support this approach in so far as it would be necessary to take this approach to monitor hospital performance effectively in Australia, at present the fragmented eight jurisdiction system is not conducive to effective reporting or monitoring of hospital performance in any useful way.

A move to a system of this nature would help in the context of measuring the relative performance of public and private hospitals, if associated with a similar shift to nationally collected databases of a comprehensive nature.

Overall we can see many conceptual limitations, data limitations, and pragmatic time limitations to the ambitious programme of work you aim to pursue, but we see this as admirable as it will highlight important data and methodological limitations to support the establishment of superior, more effective systems to allow more effective monitoring in future.

Our view is that a large scale study of hospital performance across Australia has never been effectively undertaken because of the problems highlighted in the Commission's Issues paper and this submission. The principal reason is the lack of a nationally comparable dataset. This would enable a sample size of sufficient power to detect statistically significant differences

between hospitals in terms of performance. At present some excellent within state data sets exist, and work has been undertaken to estimate hospital performance within different states, but when comparing like hospitals (an important part of comparative performance measurement) sample sizes end up being too small to measure real differences. Even within states there are often data issues, for example there are often excellent DRG based throughput data, but poor data on levels of staffing, beds, capital etc.

Data across states are not really comparable at present as different case mix funding arrangements exist. This is also the case if a comparison of private and public hospitals were to be made.

Perhaps a more fundamental system question needs to be asked – what are the priorities of the hospital system – if they are universal coverage to enable Australia to be a healthy, productive nation – why is there a need for a system with such large (in effect) subsidies and incentives for a private system, when there is little or no evidence as to the effectiveness of such a system in enabling high quality appropriate care? No other developed country has such a system, apart from a more 'extreme' version in the USA. A national comparative system of comparative performance measures may help demonstrate the costs and benefits of the system which exists, and would allow modelling of alternative funding and delivery mechanisms.

It should also be noted that hospital performance may not be the greatest priority in the objectives of certain groups. State administrators have different priorities to hospital managers (who may or may not also be clinicians). There are also equity considerations, and many other issues such as the capacity which must be held back when running an emergency department, as well as staff commitments to teaching and medical research – all critical components to a high quality health care system, and again reducing comparability of providers.

In equity terms, there are many issues raised in your paper, for example on page 3 – the 'complimentary' nature of the public and private systems (of which there is little evidence) also has equity implications whose treatment is potentially being subsidised – those in most need? There are also access issues to consider in a geographic sense.

There is a huge body of work internationally on efficiency and productivity measurement in health care, and a growing literature on the overall objectives of performance measurement in general. Ideally a whole programme of work would be established in Australia to co-ordinate these activities in the manner of other countries, such as the UK and Scandinavian countries.

Any analysis of efficiency and performance needs excellent data. This is especially the case given the frontier type techniques proposed are entirely data driven. Ideally, hospital level data (such as state level DRG data) linked up to outcomes data would be available with associated input data on numbers/costs of staff, other inputs (drug use, technology etc) and capital. Unfortunately this isn't the case, so second best data would need to be used such as the NHCDC and HCP data. Are the AIHW data too aggregate to produce useful results?

We discussed problems associated with using and pooling data sets on our visit to the Commission, and one outcome of your investigations may be that a national linked dataset needs to be created, although this would require fundamental system changes as well.

When looking at quality, several indicators should be looked at to minimise error (why pick only nosocomial infections?) . Quality assessment may only be possible in a qualitative manner at present, e.g. pick out poor performers and see what is happening on the ground. See papers by McNair et al (Medical Care 47(3), 2009 p 272-78, and the Editorial by Iezzoni in Medical Care).

If you rely on hospitals to report poor quality, then punish them, they may stop reporting accurately. Is an external audit practical, as reporting of medical conditions is so incredibly complex? There may be a possibility for partial indicators of cost/quality (see Gertler and Waldman, 1992, Journal of Political Economy, p 1232-1256).

There are many other associated concerns, even if data were ideal –e.g. scale of activities, scope of activities – comparing like samples of hospitals (this will be a big issue), efficiency measures are in part driven by outliers. This means when outliers are removed you need a large sample, over time, to detect statistically significant changes in efficiency and productivity. Dealing with specialist, or teaching hospitals is another issue.

As is dealing with the population and demographics of patients served by the hospital. This is different to taking case mix into account, and more closely related to assessing the socio-economic characteristics of patients. This brings us back to equity, and who is being treated, an issue hard to escape from when looking at efficiency – is there an efficiency/equity trade off?

In terms of outcomes and adverse events, a good start would be using the C- prefix codes in the Victorian hospital case mix data set.

Specific points: why is the definition of efficiency used in the Issues paper, for example on page VIII – not more aligned to the more traditional definitions of Farrell?
On page 8 you imply potential inefficiency of 20-25% - the evidence base is not there to make such a statement.
On page 22, you talk about the labour force – where would accurate data on this come from?

Overall we are in favour of a specific focus on hospital performance and the admirable depth the Commission is planning on taking in such a short space of time. We would recommend overall: Better data collection; a country wide approach to funding and performance assessment; and a large scale programme of research into hospital system performance over time, addressing all of the issues we have listed above.

We are happy to discuss any of these issues further and look forward to your draft report in this area.

Professor Bruce Hollingsworth
Director

Inputs to this from Professor Tony Harris; Dr Katharina Hauck; Dr Anurag Sharma.