ACHS Submission to: Productivity Commission Issues Paper – Performance of Public and Private Hospital Systems

Introduction

ACHS welcomes the opportunity to contribute to the considerations of the Productivity Commission in relation to the comparative performance of the public and private hospital systems in Australia.

The comments of the Commission regarding the complexity and diversity of the Australian health care system are of significance and ACHS supports the view that it will be necessary use more than a single indicator to make the necessary comparisons. As noted by the Commission, ACHS acknowledges that it will be a major challenge for the study to report comparable cost data, given the variance that exists in the way cost data is reported across sectors and jurisdictions.

ACHS sees as important the need to gather national data about the performance of Australian hospitals and is willing to participate in any way that is considered to be appropriate. ACHS currently collates and publicly reports de-identified information about the performance of Australian Hospitals in accreditation surveys as well the performance of those facilities that participate in the clinical indicator program.

Indicators – infection control

The proposal of the Commission to use the rate of hospital-acquired infections as a means of comparing private and public hospitals needs to be undertaken with a high degree of caution. Whilst some jurisdictions measure their own infection control performance these measures are not nationally consistent. Currently the only national infection control program is the ACHS clinical indicator program, but this is not a mandatory program. The primary purpose of the indicator program is to assist organisations to use their indicator results as part of their quality improvement program and it is a voluntary program. The majority of organisations that participate in the indicator program are members of the ACHS accreditation program, although an increasing number of non-member organisations are participating in the clinical indicator program.

The concerns expressed in the Australian Commission on Safety and Quality in Healthcare (ACSQHC) review of Australia's monitoring of health care associated infections (Cruickshank and Ferguson, 2008) regarding data collection and validation methods are reasonable to some degree and would probably also apply to the infection control data collected by jurisdictions. It is important to note that the ACHS clinical indicators are not designed to be used for the purpose of performance measurement or as an immediate response hospital surveillance program for hospital acquired infections. However, the data does provide information to those organisations that participate in the program that is useful in reviewing their infection control practices as part of wider infection control and quality improvement programs.

Of the infection control indicators, ACHS would support the use of some of the ACHS surgical site infection indicators, particularly those that measure the rates of infection following hip and knee prostheses surgery as well as blood stream infection indicators. The reason for suggesting these indicators are that they can be measured in both the public and private sectors and would probably cover more occasions of service across both sectors than the other (more specific) indicators such as blood stream infections associated with central lines, dialysis and neonates.

The most recent ACHS data analysis supports the assertion in the Issues Paper, that infection rates rarely differ significantly between public and private hospitals.

In the second half of 2008, 292 organisations submitted data to the ACHS infection control indicators. Of these, 128 organisations were from the public sector and 164 were from the private sector suggesting that a higher proportion of private hospitals use the ACHS clinical indicator program than those in the public sector. ACHS includes with this submission, the methodology and most recent analysis of the infection control indicators Version 3, that will be included in the Australasian Clinical Indicator Report 2001-2008 to be released in November 2009. The analysis is based upon de-identified, aggregated information from the participating organisations from 2001- 2008.

Of the infection control indicators the highest number of organisations collect the hip and knee prostheses surgical site infection rates and in 2008, 157 organisations collected the superficial surgical site infection rates each for hip and knee prostheses with 150 and 151 collecting the deep surgical site infection rates for hip and knee prostheses, respectively. The highest overall annual rate of infection reported is in the superficial surgical site infection rate for hip prostheses which has an annual rate of infection of 0.97 per 100 procedures. Across all of the hip and knee prostheses surgical site infection rates, the only indicator that showed a statistical difference in the rate reported between the public and private sectors is the deep surgical site infection rate for hip prostheses where the rate in the private sector is 0.68 compared with the public sector where the rate in 1.02 (with an annual overall rate of 0.76 per 100 procedures).

Indicators – other relevant indicators

Of the other proposed relevant indicators, ACHS suggests that all may have a place in highlighting potential differences between public and private hospitals except the workforce characteristics indicator (because of the significant difference in the structure of the workforces of the public and private sectors). For example, the majority of emergency services and workforce training occur in the public sector making its workforce requirements different from those of the private sector.

Data sources

For the purpose of the Commission's study, the difficulty with relying on the ACHS data as a sole means of comparing the private and public hospitals sector is the doubt about how representative the sample is of all private and public hospitals when the program is not mandatory. The suggested alternative source of data from state and territory governments is however likely to not be suitable for meaningful comparisons between states, territories and sectors given the likely variation in the data definitions. ACHS would recommend a national data source as more appropriate for comparison and would therefore suggest further exploration of the potential to use the National Hospital Morbidity Database should be considered. The lack of a reliable national data source will be a significant barrier to developing reliable comparisons for all of the suggested indicators.

Multivariate analysis

ACHS would strongly recommend a multivariate analysis as a means of concluding an overall assessment of performance of Australian hospitals. The complex nature of Australian hospitals and the systems in which they operate ensures that there is not a single measure of performance that is more significant than another in determining efficiency. ACHS is concerned about the proposed exclusion of free-standing day facilities from this analysis given the significant proportion of services now provided by this group. Most hospitals contain day only services in which efficiency should be comparable to that in free-standing day facilities and ACHS would therefore recommend that this group should be part of the analysis.

Informed Financial Consent & Indexation of Medicare Levy Surcharge thresholds

ACHS has no particular expertise or experience the in areas of informed financial consent or indexation of Medicare levy surcharge thresholds and is therefore unable to comment on the proposals discussed in the Issues paper.

Improving the feasibility of future comparisons

ACHS would suggest that the most significant way in which the feasibility of future hospital comparisons could occur would be the introduction of a mandatory national requirement for all hospitals to report against a common set of indicators. ACHS would be very interested to further develop the work of the current clinical indicator program as a means to support this initiative. Our engagement with most medical specialties as part of our current program would be a good basis upon which this development could occur. Whilst (as noted in the Issues Paper) the new National Healthcare Agreements will require the reporting of some measures, it is yet to be identified the means by which this is to happen. This may also have limited application to the private sector, given that the agreements are the basis of funding for the public hospitals.

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