Unit 17G
Level 1
2 King Street
Deakin ACT 2600
T (+61) 2 6202 1000
F (+61) 2 6202 1001
E admin@ahia.org.au
www.ahia.org.au

PRESIDENT
Mr Richard Bowden
CHIEF EXECUTIVE
Hon Dr Michael Armitage

Mr David Kalisch
Commissioner, Hospital Studies
Productivity Commission
Locked Bag 2, Collins Street East
Melbourne VIC 8003

Email: hospitals@pc.gov.au

Dear Mr Kalisch

The Australian Health Insurance Association (AHIA) thanks the Productivity Commission for the opportunity to make a submission to this research study into public and private hospitals.

Our submission is attached.

In addition to our submission, the AHIA wishes to comment on a number of general matters given the AHIA's participation in the 30 June 2009 Roundtable and our ongoing dialogue with the Commission related to this study. These matters are as follows:

Data

Recognising there is a debate about the reliability of data used to analyse the performance of the Australian health system, the AHIA notes that there is always a body of data which can be classified as the "best available data". This best available data provides a clear body of evidence for the Productivity Commission's deliberations.

The AHIA's view is that analysis of that best available data by the Commission to compare the relative efficiencies of the public and private hospital systems in this instance is the most appropriate approach to ensure improved health outcomes.

Definition of Procedure

The AHIA contends that the word "procedure" be defined by the Commission in this study, in the way a patient would associate with it if he or she were informed they needed a "procedure" undertaken. The patient would clearly understand this to mean the totality of the operation and the hospital care associated with that experience.

Risk adjustment

The AHIA is aware of the success of "risk adjustment" analysis in allowing legitimate conclusions to be drawn from disparate hospital and medical data. Indeed, the Australian Commission on Safety and Quality in Health Care recently published a study, *Measuring and Reporting Mortality in Hospital Patients (AIHW March 2009)* which supports the use of risk-adjusted data to analyse the performance of the health system.

I would be more than happy to elaborate on the AHIA's submission, or the matters listed above, in person at the request of the Commission.

Please feel free to contact me on 02 6202 1000 for any further information.

Yours sincerely

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER

27 July 2009

Australian Health Insurance Association
Submission to the Productivity Commission research study into public and private hospitals

Introduction

The AHIA is the peak body for the Australian Private Health Insurance Industry. The AHIA represents 23 health funds, which provide healthcare benefits to over 10 million Australians (reflecting close to 94 per cent of those Australians with private health insurance).

Private health funds play an important role in providing Australians access to hospital care. In the financial year, 2008/09, the AHIA's Member Funds paid benefits worth $7.6 billion for people with private health insurance to receive hospital treatment, an increase of 9 per cent over the previous 12 months.

Further, the Australian Institute of Health and Welfare (AIHW) reports that private health insurance funds 57.3 per cent of all surgery in hospitals.[1] Previous reports on the Australian hospital system by the AIHW have identified that private funding supports 55 per cent of procedures for malignant breast conditions, 55 per cent of chemotherapy cancer treatments and 70 per cent of same day mental health episodes.[2]

In addition to the direct funding of hospital treatment, private health funds also support the Australian health system through the payment of $3.3 billion worth of benefits for general treatment (financial year, 2008/09) including access to dental, optical and physiotherapy services.

The AHIA notes that previous attempts to evaluate the relative efficiencies between the public and private sectors have relied on measures of inputs rather than improvements in health outcomes. If the public hospital's response to a cardiac arrhythmia is through medicine and the private hospital's response includes an expensive device, then the only way to evaluate the efficiency of the two treatments is to understand the outcome. To reach a true measure of the relative efficiencies of these two divergent treatment options, the Commission would be required to perform a Cost-Benefit Analysis of the outcomes.

[1] Australian Institute of Health and Welfare, 2009, Selected Episodes: Hospital Statistics 2007-08
[2] Australian Institute of Health and Welfare, 2008, Selected Episodes: Hospital Statistics 2006-07

1. Partial indicators of performance

1.1 The AHIA notes the use of the two cost measures (average cost per separation and average cost per casemix-adjusted separation) that the Productivity Commission proposes to report in the study.

1.2 The AHIA does not support the use of the 20 AR-DRGs selected by the AIHW (Table 4 of the Commission's Hospital Performance Issues Paper).

The Commission should be dissuaded from using the AIHW-selected 20 AR-DRGs based on average length of stay as the AHIA does not consider them reflective of the private sector's contribution to treatment services in Australia's hospital system. For example, the AIHW list contains none of the 20 leading procedures by average cost per separation performed in the private sector and contains only three of the leading 20 procedures performed by number of separation in the private sector (I16Z, other shoulder procedures; O01C, caesarean delivery and; O60B, vaginal delivery).

The AHIA believes that the Productivity Commission should seek to compare costs between public and private sectors based on the use of two indices. These indices should be:

- The first 20 procedures common to both the public and private sectors by volume; and
- The first 20 procedures common to both the public and private sectors by cost.

By comparing procedures in this way, differentials between the two sectors can be considered.

For the information of the Commission, in a recent analysis of the variation in the cost of in-hospital procedures in the Australian health system in 2006/07, the AHIA has calculated that the overall average costs for each episode of care were:

- $2,115 per separation performed in the private hospital sector; and
- $2,667 per separation performed in the public hospital sector.

Therefore the overall costs per separation are $552 lower in the private sector, when compared to the public sector performance, representing a 21 per cent differential. In conducting these calculations, the AHIA removed from the analysis those procedures not performed in both sectors, and then compared the cost of each DRG group before averaging those findings, providing a final weighted-average comparison of costs in the two sectors.

Further, the AHIA used the 20 highest utilised individual procedures in the public sector in 2006/07 to calculate that the private sector had a lower average cost per separation for 13 of those, representing 80 per cent (2.4 million procedures) of the total separations performed in the public hospital sector.

The AHIA also analysed the 20 most expensive procedures for each of the public and private sectors, and found 11 common to both. For each of those 11 AR-DRGs, the private sector enjoyed a lower average cost per separation.

The AHIA notes that in announcing additional funding to address elective surgery waiting lists in January 2008, the Australian Government stated that a payment of $150 million to the states and territories would fund 25,000 operations in the public system. This announcement implies that a procedure in the public system would cost, on average, $6,000.[3]

This analysis of Australian Government funding for public hospital treatment, when compared against earlier AHIA calculations, provides further evidence that the private sector performs hospital procedures at a lower cost than the public sector in most instances.

1.3 The AHIA supports the Commission's proposed use of NHCDC and HCP data to compare hospital and medical costs for clinically similar procedures performed by public and private hospitals.

The AHIA contends that to ensure the most valid comparison of the two sectors, all relevant public administration costs related to public hospital services must be factored into the Commission's calculations.

For example, all costs related to a decision by a centrally-located bureaucrat in (for instance) the NSW Department of Health concerning public hospital purchasing or human relations policies, which is then relayed through the relevant Area Health Service before being enacted by the local hospital, should be considered by the Commission as an expense attributable to the delivery of the public hospital service, and therefore included in the Commission's assessment of the performance of the public sector.

If the Productivity Commission is to ensure a fair and proper comparison of the two sectors, the administration costs, including the administration of taxation receipts which in effect are the equivalent of the "health insurance premium" for public treatment, associated with the public sector should be included, as similar expenditure is used when totalling the final costs of procedures in the private sector.

It is also the AHIA's view that the costs which are to be compared by the Commission should be those costs being incurred presently in the public and private sectors and not a comparison of "world's best practice" in any particular hospital.

1.4 The AHIA has no objection to the disaggregation of hospital costs by jurisdiction, region and peer group as proposed by the Commission.

1.5 The AHIA strongly recommends that the favourable taxation treatment the public sector receives be considered by the Commission in its study.

Fringe Benefits Tax (FBT) and payroll tax considerations allow the public sector to pay higher salaries to employees because of the opportunity to classify public hospitals as public benevolent institutions.

[3] Minister for Health and Ageing, Media Release, 14 January 2008

The FBT-exempt treatment of public hospitals in particular is a major subsidy from the Australian Government (via total wages costs) and must therefore be included in the Commission's calculations. Otherwise, a form of cost shifting from the states to the Commonwealth will be entrenched in the Commission's assessment.

The AHIA notes that FBT-exempt status applies to some specific entities in the private sector, mainly religious and charitable organisations.

1.6 The AHIA encourages the Commission to consider the most appropriate form of inclusion of the cost of capital in its calculations.

A major cost for the private sector in the provision of hospital services is the supply of facilities. For valid comparisons to be made, the cost of all public sector assets, including land; construction costs; the costs of financing any capital investment; depreciation; and Commonwealth grants for the purchase of infrastructure, such as a PET machine for example, need to be included in any evaluation of the public sector's efficiency.

1.7 The AHIA strongly endorses a comparison of the level of hospital-acquired infections in the public and private sectors in the Commission's study.

Having regard to international experience, the AHIA believes the specific infections about which the Productivity Commission should seek appropriate advice for comparison are Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Difficile).

The AHIA believes that the Commission should consider the study of deep-seated orthopaedic hip and knee infections as part of its comparison of hospital-acquired infections. Other suggested areas of study for the Commission include the study of deep-seated infections related to (i) heart valve procedures, (ii) sternal infections post surgery, (iii) vascular grafts, and (iv) Staphylococcus Aureus Bacteraemia. All of these infections can be studied by usage of data which is known and documented. For example, Staphylococcus Aureus can be isolated from an infection, via a wound swab.

It is the strongly held view of the AHIA that it is not coincidental that the lowest rate of MRSA infection in Australia is in Western Australia, which is the only state or territory where notification of MRSA infection is mandatory. This notification occurs after cases of infection are confirmed by laboratory results. It would be efficacious for the Productivity Commission to recommend that notification of all cases of MRSA should be mandated in each jurisdiction.

The AHIA identifies that there is a large amount of work required to collect denominator data in the Australian Council on Healthcare Standards (ACHS) surveys on infection levels, and the complexity of the indicator makes it less comprehensible. The ACHS surveys would be potentially more effective, if simple measures such as bed days or patient discharges were used for the denominators, to compare outcomes for surgery or days during which, for example, Intravenous Lines are inserted.

The AHIA is of the view that, in considering other factors to compare, the Commission should focus on deaths, MRSA infection, unplanned readmission to hospital, unplanned readmissions to Intensive Care, and unplanned readmission to Operating Theatre. In addition, there is an agreed listing of "Quality and Safety" measures which the Australian Commission on Safety and Quality in Health Care has compiled with input from various stakeholders in the sectors, and any of these indicators could also be utilised.

1.8 The AHIA offers no comment on the matters related to workforce characteristics.

2 Multivariate analysis

2.1 The AHIA offers no comment on the matters canvassed on multivariate analysis.

3 Informed financial consent

3.1 The AHIA considers the IPSOS data suitable for the analysis of informed financial consent.

3.2 The AHIA offers no comment on the proposed disaggregation of informed financial consent data by type of provider and region.

3.3 The AHIA offers no comment on the suitability of the out-of-pocket expenses data collected.

3.4 The AHIA encourages the Commission to recommend the mandating of informed financial consent.

Medical organisations often suggest that it is difficult to discuss payment matters with all patients, particularly those who need urgent operative care. The 2006 IPSOS Consumer Survey on Informed Financial Consent found that "Anaesthetists continue to affect the great proportion of patients experiencing a gap", with 29 per cent of patients treated by this specialist group experiencing a gap. This equates to an estimated 270,000 patients who received no Informed Financial Consent from this specialty.[4]

However, the AHIA observes that the Australasian Clinical Indicator Report 2001-2007 published by the Australian Council on Healthcare Standards reports that Anaesthetists were able to record their patients' consent to anaesthesia and their receipt of information on the risks involved at 99.6 per cent and 99.5 per cent respectively.[5]

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[4] IPSOS, 2007, Consumer Survey – Informed Financial Consent, November – December 2006

[5] Australian Council on Healthcare Standards, Australasian Clinical Indicator Report: 2001-2007, Determining the Potential to Improve, 9th Edition

4 Indexation of Medicare Levy Surcharge thresholds

4.1 The AHIA recommends the linking of the Medicare Levy Surcharge thresholds to the Consumer Price Index.

The AHIA notes that the Australian Government has pre-empted the recommendation of the Productivity Commission on the indexation of the Medicare Levy Surcharge thresholds as its *Fairer Private Health Insurance Incentives* legislation, currently before the Parliament, links the proposed tiers to the Average Weekly Ordinary Time Earnings (AWOTE) index.

The AHIA recommends the Consumer Price Index (CPI) be used to adjust the Medicare Levy Surcharge on an annual basis. The use of the CPI would ensure a consistent policy approach to the adjustment of Australian Government health and welfare thresholds and payments, as the CPI is also used to adjust:

- The Medicare Levy Low Income threshold;
- The Medicare Safety Net;
- The PBS Safety Net;
- The Baby Bonus; and
- Family Tax Benefits A and B.

The AHIA notes that in the recent Budget, the Australian Government has proposed that the maximum rates of Family Tax Benefit Part A for children under 16 years be linked to CPI, instead of Male Total Average Weekly Earnings, to ensure that that payment's indexation is consistent with that for other family assistance payments.[6]

[6] Department of Families, Housing, Community Services and Indigenous Affairs, 2009/10 Budget statement, "Reform of family payments – Family Tax Benefit A – Removing the link to pension indexation"

5 Improving the feasibility of future comparisons

5.1 The AHIA recommends the public release of important health information.

The AHIA believes that comparative data on all public and private hospitals should be released to the public on an individual provider comparison basis. The information on all matters currently being considered by the Commission should be readily accessible to members of the public.

The AHIA recommends that all comparisons between public and private should be risk-adjusted. Credible examples where this occurs abound, and such risk-adjustment will prevent claims that any provider does “only” the most “difficult cases”. This change will address the problem of providers obfuscating and the strengths are that it compares like with like.