AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Submission to the Productivity Commission Issues Paper: *Performance of Public and Private Hospital Systems*

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Overview: Performance of Public and Private Hospitals

- ✓ **There are significant gaps in our ability to measure safety and quality in hospitals.**
- ✓ **Comparisons should incorporate some risk adjustment, at least by peer hospital classification and preferably by patient population characteristics.**
- ✓ **Rates of healthcare associated infection should be routinely monitored by all hospitals, and may need risk-adjustment to meaningfully compare public and private hospitals.**
- ✓ **The public and private hospital sectors, as noted in the Issues Paper, are complementary in nature. A comparison of cost of treatments in public and private hospitals should take into account non-clinical outputs such as teaching and training.**

This submission recommends that the Productivity Commission consider:

- **the eventual incorporation of private hospitals in national health care reporting, such as those currently managed through National Health Information Agreements;**
- **the development of national hospital peer groupings which include and classify private hospitals;**
- **the national development of standard measures of safety and quality which are applied across all Australian hospitals; and**
- **the promotion of routine review of safety and quality indicators by all hospitals in Australia.**

Submission

Introduction

The Australian Commission on Safety and Quality in Health Care is pleased to respond to the Productivity Commission's Issues Paper regarding the Performance of Public and Private Hospital Systems.

The Commission was established to lead and coordinate national improvements in safety and quality in health care. Further information about the role of the Commission is outlined in Appendix A, and the Australian Charter of Healthcare Rights is also appended (Appendix B)

This response has been written with reference to the five areas outlined in the Terms of Reference (p. III-IV).

- Issue A – Comparative hospital and medical costs
- Issue B – Hospital-acquired infections
- Issue C – Financial consent
- Issue D – Other relevant performance indicators
- Issue E – Future comparisons, including data and measurement issues this exercise has highlighted

Issues in comparing public and private hospital systems

Issue A – Comparative hospital and medical costs

a) Comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals, using baseline data to be provided by states and territories under the new National Healthcare Agreement, and existing data provided to the Government by private hospitals. The analysis is to take into account the costs of capital, FBT exemptions and other relevant factors.

In terms of procedure cost components, we are not in a position to discuss cost of capital[1] and FBT exemptions. However, a focus on cost efficiency alone is problematic when considering issues of safety and quality. Efficiency is but one dimension of quality; others include appropriateness, effectiveness, acceptability, access and safety.

It is the view of the Commission that the calculation of costs and hence efficiency for comparable procedures must account for procedural or institutional safety and quality. We note that there are no nationally agreed methods for accounting for procedural or institutional safety and quality in Australian hospitals.

In order for cost comparisons to be meaningful, they should account for the relative risk and burden of patients co-morbidities. Risk adjustment accounts for the differences in risk factors among groups of patient when examining outcomes[2]. Examples of such risk factors are obesity, lung and heart diseases, diabetes and renal impairment, age and fitness.

The narrow definition of performance as given in the Issues Paper revolves around productive efficiency (p.7) - measuring output against costs. Using output to measure performance does not adequately address safety and quality of care.

The Issues Paper also notes that Australia's public and private hospital systems serve somewhat different and complementary purposes (p.3), and that emergency departments are concentrated in the public sector, while "private hospitals specialise more in planned procedures". It is important to determine:

- whether additional resources are required to perform procedures on the uninsured, among whom a range of risk factors are over-represented in comparison with the insured patients[3]. 15 of the 20 selected separations suggested for comparison exclude complications, or exclude severe or catastrophic complications, and this risks underestimating the true cost of providing these types of care.
- the significance of non-clinical outputs which can include teaching and training, research, and even health prevention activities.

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[1] Except to note that, should the Productivity Commission have any success in identifying capital costs for public hospitals, the fraction of that capital cost attributable to research, teaching and training, as well as other outputs, needs to be accounted for in any comparison.

[2] Roberts CS et al, Adjustments within Economic Evaluation, from Pizzi, LT, Lofland JH, *Economic evaluation in health care: principles and applications*, Sudbury MA: Jones and Bartlett Publishers, 2006, p.87

[3] See Banks E, et al, Health, ageing and private health insurance: baseline results from the 45 and Up Study cohort, ANZJ Health Policy 2009, 6:16

Issue B – Hospital-acquired infections

b) the rate of hospital-acquired infections, by type, reported by public and private hospitals, using baseline data to be provided by states and territories under the new National Healthcare Agreement, and existing data provided to the Government by private hospitals.

The Australian Commission on Safety and Quality in Health Care wholly endorses the need to ensure measurement of healthcare associated infections (HAIs) across the system. This need was formalised in the Australian Health Ministers' Conference (AHMC) decision of December 2008, which made mandatory the national surveillance of healthcare associated infection for public hospitals, with monitoring and reporting of healthcare-associated *Staphylococcus aureus bacteraemia* and *Clostridium difficile* to jurisdictions nationally.

Meaningful comparison of rates of HAIs will be difficult, and needs to test whether there are fundamental differences between the public and private hospital casemix. Some approaches to controlling for the differences between hospitals are outlined on p.25 of the Issues Paper, and the difficulties in comparing public and private hospital procedures outlined under the Commission's response to Issue A also apply here.

Notwithstanding, HAI rates are a fundamental and unequivocal measure of safety and quality in health care, and the goal will always be to reduce HAI rates, preferably to zero. The concept of risk adjustment, however, should be noted. A range of risk adjustment tools to enable meaningful comparison of HAI rates exist. For example, the National Health Safety Network in the USA risk adjusts surgical site infection (SSI) against the following parameters:

- length of surgery;
- ASA (American Society of Anesthesiology) score; and
- Wound classification for degree of contamination of the surgical procedure.

Such risk adjustment techniques require large datasets that are not available nationally. The simplest risk adjustment is to compare rates within peer hospital groups. However, even this risk adjustment is not currently possible, as the national peer classification does not include private hospitals (see our Recommendations, Section E).

Issue C – Financial consent

c) rates of fully informed financial consent for privately insured patients treated as private patients in both public and private hospitals, categorised by type of provider (that is, public hospital, private hospital, medical practitioner [by Speciality]), and by Statistical Local Area (SLA) or equivalent, including:

> *c (i) the average cost of out of pocket expenses for patients who do not receive enough financial information from the provider to give fully informed financial consent, the range of these costs and the maximum out of pocket cost incurred by in-hospital patients categorised by type of provider (as detailed above).*
>
> *c (ii) best practice examples where fully informed financial consent is provided for every procedure, (with a specific emphasis on any best practice examples occurring in specialties where lack of fully informed financial consent is most common).*

The Australian Commission on Safety and Quality in Health Care is not in a position to analyse the extent and impact of inadequate financial information and consent. However, the Australian Charter of Health Care Rights (see Appendix B) includes the *Right to Communication* – patients have a right to be informed about services, treatment, options and costs in a clear and open way.

The Commission supports using best practice models in this area. It is essential that all known out-of-pocket costs are stated or estimated as part of the consent process.

Out-of-pocket costs for private hospital patients can include components of:

- surgical assistant fees;
- anaesthetist fees; and
- some medications

Typically, such costs are absorbed in the DRG/casemix cost modelling for public hospitals. Any cost comparison between public and private hospitals needs to account for out-of-pocket costs.

Issue D – Other relevant performance indicators

d) other relevant performance indicators, including the ability of such indicators to inform comparisons of hospital performance and efficiency.

What, if any, views do you have on the suitability of the Commission's other proposed indicators for comparing public and private hospitals? Where you identify potential weaknesses, please provide supporting evidence if possible, and suggest alternative approaches. Are there any data sources that might assist with reporting these indicators?

Currently, hospital-level data for safety and quality measures in public and private hospitals are not routinely reported nationally.

Examples of measures of safety and quality for comparison of public and private hospitals include mortality ratios, readmission rates, and patient experience.

Hospital Standardised Mortality Ratios (HSMRs)

The Productivity Commission Issues Paper refers to patient outcome measures, such as mortality rates (p.6). There is a considerable body of work nationally and internationally on the use of Hospital Standardised Mortality Ratios (HSMRs) to detect and track variations in hospital mortality. One advantage of the use of HSMRs in the comparison of hospitals is their relatively sophisticated risk-adjustment.

A recent Australian study[4] generated HSMRs for de-identified Australian public hospitals. Further work is planned by Australian Commission on Safety and Quality in Health Care and partners to test the consistency of HSMR generation between different jurisdictional coding and reporting conventions[5].

The national Measuring Mortality Technical Working Group has identified the need to test whether estimation of 30-day mortality through linkage of admitted patient and mortality data may be more meaningful than in-hospital mortality ratios.

Readmission rates

Similarly, analyses using linked admitted patient data are likely to be important for comparisons of admission and readmission patterns between hospitals. Simple readmission (to the same hospital) within 28 days for selected surgical procedures is one of the National Health Care Agreement performance indicators. However, it is important to test whether patients discharged post-procedure, who experience complications, are more likely to be admitted through another hospital emergency department, and whether that sub-population is significant.

[4] See Ben-Tovim D, Woodman R, Harrison JE, Pointer S, Hakendorf P & Henley G 2009. *Measuring and reporting mortality in hospital patients*. Cat. no. HSE 69. Canberra: AIHW.
[5] These analyses are limited to jurisdictional data from public hospitals.

Population-based linked admitted patient and mortality data are now routinely available in Western Australia[6] and New South Wales[7], and the Productivity Commission could consider comparing indicators of mortality and readmission using linked and unlinked data for these two jurisdictions.

Patient experience

The Issues Paper refers to measures of responsiveness, including patient satisfaction. The Australian Commission on Safety and Quality strongly supports inclusion of such indicators, particularly patient satisfaction and patient-reported outcomes. There is a range of jurisdictional and hospital-level surveys in place. Other examples include the Commonwealth Fund triennial international comparisons, and an impending ABS national survey[8].

Current ACSQHC activity in this area

The Australian Commission on Safety and Quality in Health Care is preparing recommendations to Australian Health Ministers' Advisory Council (AHMAC) on a suite of safety and quality indicators, which are intended to be useful for public and for private hospitals. These are intended to build upon and complement the National Healthcare Agreement (NHCA) performance indicators, announced as part of the National Healthcare Agreements[9]. The NHCA Performance Indicators are likely to be presented as aggregated jurisdictional rates, where data are available, and private hospital reporting is not part of these Agreements.

At the time of writing, the Australian Commission on Safety and Quality in Health Care recommendations to Health Ministers on a *National indicators of safety and quality* are not finalised. However, the following are receiving strong consideration for eventual recommendation by the Commission for the measurement of quality and safety, and monitoring for significant variation:

- That larger hospitals routinely generate and review their HSMRs[10] internally and against peers;
- That death in low mortality DRGs, and other disease-specific, in-hospital mortality rates are routinely generated and reviewed by hospitals;
- That true unplanned readmission rates (readmission to discharging hospital *and* data-linked readmission to *any* hospital within 28 days of discharge) be routinely reviewed and monitored by all hospitals;
- That specialised services (for example, cancer, cardiac, orthopaedic, stroke) *submit* data to clinical quality registries and routinely review their performance, outcomes and patterns of care.

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[6] The WA data linkage program is run out of the WA Department of Health, see http://www.datalinkage-wa.org/ tel (08) 9222 2413.
[7] NSW Centre for Health Record Linkage (CHeReL), http://www.cherel.org.au/, tel (02) 8374 3515
[8] The Australian Bureau of Statistics has been commissioned by the Australian Government to conduct a national survey of patient experience, to support the COAG/NHCA Performance Indicator 58 *Nationally comparative information that indicates levels of patient satisfaction around key aspects of the care they received.*
[9] See *Intergovernmental Agreement (IGA) on Federal Financial Relations*, Schedule F National Healthcare Agreement, at http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm
[10] The Ben-Tovim paper (op cit) notes that HSMRs are not applicable to smaller hospitals.

It is not yet possible to set evidence-based or even expert consensus benchmarks or standards for many of these measures. However, the literature suggests that routine review by providers of a "reliable flow of useful information"[11] in itself will support quality improvement.

In summary, the Commission recommends that all hospitals routinely review a suite of indicators of safety and quality, and that a core set of these should be common across public and private hospitals, and risk adjusted where appropriate. There are serious gaps in the ability of current data streams to support such reporting.

[11] See, for example, Baker, GR, *High Performing Healthcare Systems*, 2008, Longwoods Toronto, p.17.

Issue E – Future comparisons

e) If any of the foregoing tasks prove not fully possible because of conceptual problems and data limitations, the Commission should propose any developments that would improve the feasibility of future comparisons.

Gaps in current safety and quality reporting processes in Australian health care include:

- National and state reporting processes currently have very few elements of clinical quality – they focus on access, throughput, cost, service volumes and descriptives, population health, payments;
- There has been little evidence to date of measurable safety benefit from the rollout of incident reporting systems across most Australian hospitals, and aggregated reporting from these systems is poorly understood;
- Patient experience is not routinely and separately measured as part of national reporting;
- The focus on jurisdictional reporting under AHMAC, NHCA and COAG obscures significant variation at facility level by over-aggregating, and promotes the development of inconsistent reporting standards and methods;
- Safety and quality data for outpatient hospital care are exceptionally scant;
- The absence of integration of the E-Health/clinical information (primary purpose) and reporting information (secondary use) domains.

Patient experience and patient-reported outcomes are already strong themes of discussion at NHISSC[12] level and the NHHRC[13] recommendations. The COAG Special Purpose Payment reporting requirements, together with the National Health Care Agreements Performance Indicators, flag a stronger commitment to accountability and transparency.

This submission recommends that the Productivity Commission consider:

- the eventual incorporation of private hospitals in national health care reporting, such as those currently managed through National Health Information Agreements;
- the development of national hospital peer groupings which include and classify private hospitals[14];
- the national development of standard measures of safety and quality which are applied across all Australian hospitals; and
- the promotion of routine review of safety and quality indicators by all hospitals in Australia.

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[12] NHISSC – National Health Information Statistics and Standards Committee

[13] NHHRC – National Health and Hospitals Reform Commission

[14] The Productivity Commission poses a question on page 15 of the Issues Paper, *What views do you have regarding the…. proposed disaggregations….?* The classification proposed by the Productivity Commission is a modification of that developed by the AIHW, but is based solely on separation volume. It does not take into account geographical location, or the roles and functions of tertiary and quaternary hospitals.

Appendix A

The Australian Commission on Safety and Quality in Health Care was established in 2006 to lead and coordinate national improvements in safety and quality. Health Ministers established the Commission to:

- Lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, recommending priorities for action, disseminating knowledge, and advocating for safety and quality;
- Report publicly on the state of safety and quality, including performance against national standards;
- Recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, collection and reporting;
- Provide strategic advice to Health Ministers on 'best practice' thinking to drive quality improvement, including implementation strategies; and
- Recommend nationally agreed standards for safety and quality improvement.

The focus of Commission work is on priorities for the health system where current and complex problems and community concerns could benefit from national consideration and action. The work of the Commission has been underpinned by the right of patients and consumers to safe and high quality care, and the development of an Australian Charter of Healthcare Rights has been a fundamental part of the Commission's work.

Commission programs include:

- Implementation of the national standard for open disclosure of adverse events.
- Prevention of healthcare associated infection, which includes work on:
  - hand hygiene
  - surveillance of healthcare associated infection
  - building clinician capacity
  - revision of national infection control guidelines
  - antibiotic stewardship.
- Development of strategies to reduce patient identification errors.
- Creation of an evidence base and tools to reduce the risks associated with clinical handover.
- Implementation of a standardised medication chart and other strategies to improve the safety and quality of medicines.
- National review of safety and quality accreditation and recommendations for reform, which includes work on:
  - development and reporting of performance against Australian Health Standards

  - establishing a national quality improvement framework that addresses systems issues such as clinical governance
  - creating a mechanism for mandating an expanded coverage of accreditation of health services
  - piloting innovative accreditation methodologies
  - harmonising safety and quality reporting across the public and private sectors.
- In partnership with AIHW, developing key high level safety and quality indicators across the continuum of care including primary care.
- Developing and validating national operating principles and technical standards for clinical quality registries.
- Review and updating of national falls guidelines.
- Conducting national work to improve the identification and management of patients at risk of critical illness and serious adverse events.
- Credentialling.

The Commission is not a service provider. Its role entails influencing the system and stakeholders to make the recommended changes for the safety and quality of health care in Australia to improve. The Commission has four key standing committees, which cover the public health sector, the private hospitals and private health insurers, primary care and information strategy. These committees give the Commission's work breadth, depth and expertise and enable insight into and influence across the whole health system.

The span of interests of safety and quality stakeholders is broad and includes consumers, private and public hospital sectors, primary care, accreditation organisations, academics, industry such as health insurers, information technology providers, clinical practitioners, professional organisations and education bodies, governments and policy makers. Therefore, the Commission is uniquely placed to influence change as an "honest broker" and to assist in achieving safety and quality objectives.

Appendix B

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit www.safetyandquality.gov.au

AUSTRALIANCOMMISSIONon SAFETYandQUALITYinHEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.