Queensland
Government

Queensland **Health**

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Mr David Kalisch
Commissioner
Hospital Performance Study
Productivity Commission
LB2 Collins Street East
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Dear Mr Kalisch

Queensland Health is pleased to provide this submission to the Productivity Commission in response to the commissioned study *Performance of Public and Private Hospital Systems* and welcomes the opportunity to comment on a number of important issues relevant to making comparisons across the public and private health sectors.

In general terms, Queensland Health considers the provision of public and private health care to be predominantly complementary rather than competitive. Therefore any comparative analysis will need to carefully address the complexities of the environment in which health care takes place across the public and private systems.

The following comments are provided to specifically address a range of issues raised in the Commission's issues paper:

Measuring and comparing costs of public and private hospitals

Measuring and comparing costs of public and private hospitals is difficult for a number of reasons. A number of these are referred to in the issues paper.
For instance, to some extent public and private hospitals specialise in the provision of different services. Public hospitals provide roughly 95% of outpatient occasions of service. Private hospitals also tend to specialise more in planned procedures than public hospitals, with implications for the management of patient flows.

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A large proportion of acute hospitals are relatively small, and hence not able to take advantage of economies of scale. This is particularly the case in the public sector which is required to provide services to all geographic locations, and in a decentralised State such as Queensland. For instance, the Report on Government Services (ROGS) for 2009 reports that in 2006-2007, Queensland had 74 hospitals with 10 or fewer beds, and a further 66 with more than 10 to 50 beds. Larger public hospitals are also required to maintain a capability for major trauma events that is rarely used to capacity.

The approach to comparing costs proposed in the issues paper is to report comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals. In particular, it proposes to compare the average cost per separation for particular Diagnosis Related Groups (DRGs), and the average cost per casemix-adjusted separation.

While this will address some of the difficulties in comparing like with like, it will not address all of them. For instance, there can be significant differences in the types of cases treated at different hospitals, even within DRGs. In particular, for high acuity DRGs the most complex cases are typically not undertaken in medium sized regional hospitals or private hospitals but are referred to the major (generally public) tertiary hospitals in large metropolitan centres. As such, the major tertiary hospitals will on average treat higher complexity (and hence higher cost) cases within any given DRG than regional hospitals or private hospitals. The proposed comparisons will also not fully address the issues outlined above, for example the greater incidence of planned procedures in private hospitals and diseconomies of scale in small regional hospitals.

Moreover, it is important to note that public and private hospitals are inter-dependent parts of the overall hospital system. While many private hospitals do undertake a training role, the primary responsibility for clinical education and training lies with the public hospital system, particularly the major tertiary hospitals. This role would need to be taken into account in any cost comparisons. In addition, as the issues paper notes, a significant number of private patients are treated in public hospitals, and a smaller number of public patients are treated in private hospitals. Many clinicians also work across both the public and private sectors through right of private practice and other arrangements.

As noted, costs are currently not reported on a consistent basis between jurisdictions, or between public and private hospitals within jurisdictions. For instance, the issues paper notes that private hospital data in the National Hospital Cost Data Collection (NHCDC) is not available for all years, and even where it is available it excludes a large proportion of medical and pharmaceutical expenditure. It is not clear how comparable it will be to supplement the NHCDC data with Hospital Casemix Protocol (HCP) data which are collected for a different purpose. As noted by the Commission, the lack of comparable cost data will be a major challenge for the study.

Queensland Health notes that comparisons between the public and private hospital systems will only contribute to improved transparency, accountability and performance if the fundamental differences between the two systems are acknowledged and taken into account.
For example:

- Mix of planned and unplanned services: with private hospitals providing mostly planned procedures, and public hospitals responsible for unplanned (emergency) services
- Size of individual facilities: with the public system required to provide services in smaller regions, which cannot achieve the same economies of scale as larger facilities
- Acuity level: with major public hospitals typically undertaking more complex procedures
- Training obligation: with the public system holding primary responsibility for clinical training.

Quality indicators

Nationally consistent data on hospital acquired-infections and the other indicators suggested in the issues paper are not yet available. While some data from the Australian Council on Healthcare Standards (ACHS) are currently included in the ROGS those data have serious limitations with respect to scope, coverage, sample sizes, collection and validation methods. The indicators are designed for internal clinical review by individual hospitals, and are not suitable for use in inter-hospital or inter-jurisdictional comparisons. This is acknowledged in the ROGS, where presentation is jurisdiction by jurisdiction, and there are detailed caveats attached to each of the ACHS indicators published.

The Health Working Group has agreed to consider alternative indicators and/or data sources to replace the indicators in the ROGS that are currently derived from ACHS data. Possible alternatives to be considered include the recommendations on the suite of safety and quality indicators, developed by the Australian Institute of Health and Welfare (AIHW), which the Australian Commission on Safety and Quality in Healthcare will make to AHMAC in the second half of 2009, and the indicators that are being developed for National Healthcare Agreement (NHA) reporting. The National Hospital Morbidity Database may be enhanced to become a future source of data for some of the NHA indicators, but it is not currently an appropriate source for the indicators suggested in the issues paper.

With specific reference to the 'rate of hospital acquired infections' as a (partial) indicator of performance, Queensland public and private hospitals are currently required to submit healthcare associated infection (HAI) data to a number of bodies including:

1. Health Quality and Complaints Commission (HQCC) - public and private hospitals make mandatory submission of the number of surgical site infections and *Staphylococcus aureus* bacteraemias (SAB). The HQCC will be required to liaise with Queensland Health if data is to be released to the Productivity Commission.
2. Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP), Queensland Health - Collates reporting by 24 public hospitals on a voluntary basis of surgical site infection for 16 indicator procedures, healthcare associated bloodstream infection (bacteraemias) including SAB, significant organism (e.g. MRSA), occupational exposure (e.g. needlestick injuries), and hand hygiene compliance data.
3. Australian Commission on Safety and Quality in Health Care (ACSQHC) via Hand Hygiene Australia - Public and private hospitals provide data on a voluntary basis for healthcare worker (HCW) hand hygiene compliance and SAB data.
4. Australian Council on Healthcare Standards (ACHS) - Public and private hospitals make voluntary submission of data for 47 infection control indicators (including staff exposures to blood and body fluids).

Reporting will be required under the National Healthcare Agreement for SAB. In addition, reporting may also be required by the Australian Health Ministers' Conference for SAB and *Clostridium difficile.*

Difficulties to be addressed in reporting 'rate of hospital acquired infections' data include, but are not limited to, differing data definitions currently used by collection bodies, variation in the surveillance methodology used by public and private hospitals, and data being retrospective of varying time periods.

Informed financial consent

Queensland Health provides health care services in accordance with the Medicare Principles outlined in the National Healthcare Agreement to enable eligible persons to be given the choice to receive health and emergency services free of charge as a public patient.

Where a patient elects to be treated as a private patient and is to be responsible for paying fees for the services provided to them, Queensland Health staff are required to make the patient aware of the financial consequences of their choice. This is outlined in the Queensland Health guidelines *Private Patient Services: Medicare and Healthcare Agreement requirements (April 2009).*

An election by an eligible patient to receive admitted services as a private patient is required in writing at the time of, or as soon as practicable after the patient's admission.

Private non-admitted patients do not have to make a written election, however the patient must choose to be treated as a private patient. Private non-admitted patients are seen in Queensland Health facilities for specialist medical outpatient services and diagnostic services where the patient holds a valid referral to a named public hospital medical specialist who is exercising a right of private practice; and for urgent care where patients may have presented at an emergency department but are offered alternative service provision options to ensure faster access to an appropriate level of ambulatory care.

Medicare Levy Surcharge thresholds

When considering indexation arrangements for the Medicare Levy Surcharge thresholds, one relevant issue relates to the impacts on private hospital insurance coverage and demand for public hospital services.

When the Commonwealth announced significant changes to the Medicare Levy Surcharge thresholds in the 2008-2009 Budget, the then Queensland Minister for Health noted in his capacity as Chair of AHMAC that if the changes led to additional financial pressures on the States in terms of their health budgets, the States would seek to negotiate additional healthcare funding from the Commonwealth based on the costs of increasing demand in the public hospital system.

These considerations also apply to the more recent changes to the Medicare Levy Surcharge thresholds and private health insurance rebate announced in the 2009-2010 Federal Budget, and to any future decisions made in relation to indexation of thresholds. Queensland Health will continue to monitor the impact of such policy changes on the public hospital system.

Queensland Health looks forward to the release of the Commission's draft report in September and participating in the next roundtable in October 2009.

Should you require further information, Queensland Health's contact is Mr Paul McGuire, Senior Director Funding and Resourcing Branch, on telephone (07) 3234 0868.

Yours sincerely

Michael Reid
Director-General

IN CONFIDENCE

Australian Health Ministers' Advisory Council considerations

It is understood the Chair of the National E-Health Information Principal Committee Australian Health Ministers' Advisory Council (AHMAC) has written to you in relation to data confidentiality issues and conditions surrounding the release of jurisdictional data. It is expected these issues will be subject to considerations by AHMAC and they are not considered in this submission.

Asset values for public hospitals

The issues paper notes that the Commission intends to source asset values for public hospitals from the States and Territories.

In general, it would appear that the asset data required for the study as outlined in the issues paper is collected by Queensland Health. It should be noted that manual manipulation of the data may be required to generate asset data by facility.

Any such data provided by Queensland health would also be subject to the same confidentiality issues and conditions surrounding the release of jurisdictional data currently held by AIHW. As noted above, these issues are being considered by AHMAC. Discussions would also need to take place between Queensland Health's Finance Branch and the Productivity Commission regarding exactly what data is required and ensuring that manageable timeframes can be achieved.